

**NURSES' DESCRIPTIONS OF THE EXPERIENCE OF
CARING FOR CULTURALLY DIVERSE CLIENTS**

by

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ABSTRACT

Over the last few decades, Canada has become a culturally diverse society. It is now commonplace for nurses to care for clients from cultures different from their own. Caring for culturally diverse clients present unique challenges to nurses. These clients often do not speak English and come to the hospital setting with varying health beliefs and customs. Furthermore, the challenge of caring for culturally diverse clients may uncover feelings in nurses about various ethnic groups. While there is an encouraging trend to include cultural content in nursing curricula, the effectiveness of nursing programs in preparing nurses to care for culturally diverse clients is not known. Additionally, there is evidence to suggest that culturally diverse clients may receive a lower standard of nursing care that might be explained by factors such as the nurse's knowledge, previous contact with ethnic minorities, attitudes, education, support, and the hospital setting. Few studies about nurses' experiences of caring for culturally diverse clients have been found.

The purpose of this study was to explore the descriptions of recently graduated nurses of their experiences of caring for culturally diverse clients and to thereby gain an understanding of both the nature of the experience and any factors influencing the experience. A descriptive-exploratory design in the qualitative (naturalistic) tradition was selected to address the Level 1 question. The design took some direction from the phenomenological objective about understanding lived experience, but broadened that perspective to focus upon the shared elements within the specific experience of caring for culturally diverse clients. Eight recently graduated nurses

were each interviewed twice. Data analysis proceeded simultaneously with the interviews through a process of constant comparative analysis. The conceptual structure that emerged from the thematic analysis was validated with the participants during the second interviews.

The findings of the study revealed the experience of caring for culturally diverse clients as one of considerable complexity and persistent challenge. On the basis of the participants' varied descriptions, the nurses were conceptualized on a continuum of commitment to cross-cultural nursing, ranging from being resistant to being competent to being impassioned. While the nurses demonstrated a propensity to practice from a particular position on the continuum, their level of commitment at any given point might be influenced by personal or contextual factors that moved them toward either end of the continuum. Notably, the impassioned nurses all described an experience of awakening to the complex imperative of cross-cultural nursing that came out of specific situations in which they were sensitized to the minority experience.

In order to provide culturally sensitive care, the participants implemented creative and flexible efforts in connecting with the client, working with the family, accommodating for cultural practices, and balancing expectations. The nature of the experience for the nurse and the quality of care provided to culturally diverse clients was also influenced by certain contextual factors, or catalysts, beyond the control of the nurse. The catalysts identified were the setting of health care, the support of colleagues, the commitment of the institution, and the foundation of education. Most significantly, the study uncovered the presence of racism in health care settings. The

most obvious examples of racism came in the descriptions by the participants of the resistant nurses who were not represented in the sample. Other examples included inequities at the institutional level. In light of these findings, implications for education, administration, practice, research, and public policy were identified.

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CHAPTER ONE: INTRODUCTION

Background to the Problem

Over the last few decades, Canada has become a culturally diverse society. It is now commonplace for nurses to care for clients from cultures different from their own. Caring for culturally diverse clients presents unique challenges to nurses. These clients often do not speak English and come to the hospital setting with varying health beliefs and customs. Furthermore, the challenge of caring for culturally diverse clients may uncover feelings in nurses about various ethnic groups. While there is an encouraging trend to include cultural content in nursing curricula, the effectiveness of nursing programs in preparing nurses to care for culturally diverse clients is not known. Few studies about nurses' experiences of caring for culturally diverse clients have been found. A descriptive-exploratory study was proposed to address the research question: How do nurses describe the experience of caring for culturally diverse clients?

Because few researchers have addressed the question under investigation, it is important to explore the background that leads to it and, in the process, establish its significance. The composition of Canadian society, government policies, and the emerging evidence of a lower quality of care for culturally diverse clients are examined. Possible factors affecting nursing care are presented and the response of the nursing profession is discussed, from the perspectives of nursing theory and research, governance, and education.

Canadian Context

Canadian society is becoming increasingly diverse in its cultural composition. In the 1986 census, 37.5% of the population reported ethnic origin other than British or French (Tournishey, 1991). A steady increase in minority groups leads to the projection that they will represent 46% of the population by the turn of the century (Tournishey). Moreover, the mix of new immigrants to Canada has changed dramatically over the past decade. While earlier immigrants came primarily from Europe, by the late 1980's, 70 % came from non-European origins such as South and Southeast Asia, Central and South America, Africa, and China (Masi, Mensah, & McLeod, 1993, p.4).

In response to Canada's pluralistic society, the government has enacted several policies. Through the *Multiculturalism Act (1988)* and the *Charter of Human Rights and Freedoms (1984)*, the federal government has established the expectation that the cultural contexts that determine and direct the ways of Canadians are to be respected and taken into account by those providing services. The federal health policies as outlined in the *Canada Health Act (1984)* and in *Achieving Health for All: A Framework for Health Promotion (1986)* clearly state that all Canadians have the right to health care that is equitable, accessible, comprehensive, culturally sensitive, and appropriate (Tournishey, 1991). In British Columbia, the Seaton report (1991) calls for a commitment to universal health care that pays attention to cultural and linguistic factors. In keeping with official government policies, the Canadian Council of Multicultural Health has been established to work for the incorporation of multiculturalism at all levels of health systems and services. In summary, the

changing Canadian societal and health care contexts point to the importance of providing culturally sensitive care to culturally diverse clients.

Quality of Care

The official Canadian policies outlined in the preceding section are important in influencing attitudes and generating changes whereby all cultural groups have equal access to the services of Canadian health care. The ideal represented by these policies, however, has not yet been fully recognized (Masi, Mensah, & McLeod, 1993; Saldov & Chow, 1992).

Several authors suggest that culturally diverse clients in health care settings may be treated in different and potentially harmful ways (Andrews, 1992; Beaupre, 1993; Bonaparte, 1979; Jones & Van Amelsvoort Jones, 1986; Lea, 1994; Murphy & Clark, 1993; Rootman, 1988; Saldov & Chow, 1992; Seaton, 1991; Windsor-Richards & Gillies, 1988; Wollett & Dosanjh-Matwala, 1990). For example, researchers studying communication patterns between nursing staff and the ethnic elderly in a long-term care facility found that female ethnic residents were spoken to less than any other residents (Jones & Van Amelsvoort Jones, 1986). In another study regarding the ethnic aged, Saldov and Chow (1992) found that the majority of the participants were unable to obtain the care needed to meet their daily living requirements due to a lack of professional interpreter services. Furthermore, derogatory attitudes toward and stereotyping of Asian clients by health care workers were reported in a study completed in England (cited in Murphy & Clark, 1993). In a study exploring refugee claimants' experiences accessing health care in British Columbia, Beaupre (1993) found that difficulties were encountered in response to

social, political, and economic factors. Situations perceived by participants as discriminatory, that occurred in a number of different settings, resulted in the participants feeling inferior and marginalized. In two studies examining the relationships between midwives and British Asian women, strained relationships were reported as a result of language barriers and cultural differences (Windsor-Richards & Gillies, 1988; Wollett & Dosanjh-Matwala, 1990).

The Seaton report (1991) states that many culturally diverse people are not using existing services because those services are not culturally responsive or accessible to them. To illustrate, the health status of Native Indians points to a lower standard of care; the average life expectancy for both males and females is ten years less than in the national population (Rootman, 1988). Rootman also states that, while there is a virtual absence of data on the health of other ethnic groups in Canada, there are indications that our health and social services have not adequately responded to the needs of such groups. The possibility of a lower standard of care for culturally diverse clients is a serious matter that requires the attention of the health care community.

Factors Influencing Nursing Care

The care of culturally diverse clients presents unique challenges to nurses. A small number of studies have addressed factors that might have an impact on the nurse's ability to care for these clients. These factors relate to the nurse's knowledge about and attitudes toward culturally diverse clients. For example, Frenkel, Gredin, Robinson, Guyden, and Miller (1980) conclude that direct nurse-client contact affected racial perceptions in a negative direction. The personality traits of closed

mindedness, ego defensiveness, and intolerance of ambiguity have also been linked to negative attitudes (Bonaparte, 1979; Ruiz, 1981). Bernal and Froman (1987) found that community health nurses, regardless of their age, years of practice, specialty or educational preparation, shared a lack of confidence in cross-cultural nursing. In contrast, two studies exploring the relationship between knowledge and attitudes of nurses toward culturally different clients identified education as an important factor (Felder, 1990; Rooda, 1993). Thus, while several factors have been implicated in influencing nurses, a consistent pattern has not yet emerged from the research findings.

Non-research literature identifies a nurse's attitude as critical in influencing care; ethnocentrism and racism result in discriminatory nursing practices (Eliaison, 1993; Fong, 1985; Francis, 1993; Louie, 1985a; Thiederman, 1986; Tullmann, 1992; West, 1993). On the other hand, in an effort to meet an egalitarian ideal (i.e., the ideal that everyone should be treated in the same way), nurses may unintentionally, but profoundly, limit their acknowledgment of the central role of culture in the experience of health and illness, thus undermining the delivery of health care in transcultural situations (Majumdar & Hezekiah, 1990).

Other writers explain the importance of role-modeling and support from colleagues and administration in encouraging culturally sensitive nursing care (Bernal, 1993; Stern, 1985; Tullmann, 1992). In considering the influence of the health care system, Grypma points out that the Canadian health care system was established before the increase in non-European immigrants and without input from native groups. As a result, "the values of many nurses still reflect those of the dominant

culture, often to the exclusion of other cultures" (Grypma, 1993, p.33). Furthermore, the structured, impersonal hospital setting is seen as a natural deterrent to culturally sensitive care (Chrisman, 1982; Hartog & Hartog, 1983; Kavanagh & Kennedy, 1992; Kleinman, 1989). Chrisman (1982, p.122) posits that nurses working in medical-surgical settings are likely to place their focus upon medical characteristics of their clients and usually consider sociocultural factors only insofar as they directly influence adaptation to hospital life. Yet, it should be noted that more hospitals across Canada are developing multicultural programs in an effort to provide culturally sensitive care. Examples of such programs include those at Mount St. Joseph Hospital in Vancouver and Montreal Children's Hospital in Montreal.

In summary, both research and non-research literature consider various influences on the provision of care to culturally diverse clients by nurses. As Mensah (1989) observes, however, "further analysis is needed regarding the constraints faced by nurses who experience obstacles in carrying out care which addresses the cultural aspects of the individual and family" (p. 50).

The Response of Nursing Theorists and Researchers

In response to an increasingly culturally diverse society and the imperative of caring for culturally diverse clients, the body of nursing theory related to cross-cultural issues is growing significantly (Anderson, 1987, 1990; Andrews, 1992; Germain, 1992; Leininger, 1978, 1984, 1994; Lynam, 1992; Rosenbaum, 1991; Tournishey, 1991; Wilkins, 1993). Although the knowledge base of transcultural nursing was derived from the parent discipline of anthropology, new ideas have been developed and other content transformed to make it unique to nursing (Leininger,

1984). Nurse scholars such as Leininger and Anderson have developed theories and models to guide nursing care, based on the inextricable link between caring and culture.

Nursing research to date has focused on describing the cultural beliefs and health and illness experiences of various ethnic groups (Anderson & Lynam, 1987; Aroian, 1990; Stevens, Hall, & Meleis, 1992; Tripp-Reimer, 1983; Yoshida & Davies, 1982). Most transcultural nursing textbooks follow this pattern of describing various ethnic groups (e.g., Giger & Davidhizar, 1991; Waxler-Morrison, Anderson, & Richardson, 1990).

Tension exists as to the merit of a specific focus on transcultural nursing. There is a fear that transcultural nursing theory may reinforce the very problems of paternalism and ethnocentric care it seeks to address (Wilkins, 1993). For example, there is a tendency to focus on a client's culture as the problem, rather than seeing culture as an influencing factor in the context of overall health (Huby & Salkind, 1989). On the other hand, writers such as Germain (1992) call for recognition of the body of cultural nursing knowledge in its own right, rather than its being subsumed under the more general topic of "psychosocial" nursing. Another current discussion centers on whether students should be taught ethno-specific content or whether broad concepts and processes that are useful in understanding people across cultures should be the primary focus (Lynam, 1992). The associated danger of teaching ethno-specific content is a reinforcement of stereotyping, rather than teaching cultural sensitivity. Despite such tensions, there is strong consensus in nursing literature that

holistic health care must be culturally sensitive; indeed, the literature includes a "rhetoric about the need for an ethnically sensitive health care" (Lock, 1990, p.240).

The Response of Nursing Associations

Nursing associations are also beginning to acknowledge the importance of culturally sensitive care. For example, the *Code of Ethics for Nursing* (1991), adopted by the Canadian Nurses Association (CNA), states that a nurse is obligated to individualize nursing care to accommodate the psychological, social, cultural, and spiritual needs of clients and that factors such as the client's race, religion, and ethnic origin must not compromise a nurse's commitment to that client's care (CNA, 1991, p.1). Similarly, the College of Nurses of Ontario include assessment of the client's cultural background as an expectation of nursing practice (Carpio & Majumdar, 1993). While the National League for Nursing in the United States has made the inclusion of cultural content mandatory in nursing curricula (Rooda, 1993), this has not followed in Canada. The Registered Nurses Association of British Columbia (RNABC) is considering a specific statement about culturally sensitive care in the next revision of the document listing competencies required of the graduate nurse (Linda Bell, Nursing Education Consultant, RNABC, personal communication, November 27, 1993). Currently, the expectation of culturally sensitive nursing care is included under the broad standard of respect for all clients (RNABC, 1992).

The Response of Nursing Educators

Much is being written about the importance of including cultural content in nursing curricula (Capers, 1992; Carpio & Majumdar, 1991; Fulton, 1985; Glynn, 1986; Lindquist, 1990; Lynam, 1992; MacDonald, 1987; Mattson, 1987; Nkongho,

1992; Princeton, 1993; Tuck & Harris, 1988). Included in this literature is a discussion of what content should be included and how this content should be presented. As well, various teaching strategies have been described (Barton & Brown, 1992; Bartz, Bowles & Underwood, 1993; Carpio & Majumdar, 1993; Holtz & Bairan, 1990; Huttlinger & Keating, 1991; Wuest, 1992). Indeed, when the literature was scanned for the inclusion of cultural content in the curricula of other health professions (e.g., physical therapy, occupational therapy, dental hygiene, medicine, social work), it appeared that nursing has made greater progress in this area than have many other disciplines.

In 1991, a questionnaire was sent to the deans and directors of schools of nursing across Canada to identify the multicultural content and teaching methods currently used. Despite the low response rate (39%), it was discovered that most programs include multicultural content in their curricula (Tournishey, 1991). While this report is encouraging, one wonders if the 61% who did not respond represent schools in which cultural content is not as valued. The research also uncovered the following barriers to the implementation of multicultural content in curricula: crowded curricula, lack of financial resources, limited faculty support, finite personal resources, and scarcity of educational resources (Tournishey). Nevertheless, nursing curricula are moving to address the issue of the provision of culturally sensitive care.

There is, however, a danger in assuming that the inclusion of cultural content in nursing curricula will ensure improved client care. The communication of information does not always result in learning, and knowledge does not necessarily change behaviors and attitudes. Moodley (1992) suggests that "ethnocentrism and

racism reflect individual predispositions and social forces beyond the reach of conventional pedagogy" (p.7). It may be, then, that the inclusion of cultural content in nursing curricula is neither consistent nor effective in preparing nurses for the complex challenges of caring for culturally diverse clients. Unfortunately, no research has been found to establish the effectiveness of our current education in preparing nurses to care for these clients.

Summary of Background Issues

The importance of culturally sensitive care is clear when considering the increasing ethnic diversity of Canadian culture. The nursing profession is responding to the imperative of culturally sensitive care; the theory of cross-cultural nursing is growing, nursing associations are beginning to reflect the importance of culturally sensitive care in their policy statements, and nursing curricula are moving to include cultural content despite existing barriers. Nonetheless, there is evidence to suggest that culturally diverse clients may receive a lower standard of nursing care that might be explained by factors such as the nurse's knowledge, previous contact with ethnic minorities, attitudes, education, support, and the hospital setting. A gap exists in nursing knowledge as to the actual care of culturally diverse clients, factors influencing this care, and the experience of nurses in caring for these clients.

Problem Statement

The research question posed to address this gap in nursing knowledge was: How do recently graduated nurses describe the experience of caring for culturally diverse clients in hospital settings? Without understanding the experience of nurses, it is not known if the responses of the nursing profession (i.e., nursing theory and

research, policies, and nursing education) are effective in dealing with the issues of a changing population and a lower standard of care for culturally diverse clients.

Recently graduated nurses are often employed in hospital care settings where they care for culturally diverse clients. In caring for these clients, nurses draw primarily on the knowledge gained prior to and during their educational programs, rather than on years of nursing experience. Recent nursing graduates offer insight into both the experience of caring for culturally diverse clients and the effectiveness of nursing curricula in preparing nurses for the experience of caring for such clients.

Purpose of the Study

The purpose of this study was to explore the descriptions of recently graduated nurses of their experiences of caring for culturally diverse clients and thereby gain an understanding of both the nature of the experience and any factors influencing the experience. A secondary purpose was to explore the suggested link between education and culturally sensitive care.

Significance of the Study

The practical significance of this study is clear when considering the increasing number of culturally diverse clients in Canadian hospital settings. The literature suggesting a lower standard of care for these clients is disturbing, particularly in light of Canada's multicultural stance that calls for the respect and valuing of ethnocultural diversity, along with a commitment to human rights that necessitates equitable health care for all. Ethically, these discrepancies in care must be addressed (Eliaison, 1993). This study begins to address the gaps in nursing knowledge regarding the care of culturally diverse clients and the factors influencing the care of these clients. For

example, by exploring the experience of caring for culturally diverse clients in hospital settings, insight is gained into the nurses' perspectives on the quality of care received by these clients. The study also contributes to an understanding of factors, such as education, that influence nurses in providing care to culturally diverse clients. The findings of the study would have implications for nursing practice in improving client care and for nursing education.

The scientific significance derives from the descriptive-exploratory method that generated a description for the purpose of a deeper understanding of the phenomenon of interest. The findings of this study contribute to nursing's body of knowledge – the study adds to the small body of research examining the experience of nurses caring for culturally diverse clients.

Definition of Terms

For the purposes of this study, key terms were used in the following way:

Culture – an integrated system of learned patterns of values, beliefs, customs, and behaviors that are shared by a group of interacting individuals (Tripp-Reimer, 1984).

Culturally diverse clients – clients who have ethnic and social origins and cultural values and practices other than those of the Canadian majority (i.e., European descent).

Culturally sensitive care – nursing care based on an understanding of the client's perspective and social context.

Recently graduated nurses – Registered nurses (RNs) who have graduated from a Canadian diploma or baccalaureate program within the last two years.

Summary

This chapter has introduced the research question under consideration: How do nurses describe the experience of caring for culturally diverse clients? The challenge of providing culturally sensitive care is becoming increasingly common for nurses in light of the increasing ethnic diversity of Canadian culture. The nursing profession is moving to address this issue. However, there is evidence to suggest that culturally diverse clients may receive a lower standard of nursing care that might be explained by factors such as the nurse's knowledge, previous contact with ethnic minorities, attitudes, education, support and the hospital setting. Without understanding the experience of nurses, it is not known if the responses of the nursing profession are indeed effective in dealing with the issues of a changing population and a lower standard of care for culturally diverse clients.

Organization of the Thesis

In Chapter Two, the fore-structure, that is, the understanding that I brought to the study, is presented. This discussion includes a review of the related literature, a presentation of my experience and assumptions, and an explication of the conceptual framework directing the study. In Chapter Three, the research method regarding the design, sample and setting, the generation and analysis of data, strategies employed to ensure rigor, ethical considerations, and limitations of the study are discussed. In Chapter Four, the findings of the study are presented. Selected findings of the study are discussed in Chapter Five, as they relate to the literature and contribute to new understandings. Chapter Six concludes the thesis with a summary of the study, a

presentation of the key conclusions, and a discussion of further implications for practice, education, administration, research, and public policy.

CHAPTER TWO: FORE-STRUCTURE

Introduction

The interpretive tradition emphasizes that there is no detached, privileged standpoint from which one objectively records "reality" (Addison, 1989). Rather, researchers' pre-understandings, assumptions, and the existing bodies of scientific knowledge predispose them to interpret the nature of phenomena in keeping with their ways of being and thinking. Examining the fore-structure of one's understanding and its effect on the research is an integral part of the qualitative research approach; therefore, my understandings, experiences, and assumptions, along with the theories and literature I drew from, are made explicit in this chapter. As well, the background to the problem discussed in Chapter One can be seen as part of the fore-structure brought to this research study.

Review of Literature

The research question directed me to explore literature related to the experience of caring for culturally diverse clients. First, the writings of key nurse and anthropologist scholars who have developed theories about the experience of cross-cultural health care are reviewed. Second, non-research literature (i.e., anecdotal reports) describing the experience are summarized. Finally, research studies describing the experiences of nurses are examined.

Theoretical Literature

A review of several key theories, from the fields of nursing, anthropology, and multiculturalism, related to cross-cultural health care contributes to the fore-structure of the research question under consideration.

Transcultural nursing. Although many nurses have been involved in the development of transcultural nursing in North America, Leininger is acknowledged as the pioneer, developing the theory of transcultural nursing from the late 1960's onwards (Dobson, 1991). Leininger describes transcultural nursing as

the subfield of nursing which focuses upon a comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior; nursing care; and health-illness values, beliefs and patterns of behavior with the goal of developing a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care practices. (Leininger, 1978, p.8)

The aim of transcultural nursing is to understand the beliefs, values, and practices of different cultures in order to provide culturally sensitive care.

Initially, Leininger developed a research conceptual model that included ethnonursing care constructs such as comfort, empathy, nurturance, and succorance (Leininger, 1978). More recently, she has developed the cultural care diversity and universality theory, portrayed by the sunrise model, to guide nurses in making culturally congruent nursing assessments and clinical decisions (Leininger, 1991). The model emphasizes the use of three culture-related nursing care actions: cultural care preservation/ maintenance, cultural care accommodation/negotiation, and cultural care repatterning/ restructuring.

In addition to theory development, Leininger has published prolifically and has established several graduate programs in transcultural nursing in the United States (Leininger, 1984). Transcultural nursing conferences are widely held and the Journal of Transcultural Nursing, that Leininger founded and continues to edit, is devoted to the furthering of nursing knowledge in the field of transcultural nursing.

Transcultural nursing has been criticized as oversimplifying the role of culture by establishing straightforward cause and effect relationships between cultural backgrounds and behaviors, rather than acknowledging the complex interplay of many other influencing factors (Mason, 1990; Outlaw, 1994). Nonetheless, the theory of transcultural nursing has played a crucial role in alerting nurses to the importance of providing culturally sensitive care.

Other nursing theories. Several other theories and models have been developed to provide guidance to nurses when caring for culturally diverse clients. Giger and Davidhizar (1990, 1991) present an assessment model for the evaluation of six essential cultural phenomena evidenced among all cultural groups: communication, space, social organization, time, environmental control, and biological variation. Tripp-Reimer and Brink (1984) offer an assessment guide that focuses on specific content obtained by the stance of cultural relativism.

Other theory development has moved beyond the description or assessment of cultures to the process of facilitating interaction between cultures. West (1993) has developed the cultural bridge model that emphasizes bridging between interacting groups of people through assimilation, integration, education, and tolerance. The model is based on mutual respect and the goal of maintaining cultural differences

and uniqueness while having meaningful relationships. The model, then, offers the nurse several strategies with which to "bridge" cultural differences. In essence, the model places the responsibility for culturally sensitive care on the nurse and does not acknowledge the many other complicating influences inherent in a complex health care system.

Anderson, in the nurse-client negotiation model (1987, 1990), recognizes that discrepancies exist between the beliefs of nurses and clients regarding health, illness, and treatments, and seeks to bridge the gap between these perspectives. The process of negotiation begins with eliciting the views of the client and evolves as an exchange of information between the nurse and the client/family. As well, the model draws attention to the context of health care by examining the three structural domains of the professional sector, the popular sector, and the folk sector as developed by Kleinman (see below).

Sands and Hale (1987) have developed a systems framework to target culturally sensitive issues in nurse/client interactions. Variables from three systems (i.e., the client system, the health care provider system, and the hospital system) influence quality of care (see Table 1). The model provides guidance in dealing with cultural conflict by emphasis on the professional role of the health care provider within the dynamic interaction with the culturally diverse client.

The concept of culture brokerage, evolved from anthropology, has been developed as a nursing intervention (Jezewski, 1990, 1993; LaFargue, 1985; Tripp-Reimer & Brink, 1985). Culture brokerage involves "the nurse's acting as a mediator between clients and members of the orthodox health professions" (Tripp-Reimer &

Table 1. Variables Which May Dehumanize Quality of Care

CLIENT	HEALTH CARE PROVIDER	HOSPITAL OR AGENCY
<p>Cultural background and expectations different from staff.</p> <p>May not speak English as first language.</p> <p>Perceptions of health care system.</p> <p>May delay seeking help until problem is crisis.</p> <p>Often has poor self image and self concept.</p> <p>The sick role may make patient feel powerless, vulnerable and out of control.</p> <p>Subjected to routine registration process.</p> <p>Potential for long waiting period before being seen.</p> <p>May sense negative, demeaning attitudes of personnel.</p>	<p>Lacks clear understanding of feelings toward minorities.</p> <p>Reared in culture different from clients.</p> <p>Inadequate knowledge and skills with transcultural nursing, therapeutic nurse/client relationship, psychosocial assessment, crisis theory.</p> <p>Professional role and identity equated with efficient technical skills and physical care.</p> <p>Educated to deal with physical emergencies and curing patients; treat patients according to health team norms (medical model).</p> <p>Acting-out behaviors of client personalized.</p> <p>Influenced by society's negative attitudes regarding other cultures, alcoholism, drug abuse.</p> <p>Values conflict with client's.</p>	<p>Large, complex system which may frighten and confuse clients.</p> <p>Programmed to care for acute, physical emergencies in spite of changing population</p> <p>Emphasis on volume.</p> <p>Keep clients in unit until beds available.</p> <p>May not have adequate health care providers.</p> <p>Routines such as registration process.</p> <p>Nurse/physician relationships.</p>

Note. Adapted from Sands, R., & Hale, S. (1987). Enhancing Cultural Sensitivity in Clinical Practice. Journal of National Black Nurses' Association, 2(1), 54-63.

Brink, 1985, p.352). Transcultural reciprocity, a closely related concept, is envisaged as an inter-cultural process rooted firmly in the reciprocation of cultural respect and understanding between the nurse and the client (Dobson, 1989).

As in other areas of nursing theory, there has been discussion regarding the appropriateness of borrowing knowledge from other disciplines, particularly anthropology, to guide nurses in the provision of culturally sensitive nursing care. For example, Leininger (1994) has consistently called for the application of transcultural nursing theory, rather than applying anthropological principles to nursing settings.

Kleinman's explanatory model. Kleinman (1978, 1982) has developed a useful conceptual model that provides a method for describing individual systems and for making cross-cultural comparisons between different medical systems. Underlying the model is the premise that, as part of a cultural system, health, illness, and health care need to be understood in relation to one another.

The model's primary purpose is to facilitate an understanding of the structure of the health care system. Kleinman (1978) maintains that most health care systems contain the three social arenas of popular (the family context of sickness and care along with the social network and community activities), folk (non-professional healing specialists), and professional (Western medicine and professionalized indigenous healing traditions). Between 70% and 90% of sickness is managed solely in the popular arena. These arenas serve as socially legitimized contexts of sickness and care or clinical realities.

In each of these three arenas, explanatory models can be elicited from practitioners, clients, and family members regarding etiology, onset of symptoms, pathophysiology, course of sickness, and appropriate treatment (Kleinman, 1978, p.87). Health care relationships can be understood and examined as transactions among different explanatory models.

Because of the differing explanations of the illness, conflicts often arise in the way clinical reality is conceived; however, amidst such conflicts, health care practitioners must affirm the client's right to have an alternative view. When alternative views are acknowledged and affirmed, negotiation can occur (Kleinman, 1989, p.40). Health care practitioners must explicate the explanatory models of all parties involved and negotiate appropriate and mutually satisfying care. Kleinman, Eisenberg, and Good (1978) suggest the following questions in exploring the explanatory model of the client:

- 1) What do you think has caused your problem?
- 2) Why do you think it started when it did?
- 3) What do you think your sickness does to you? How does it work?
- 4) How severe is your sickness? Will it have a short or long course?
- 5) What kind of treatment do you think you should receive?
- 6) What are the most important results you hope to receive from this treatment?
- 7) What are the chief problems your sickness has caused for you?
- 8) What do you fear most about your sickness? (p256)

Once the explanatory models have been clearly expressed by both client and practitioner, the practitioner actively negotiates with the client, as a therapeutic ally, about treatment and expected outcomes.

Recently, the explanatory models approach has been criticized as being inadequate for addressing all the major factors influencing the health care professional-client relationship. The approach limits the analysis to the meanings or health beliefs held by the involved parties, rather than including analysis of the interaction itself. "Explanatory models writers cannot arrive at a clinical praxis when they study only beliefs that are brought to the clinical interaction and do not include the behavior of both clients and clinicians" (Lazarus, 1988, p.44). The client-clinician relationship must be considered within the context of their respective differential power in social relations. Nonetheless, Kleinman's model offers a useful theoretical understanding of the experience of caring for culturally diverse clients; that is, the model establishes that the conflict between cultural beliefs (i.e., popular and professional arenas) may serve as a point of difficulty that requires explication and negotiation.

Multiculturalism theory. Multiculturalism is based on the view that ethnic differences are worth perpetuating to enhance the character of Canadian society (Moodley, 1992, p.7). Blum outlines three subvalues encompassed in multiculturalism:

- 1) affirming one's own cultural identity;...
- 2) respecting and desiring to understand and learn about (and from) cultures other than one's own; and

- 3) valuing and taking delight in cultural diversity itself, that is, regarding the existence of distinct cultural groups within one's own society as a positive good to be treasured and nurtured. (Blum, 1991, p.8)

When first introduced in Canada in 1971, the three main aspects of multiculturalism presented by the Prime Minister were that 1) there is no official culture in Canada, 2) there must be creative exchanges or relationships among the various cultural groups, and 3) all immigrants to Canada should have access to learning one of Canada's two official languages (McLeod, 1992, p.217). Since that time, multiculturalism in Canada has evolved from an emphasis on life-style to the current attention to access, participation, and equality of opportunity, outcome, and success (McLeod).

With multiculturalism as an official government policy in Canada, several documents have been published to facilitate the goal of equity in health in our pluralistic society. In one of these documents, a cultural competence model defines the "set of congruent behaviors, attitudes and policies that comes together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Ministry of Social Services, 1992, p.39). The model conceptualizes the cultural competence of caregivers on a continuum ranging from cultural destructiveness to cultural proficiency. As well, five essential elements contributing to cultural competence are delineated: valuing diversity, cultural self-assessment, dynamics of difference (i.e., understanding the interaction between the system or health professional and cultures with which it interacts, and choosing actions that minimize cross-cultural barriers),

institutionalization of cultural knowledge, and adaptation to diversity. This model is helpful in providing a method for evaluating cross-cultural care, as well as identifying key contributors to culturally sensitive care. At a broader level, multiculturalism provides a foundational philosophy from which to implement cross-cultural health care.

To conclude, as this brief review of nursing, anthropological, and multicultural theory demonstrates, much has been accomplished since Leininger first brought together the worlds of culture and nursing. What is critical, however, is not how theory development has progressed, but rather the application of this theory in nursing practice. Kavanagh (1993) maintains that while "the culture of nursing and the nursing of culture have been studied, most nurses remain in a quandary about what to do with all of this" (p.9). Similarly, Malone (1993) states that the ideals of culturally sensitive care are "valued and promulgated by the profession but often selectively applied in the daily interactions of the nurse" (p. 22). Research is required to evaluate the current state of cross-cultural nursing in practice settings.

Non-research Literature

Clinical examples of transcultural nursing needs and applications abound (e.g., Galanti, 1991; Kavanagh & Kennedy, 1992; Spector, 1991). Many of these writings make brief comments about the nature of the experience of caring for culturally diverse clients. Generally, these comments reflect the challenging and frustrating nature of the experience and common sources of difficulty. A summary of this anecdotal literature follows.

Shareski, in an article about cross-cultural care, comments on the "frustration of caring for someone we don't understand" (1992, p.12). The term "frustration" is used by numerous authors in describing the experience of cross-cultural care (Adams, Briones & Rentfro, 1992; Anderson, 1986; Bernal, 1993; Kubricht & Clark, 1982; Manio & Hall, 1987; Thobaben & Mattingly, 1993). The experience is also described as stressful (Manio & Hall, 1987; Rothenburger, 1990), exhausting (Bernal, 1993), and pressured (Fong, 1985).

Various responses are engendered by the experience, particularly when it is viewed as negative. Reported emotions include anxiety, anger, confusion and disorientation, irritation, hurt, insecurity, helplessness, fear of being called a racist, and impotence (Adams et al., 1992; Anderson, 1986; Dawes, 1986; Durst, 1992; Huby & Salkind, 1989; Kavanagh & Kennedy, 1992; Leininger, 1994; Thobaben & Mattingly, 1993). As a result of such emotions, behaviors of nurses include avoidance and professional arrogance (Anderson, 1986; Dawes, 1986; Durst, 1992), as well as task orientation and reliance on stereotypes (Kavanagh & Kennedy, 1992, p.42).

The anecdotal literature also identifies common sources of challenge in caring for culturally diverse clients. Communication, particularly due to language barriers, is cited frequently as a source of difficulty (Bernal, 1993; Clark, 1983; Hartog & Hartog, 1983; Louie, 1985b; Masi, 1989; Rothenburger, 1990; Steffenson & Colker, 1982). Furthermore, the use of interpreters presents a challenge – not only must the language be translated, but also the cultural beliefs imbedded in the language must be interpreted (Haffner, 1992; Hagland, Sabatino, & Sherer, 1993; O'Neil, 1989). As

well, interpretation is not readily available in many settings. The Canadian Council for Multicultural Health (1992) reports that "the availability of trained medical interpreters in Canada remains abysmally low" (p.7). A second source of difficulty is the establishment of relationships with culturally diverse clients. Durst (1992, 1993) writes about the difficulty in establishing trustworthiness as a way of bridging cultural gaps. Anderson (1986) observed a lack of reciprocity between practitioners and families in a study of Asian families with chronically ill children. A third source of difficulty stems from cultural differences and conflicts regarding health beliefs and cultural values. For example, visiting patterns were cited as a source of conflict (Adams et al., 1992; Dawes, 1986) and understanding the use of traditional remedies and herbs, along with dietary patterns, is reportedly a problem area (Louie, 1985a). Finally, caring for culturally diverse clients is described as time-consuming (Hagland et al., 1993; Harwood, 1981, p.496; Kavanagh & Kennedy, 1992).

The descriptions reviewed present a rather negative picture of the experience of caring for culturally diverse clients. In considering the reported frustrations associated with the experience, one wonders whether the quality of care for culturally diverse clients cannot help but suffer. One also questions whether the nurses experiencing such distress have been educated regarding cross-cultural care; if so, the efficacy of the education is in doubt.

On the other hand, other literature describes the experience of caring for culturally diverse clients as positive and professionally satisfying (Canadian Council for Multicultural Health, 1992; Leininger, 1994). Literature regarding nursing education points to a link between increased satisfaction in the cross-cultural

exchange and education focusing on cultural issues. In the process of describing various educational approaches, several authors comment briefly on students' experiences in caring for culturally diverse clients (Barton & Brown, 1992; Bartz, Bowles & Underwood, 1993; Wuest, 1992). For example, Barton and Brown (1992) analyzed the journals of 13 students after a summer community health nursing course involving transcultural health care with migrant farm workers. The findings confirmed deepening respect for a cultural minority group, identification of differences in cultural norms, and recognition of the rewards gained in the transcultural experience. The authors recognize that personal characteristics of the students (i.e., high motivation and self-direction, personal maturity, self-selection to participate in the course) may have influenced the findings. However, one can deduce from this report that these students had positive experiences in caring for culturally diverse clients.

Bartz, Bowles, and Underwood (1993) describe a specific transcultural nursing course in which students cared for American Indians in a community setting. The students described initial frustrations in conflicting cultural values (e.g., time-orientation) and fears related to the new settings and experiences. By the end of the course, students felt truly changed and enabled by the experience. The authors do not, however, explore the specific reason for the change in student perspective (i.e., the theoretical content or simply the cross-cultural exposure).

Wuest (1992) reports on a transcultural experience with third year nursing students in New Brunswick who were involved with primary health care for Native Indians. The presence of key informants and reciprocity between the students and

clients were identified as factors that increased the quality of the experience for the students.

Overall, in the evaluation of specific elective courses that focus on transcultural nursing, students report positive experiences in caring for culturally diverse clients.. It is not known if students experience similarly positive experiences when the content of culture is integrated throughout a curriculum, rather than in a specific course. Furthermore, one might assume that the students participating in the elective courses had personal interest in cross-cultural nursing care and, therefore, their experiences might not be reflective of those of all nursing students. For example, a student with racist attitudes would not likely choose an elective in transcultural nursing.

To summarize, in the non-research literature, both positive and negative experiences are described in the care of culturally diverse clients. These anecdotal reports should be corroborated by research findings and factors that influence the nursing care of culturally diverse clients should be systematically explored.

Research Literature

Some aspects of nurses' care for culturally diverse clients have been studied. In reviewing the literature, those research studies directly and indirectly related to the experience of caring for culturally diverse clients were selected and are summarized below.

A study carried out in Australia examined health professionals' perceptions and understanding of communication difficulties in cross-cultural health and medical settings (Pauwels, 1990). Although the study was carried out by linguists and focused

specifically on the use of language, it offers further insight into specific issues faced by health care professionals regarding communication with culturally diverse clients. Thirty-two informants were interviewed regarding communication difficulties with non-English speaking background (NESB) clients, colleagues, and students and regarding strategies used to minimize such difficulties. Comments about cultural differences were much more common than comments about language; however, because the focus of the study was on linguistics, the analysis of the data was restricted to that area. The health professionals identified difficulties in communication arising from the absence of a shared language and difficulties in communication resulting from cultural and linguistic differences in the use of the same language. In dealing with a lack of a shared language, the informants mentioned the following strategies: 1) they used an interpreter, 2) they used another means of communication (e.g., non-verbal communication such as gestures or hand signals), and 3) they postponed the interaction until an interpreter could be present. While the informants recognized the difficulties in using non-professional interpreters, they seemed to have little understanding of the fact that interpreting skills and techniques are not identical to having competence in another language. The informants were, however, unanimous in their recommendation for further training of how to work effectively through an interpreter. This study, then, draws attention to the role of language in cross-cultural communication.

In an effort to determine the needs of students and educational programs, Pope-Davis, Eliason, and Ottavi (1994) carried out an exploratory study investigating undergraduate nursing students' multicultural competencies in working with culturally diverse clients. Research questions, administered via the Multicultural Counseling Inventory (MCI), explored differences in multicultural skills, knowledge, awareness, and relationships across variables such as age, gender, work experience, and academic class standing in a sample of 120 students at a large American university. The participants reported a reasonable level of multicultural competency, particularly concerning multicultural relationships. Multicultural awareness fell below the midpoint on a four-point Likert scale. In analyzing the influence of the demographic variables, statistical analysis revealed that students with work experience had higher multicultural skill and knowledge levels than students without work experience. None of the students had completed a course or seminar addressing multicultural issues in nursing. In explaining the results, the researchers speculated that the students with experience may have been operating from a false cultural awareness, based on stereotypes, because their self-perceived knowledge and skill were not accompanied by more multicultural awareness or competency than those of students without work experience. As well, the students may have developed a set of skills and knowledge for the work environment without fully comprehending why those skills were important. This study is helpful in that students have described (via the MCI) their experiences of caring for culturally diverse clients. In addition, the influencing factor of previous work experience is identified as significant in facilitating the experience. The study is limited in its applicability because it

describes the experiences of students who have not had transcultural nursing education.

Gunter (1988) reports a study completed in conjunction with a transcultural nursing course taught in Philadelphia. Included in the course was a one-week practicum in Jamaica. The students provided high evaluations of the course; however, in order to assess the impact of the course on attitudes and behavior, a scale was administered to measure attitudes toward two groups, Jamaicans and Vietnamese, before and after the experience. The scale was developed by Grice in 1934 but all original items were deemed appropriate by the investigators. The study revealed a positive change in attitude toward the Jamaicans after the experience; however, no significant change was noted for the Vietnamese. These findings seem to indicate that the course contributed toward developing more positive attitudes toward a defined group (e.g., the Jamaicans) but that the results of the learning were not generalized to the development of more positive attitudes toward another defined group (e.g., the Vietnamese). It is not known how the course would have affected attitudes if the transcultural experience had not been as positive.

Bernal and Froman (1987) carried out a study of the confidence level of community health nurses when caring for culturally diverse clients. The Likert Cultural Self-efficacy Scale was given to 190 community health nurses in Connecticut to determine their confidence level in caring for Black, Puerto Rican, and Southeast Asian clients. The research questions were: (1) What is the degree of self-efficacy among a sample of community health nurses in caring for Black, Puerto Rican, and Southeast Asian clients? (2) What is the degree of influence of the various

background variables on the nurses' level of self-efficacy? and (3) What is the difference in the level of self-efficacy for caring for the three ethnic groups? The results showed that confidence levels for caring for Black and Puerto Ricans were neutral or non-committal, while confidence for caring for Southeast Asians was weak. In regard to the second question, Bernal and Froman found that community health nurses, regardless of their age, years of practice, specialty or educational preparation, shared a weak sense of confidence in cross-cultural nursing. Finally, no statistical differences were noted between the levels of confidence in caring for the three groups. The researchers implicate the educational preparation of the nurses as not equipping the nurses to feel confident in caring for culturally diverse clients. It is not certain how this assertion was reached. Although this study does not give insight into the complexities of the experience, it is nonetheless important because it begins to address the experience of caring for culturally diverse clients. Furthermore, although the nurses did not describe their experiences per se, the findings (i.e., weak sense of confidence) suggest that the experiences of caring for culturally diverse clients may not have been positive for these nurses.

In a second study, Bernal and Froman (1992) extended their previous work with the Cultural Self-efficacy Scale with a sample of 315 community health nurses across the United States. The results were comparable to the 1987 findings – the average ratings of self-efficacy showed a rather low level of confidence in the nurses' ability to care for the three culturally distinct population groups (i.e., Black, Latino, Southeast Asian). The number of courses taken related to cultural diversity, extent of cross-cultural exposure, and years of experience as a nurse were positively related to

efficacy. In contrast to the findings of the previous study, cross-cultural education increased nurses' confidence.

In an effort to shed light on the subjective elements of the experience of caring for culturally diverse clients, Bernal, Pardue, and Kramer (1990) surveyed twelve nurses who had worked in a Hispanic community health unit. The nurses responded to three open-ended questions regarding the frustrations, rewards, and long-term benefits derived from the experience of working in the Hispanic unit. Reported frustrations were categorized as personal, culturally-related, and bureaucratic in nature. In the area of personal frustrations, inability to speak fluent Spanish impeded the nurses' ability to assess and manage complex cases as efficiently and effectively as they would have liked. Nurses also expressed feelings of inadequacy at the perceived inability to effect long-term change. Differences in world view and priorities led to cultural frustrations such as "not-home" visits, clients not following instructions, and dependency on the nurses to advocate for the needs of the non-English speaking clients. Bureaucratic frustrations included negative stereotypes by others in the health care system and barriers to other services due to excessive bureaucracy. In describing the rewards, the greatest reward pertained to the generosity and hospitality of the clients in the face of many hardships. Other sources of satisfaction were helping people with great needs, promoting self-sufficiency, learning about another culture, and learning to communicate in another language. Long-term benefits related to personal and professional skill development, broadened world views, and greater independence and creativity in practice.

Kubricht and Clark (1982) surveyed nurses in a southern United States health care facility regarding problems encountered when caring for culturally diverse clients. A questionnaire incorporating a hypothetical case of a hospitalized Russian seaman was developed and distributed. Nurses were asked to identify expected problems in caring for this client. Communication was considered the outstanding problem, along with feelings of frustration and inadequacy when attempting to meet his physiological and psychosocial needs. Unfortunately, the research report gives minimal information regarding the design of the study (e.g., sample size and recruitment, method of analysis). Moreover, the validity and reliability of responses to a hypothetical case could be questioned.

Butrin (1990) studied the experience of culturally diverse nurse-client encounters from the perspectives of both nurse and client. Fifteen nurses and fifteen clients from two southeastern United States public health clinics participated in the phenomenological study. Three categories of nurse-client encounters emerged from the data analysis. The categories were mutually satisfying encounters, incongruent perceptions of the encounters, and mutually unsatisfying encounters. The majority of the nurse-client dyads fell into the category of mutually satisfying encounters. Descriptions that characterized mutually satisfying encounters were mutual respect and liking, mutual understanding, mutual satisfaction, a feeling of being helped, cared for or comfortable with, and sharing of similar values. Three dyads were incongruent in their perceptions of the encounter. The qualities of the incongruent encounters were stereotypic bias and ethnocentrism, interpreter presence impeding openness in the encounter, and dissimilar values. Two dyads experienced mutually unsatisfying

encounters. Descriptions that emerged in the mutually unsatisfying encounters were those of a mutual sense of uncertainty and a mutual sense of difficulty in establishing rapport. Butrin concludes that, based on the mutually satisfying encounters, meaningful nurse-client relationships can occur despite cultural and language differences. While the author describes her study in terms of three categories of themes based on the nature of the encounters (i.e., mutually satisfying, incongruent, and mutually unsatisfying encounters), in reality, the analysis simplifies the descriptions to one single theme, that of whether or not the encounter was satisfying. Some of the richness of the data may have been lost in such an oversimplification of the experience.

A recent qualitative study by Murphy and Clark (1993) examined British nurses' experiences of caring for ethnic-minority clients. The researchers interviewed 18 RNs from units that had a higher than average client group from ethnic minorities. Data analysis revealed issues in communication, nurse-client relationships, dealing with relatives, nurses' feelings of frustration, stress, and helplessness, and a lack of knowledge about cultural differences. Many of the respondents felt that the care ethnic-minority clients received fell below a desired standard. All of the respondents felt that their education had not prepared them for the problems and difficulties they experienced in caring for ethnic-minority clients. By using an exploratory, descriptive method, the researchers gained "rich" data regarding the experiences of nurses; however, the analysis did not go beyond an ordering and description of the data to reach a level of abstraction or theorizing.

Summary of Literature Review

In summarizing the literature review, several key themes arising from the research and non-research literature are identified. Additionally, the contributions of the various studies are related to the present study.

The first theme arising from the literature is that of the general nature of the experience of caring for culturally diverse clients. The predominant description is one of challenge and frustration, although positive aspects are also described. The second theme acknowledges the sources of difficulty within the experience of caring for culturally diverse clients. These sources of difficulty include cultural differences in values, beliefs, and customs; communication difficulties, particularly those associated with language barriers; and barriers from within the environmental context, such as bureaucratic health care systems. The final theme identifies specific nurse-related factors as influencing and/or enabling the individual nurse in caring for culturally diverse clients. These factors include education, cross-cultural exposure, open attitudes, and previous work experience.

While several studies were found that addressed the matter of caring for culturally diverse clients, these studies are generally inadequate in explicating the experience of recently graduated nurses in caring for such clients in Canadian hospital settings because they draw on different populations in different settings (i.e., students' and community health nurses' descriptions, American and Australian settings). Nonetheless, the Murphy and Clark (1993) study is of particular interest because it addresses a similar question to that of the present study. Moreover, the findings are closely aligned to the issues outlined in the fore-structure of the question

under investigation. First, the research findings suggested a link between nursing education and the ability to care for culturally diverse clients. Second, the researchers included implications for nursing practice, particularly in regard to the quality of care received by culturally diverse clients. Finally, the qualitative methodology proved to be effective in generating "rich" data.

The Murphy and Clark study is, however, insufficient in answering the research question for several reasons. The study represents a different population in a different setting than the present study. The British health care setting, as well as the social setting differ from those of the present Canadian study – Canada's multiculturalism policy and high immigration rate are anticipated influences. Additionally, Canadian hospitals represent a different health care system than that in Britain and the nursing education systems differ. Murphy and Clark's sample also differs in that they did not distinguish the nurses' years of experience. In contrast, the present study involves recently graduated nurses.

To conclude, the study by Murphy and Clark is similar to the present study in both the question explored and the research method employed. It differs, however, in the sample it draws from and in the setting in which it was implemented. The present study, then, sought to extend Murphy and Clark's study by examining the same issue in another context and by inductively analyzing the data to move beyond a simple description of the experience. In addition, I sought to expand and describe the themes identified from the literature as they related to the experiences of recently graduated nurses caring for culturally diverse clients in Canadian hospital settings.

Researcher's Experience

My interest in this area of study evolved from my experiences of caring for culturally diverse clients in both hospital settings and developing countries. In these situations, I often felt a lack of resources to draw from, both in my educational preparation and in the existing nursing structures. Thus, I found myself relying on my intuitive sense and my compassion for these culturally diverse clients.

My more recent experience as a nursing educator further contributed to my concern. I have observed that the content of culturally sensitive care has been haphazardly integrated into nursing curricula and students often appear unable to respond to the specific and individual cultural needs of clients. I have also been troubled by fellow educators who do not evidence a clear commitment to the deliberate inclusion of cultural content. In reviewing related nursing literature, I was struck by what seems to be an assumption that culturally sensitive care will somehow result from a cursory inclusion of cultural content about various ethnic groups. In these ways, I was aware of the experiences and presuppositions I brought to this study.

Assumptions

Along with the assumptions inherent in the method of qualitative research, the following assumptions were carried into this study.

1. Caring for culturally diverse clients presents a unique challenge for nurses.
2. Educational programs seek to prepare nurses for this challenge.
3. Recently graduated nurses will be able to articulate the nature of their experiences in caring for culturally diverse clients.

4. There are both positive and negative shared elements in the experience of caring for culturally diverse clients that can be described by nurses and subsequently categorized as themes by the researcher.
5. The understanding of these shared experiences will be useful for nursing practice and education.

Conceptual Framework

The conceptual framework for the study was based on the philosophy of qualitative research, the stance of multiculturalism, and the fore-structure of existing knowledge related to the research question. First, qualitative research suggests that the subjective experience of the individual or group is valued and described (Munhall, 1994, p.11) because knowledge (or contextual reality) is imbedded in this experience. The stories and descriptions of the nurses in this study were listened to carefully in an effort to discover and understand common themes.

Second, the stance of multiculturalism acknowledges the role of culture in influencing the experience of health. Multiculturalism celebrates diversity – cultural diversity is seen as an enabler rather than as a resistant force (Caudle, 1993). At the same time, culture is seen in its particular context of historical, economic, social, political, and geographical elements. "Culture can never be considered in a vacuum, but only as one component of a complex mix of influences on what people believe and how they live their lives" (Helman, 1990, p.5). The stance of multiculturalism directed me to approach the study from the positive perspective of appreciating cultural diversity while recognizing the complexity and interrelatedness of other influencing factors.

Finally, the fore-structure, as presented above, informed this study by acknowledging the challenge of providing care to culturally diverse clients. As well, the fore-structure guided me to seek an understanding of the shared elements of the experience of caring for these clients while identifying factors such as education, attitude, and setting that have an impact on the experience.

According to Catanzaro (1988), the conceptual framework in a qualitative study serves to direct the researcher to important aspects to be studied and also provides for the first broad groups for data categorization. In this study, the conceptual framework directed me to listen carefully to the descriptions provided by the nurses in order to understand their experiences. As well, the framework served to remind me of the complex and interrelated factors influencing the issues of culture, thus preventing simplistic or premature conclusions. More specifically, the framework directed me to explore the following themes.

- 1) Description of the general nature of the experience of caring for culturally diverse clients. (i.e., what is it like to care for culturally diverse clients?)
- 2) Description of the sources of difficulty and reward in caring for culturally diverse clients. (i.e., what is it about the experience that makes it difficult or rewarding?)
- 3) Description of influencing and/or enabling factors for the individual nurse in caring for culturally diverse clients. (i.e., what prepares the nurse for and assists in the experience?)

It was anticipated that these three themes would also be used as broad groups for initial organization of the data. This conceptual framework, then, provided

direction toward the ultimate goal of describing the experience, and contributing to a higher standard of nursing care in keeping with the applied and practical nature of nursing knowledge.

Summary

The fore-structure brought into this study has been presented in this chapter. Theoretical, non-research, and research literature related to the experience of caring for culturally diverse clients was reviewed. My experience and assumptions were presented, along with the conceptual framework that guided the study.

CHAPTER THREE: RESEARCH METHOD

Introduction

This chapter presents the research method employed in the study. A descriptive-exploratory design was chosen as most appropriate to the question under investigation. Discussion of the descriptive-exploratory method, as applied in this study, is presented in relation to the following areas: rationale for the design, selection of sample, generation of data, and analysis of data. The chapter then describes how rigor was ensured in the research process. Finally, ethical considerations and limitations of the study are outlined.

Research Design

In selecting a research design, the foremost direction is that provided by the research question under consideration. Because little was known about nurses' experiences in caring for culturally diverse clients, this question required a Level I study. Furthermore, the question necessitated a design that allowed for the anticipated multiplicity of experiences by nurses while identifying shared themes and elements. At this initial descriptive level of study, exploratory power was sought rather than explanatory power; thus, a descriptive-exploratory design in the qualitative (naturalistic) tradition was selected. The design took some direction from the phenomenological objective about understanding lived experience, but broadened that perspective to focus upon the shared elements within the specific experience of caring for culturally diverse clients.

Several key axioms of the naturalistic approach, as delineated by Lincoln and Guba (1985, p.37), provided the philosophical underpinnings of the research design:

- 1) There are multiple constructed realities that can be studied only holistically. Thus, reality is complex, contextual, constructed and ultimately subjective.
- 2) The inquirer and the "object" of inquiry interact to influence one another; indeed, the knower and known are inseparable.
- 3) No *a priori* theory could possibly encompass the multiple realities that are likely to be encountered; rather, theory must emerge from (be grounded in) the data.

Studies based on the naturalistic paradigm generally share qualitative data collection methods based upon unstructured interviewing techniques, unstructured observations, unstructured available data, small samples, and a variety of forms of inductive analysis. They are also purposefully flexible, allowing researchers to discover new phenomena or to gain new insights into known phenomena (Brink, 1989, p.142); that is, the research methodology allows for an emergent design in keeping with the nature of naturalistic inquiry (Lincoln & Guba, 1985, p.41). The research plan "serves only to chart an initial direction and to erect an outer boundary for inquiry" (Sandelowski, Davis, & Harris, 1989, p.79).

In the case of this study, I deliberately chose not to follow any one of the popular methodologies currently used in nursing research (i.e., phenomenology, grounded theory, and ethnography). Rather, the descriptive-exploratory design in the qualitative tradition was chosen to fit the specific research question. In so doing, I

acknowledged the current discussion in the nursing research literature regarding the blending of qualitative methodologies (e.g., phenomenology, grounded theory and ethnography) without regard for the underlying philosophical traditions (Baker, Wuest, & Stern, 1992; Morse, 1991c). Yet, other nurse scholars posit that derivative methods may indeed best serve the nature of many nursing inquiries (Lederman, 1993; Lowenberg, 1993; Swanson-Kauffman, 1986; Thorne, 1991). Furthermore, Morse (1991c) points out that "qualitative researchers do legitimate qualitative research for which, as yet, there is no name" (p.18).

In light of this discussion, and particularly as a novice researcher proceeding with a broader research design rather than a more guided approach, two specific strategies were employed in the way of safeguard. First, I clearly explicated all aspects of the research design as suggested by Hutchinson (in conversation, Morse, 1991a, p.257). Second, I worked closely with and relied on the expertise of my committee to guard against the "sloppy mishmash" (Morse, 1991c, p.15) of a weak study.

In conclusion, exploratory designs have two major goals: 1) problem discovery by identifying and describing a problem area never previously studied or known, and 2) problem definition by exploring a concept in depth in as loose and as free ranging a way as possible to arrive at a description of an experience or its meaning (Brink, 1989, p.141). The descriptive-exploratory method is particularly well-suited to this research question because little is known about the nature of the experience of caring for culturally diverse clients. By taking a broad approach to the question, the essences of the experience became apparent.

Sample and Setting

In qualitative research, purposive sampling provides the researcher with participants according to the needs of the study. Moreover, the researcher must have control over the composition of the sample (Morse, 1991b). Participants for this study were sought from hospitals in communities that have a high population of culturally diverse clients.

Eight nurses from a total of six hospitals participated in the study. A sample size of seven to ten participants had been anticipated because a small sample yields significant data in qualitative research (Ray, 1990). As data analysis progressed concurrently with the data collection, the sample size was directed by the point of redundancy or saturation of conceptual categories. Saturation refers to the point where the researcher finds no new information emerging from the interviews (Baker, Wuest, & Stern, 1992). As well, theoretical or purposeful sampling suggests that consideration be given to maximum variation sampling in order to achieve a breadth of experiences and adaptations to different conditions (Lincoln & Guba, 1985, p.200). As the study progressed with expanded descriptions of the experience, participants with specific knowledge were deliberately sought. For example, participants from minority groups were sought.

The sample was volunteer with secondary selection by the researcher (Morse, 1991b, p.136). I met with the nurse researcher and several clinical teachers at a community hospital who offered to circulate information letters provided by me (see Appendix A). Recently graduated nurses were also approached through notices in communication books kept on the surgical and medical units of the hospital. Further

recruitment occurred through snowball sampling (Polit & Hungler, 1991, p.257). Participants in the study suggested and contacted other nurses who might be interested in participating. Those interested were asked to contact me. When the volunteers initially contacted me by phone, I inquired generally about their nursing careers in order to establish if they met the criteria for the study. After I provided more information about the study, appointments were made for the interview. At the onset of the interview, I reviewed the purpose and nature of the study and allowed opportunity for questions. Each participant's agreement to participate in the study was then formalized by obtaining written consent (See Appendix B).

Description of the Participants

The following selection criteria were established: 1) having graduated within the last two years, and 2) having cared for culturally diverse clients within the last three months. As the study progressed, I became convinced of the need to include participants from visible minority groups. I believe that research must not be based solely on the experience of the dominant majority; participants from outside the nursing majority (i.e., white females) offer a broader perspective to the study. Efforts were therefore made to recruit such participants into the theoretical sample. However, the only minority nurse who volunteered to be in the study had graduated three years prior to the study. Because of the unique group she represented, the criterion for selection (i.e., recent graduate of two years or less) was extended in her case. The clients she cared for were from minority cultures distinct from hers.

The eight participants, all female, ranged in age from 25 to 39. Five of the participants had graduated from generic baccalaureate nursing programs. Two

participants had graduated from diploma programs before completing post-RN degree programs. One participant had graduated from a diploma program. The nurses worked in a variety of settings. Three nurses worked on surgical units, one nurse worked on a medical unit. The other areas represented were oncology, psychiatry, pediatrics, and obstetrics. Seven of the eight participants stated that their client assignments usually included at least one culturally diverse client. The eighth participant observed that cultural diversity was not very common on her unit but that she had recently cared for a culturally diverse client over an extended period of time.

Generation of Data

In naturalistic inquiry, the major data collection instrument is the inquirer him/herself (Lincoln & Guba, 1985, p.267). In this study, data were generated by interviewing the participants. These face-to-face interviews were arranged in environments preferred by the participants. Three of the interviews took place in the participants' homes; another two were conducted at my home. The other three took place in conference rooms at the hospital and the university. The interviews were audio-taped and transcribed with permission from the participants. Privacy was ensured wherever possible to encourage open conversation and expression of personal views. The initial interviews lasted from 45 minutes to one and one-half hours. Second interviews were conducted for clarification and validation as data analysis proceeded. Three of the follow-up interviews were conducted in person; the remainder were telephone interviews. I was unable to arrange for a second interview with one of the participants.

The use of self in a trusting relationship was a key in generating data through the interview process; consistent efforts were made to be genuine. I encouraged disclosure by communicating interest in understanding the participants' experiences and by suspending moral judgment (Knaack, 1984). The use of listening skills enhanced the process. At the outset of each interview, I consciously placed myself in the role of a learner.

The interviews were unstructured to allow the participants to describe their experiences. I initiated the conversation with several general or "grand tour" questions (e.g., "What makes a typical day for you on your unit?") that gave the participant "practice in talking to me in a relaxed atmosphere while at the same time providing valuable information about how the participant viewed the general characteristics of the context" (Lincoln & Guba, p.270). As the interview progressed, several open-ended questions provided me with guidance and minimal structure for the interview (see Appendix C). As well, I used clarifying questions that followed the story of the participant as necessary. The interview was terminated when it was no longer productive, as evidenced by longer pauses between comments and my sense that the participant had little else to say. At this point, I briefly summarized the discussion and invited any final comments. Interestingly, given this opportunity for final comments, most participants offered their personal perspectives on what they considered to be the most critical issues involved in cross-cultural nursing. Thus, the final minutes of the interviews often generated "rich" data. Thereafter, I thanked the participant for her cooperation.

The second interviews were more structured because I was seeking to validate and expand my conceptualization and analysis to date. The questions corresponded with the participant's responses in the initial interview. For example, nurses who had evidenced a strong commitment to cross-cultural nursing were asked different questions than the nurses who did not see caring for a culturally diverse client as any different than caring for any other client.

Besides the data generated from the interviews, demographic data were gathered using a demographic data sheet distributed at the beginning of the first interview (see Appendix D). I used field notes to assist in keeping track of thoughts and feelings experienced in response to the participants' stories. After the interviews, I summarized my impressions of the process and the key themes in the field notes. Along with the field notes, I kept a reflexive journal in which insights and sources of satisfaction and frustration were reflected upon, day-to-day activities were recorded, and methodological decisions were noted (Lamb & Huttlinger, 1989; Lincoln & Guba, 1985). Special attention was given to the matter of reactivity; that is, the "response of the researcher and the research participants to each other during the research process" (Paterson, 1994, p.301). Specifically, the reactivity analysis framework (Paterson) that considers the factors of emotional valence, distribution of power, importance of the interaction, the goal of the interaction, and the effect of normative or cultural criteria was applied in the reflexive journal after each interview.

Data Analysis

The process of data analysis within the naturalistic tradition is inductive and synthetic; "the constructions that have emerged from the interactions are

reconstructed into meaningful wholes" (Lincoln & Guba, p.333). In this study, the themes that emerged from the eight interviews were integrated into a final conceptualization of the experience of caring for culturally diverse clients. This process matched the analytic tasks of descriptive, qualitative research as suggested by Knafl and Webster (1988, p.197):

- 1) identification of themes within coding categories, and
- 2) identification of themes across coding categories.

Thematic analysis of the generated data was accomplished by the constant comparative method developed by Glaser and Strauss (1967) and delineated by Lincoln and Guba (1985) and Strauss and Corbin (1985). The two analytical procedures basic to the constant comparative method are the making of comparisons and the asking of questions (Strauss & Corbin, 1985, p.62). These analytical procedures were accomplished by the cognitive efforts of comprehending, synthesizing, theorizing, and recontextualizing (Morse, 1994). These analytical efforts were complemented with intuitive processes that linked the various conversations (e.g., the words, the inflections, the body language, and the ideas) together.

In keeping with the constant comparative method, data analysis was ongoing and began after the first interview in order to facilitate the "emergent design, grounding of theory, and emergent structure of later data collection phases" (Lincoln & Guba, 1985, p.242). In this way, each interview built on the preceding ones; ongoing analysis "...stimulated creativity and energized the entire project" (Catanzaro, 1988, p.440). The first interview, in a sense, served as a pilot study in that I sought

feedback from the thesis chairperson regarding my interviewing skills and initial data analysis.

More specifically, I transcribed the interview tapes verbatim, leaving a 4-inch margin to the right of the text. I then read the participants' descriptions several times in order to acquire a feeling for them. Initial notes about themes and commonalties were made and as the constant comparative method was employed, I moved between coding of smaller units (e.g., line-by-line) and conceptualizing across categories. In this way, data analysis was not a linear process; rather, it involved moving back and forth between the parts and the whole. During this phase, I frequently jotted notes in my journal in order to clarify the relationships between the emerging themes. After the first round of interviews, special attention was given to the conceptual structure to-date, with the purpose of planning the second round of interviews to validate and expand the conceptual understanding. The themes were discussed with the thesis chairperson and were reconstructed into a conceptualization that captured the key themes. As a last step, the data generated by the follow-up interviews were incorporated into the conceptual structure.

In summary, the inductive method of thematic analysis involved the process of description and evolving abstraction. Ultimately, a description of the shared themes, across participants, within the experience of caring for culturally diverse clients resulted. After analysis was complete, the findings were compared to the literature. The final product, thus, is:

an integration of the participants' description of their experience, the researcher's description and interpretation of the data, the researcher's intuitive grasp of the whole of the experience, the researcher's use

of...literature...and the researcher's creativity in organization and explication of the phenomenon as theory. (Ray, 1990, p.178)

Ensuring Rigor in the Research Process

Rigor, or trustworthiness, was ensured in this research project by following Lincoln and Guba's (1985) criteria for qualitative approaches: credibility, transferability, auditability, and confirmability.

Credibility

A qualitative study is credible when it presents such a faithful description of human experience that it is recognizable as one's own to others who have experienced the same phenomenon. Credibility is threatened by the closeness of the researcher-participant relationship (Sandelowski, 1986). Anderson (1991) posits that "field work is inherently dialectical – the researcher affects and is affected by the phenomena (s)he seeks to understand" (p.117). Reflexivity, the "critical thinking that reflects the dynamic interaction and exchange between the investigator and the total research environment" (Lamb & Huttlinger, 1989, p.766), is a means of ensuring credibility. Self-awareness is needed to balance this exchange. Reflexivity includes

- 1) explicating the researcher's perspective,
- 2) bracketing a priori explanations about the phenomenon,
- 3) selecting unfamiliar settings, people, and circumstances for the study,
- 4) assuming a posture of unobtrusive presence with the subjects, and
- 5) performing the study with a coresearcher in order to use dialogue throughout the process to transcend individual bias (Oiler, 1986, p.80).

In this study, several strategies were employed to ensure credibility. First, triangulation in the form of input from thesis committee members facilitated the transcendence of individual bias. Discussion with other nurses to broaden my views and the use of literature in the final stages of the analysis process served as further triangulation. Second, member checking (Lincoln & Guba), both formally and informally, throughout the research process, provided a credibility check. As Sandelowski, Davis, and Harris (1993) point out, however, there are certain problems inherent in member checking such as members not recognizing their personal experiences in the researcher's representation of the multiple realities. Member checking is seen as only one way of ensuring credibility. In this study, the participants validated the conceptualization of the findings during the second interviews. Finally, the use of a reflexive journal along with field notes, provided for a check against personal biases.

Transferability

The transferability or fittingness of qualitative research is evaluated by how well the findings "fit" into contexts outside the study situation and by how its audience views its findings as meaningful and applicable (Sandelowski, 1986). Also, the findings must "fit" the data from which they were derived. Toward this end, verbatim recording of data in this final research report serves to illustrate the "fit" between the data and the findings. Continual comparison between the accounts of all the participants protected against overweighting certain stories or not keeping certain descriptions in their proper perspective (Sandelowski, 1986, p.32). Furthermore, the generation of "thick" data and an awareness of the danger of

premature closure during data analysis strengthened the transferability of this study. Purposeful sampling for a diversity of experience contributed to the generation of "thick" data.

Auditability

The consistency of qualitative studies is determined by the auditability of the analysis; that is, another researcher is able to clearly follow the "decision trail" used by the researcher (Sandelowski, 1986). Given the researcher's data and fore-structure, a second researcher should be able to arrive at similar conclusions. In this study, I requested that my thesis chairperson review the first transcript for both the interview style and the initial attempts at data analysis in order to assure auditability. Ongoing direction from the thesis committee enhanced consistency. As well, special attention was given to leaving a clear "decision trail" through the use of field notes and other methodological notations in the reflexive journal.

Confirmability

While neutrality and freedom from bias are the goals of quantitative research, qualitative research values subjectivity. Lincoln and Guba (1985) suggest that confirmability is achieved when auditability, truth value, and applicability are established. The methods employed for the achievement of these criteria have been outlined above.

Ethical Considerations

The rights of the participants were protected in the following ways:

- 1) Written approval to conduct the study was obtained from the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects.
- 2) Agency approval was obtained to recruit participants.
- 3) Informed written consent was obtained prior to the first interview. Participants were informed verbally and in writing of the nature and purpose of the study, their involvement, how the data were to be collected, handled, and disseminated. (See Appendix B for consent form.)
- 4) Process consent was continually obtained because the emergent design of qualitative research made it difficult to predict the direction of the project (Munhall, 1988; Ramos, 1989). The participants were kept informed as to their vulnerability and consent was considered as an ongoing process.
- 5) Confidentiality was assured by erasing the tapes at the end of the project. Names were not used in the written report and descriptions of circumstances were general in order to protect the identity of the participants. Access to the data were limited to the researcher and her thesis committee.
- 6) Participants were offered a summary of study results.

Limitations of the Study

Limitations of this study relate to the generalizability of the findings and to my lack of research experience. This inexperience may have affected the quality of the data generated by the interviews and may also have affected the data analysis. The findings represent the experience of caring for culturally diverse clients in hospital settings only. The volunteer nature of the sample further limits the generalizability of

the study. As well, the study is limited to describing the experiences of recently graduated nurses and, thus, are not transferable to more experienced nurses. Another limitation is the absence of the male voice among the participants. Consideration was given to this decision as the study progressed. To avoid adding another variable to the study and because gender issues had not emerged as a central issue, the decision was made not to recruit a male. As with all qualitative studies, the study offers an interpretation from a specific group of eight nurses; the findings cannot be seen as representative of the descriptions and experiences of all nurses.

Summary

In this chapter, the descriptive-exploratory research method employed in this study has been presented. Theoretical sampling provided for a sample of eight recently graduated nurses. Data were generated through unstructured interviews. Thematic analysis, within the constant comparative method, uncovered themes of common experience. Rigor was ensured through a systematic consideration of the issues of credibility, transferability, auditability, and confirmability. Ethical considerations and limitations of the study were also described.

CHAPTER FOUR: PRESENTATION OF FINDINGS

Introduction

In this chapter, the findings of the study are presented in the form of an interpretive summary of the nurses' descriptions of the experience of caring for culturally diverse clients. This understanding evolved throughout the data collection by my application of the constant comparative method of data analysis. As the conceptual structure emerged, a second round of interviews was completed to validate and expand on the conceptual understanding. This summary of the experience of caring for culturally diverse clients represents the shared elements of the experience as described by the nurses.

Generally, the nurses described caring for culturally diverse clients in hospital settings as a considerable and persistent challenge; yet, because of the complexity of the health care setting, an issue easily overlooked. They also spoke enthusiastically about the rewarding nature of cross-cultural nursing. As one nurse explained:

Generally speaking, I find it sometimes seems like a challenge, but then I think it is more like it is really rewarding. I find it so interesting getting to know someone who comes from a totally different culture. I just love it!

The participants enjoyed personal growth as a result of the experience, both in the knowledge they gained about other cultures and in the knowledge they gained about themselves. Further, they expressed satisfaction with a job well done; appreciation from the family reinforced this sense of gratification.

Although the participants worked diligently to provide a high standard of care for these clients, they identified situations in which it was particularly difficult to provide quality care. Additionally, they offered their perspectives on the nature of the hospitalization experience for culturally diverse clients. Many of the participants empathized with the clients, suggesting that the clients felt "incredible isolation" and were often "totally helpless." Such feelings resulted from a myriad of factors, including the unfamiliarity of the setting and the language barrier. As I sought to understand the experience of culturally diverse clients and the nurses caring for them, the complexity of cultural issues quickly became apparent. While some of the cultural issues derived from language barriers, the issues extended far beyond matters of language to include beliefs and values, health practices, social customs, and overarching factors such as societal and political will. The findings of the study are presented against this backdrop of challenge and complexity.

Emerging from the interview data are three themes regarding the experience of caring for culturally diverse clients: 1) a continuum of commitment to cross-cultural nursing, 2) strategies employed by the nurses, and 3) contextual catalysts influencing the care of culturally diverse clients. The nature of the experience, that is, the quality of care received by the clients and the rewards and challenges experienced by the nurses, was dependent on nurses' commitment to cross-cultural nursing, the strategies employed, and the contextual catalysts.

Nurses' Commitment to Cross-cultural Nursing: A Continuum

The nurses in the study described the experience of caring for culturally diverse clients in different ways, with varying degrees of commitment, and with

diverse levels of insight. As the data were analyzed, it became apparent that these differences could be conceptualized as falling along a continuum. At one end, nurses were described as being resistant to cross-cultural caring. In contrast, certain nurses were obviously impassioned about the care of culturally diverse clients. Other nurses, in between the resistant and impassioned nurses, provided respectful and competent care but did not see the care of these clients as much different from that of any other clients.

Levels of Commitment: Resistant, Competent, and Impassioned

None of the nurses interviewed fell into the category of resistance; however, by the participants' descriptions of resistant colleagues, this category became evident. By the self-selective nature of a voluntary sample, it was not unexpected that resistant nurses did not volunteer to be in the study. One participant inquired if a certain colleague had volunteered to be in the study:

I told her to talk to you. She is racist towards Orientals. I told her it might help her to talk to you. But she said, no, she didn't want to be judged for her prejudice and that the researcher wouldn't want to hear what she had to say.

Thus, the descriptions of this group of nurses came solely from other participants:

Four of the nurses participating in the study fell into the category of competence in their approach to cross-cultural clients. As one participant explained, "most of the nurses I work with fit into the middle-of-the-road group." These nurses acknowledged that they had not given a lot of thought to the issue but were committed to giving respectful and individualized care to all of their clients. One

participant stated, "I don't really think of it that much, although I see the differences."

Similarly, another participant said:

Maybe I miss some of the issue. I would be interested if you talked to other nurses from my unit. Maybe this stuff goes right over my head.....To me, the basic respect and the information-seeking are enough.

The final group of nurses were impassioned about caring for culturally diverse clients. They expressed a high degree of personal commitment to the matter and were thoughtful in their descriptions. Each nurse was able to clearly articulate why she was so devoted to cross-cultural caring; indeed, each nurse described an experience of *awakening* to the complex imperative of cross-cultural nursing. For two participants, the awakening occurred while living in another country:

What sparked my interest was working in the Philippines, that gave me an appreciation for a totally different culture than mine. That was really profound, just having to deal with how different these people are made me look at my own biases....So I think that was probably a significant turning point in the way I viewed multiculturalism.

When I was 11, we moved to Japan from this small town in Kentucky where I didn't see a black person until I was 12, to be surrounded by Japanese. I remember it was such a difficult transition for me, but I don't think I was ever the same after that. Having an experience like that is going to change you for sure. And not everyone has had that struggle....Some people just purely haven't had their eyes opened. And so, they can't relate....If you have been in another culture, it takes about two seconds to figure out that you are from Mars and this country doesn't understand you.

For another participant, the experience of negotiating the health care system as a visible minority represented a turning point. The fourth participant described an IndoCanadian childhood friend who helped her understand the minority experience.

All the participants concurred with the conceptualization of a continuum of commitment when it was presented to them during the follow-up interviews. One nurse responded, "Even as you were talking, I had a picture of my ward and where everyone fell in." One nurse, however, was hesitant to validate the resistant category, especially in describing this group as being racist. She commented, "we all have our biases and must admit it. We lie if we say we don't have judgments. We all have blind spots." She did, however, see a difference in this group as being less thoughtful about their nursing practice with culturally diverse clients. Hence, her understanding may stem from either of two sources: a) her more charitable approach toward her colleagues or b) her experience of working only with competent and impassioned nurses (i.e., not working with resistant nurses). Thus, the conceptualization of differing levels of commitment to cross-cultural nursing falling along a continuum seems helpful in accounting for the varying descriptions of the experience of caring for culturally diverse clients.

The Fluid Nature of the Continuum

While the three groups of nurses (i.e., resistant, competent, and impassioned) represented three levels of commitment, their placement in a continuum must be understood as being somewhat fluid. That is, a nurse's level of commitment at any given point could be influenced by personal or contextual factors that moved him/her toward either end of the continuum. For example, one participant described how a cultural conflict might move a nurse toward resistance:

Asian parents have rules about washing children when they are sick. If these kids are immunosuppressed, they need to be clean. Every bug on their body is just waiting to crawl into that body. Yet, parents may

believe the child will get a cold if he has a bath. This can bring out resentment in the nurse and move her toward the resistant category....It is easy for the middle group to move either way, depending on the situation and the presence of conflicts.

Another nurse noted how the multiple stimuli in the working environment could affect her care:

There is movement in this. Now that I am living the reality of shift work and a busy unit where you may be stretched to the limit ... there may be moments when we move back and forth. If you are tired and just had a difficult case, you can't just shake it off. Your tolerance or ability to cope may be less. That may turn you off.

In keeping with the fluid nature of the continuum, the nurses described distinct turning points generally precipitated by some specific experience. The turning points could move the nurse toward an impassioned stance as described earlier, or toward a more resistant level. One participant told the story of a colleague who was divorcing her Asian husband. Her personal experience was affecting her ability to care for Asians in the hospital to the extent that she would ask other nurses to administer medications to these clients. The participant went on to say:

I never saw this in her before. I would never have thought she would be like this. She is going through a personal experience with race right now, and bringing it to work and now she is transferring this to her patients.

Other turning points could be likened to awakenings that convinced competent nurses of the imperative nature of cross-cultural nursing. One nurse commented, "Competent nurses need something to twig their awareness, although it might come along with exposure. I would say it would happen sooner with an experience." The impassioned nurses all agreed that some turning point or enlightenment was necessary to move them beyond the competent position. One

participant explained, "This awakening thing makes such sense. Something has to stun you out of 'it just is'."

Apart from the turning point experiences, personal influences could also gradually move a nurse along the continuum. The basic determinant of a nurse's starting point on the continuum (i.e., how the nurse will practice as a student and a new graduate) was his/her exposure to and experience with various cultural groups. The participants reasoned that resistant nurses likely had spent most of their formative years in homogeneous settings. Several of the competent nurses in the study also admitted to having had little exposure to cultural diversity prior to their nursing experience. On the other hand, all of the impassioned nurses were comfortable in diverse settings; three of them had lived as minorities in another culture. In keeping with the importance of experience with cultural diversity, the participants stressed the key role of exposure to clients from different cultures during their nursing education. One participant explained how she became more comfortable with repeated experience:

As I encounter more and more of them [IndoCanadians] in my practice, their cultural practices don't become as foreign to me. It gets to the point where I am comfortable with what they do, and although I might not understand why they do it, I understand that the IndoCanadian cultures like doing this. I can predict what they like or expect it. It becomes easier for me in that it doesn't come as a surprise. I have encountered this before in my practice.

It seems, then, that repeated experience with culturally diverse clients moved certain nurses further along the continuum.

Thus, while these nurses generally practiced from a certain point on the continuum, they moved along the continuum either temporarily due to the influence

of personal experiences and contextual factors, or more permanently because of a distinct turning point such as an immersion experience in another culture.

Contrasting Resistant, Competent, and Impassioned Nurses

Differences between the commitment levels of the nurses can be understood within the subthemes of philosophical stance, intellectual process, and nursing practice. The three groups differed in their beliefs or philosophical stances regarding cultural diversity. Further, the nurses' intellectual processes – what they knew and how they thought about cultural issues – were based on their philosophical stances. Finally, their nursing practice varied in keeping with their philosophical stances and intellectual processes. (See Appendix E for summary of differences).

Philosophical stance. Resistant nurses ignored or resented the cultural diversity of their clients, considering culture to be an inconvenience or a "problem." One participant described resistant nurses as either putting aside their resentment to "take care of them...but not give them their all" or being open about their resentment and avoiding or complaining about the clients. Another participant explained:

It [caring for culturally diverse clients] may not be a conscious issue for resistant nurses. It tends to come up as inconvenience that they have to abide by these extra requests, or work around these extra visitors It is the fact that the nurse has to go out of their way to accommodate. That becomes a problem.

From this philosophical stance, resistant nurses expected the assimilation of culturally diverse clients into mainstream Canadian ways. For example, resistant nurses were reported as saying:

They [immigrants] are coming in here and changing us. The hospital allows their signs here. Wait a minute. This is Canada. We need our English signs. They should have to learn our English.

Another participant recalled hearing the following comments in the staff room:

You are in Canada now. You have been here for 10 years. You should have learned the language by now. You should at least try. You chose to immigrate here. You should choose to adapt to more of the Canadian culture.

Competent nurses acknowledged and accommodated for cultural diversity; yet, they viewed culture as a non-issue. They believed that common respect for all clients would ensure appropriate care for culturally diverse clients. They saw the culturally diverse client as "just another patient." One participant described this group of nurses in the following way:

Some staff are of the opinion of, well, they're your patients and you have to do your best job, but still no respect for their culture. Just treating them as a patient. In keeping with this philosophical stance, ethnicity was equated with disease prototypes, such as ulcerative colitis, by several participants; that is, the culture of an ethnic group was similar to the culture of any group of people with a particular disease. Cultural diversity was dealt with by the credo of "common respect for all." One nurse explained:

I don't see it as an extra effort, beyond the patient who has a different problem. That kind of effort has to be applied to all patients, just by virtue of being an individual.

Impassioned nurses went beyond accommodation to appreciation of cultural diversity. During the interviews, the impassioned nurses frequently pointed out the richness of other cultures. For example, one nurse described a Native Indian birth with warm appreciation and respect. Another participant, who was also working in home care, observed that not only did the experience of going into the homes of

culturally diverse clients serve as an "eye opener", but that the experience also made her become appreciative of the other cultures. These nurses perceived the provision of health care to culturally diverse clients to be a central issue for nurses and consequently were alert to the multiple challenges involved. To illustrate the magnitude of the issue compared to other issues facing nurses, one nurse rated caring for culturally diverse clients as an eight on a scale of one to ten, with ten being the largest issue imaginable. Additionally, these nurses clearly articulated their personal commitment to multicultural nursing. In a quiet voice, one nurse said:

The more I'm nursing, the more I realize I very specifically want to help immigrants so that they are not feeling lost. Very specifically want to help minorities.

To summarize, distinct patterns could be described regarding the philosophical stances of the nurses, depending on their beliefs about cultural diversity. These views ranged from resenting diversity to accommodating diversity to appreciating diversity.

Intellectual processes. Analysis of the knowledge and thoughts of the participants indicated that the resistant nurses were seen as frequently relying on negative stereotypes. Comments such as "the whole Chinese community is like that" and "these kinds of people just want to come to a rich country" were reported. Furthermore, several situations were described by the participants in which any negative or foreign behaviors in culturally diverse clients were automatically attributed to the cultural group, rather than to the individual personality:

If there is a problem, a personality problem, or a family conflict, it is not blamed on the family, it is blamed on the culture. Whereas, you can be looking after two patients from the same descent, this one is a

bad patient. It is blamed on the culture, even though you have a good patient from the same culture...one bad egg spoils the whole crop.

These nurses were also seen as avoiding education or any further knowledge regarding cultural diversity. One participant observed:

The troublemakers don't even want to show up for these things [seminars]. They are the troublemakers, and you can't force them to go.

According to their more committed colleagues, this lack of knowledge regarding cultural beliefs impeded the resistant nurses in providing appropriate nursing care. For example, the lack of knowledge about the hot/cold beliefs of the Asian community would prevent the nurse from recognizing the inappropriateness of placing an icepack on the perineum of a postpartum woman.

In the middle of the continuum, the competent nurses' cultural knowledge was based on generalizations and stereotypes that were predominantly positive. Although they did not have an in-depth knowledge base to draw on, they were expanding their understanding by seeking specific facts and strategies regarding cultural diversity. For example, one nurse was unsure of her clients' specific cultural group or belief, describing them as being "East Indian, or Indian, I don't know if they're East or you know, from India somewhere." Another nurse stressed that the challenge in caring for culturally diverse clients was knowing specific details about their cultures:

Caring for these clients is more of a learning issue, the only way it is really a problem is nurses not being aware, and not knowing how to deal with the different cultures....We need to learn different ways that immigrants deal with things in the health care setting.

Competent nurses were beginning to see predictability and familiarity in cultural groups; that is, they saw patterns in the diversity. "With Japanese, you speak to the

family before you speak to the patient, which I might not agree with, but that is the way they make their decisions." Overall, competent nurses had not reflected on cultural issues to any significant extent. One participant mentioned that the interview was making her consider things she had not thought about before. Another participant admitted, "Maybe I miss some of the issue. Maybe this stuff goes right over my head."

The intellectual processes of the impassioned nurses contrasted with those of the resistant and competent nurses. Impassioned nurses perceived, but were not threatened by, the complexity and ambiguity of cross-cultural situations. They talked about how "tricky" cross-cultural situations were. "Cross-cultural nursing, cross-cultural everything. Nothing is black and white." These nurses were analytical and thoughtful in appreciating this complexity. They were more likely to speak about cultural issues at theoretical levels, often making links to larger societal issues such as Canada's multicultural policies or the ethics of certain cultural practices (e.g., female circumcision). One participant warned against a simplistic approach to culture:

The danger of being educated about cultures is that you can generalize Just because you think that if you just read a chapter about Chinese families living in North America, then you apply this to every Chinese family you meet. You are doing everybody a big disservice by doing that. Generalization leads to discrimination which leads to racism.

The impassioned nurses analyzed challenging cultural situations from the clinical setting, "looking for other roots to the problem." To illustrate, one nurse, who frequently cared for Asian women in labor, was methodical in attempting to understand the different patterns she was observing in their labor and the resultant

interventions. The nurses reflected on their own practice, identifying and dealing with biases in themselves. One participant commented:

I have a cultural bias because I totally and firmly believe that everyone should be totally informed about their illness, and that everyone should know about the fact that their disease has recurred So I can't enforce my belief on somebody.

In keeping with this thoughtful approach to the complexities of cross-cultural nursing, the impassioned nurses were careful not to make assumptions or generalizations about culturally diverse clients, frequently referring to the variability within cultural groups. One participant explained:

You cannot generalize. You cannot stereotype. Everyone is different. You cannot assume that because someone has been in Canada for 20 years that their English will be fluent. Some people can be here for only a few years and be completely assimilated. Others have been here for many, many years and have retained a lot of their culture....There is a big range of variability.

Another nurse contrasted the Vietnamese refugee with the Hong Kong professional immigrant in illustrating the variations within cultures she might expect among laboring women. Finally, the impassioned nurses planned both personal and professional development activities to further develop their cross-cultural skills. Two participants were studying Asian languages. Another described how she tailored her BSN program to focus on multiculturalism. Personal responsibility for gaining knowledge was emphasized, "the moment you feel threatened, go read a book."

In short, the intellectual processes of nurses seemed dependent on their philosophical stance. Nurses varied along a continuum: resistant nurses drew predominantly on negative stereotypes; competent nurses looked for generalizations, specific facts, and strategies as guides; and impassioned nurses avoided

generalizations and, instead, perceived the complexity and ambiguity of cross-cultural nursing.

Nursing practice. Just as the nurses' descriptions regarding their philosophical stance and intellectual processes varied in keeping with their position along the continuum, so their descriptions of nursing practice itself varied. More explicitly, their nursing practice flowed from what they believed, thought, and knew about cultural diversity. For example, the impassioned nurses, in their appreciation of the complexity and ambiguity of diversity, entered into the dilemmas of caring for culturally diverse clients by seeking to create partnerships with these clients. On the other hand, resistant nurses who ignored or resented diversity were described as being rigid and controlling in their nursing care of culturally diverse clients.

The participants described different emotional responses to cross-cultural nursing; that is, they described what it feels like to care for culturally diverse clients. All the nurses described the experience of caring for culturally diverse clients as frustrating at times; however, the sources of this frustration varied across the continuum. Resistant nurses were observed to be frustrated with clients and their families; their frustration centered on what the experience meant to them personally. A resistant nurse was heard saying:

From the moment I walk in there, it is the look they give me. Look at their body language. It says I am subservient....Get me a drink, eh? I am not somebody to order around.

These nurses were frustrated by what they interpreted to be an expectation to "cater to" culturally diverse clients. Linked to this was the feeling that they were not being

respected by such clients. The nurses in the study explained that the resistant nurses felt threatened and resentful.

The competent nurses were frustrated by barriers to "getting the job done." They were more likely to see language as a big issue and were aware of the extra time it took to accommodate for cultural preferences:

It is anxiety producing because it is a time factor. It is going to take you so much longer to help care for this person if you can't communicate with them.....You'll get everything set up to wash them and then, "no, no, my wife will do it" and it is, "ugh..."

Along with the frustration and anxiety, the competent nurses also reported feelings of uncertainty in caring for culturally diverse clients. One participant described her uncertainty when she heard a grieving Asian family, "I didn't know what to do, I thought, 'oh my god, get the Ativan'." Similarly, another participant recounted the following story:

I remember learning about saying prayers before taking pills.... I didn't understand why this Iranian gentleman was not taking his pill. I didn't understand, I gotta admit, I was really anxious, "Is he hoarding his pills under the mattress?"

The impassioned nurses also reported frustration in the experience of caring for culturally diverse clients; however, their frustration stemmed from the knowledge that these clients were not getting the "quality of care I [they] would like to give." Generally, the emotional responses of the impassioned nurses were those of confidence and enjoyment. One participant explained that she was comfortable with other cultures and therefore was not threatened by the experience. Another nurse commented that caring for culturally diverse clients was "'fun" and "more rewarding than challenging." Thus, the emotional responses of the different nurses to caring for

culturally diverse clients were in keeping with their philosophical stances and intellectual processes.

In the participants' descriptions of their nursing practice, their emotional responses were intertwined with portrayals of the nursing care they provided. Generally, their approaches with and care for the clients corresponded to their position along the continuum. Resistant nurses tended to be task-focused, rigid in their approaches, and took ownership and control over the client. A common control issue was the number of visitors. An incident described by a participant involved postpartum care:

Nurses need complete control. After the birth of an East Indian boy, eighteen visitors may be present to celebrate and party. Nurses don't like that. This is my patient, I have things to do, and would you get out of my way please....This woman only has two days postpartum, she has to learn everything and if all those people are around her, I am trying to teach her breast feeding.

Caring for culturally diverse clients represented change for them and they were described as being resistant to change. This resistance could extend to actually blocking the efforts of other nurses in providing culturally sensitive nursing care. One nurse described how resistant nurses "hassled" her about the time she was spending with culturally diverse clients, telling her that she would have to get over her "degree thinking." She elaborated:

I was having a discussion with that LPN about culture, how to cater more to the different needs, [but] it's just bash, bash, bash. You could talk till you're blue in the face about it and make comparisons, "If you were in another country...", well, it doesn't work. "We are here, this is now."

Competent nurses gave efficient and considerate nursing care. They appreciated the involvement of family and described effective cross-cultural communication. While these nurses encouraged cultural practices (e.g., bringing food from home), they were less likely to make a concerted effort to ensure a high standard of culturally sensitive care.

Impassioned nurses were similar to the competent nurses in the care they provided although they were likely to put more effort into all that they did. The following excerpt from an impassioned participant highlights the difference between the competent and the impassioned nurse:

I am putting in all this extra effort, explaining things, having fun, building rapport, doing hand signals, giggling....I've seen other nurses, they peek in, "How are you doing?" The patient shakes their head, no English, the family is there, no English. The nurse says, "I'll try to find a translator" and will leave. But there is no attempt. You can't do as much so you just accept that. If you don't get a translator, "que sera, sera, I am too busy anyway." Whereas, I will get in there and make them feel more comfortable.

The impassioned nurses also entered more deeply into the dilemmas represented by cultural conflict. One nurse expanded on a common cultural conflict in obstetrical care:

Chinese women don't like cold; the thing that has come up and up and up for me is a lot of them have ended up with episiotomies and swollen perineums. You want to put an ice pack on there. And they refuse, they think that it increases their chance of getting arthritis later on....As a nurse, you know that if you don't put an icepack on there, it is going to be swollen for days and they won't be able to sit, much less breastfeed. So, what can you do? It is a dilemma, right?I think that when we move in and try to do it our way, you can do more harm than good.

As the interviews progressed, it was evident that the experience of caring for culturally diverse clients was generally viewed positively by the competent and impassioned participants. However, what was distressing for them was the presence of racist attitudes in their colleagues and in the health care system itself. Several of the participants spoke passionately about the discriminatory practices of their colleagues, labeling them as racist. Other nurses would describe incidents that included discriminatory practices but would back away from the conclusion that racism was the underlying cause of such practice. To illustrate, one participant described her colleagues in this way:

I know some of them don't have patience for it. A lot of them believe, "If you are going to be here, speak English"....A lot of them have just dealt with it longer than me and they are fed up....Maybe they are prejudiced and I don't know it. It is more of a frustration from what I sense.

Racism, then, influenced all of the nurses in this study in some way. In some cases, the presence of racism was subtle and difficult to identify. In other cases, the racist attitudes of colleagues were blatant and disruptive for all of the nurses on the unit. Further, racism was a critical determinant of the quality of care received by culturally diverse clients.

Data analysis revealed that nurses varied in their participation in and response to racism in keeping with their commitment to cross-cultural nursing. Resistant nurses were described as practicing both overt and covert racism, although they might or might not admit to discriminatory attitudes. Most typically, these racist attitudes were expressed in judging behaviors, ignoring client needs, and complaining. In one example of judging, nurses were reported as whispering about

an IndoCanadian family who had brought their elderly father to Canada, "They shouldn't have brought him over here. Can't they see he is an elderly man. What are they trying to prove? He broke his hip in the first week. Doesn't that tell them anything?" One participant described the response of a colleague to a patient who had spit on the floor:

She went over and said, "Don't do that." Like she (the patient) was a dog, without much of an explanation, roughly wiped it up and looked at her in disgust, like, "Good god, spitting. Now I've seen it all."

Resistant nurses also ignored the requests or cultural preferences of culturally diverse clients. For example, one family had repeatedly requested that their son be given holy water that had been couriered from India, "we've been asking for a while and we've been trying for this and we are not getting anywhere." Their request had been alternately ignored and denied by resistant nurses. Complaints from resistant nurses typically happened outside the client's room (e.g., at the work station or in the staff room); for example, nurses might complain about the "50,000 visitors" in a client's room.

The competent nurses identified discriminatory attitudes in their colleagues but typically chose to "put up" with them and, thus, were passive participants in racist practices. One participant explained that most nurses would not challenge colleagues regarding racist attitudes, but rather accepted the behavior as less than ideal, "That so-and-so. That's just them. They are not going to change. They are working on their pension." Another participant described the resistant nurses as "fed up" and "burnt out." Other competent nurses went as far as to offer positive views of culture in response to their colleagues' complaints:

If a comment were made about a family, I would state my opinion. I do not have an obligation to change their beliefs. But if quality of care were affected, I might say, "You are having a problem looking after this family. Would you like to trade assignments?" I would do this for the sake of the family, not for the nurse.

The competent nurses empathized with the experience of the culturally diverse client in the hospital but did not feel empowered to bring about substantial change.

The impassioned nurses, on the other hand, identified institutional and individual racism. One nurse noted the difficulty minorities had in navigating the bus system. Another nurse pointed out the imposition placed on other cultures to conform to the Western norm of having husbands present at birth. Such identification of racism at institutional levels was unique to the impassioned nurses and corresponded to their heightened level of awareness and insight. Moreover, the impassioned nurses felt empowered to advocate and negotiate to overcome such barriers. Two nurses described how they negotiated around the insulin schedules and diabetic diets for culturally diverse clients:

Some nurses flip out with the traditional Chinese diet, I don't bother in the postpartum case of gestational diabetes. To hell with her diabetes for the moment. But a lot of nurses are afraid to shift from that. The institution creates a sense of fear in you, you may get your hand smacked.

One participant went to considerable length to advocate that a client be allowed to take holy water and have a quiet place to say prayers. When she met resistance from her colleagues and administrator, she asked the doctor to write an order for these two cultural-religious practices. Another nurse described how her colleagues had negotiated to have the smoke alarms temporarily turned off in order for a family to burn incense in a healing ceremony. While the impassioned nurses were more likely

to identify and deal with discriminatory practices, they also expressed how difficult it was to address racism in their colleagues:

It gets tricky when you have to confront a coworker. I really don't like to do that...you have to be really careful not to tread on toes because you are going to work with this person for years and years on end but the patient will go home in two weeks.

The theme of racism was present in all of the interviews, although some participants were more hesitant to label attitudes as racism, preferring instead to talk about prejudice and discrimination. Nonetheless, the differences in attitudes were clearly contrasted between the resistant, competent, and impassioned nurses. According to the participants, the resistant nurses practiced both overt and covert racism. While both the competent and impassioned nurses were disturbed by such racism among their colleagues, only the impassioned nurses discerned racism as extending beyond the individual level to become a system-wide problem that they had a responsibility to address.

In summary, the analysis of the data led me to conceptualize the commitment of nurses to cross-cultural nursing as falling along a continuum ranging from resistant to competent to impassioned. It was my impression from the accounts of these nurses that the majority of their colleagues fell into or near the competent category. The resistant nurses may have moved to that position because of a negative experience or turning point, or, as suggested by the participants, may have come from homogeneous settings where they had little exposure to culturally different people. Impassioned nurses described an awakening to the imperative and complex

nature of cross-cultural nursing. These nurses were comfortable with the ambiguous and challenging character of caring for culturally diverse clients.

Notably, the nurses' philosophical stance toward cultural diversity influenced their pursuit of further knowledge, their interpretation of cultural matters, and, most importantly, their provision of nursing care. The reported racism within health care settings was disturbing both in its presence and influence. Culturally diverse clients experienced discriminatory care from resistant nurses who were racist. Moreover, according to all of the participants, racism among their colleagues was very difficult to address, leading to passive participation in racist practices by the competent and impassioned nurses. Racist practices were more than isolated incidents. The impassioned nurses perceived that discrimination existed at the institutional level. In these ways, racism was a powerful influence in the experience of caring for culturally diverse clients.

Strategies Identified in Caring for Culturally Diverse Clients

Nurses in the study described strategies they used when caring for culturally diverse clients. Competent and impassioned nurses offered very similar descriptions of strategies; however, impassioned nurses were often more deliberate in choosing strategies and went to further lengths to provide culturally sensitive care. According to the descriptions of the nurses in this study, resistant nurses did not appear to use these strategies – they were more likely to ignore the specific needs of the culturally diverse client and focus instead on providing routine, task-focused, physical care. This discussion centers on the strategies identified by competent and impassioned nurses with differentiation between the two groups where applicable.

The participants consistently described the specific, sustained efforts they made in caring for culturally diverse clients. One participant summarized the nature of these strategies by saying, "If you have a goal in mind, you can achieve it, regardless of language or culture barriers. It is a matter of being flexible and creative in planning different ways to meet this goal." More specifically, through the process of data analysis, I identified the four strategies of connecting with the client, working with the family, accommodating for cultural practices, and balancing expectations.

Connecting With the Client

The participants were keenly aware of the challenge of developing nurse-client relationships, or "connecting," with culturally diverse clients. This challenge was heightened: a) if the client did not speak English, b) during particularly busy times, and c) when dealing with an acute situation. Most often, the cultural beliefs and practices of the culturally diverse client, along with the language barrier, presented the nurse with variables not typically encountered in the development of a helping relationship. According to the nurses, they overcame these variables with various approaches, centering mainly on communication. They connected with the clients through the help of a translator and through their own communication efforts.

Translation most commonly occurred through family, although other hospital staff might be called upon either informally or through the formal agency translation service. Translation was presented by the nurses as a complex process of actual translation, as well as interpretation of culture. The translator was described as a "filter." One participant summarized the potential conflict inherent in this "filter" role:

The only time I find it [the use of a translator] frustrating is in certain situations where I want the interpreter to translate literally what I am saying and I don't want the interpreter to sum up and pass on only what they think is important.

For this reason, some nurses preferred to work without a translator. One nurse explained, "I feel closer to the patient without the translator, even if I don't speak their language." On the other hand, another participant remarked that developing a partnership with the culturally diverse client required language. This nurse presented the nurse-client relationship as triangular in nature, with the translator as the third point, "you almost feel more connected with the translator. It is because you are communicating with them that you understand them, you are hearing their voice."

Regardless of the presence of a translator, the nurses described several other strategies to connect with the client. First, they stressed the importance of eye contact, friendly facial expressions, and face-to-face positions. One nurse suggested:

I think a smile is interpreted the same way in every culture so I think that conveys friendliness. Also sort of gazing into somebody's eyes, just a little bit longer, just to, I don't know, maybe there is some sort of inner connection.

Even when talking through an interpreter, the participants were careful to face the client and include the client by addressing their comments to them. Second, the nurses used touch to express caring to their clients. This touch included a comforting, nurturing touch and the "working touch of not only peeking, but palpating, really checking the IV, going around checking all the tubes and drains, really spending time." One participant emphasized:

I like to use a lot of touch in my care. I think just between that, and charades, facial expressions, and eye contact, we can get our point across. I don't have a problem letting patients know that I care and if

something is not right, please let me know. I don't have a problem getting that across. That is not spoken.

Finally, the nurses used universally understood language such as charades, drawings, and common words such as "peepee." One nurse humorously described the charades she had gone through to prepare a laboring woman for a saline enema. Thus, the participants described creative and flexible approaches in connecting with culturally diverse clients, both with and without translators.

Working With the Family

The participants were unanimous in the clear emphasis they placed on working with the family. According to the nurses, the families fulfilled several roles for the clients: 1) security and support, 2) liaison, and 3) caregiver. The support role included being there for the clients and assuring them that they were in "good hands." As liaison, the families would exchange information with the nurse, and then pass on to the client what the family wanted the client to know. The caregiver role included bringing in food and providing physical care such as assisting with hygiene and repositioning.

The approaches employed by the nurses related to supporting families in their roles. First, the nurses agreed that families must be treated respectfully with the goal of establishing trust. One participant described how she developed a relationship with a family after they had experienced a conflict with another nurse regarding the number of visitors in the room. After the participant had negotiated the conflict with her colleague, a family member said, "we knew you were a true daughter." Using this example, the participant stressed the importance of initial impressions with

families, "After this, the trust was there...first impressions are really important. They know who is another unaccepting Canadian, and who isn't."

The second approach commonly used was that of identifying a spokesperson in the family, often the family member most proficient in English. The nurse and other health care professionals would then communicate with the spokesperson, knowing that he/she would pass on the information to the rest of the family. Thus, all the participants identified the critical strategy of working with the family.

Accommodating for Cultural Practices

Accommodating for cultural practices was the third strategy that emerged from the data. Cultural practices might require little response from the nurse (e.g., the family bringing in food for the client) or considerable negotiation (e.g., a conflict between Western medicine and the practice of using ginseng). However, the basic methods implemented by the nurses to deal with cultural practices followed a similar pattern, regardless of the degree of difference or conflict. Ultimately, the methods represented the process of accommodation.

The first method was that of information-seeking to clarify the meaning of cultural practices for the client. For example, one nurse who worked in a pediatric setting explained her use of information-seeking:

I really like to ask families and the kids about their cultural background, where they're from, how long they have been in Canada. If I see them eating something and I don't know what it is, I'll ask them what it is....I find most families really appreciate the interest. If the child was wearing a bracelet and I had to remove it....I would ask, "What is the significance of the bracelet?" I think that opens a door of mutual respect.

Information-seeking, in this case, served to clarify a cultural practice as well as establish rapport with the family.

The second method was that of negotiation. While negotiating, the nurses typically explained their perspectives on the issue at hand, presented and explored alternatives, and then worked at coming to a consensus or plan. Suspending personal judgment was the third method that occurred regardless of whether the nurse agreed with the final decision. The scenario mentioned earlier of applying an icepack to the perineum of a postpartum Asian woman captures the three strategies of accommodation:

I would initially try to find out more about it. Is it cold altogether or for a certain length of time? I would explain the empirics and let her judge. I definitely would not push it on her. Maybe cool would be OK. Try to accommodate it that way within the constraints of the cultural belief.

In accommodating cultural practices, the impassioned nurses were more likely to enter deeply into the dilemmas, advocate for the client, and sidestep existing policies or rules if necessary.

Balancing Expectations

The participants also described the reflective process of balancing expectations as a strategy they used when caring for culturally diverse clients. As described in the foregoing discussion, they would put creative and flexible effort into caring for culturally diverse clients. Yet, in spite of their efforts, there were situations that left them dissatisfied or frustrated with the outcome of care. In some way, the nurses had to accept that, due to barriers beyond their control (e.g., unavailability of a translator), a reduced standard of care was inevitable. One nurse explained:

Your expectation is for the best quality of care, but in the long run it may not be possible because of language barriers. This causes tension that is balanced by the satisfaction with the effort. It is disturbing to not know if a family understood [an explanation], but knowing that really we did the best we could and that the client would still get good care.

Thus, resultant feelings of dissonance in the nurses were dealt with by the balancing of expectations. They balanced their expectations, not in expecting less of themselves, but in accepting a less than ideal outcome. For example, a participant explained that, although epidurals were much more common among laboring Asian women, she continued to "suggest everything [non-pharmaceutical methods of pain relief in labor] every time. I don't suggest them in a less enthusiastic way."

Ultimately, because the participants knew that they had put forth their best effort, they resigned themselves to accepting a lower quality of patient care. Despite this resignation, they felt strongly about the importance of a high standard of care for all clients. During the follow-up interviews, the nurses reacted with emotion to the suggestion of a lower standard of care, "You hate to think that you are giving them a lesser standard, but you kind of end up doing that." Another participant emphasized, "I would never shaft somebody because they are from another culture....Maybe the qualifier is that it is not conscious. You do the best you can do, but there are external factors." The ideal of justice in providing a high standard of care for all clients was stressed:

It is not fair to the patient, that just because they don't speak English, that they don't come out of this program with a good cardiac rehabilitation. It is not fair to the patient and it is not very professional of us....Then you have two standards of care. Whether they be based on wealth, social class, or culture. It won't do.

In brief, the responses of the participants point to the tension of balancing expectations regarding the care of culturally diverse clients. The nurses carried high ideals for the care they provided, yet they had to struggle with the fact that outcomes were not always as they had wished. It seemed that, despite the extra effort the nurses put into their care, there were times when they had to resign themselves to a less desirable outcome.

To conclude, caring for culturally diverse clients presented the participants with unique challenges that required flexible and creative strategies from the nurses. They connected with the client through the use of translators and by their own efforts at communication that expressed caring and acceptance. The nurses in the study respected the presence of the family by working with a spokesperson. As well, they accommodated for cultural practices by the processes of information-seeking and negotiation. Finally, although the nurses carried high ideals for the care they provided, there were situations in which they balanced their expectations regarding the outcomes of care.

What distinguished the impassioned nurses from the competent nurses in the application of these strategies was basically a matter of degree; that is, impassioned nurses were more persistent in their advocacy and more creative in their connecting efforts. While the strategies of the resistant nurses have not been presented here, the accounts of the participants suggest that they made little effort to connect with the patient, focusing instead on tasks and physical care. It was also suggested that they dealt with the family in less accommodating ways, ranging from ignoring them to

hostile confrontations. Cultural practices requiring accommodation were apparently discouraged.

Catalysts Influencing the Experience of Caring for Culturally Diverse Clients

Contextual factors (i.e., beyond the nurse), termed catalysts in this study, influenced the experience of caring for culturally diverse clients. The catalysts were the setting of health care, the support of colleagues, the commitment of the institution, and the foundation of education. The identification of catalysts was an important theme in the data because of their direct impact on the outcomes of patient care. Yet, in keeping with the involved nature of cultural issues, the interpretation of these catalysts presented a challenge because the nature of the influence (i.e., the direction and strength) depended, in part, on the perception of the nurse. Therefore, a catalyst such as the diversity of the community could either constrain or enable culturally sensitive care, depending on the nurse's attitude toward cultural diversity. In most situations, however, the presence of a catalyst supported the nurses in the care of culturally diverse clients. Further, not only did the nurses perceive the catalysts in different ways, they also varied in their efforts to manage them. For example, some nurses were more likely to access the resources of the agency or prioritize nursing care on fast-paced units to allow time for culturally sensitive care. As well, the participants referred to catalysts both in an analysis of current conditions and with recommendations for the ideal. In keeping with such complexity and variability, the catalysts identified in the following discussion have not been categorized definitively in regards to their constraining or enabling influence; rather, variable interpretations, as described by the participants, are offered.

The Setting of Health Care

The larger context of health care in Canada was mentioned by several nurses as important in influencing the experience of caring for culturally diverse clients.

One of the impassioned nurses talked about Canada's multicultural policies:

The American view is the melting pot, everyone assimilates. I think the Canadian view is a patchwork quilt. Together we make a whole. You respect the difference....I think that the Canadian culture has made a big effort.

Other nurses referred to the increase in non-Caucasian immigrants to the province and the implications this had for who they might care for in the hospital. The changing immigration patterns made cross-cultural nursing commonplace in the settings of most of the participants. Three of the nurses who worked in a non-teaching hospital made positive references to the diversity of the surrounding community. In contrast, some of their colleagues were threatened by the diversity of the community and brought their resentment into the workplace. One of the participants observed how the "growing up issues" of the community spilled over into the hospital. She explained that the nurses who were "bugged" by the minorities in the shopping mall were also resentful of culturally diverse clients in the hospital. "The community is so diverse, it is so equal and yet nurses have such trouble with that....their own personality... seeps into their professional life." The participants also speculated that discriminatory attitudes were more likely in homogeneous communities where people had limited exposure to diversity. The catalyst of a diverse society, then, either enabled or constrained nurses in the provision of culturally sensitive care.

The workload and objectives of the unit in which the participants practiced were identified as significant catalysts. Six of the nurses worked in units that were described as being very fast-paced and "heavy." Frustration resulted when their workload threatened their ability to give the care they wished for culturally diverse clients. One participant remonstrated, "if they had one or two more staff members ... nurses would be willing to spend extra time [with culturally diverse clients] but that is not the state of things today." According to the participants, the time constraints on these units prevented the nurses from communicating effectively, connecting with the client, and understanding the interplay between the illness experience and cultural beliefs. One nurse described how she was unable to take the time to locate a translator during a crisis, "I could tell from her [the patient's] face that she was freaked out but I couldn't explain what was going on." The participants contrasted these fast-paced settings to more relaxed units where there was more time to establish rapport with culturally diverse clients and to arrange for translation.

Along with the workload of a unit, the objectives of the unit were also influential. For example, one nurse explained that the health care professionals on her unit did not do well with dying clients because of the unit's curative philosophy:

Our model is so set up on cure that when we get to that point when we don't cure them, we don't know how to approach them to talk about death....So when we don't understand the difference a culture might have, then we really do a disservice to people.

Clearly, the setting of health care, both in the larger community and in the immediate unit, functioned as a significant catalyst in influencing the experience of caring for culturally diverse clients.

The Support of Colleagues

The nurses consistently acknowledged the important role of colleagues in the provision of culturally sensitive care. Two patterns were described: a) a supportive, accepting group of nurses who worked together, and b) a complaining, negative group of nurses who discouraged others in their efforts to care for culturally diverse clients. When staff worked together, they used each other as resources to explain cultural practices and to discuss challenging cases:

I appreciate talking about it with my colleagues whenever we have a patient who is more challenging to care for because of their culture ... Being able to talk about the experiences, my feelings about that patient helps me uncover my biases... Sometimes I might not see something that someone else might see.

In the second case of negative colleagues, participants commented how this could "spoil their day." One nurse explained that she "didn't listen" to the complaints of her colleagues in such situations because she didn't want it to "bring me down ... it gives you a horrid day."

Additionally, a culturally diverse staff contributed positively to the experience of caring for culturally diverse clients. They often served as translators and would interpret cultural practices for nursing staff. Perhaps most importantly, working with culturally diverse colleagues fostered openness and flexibility in the other nurses. One participant observed that the diversity of a unit she had previously worked on made it open and accepting, whereas the unit she presently worked on had a homogeneous and non-tolerant staff. One participant, of Asian descent, observed how she served as "a bridge":

It is an eye opener. The more exposure you get, the more familiar you are. You [other nurses] are exposed to a different culture through someone you have a connection with and therefore it is not as foreign to you as it would be through a patient. You are coworkers, you are both nurses.

In summary, the milieu of the unit as it was created by the nursing staff was a strong catalyst in caring for culturally diverse clients. Negativity toward cultural diversity by some of the staff constrained the rest of the nurses on the unit in the provision of culturally sensitive care. In comparison, an accepting and diverse staff enhanced the experience of caring for culturally diverse clients.

The Commitment of the Institution

The hospital administration's commitment to multicultural care (i.e., by a comprehensive plan promoting cultural diversity and culturally sensitive care) was recognized as another catalyst. According to the participants, hospitals demonstrated this commitment, or lack thereof, by their policies, resources, and the support of nurse managers. Of the six institutions represented among the nurses, only one had taken an active approach that the nurses were aware of in establishing specific policies to accommodate for cultural diversity. The nurses from the other five institutions could not recall any policies or inservices that were aimed at promoting culturally sensitive care, although they remarked that inservices would be very helpful for them.

Policies regarding visiting hours were perhaps the most obvious in demonstrating commitment to multiculturalism. One hospital had recently adopted a 24-hour visiting policy that the participants viewed very positively. One participant observed how this policy promoted culturally sensitive care, "it doesn't give the

resistant nurses a ground to stand on. They can't throw visitors out just because it is 8 p.m." This hospital also posted multilingual signs and served a diverse menu in the cafeteria.

Two participants considered support from nursing management as important. One used her nurse manager as a sounding board regarding cultural issues; the other nurse was disappointed in her nurse manager who did not promote culturally sensitive care.

In considering the services or resources provided by the hospital, the participants identified the following three as instrumental in contributing to the experience of caring for culturally diverse clients: food services; client education resources; and translation services.

Food was considered a "big issue" for clients during their hospitalization. The hospitals varied in the diversity of their menus; to illustrate, although one hospital apparently did not serve ethnic food, another offered a menu with various ethnic selections. While families often brought in food, clients on restricted diets represented special challenges. One participant elaborated:

One of the big problems in caring for multicultural clients is food. Especially with patients on calorie-restricted diets and the family bringing in food. We really have to negotiate. "OK, this person is a brittle diabetic, if you are going to be bringing your own food, then maybe we should be taking parts of the tray away so you are not going over your calorie restriction."

Another participant suggested that along with an ethnic menu, food services should offer a variety of ethnic snacks.

Client education resources were another area of concern identified by the nurses. Two of the participants mentioned that some of their teaching pamphlets had been translated into other languages. For example, one nurse reported that an epidural teaching sheet had been translated into 24 languages; however, she questioned whether the Chinese sheet carried the equivalent information. "I have no idea what it says. Once they read that sheet, they are always willing to go for it. I'm sure it doesn't say what it says in English." Another participant added that the advertising for the Heart-to-Heart program was now also posted in Chinese, although the program itself was just offered in English. The participants stressed the need for the development of more educational resources in other languages, such as programs on the in-house TV channel, childbirth preparation classes, pre-admission teaching, and cardiac rehabilitation programs.

Seven of the participants were aware of the translation service in their institutions, but only two had ever used the service. Reasons for not using the service related to the time constraint of phoning for arrangements and the lack of access during hours other than daytime. Instead of using the formal translation service, the participants relied on the family and on an informal system of calling another floor where they knew a staff member spoke the particular language. Two nurses in the study who spoke Mandarin recounted numerous occasions when they had been called upon to translate on their own units and in other areas of the hospital. Translation was less effective in situations when nonmedical staff were called upon to translate. One nurse described the difficulty of using someone "from housekeeping without medical knowledge" to translate in a family conference. The

nurses did not generally consider the use of family for translation as an issue although they gave several examples of concerns that had arisen. One participant mentioned that there were times when selective translation, or "filtering" by the family, was frustrating for her. "I've thought about getting an official translator to come up but I think that would be more disrupting and more hurtful for the family members who care to interpret." Nurses relied on family members to translate even when this appeared to place an unrealistic expectation on the family. In one situation, two teenage boys came in for fifteen minutes on their way to school at 6:00 a.m. to translate for a laboring cousin:

It was like a fast and furious session for her...to have all this stuff thrown at her....I told them absolutely everything I could imagine that she would need to know....And I knew she would understand only a fraction of it, but it was my only chance. They couldn't stay.

Although the participants were creative and flexible in arranging for translation apart from the formal translation service, they lamented that the service itself was not more accessible (i.e., outside daytime hours) and appropriate (i.e., trained medical translators).

Furthermore, the participants identified three situations, related to the presence of a language barrier, in which the quality of care they provided to culturally diverse clients was threatened, regardless of their commitment or strategies. First, client education was difficult to accomplish, even with a translator. Whereas nurses typically included teaching on an ongoing basis in the care of English-speaking clients, this was less likely with non-English speaking clients. Moreover, printed education resources were seldom available in languages other than English.

Therefore, the nurses had to rely on the interpretation of these resources by family members who were most often not familiar with medical terminology and concepts. The second area identified was that of informed consent. If clients were not fluent in English, nurses found it difficult to establish if they understood the reasons for various nursing and medical interventions. For example, one participant described her frustration in not being able to involve a client in the decision to perform a vaginal examination during labor. "I felt like she was not given the chance to be a partner to that." Third, the nurses described the difficulty of performing certain assessments (e.g., pain assessment) and their accompanying fear of proceeding with an inappropriate or inadequate intervention. In these situations, nurses relied on "guesswork" to plan their nursing care. Adequate and accessible translation services would contribute to an improved quality of care in each of these three situations. Without the catalyst of translation services, culturally diverse clients might well receive a lower quality of care in such situations, despite concerted efforts by nurses.

To summarize, the nurses in the study put considerable effort into providing culturally sensitive care; yet, they were limited in their efforts by the constraints of the institutions in which they worked and, at times, the lack of commitment by the institution to address cultural issues. The participants voiced strong concerns about this:

It is as much a task of the hospital to create an environment, state that something is important, twig the nurse to know that we don't just care if you do postpartum checks every 15 minutes, we also care about multicultural issues....The environment affects you and the kind of nurse

you are. It should be a nursing administration or hospital-wide thing, a drive to make it visible and important.

Thus, the nurses believed that institutions should be visible and deliberate in establishing policies and providing resources that promoted multiculturalism (i.e., a comprehensive plan promoting cultural diversity and culturally sensitive care).

Further, the institutions should take a firm stand to enforce the policies. One nurse noted:

Changing beliefs is very difficult, but an institution should take a hard line – if you want to work here, this is what you must do. Then you document and discipline if there is not respect shown for other cultures. You can insist on changed behaviors, even though you cannot change beliefs.

According to the nurses in this study, the commitment of the institution to multiculturalism represented a vital catalyst for the provision of culturally sensitive care. Policies that promoted multiculturalism, resources that facilitated care, and the encouragement of nurse managers were necessary in order to support the nurses in providing a high quality of care to culturally diverse clients.

The Foundation of Education

The eight participants expressed various opinions regarding the effectiveness of their own education in preparing them to care for culturally diverse clients. The three nurses who had completed diploma programs at community colleges denied receiving any useful education regarding cultural diversity. Two of these nurses went on to complete post-RN nursing degrees and found that experience more satisfactory, not because of any significant cultural content, but because they felt that the degree made them a "much more sensitive and aware nurse." Five of the participants were

graduates of generic baccalaureate nursing programs. Three of them felt that their education had prepared them to care for culturally diverse clients. One felt that the value of her education was the emphasis on holistic, respectful care for all clients. She said, "I don't feel I got any particular education about different cultures. There were bits and pieces, but nothing that stood out in my mind. But what really stood out is the respect of people." The second was pleased with her education but described a dissonance between what was taught in school and what she experienced in practice, "to see prejudice in others was very shocking." The third generic graduate stated that culturally sensitive care had been an emphasis in her education. The final two degree-prepared nurses found their education inadequate in preparing them for cross-cultural nursing. One of these nurses commented, "I was very disappointed in the cross-cultural content of my BSN....it was ridiculous, it was so horrendous, I was so angry....my evolution has happened more out of practice than out of education."

To summarize these perspectives, the diploma-prepared nurses did not perceive their education as helpful in preparing them for cross-cultural nursing. The degree-prepared nurses were split in their opinions, with only one nurse completely satisfied with her education in this regard. Education, as experienced by these nurses, apparently did not influence their position on the continuum of commitment to cross-cultural nursing. While most of the participants did not perceive their own education as an enabling catalyst, they offered suggestions for more effective education. In this way, they affirmed the potential of education to be an enabling catalyst for the provision of culturally sensitive care.

On the basis of the contributions of the participants, an analysis of the data revealed four themes, or criteria, for effective multicultural education:

- 1) exposure to culturally diverse clients in clinical settings,
- 2) presentation of theoretical and factual information regarding cultural groups, strategies, and skills useful in providing nursing care,
- 3) examination of values and attitudes, and
- 4) preparation to address racism and hegemony in the health care system.

The participants emphasized the importance of providing students with opportunities to care for culturally diverse clients; practical, immediate learning in the clinical setting was seen as being central to multicultural education. Toward this end, the participants suggested that the clinical teachers not "protect" the students from the experience of caring for culturally diverse clients. Together with exposure in the clinical settings, the nurses also speculated about placing students in situations where they were cultural minorities to sensitize them to the lost feeling of culturally diverse clients in hospital settings. International travel, visits to core areas of the city, home visits to culturally diverse clients, and participation in non-English classes (e.g., Vietnamese childbirth preparation classes) were some of their recommendations.

The participants suggested that practical experience should be balanced with theoretical and factual information about patterns of cultural beliefs and habits. Most of the participants mentioned Cross-Cultural Caring by Waxler-Morrison, Anderson, and Richardson (1990) as a helpful text summarizing key health-related cultural beliefs. However, they were careful to warn against education that simplified, generalized, and stereotyped. Rather, they advocated that factual information be

presented as a starting point or background against which to provide cross-cultural care. Along with specific factual information, they also suggested that nurses be taught the skills (e.g., collaboration, negotiation, working with a translator) necessary to care for culturally diverse clients. To build on the factual information and specific skills, another nurse recommended a focus on the analytical skills necessary to interpret culture:

It is very subtle to interpret what culture means...It is hard to teach about how much damage you do when you separate an East Indian woman from her family who were supposed to care for her and her new baby.

Self-examination of attitudes and values was also identified as a criterion for multicultural education. As one nurse explained, "you have to educate nurses to dig deep into themselves to get in touch with that side of them that is going to make them open and flexible and not afraid of something different." Seminars were proposed as excellent settings in which to discuss personal attitudes and biases in an effort to foster self-awareness in nurses. As well, a broad, liberal education was suggested because "those courses open your mind."

Finally, several nurses emphasized the importance of preparing nurses to address racism and hegemony in the health care system. One participant made an emotional appeal to me to teach students how to "deal with the resistant." Hence, while the participants were generally not that positive about their own education in preparing them to care for culturally diverse clients, they offered clear recommendations to ensure multicultural education in the future.

In summary, the catalysts that emerged from the data were central in influencing the quality of care for culturally diverse clients. The diversity of the community in which the health care agency was located was identified by the participants as either enabling or constraining culturally sensitive care, depending on the nurse's attitude toward cultural diversity. Fast-paced units with curative philosophies were negative catalysts. An accepting and positive climate on a unit was identified as instrumental in promoting culturally sensitive care, in contrast to negativity from colleagues that inhibited such care. The participants also noted the positive effects of a diverse staff. The commitment of the institution to multiculturalism represented another vital catalyst. Policies that promoted multiculturalism, resources that facilitated care, and the encouragement of nurse managers were necessary in order to support the nurses in providing a high quality of care to culturally diverse clients. Finally, although most of the nurses in this study did not feel that their education had prepared them to provide culturally sensitive care, they envisioned education as another catalyst that could enhance cross-cultural care. They recommended that multicultural education should include exposure to culturally diverse clients, presentation of theoretical and factual cultural information, examination of values and attitudes, and preparation to address racism and hegemony in the health care system. In some situations, then, the best efforts by competent and impassioned nurses were thwarted by constraining catalysts. Similarly, enabling catalysts significantly contributed to culturally sensitive care. The impact of the catalyst on the outcome of care depended on the nature of the catalyst itself, the

perception of the catalyst by the participants, and the extent to which the nurses managed the catalyst.

Summary

In this chapter, the study findings in relation to the eight nurses' descriptions of the experience of caring for culturally diverse clients were presented. In general, these nurses described caring for culturally diverse clients in hospital settings as a considerable and persistent challenge. The nurses also spoke enthusiastically about the rewarding nature of caring for culturally diverse clients.

The nurses were conceptualized on a continuum of commitment to cross-cultural nursing, ranging from being resistant to being competent to being impassioned. The participants represented the two positions of competent and impassioned; however, from their descriptions, it seemed that the overall range of nurses included those who were resistant to cross-cultural nursing. The resistant nurses ignored or resented the cultural diversity of their clients, considering culture to be an inconvenience or a "problem" and expected the assimilation of culturally diverse clients into mainstream Canadian ways. Further along the continuum, the competent nurses acknowledged and accommodated for culture; yet, they viewed culture as a non-issue. They believed that common respect for all clients would ensure appropriate care for culturally diverse clients. In contrast, the impassioned nurses went beyond accommodating to appreciating diversity. These nurses perceived the provision of health care to culturally diverse clients as a central issue for nurses and consequently were alert to the multiple challenges involved.

In order to provide culturally sensitive care, the participants implemented creative and flexible strategies in connecting with the client, working with the family, and accommodating for cultural practices. However, despite these efforts, there were inevitably situations that left them dissatisfied or frustrated with the outcome of care. The nurses dealt with these feelings of dissonance by balancing their expectations, not in expecting less of themselves, but in accepting a less than ideal outcome.

The quality of care was also influenced by certain contextual factors, or catalysts, beyond the control of the nurse. The catalysts identified were: the setting of health care; the support of colleagues; the commitment of the institution; and the foundation of education. The participants highlighted the impact of a hospital's visible commitment to multiculturalism: policies that promoted multiculturalism, resources that facilitated care, and the encouragement of nurse managers were necessary in order to support the nurses in providing a high quality of care to culturally diverse clients. Although the participants were generally not entirely positive about their own education in preparing them to care for culturally diverse clients, they offered clear recommendations to ensure multicultural education in the future.

The most disturbing finding of the study was the reported presence of overt and covert racism in resistant nurses and the, at times, passive acceptance of this racism by competent nurses. Even impassioned nurses, who were more likely to identify and deal with discriminatory practices, expressed how difficult it was to address racism in the health care setting. Along with examples of individual racism, the study findings also revealed the often subtle presence of institutional racism in

which the policies or practices of the agency disadvantaged culturally diverse clients. Thus, while the experience of the client was not the focus of this study, the findings suggest that, at times, culturally diverse clients received a reduced quality of care. The findings and their implications for future nursing practice, education, administration, research, and public policy will be discussed in more detail in Chapters Five and Six.

CHAPTER FIVE: DISCUSSION OF FINDINGS

Introduction: The Complexity of Cross-cultural Care

In this chapter, I discuss in depth several selected findings of the study. The findings discussed are the disturbing presence of racism in health care settings and the development of commitment to cross-cultural nursing. These foci have been chosen by the application of the following criteria:

- a) relevance to quality of care for culturally diverse clients,
- b) relevance to nursing practice and education, and
- c) contribution to nursing knowledge.

The chapter is introduced with an overview of the complexity of cultural care as illuminated by this study. A brief return to the literature reviewed in the fore-structure of the study follows. Next, the troubling evidence of racism in Canadian health care settings is explored. The participants' descriptions of both individual and institutional racism revealed the impregnable nature of racism, complicated in the Canadian setting by a denial that anything but tolerance exists. After establishing the existence of racism, the discussion moves on to consider the study findings that suggest nursing education and administration as two routes by which to address the monumental task of eradicating racism in health care settings. An examination of institutional barriers contributing to racism is included. Of note, the participants described several situations in which the quality of care for non-English speaking clients was inhibited; yet, formal translation services were rarely sought. In an effort to understand this seeming incongruency, the literature regarding interpretation

services is reviewed. The presence of racism in Canadian health care settings, thus, provides the context for the remainder of the discussion.

Thereafter, the development of commitment to cross-cultural nursing is contemplated in order to understand how movement along the continuum (i.e., acquisition of cultural sensitivity) might be encouraged. Models of cultural competence, from the fields of counseling psychology and education, are both helpful and limiting in understanding movement along the continuum from the resistant to the competent to the impassioned nurse. The discussion presents exposure to cultural diversity as an important means of moving nurses along the continuum of commitment to cross-cultural nursing.

The issues of the quality of care provided to culturally diverse clients and the complexity of cross-cultural nursing serve as overarching themes in the discussion of this chapter. Racism at individual and institutional levels and nurses' commitment to cross-cultural nursing carry sizable ramifications for the quality of care received by culturally diverse clients. The participants' descriptions elucidated the interrelatedness of personal and contextual factors influencing the experience of caring for culturally diverse clients. For example, the commitment to cross-cultural nursing was not the sole factor influencing the quality of care provided to culturally diverse clients. Catalysts, such as the availability of resources, the policies of the institution, and the community setting, inextricably influenced the nurses in the provision of culturally sensitive care. Such complexity extends to the interplay of gender, class, and poverty with cultural issues. Therefore, a holistic approach must be sought in discussing cross-cultural nursing. To do otherwise is to reduce and limit

the experience, with the accompanying risk of ignoring larger historical, societal, and political forces. Nursing has tended toward myopic approaches to health care, seeking to intervene at individual levels when larger forces prohibit any significant changes. In the case of cross-cultural nursing, a critical social orientation is required to consider broadly-based issues outside the simple one-to-one encounter with the client (Lynam, 1992).

By such a standard, the theoretical literature reviewed in Chapter Two is insufficient in scope to elicit the complexity of cross-cultural nursing. The theories tend toward oversimplification (e.g., Leininger's theory suggests straightforward cause and effect relationships between culture and behaviors; West's cultural bridge model places the responsibility for culturally sensitive care on the nurse alone; and Kleinman's explanatory model does not account for differential power in health care relationships). Similarly, the anecdotal literature is limited to focusing on the nurse-client interaction in isolation of larger, contextual influences. Apart from the Bernal, Pardue, and Kramer (1990) study that acknowledges bureaucratic barriers, the research literature also presents a narrow interpretation of cross-cultural nursing. The findings of this study, then, are enlightening in their presentation of the complexity of cross-cultural nursing. Culturally sensitive nursing care is dependent on the personal commitment of the nurse, the strategies employed by the nurse, and the broader catalysts influencing the nurse and the client.

With this study, I proposed to extend the qualitative research completed by Murphy and Clark (1993) in Britain. Therefore, it is useful to briefly compare and contrast Murphy and Clark's findings before proceeding with the rest of this chapter.

Murphy and Clark reported remarkable consistency in the accounts given by the participants in their study. In contrast, the participants in this study varied in their descriptions of the experience of caring for culturally diverse clients. With the conceptualization of the continuum of commitment to cross-cultural nursing, however, consistency was apparent in keeping with the positions along the continuum (e.g., the competent nurses gave similar descriptions of the experience). The issues raised in the Murphy and Clark study (i.e., communication; nurse-client relationships; relatives; nurses' feelings of frustration, stress and helplessness; and lack of knowledge about cultural differences) were also present in the descriptions of the participants in this study. Nurses in both studies identified the challenges inherent in communicating with culturally diverse clients; yet, they used the agency translation services infrequently. The findings of both studies revealed insufficient resources available for cross-cultural care, most notably, in the areas of translation and dietary services. Moreover, a concern for the quality of care received by culturally diverse clients was expressed by nurses in both studies. Finally, frustration among the nurses was reported in both studies, although the sources of frustration varied.

Along with these common findings, there are also contrasting themes in the two studies. First, the participants in this study spoke positively of the relationships they developed with culturally diverse clients and of the supportive role of the family. The participants of the Murphy and Clark (1993) study were mixed in their descriptions of their relationships with clients and families and referred to their inability to give "total care." This difference may be accounted for by the level of commitment (i.e., competent and impassioned) in the nurses I interviewed. In

contrast, Murphy and Clark may have had several resistant nurses in their sample. Second, Murphy and Clark reported findings of ethnocentrism but not racism. In contrast, racist attitudes and actions by resistant nurses were described by the participants of this study. It is unlikely that this difference can be simply accounted to an absence of racism in Britain and a corresponding presence of racism in Canada. Nursing literature contains numerous references to the problem of racism in the British health care system but few references to racism in the Canadian context. The contrast in the study findings may not be representative of an actual difference in nursing practice; that is, racism is likely present in both British and Canadian health care settings. The varying findings, thus, may be due to the nature of the interview questions that generated different answers. Another difference in the study findings involves the role of education in preparing nurses to care for culturally diverse clients. None of the respondents in the Murphy and Clark study felt that their education had prepared them for the problems they encountered. In contrast, the Canadian nurses were mixed in the evaluation of their education. The inclusion of cultural content is common in Canadian nursing education (Tournishey, 1991) which may account for the discrepancy between the findings of the two studies. Finally, data analysis in the Murphy and Clark study is largely descriptive as compared to a degree of explanatory power in the current study. This study offers further insight into the complexities of caring for culturally diverse clients by explicating the continuum of levels of commitment to cross-cultural nursing and the influencing catalysts. The findings of this study, therefore, corroborate and extend the Murphy and Clark study.

The complexity of caring for culturally diverse clients and the quality of care provided to these clients are integrating themes for the remainder of this chapter. The two topics of racism in Canadian health care settings and development of commitment to cross-cultural nursing have been chosen for further exploration based on their practical and theoretical significance. However; neither the sum of these issues, nor the individual weight of either of these issues can capture the complexity and challenge of caring for culturally diverse clients. Nonetheless, a discussion of these issues illuminates the experience of cross-cultural nursing.

Racism in Canadian Health Care

The most disturbing finding of this study was the presence of racism in health care settings. This was, to some degree, an unexpected finding. The literature reviewed as fore-structure to the study included mention of racism but did not feature it as a dominant theme. However, in the analysis of the accounts of the nurses interviewed in this study, racism, with accompanying prejudices and inequities, is a consistent, undergirding presence.

The Existence of Individual and Institutional Racism

According to the participants, racism is present at both individual and institutional levels. The most obvious examples of racism were in the descriptions by the participants of resistant nurses but other examples included inequities at the institutional level. Institutional racism, as described by the participants, involved barriers to quality care (e.g., rigid hospital schedules, policies, and procedures). Examples of racism in this study included both overt and covert behaviors. Overt, or blatant, racism was evident when client needs and requests were ignored and when

behaviors were judged on the basis of ethnicity. For example, offensive behaviors by culturally diverse clients were attributed to their culture while the same offensive behavior in a Caucasian client would be accounted to their obnoxious personality. Covert racism included the use of black humor as a tension release and the demonstration of subtle preferences for Caucasian clients. Complaining about large families and passive participation in institutional racism (e.g., not negotiating around discriminating visiting policies) were other examples of covert racism identified by the participants.

The existence of racism resulted in interpersonal conflict and inner turmoil for the nurses. According to two participants, some resistant nurses blocked and belittled nurses who made efforts to provide culturally sensitive care. Inner turmoil resulted for competent and impassioned nurses when they found themselves in a position to identify and address racism. The responses of competent nurses tended toward rationalizing the behavior (e.g., "the nurse is 'fed up'" or "that is just her") or ignoring it (e.g., "minding my own business"). In these ways, status quo that included racism was perpetuated. The impassioned nurses, who were more likely to identify racism at individual and institutional levels, also described the dilemma of addressing racism among their colleagues. They were more likely to take over for their colleagues than to directly confront discrimination. These examples speak to the impregnable nature of racism in Canadian health care settings – racism in its overt and covert forms is very difficult to address.

A return to the racism literature elucidates the nature of racism in Canadian health care. While literature regarding racism in American, British, and Australian

health care is readily available (Connell, 1989; Curtin, 1994; Funkhauser & Moser, 1990; George, 1994; Howie, 1988; Keene, 1988; McGee, 1993; Pearson, 1987; Torkington, 1986), little has been written about racism in Canadian health care settings. This may be due to the subtle presence of racism, making it less identifiable. On the other hand, in a nation that prides itself in multiculturalism and tolerance, racism is not easily admitted. Therefore, racism may be much more common than represented by the literature but may be disguised under a veneer of politeness and token support of multiculturalism. This conclusion is supported by the responses of the nurses in this study. Although most of the participants identified instances in which colleagues had evidenced discriminatory attitudes and practices, they were hesitant to attach the label of racism to such situations. Furthermore, institutional barriers to quality care for culturally diverse clients were often not recognized by the participants, although the impassioned nurses were more likely to do so.

In order to interpret this theme of racism in the context of Canadian health care, it is useful to clarify the theoretical understandings of individual and institutional racism and to consider the related research literature. Racism is best understood along with the terms prejudice and discrimination. Prejudice, put simply, is a dislike of people on the basis of a personal characteristic; thus, prejudice is an attitude in which individuals are prejudged, often in a negative light (Fleras & Elliott, 1992; Tomlinson, 1990). Discrimination is the enactment of prejudice, or its behavioral counterpart, in the form of maltreatment of minorities on the basis of color, sex, disability, or other attributes. Racism occurs when prejudice is combined with power

to effect discrimination that can influence a person's ability to obtain housing, employment, education, medical services, etc. on the basis of his/her race or ethnicity. As such, racism is "the denial of the fundamental moral equality of all human beings" (Blum, 1991, p.2). Racism includes whatever individual acts or institutional procedures that create or perpetuate sets of advantages or privileges for the dominant group (e.g., the whites) and exclusions or deprivations for minority groups (e.g., immigrants, especially those of non-Caucasian heritage). Inherent in this description of racism is the ideology of the superiority of the dominant group, along with the power to implement that ideology (Chesler, 1976).

According to this delineation, the findings of both individual and institutional racism are supported in this study. The exercise of advantage and power, key in racist practices, is still commonplace in the health care system. Based predominantly on biomedicine that claims to be the only "scientific" tradition, the health care system carries considerable authority and power. Indeed, biomedicine "has achieved a position of social prominence sufficient to allow it political and legal dominance over all other competing systems" (Thorne, 1993). Thus, power relationships are inherent in the very nature of our health care system. When nurses practice in such a setting, it is easy for them to misuse the power they carry simply by being associated with the health care system. An illustration of the link between institutional racism and misuse of power in nursing practice is the ownership resistant nurses took over culturally diverse clients in strictly enforcing visiting policies that limit visitors.

Institutional racism is one situation in which nurses may consciously or unconsciously participate in racist practices. Institutional racism exists when

institutions are not geared to meet people's needs and when a uniform culture is assumed (French, 1992). For example, a lack of accessible and appropriate translation services reflects an institution not geared to meet the needs of culturally diverse clients. Similarly, a uniform culture is assumed when the Western ideal of having a husband present at birth is forced on other cultural groups. Torkington's (1986) observations regarding the embedded and prevalent nature of institutional racism are helpful in bringing this phenomenon to light. Racism may operate by "default" where an institution adheres to traditional methods and ignores the multiracial and multicultural nature of the society it is called to serve. This "default" may be seen as an accidental by-product of administrative inertia associated with large organizations. However, when recognizing such inertia, one must not see administrative systems as inhuman bureaucracies. They are run by individuals and therefore the rapidity or the sluggishness with which those systems adapt is indicative of the attitude held by the administrators controlling them. If ethnic minorities are not regarded as an integrated and legitimate part of Canadian society, it is unlikely that administrators will adapt the systems to meet their needs. Therefore, at closer examination, what is initially seen as "default" or unintentional racism by institutions may indeed be informed and influenced by a prevalent collective consciousness (Torkington).

Theoretical literature offers a useful explanation regarding the nature of individual and institutional racism in health care settings. Unfortunately, little research was located that addressed the presence of racism in Canadian health care settings. In a study conducted in Calgary, Chugh, Dillmann, Kurtz, Lockyer, and

Parboosingh (1993) reported racism perceived by immigrants seeking health care from their physicians. Several Canadian studies reveal that immigrants and refugees under-utilize mental health services and conclude that this is due to discrimination and inappropriate services (Lo & Lee, 1993; Peters, 1993). In a study exploring refugee claimants' experiences accessing health care in British Columbia, Beaupre (1993) found that difficulties were encountered in response to social, political, and economic factors. Situations perceived by participants as discriminatory, that occurred in a number of different settings, resulted in the participants feeling inferior and marginalized. These studies, then, give credence to the findings of individual and institutional racism in Canadian health care settings.

Several anecdotal reports also acknowledge the reality of racism in these settings. Most notably, recent government documents argue against racism in health care. For example, the Royal Commission on Health Care (Seaton, 1991) reports that once immigrants have access to a particular service, their comfort level is low because of the way they are treated. "There are often problems due to a lack of sensitivity to cultural differences on the part of care givers" (p.C-36). In a follow-up document, key multicultural health issues identified include cultural insensitivity and racism among care givers and institutional barriers that block individuals and communities from access to adequate health care (BC Ministry of Health and Ministry Responsible for Seniors, 1995). In the report of a forum held by a small group of nurses in Ontario to address racism, Farr (1991) describes the participants' feelings: "the hurt that comes with overhearing racial slurs, even unintended ones, from patients and other staff in the workplace; the frustration of promotions denied for no

for no apparent reason; the anger that inevitably builds with suspicions (difficult to prove but undeniable nevertheless) that in many complex ways, not having white skin, and speaking English with a foreign accent, can make it harder to get ahead" (p.9). While Farr's report deals with racism experienced by culturally diverse nurses, it is, nonetheless, evidence of racism in the Canadian health care system and, in this way, corroborates the findings of this research.

In summary, both individual and institutional racism are present in our health care system and threaten the quality of care provided to culturally diverse clients. The participants of this study realize the resistant nature of racism, at both individual and institutional levels. The presence of racism presents considerable challenge to nurses at several levels. Not only do they find it difficult to address racism among their colleagues, they must also be vigilant to institutional racism that is perhaps even more difficult to overcome. The public policy of multiculturalism may make racism even more difficult to identify and deal with because racism is not supposed to exist in our tolerant and accepting society. The sobering finding of racism in Canadian health care requires further analysis.

Addressing Racism Through Education and Administration

Beyond establishing the existence of racism at the individual and institutional levels, the study findings also suggest that nursing education and administration are two routes by which to address the monumental task of eradicating racism within nursing. While most of the participants did not perceive their own education as an enabling catalyst, they offered suggestions for more effective education. On the basis

of the contributions of the participants, an analysis of the data revealed four themes, or criteria, for effective multicultural education:

- 1) exposure to culturally diverse clients in clinical settings,
- 2) presentation of theoretical and factual information regarding cultural groups, strategies, and skills useful in providing nursing care,
- 3) examination of values and attitudes, and
- 4) preparation to address racism and hegemony in the health care system.

The last two criteria are particularly relevant in this discussion of racism. In light of the existence of racism and the difficulties experienced by nurses in identifying and addressing racism, nursing education may be in a strong position to assist students in examining their own values and attitudes for the presence of prejudice and racism.

In addition, nursing education can equip students with the analytical and activist skills necessary to identify and address racism and hegemony in individuals and institutions. Such a mandate would require a rethinking of current nursing education.

Moodley (1992) suggests that "ethnocentrism and racism reflect individual predispositions and social forces beyond the reach of conventional pedagogy" (p.7).

When cross-cultural nursing is included in curricula, the focus has been more of a descriptive approach in learning about different cultures, rather than a critical approach of exploring social structures and their interactions. Multicultural education for nursing would suggest going beyond descriptions of diversity to explorations of discriminatory practices. Furthermore, the process of education would be emphasized, rather than the content, for the development of skills such as critical thinking and participation in political processes.

Blum (1991) identifies four interacting values essential to an educational program for a multicultural society: antiracism; multiculturalism; interracial community; and treating persons as individuals. Antiracism focuses on the equal dignity of all people in the context of victimization and oppression. Multiculturalism, on the other hand, focuses on diversity with an appreciation for the contributions of different people groups. According to this perspective, nursing education, to date, has included multiculturalism (i.e., cultural diversity) but has neglected antiracism. While the acknowledgment of diversity is useful, it may promote stereotyping (Lynam, 1992) and may avoid the racial discrimination inherent within society (Fleras & Elliott, 1992). Antiracist education, then, would provide a necessary balance to multicultural education. In order to be considered truly multicultural, it would seem that nursing education ought to reflect all four values of antiracism, multiculturalism, interracial community, and respect for the individual.

Antiracist education prepares students to identify racism within themselves and within the larger community (Blum, 1991). A process approach with an emphasis on self-reflection and critical analysis assists in uncovering subtle racist influences. Courses include discussions of racism, encourage self-examination, and attempt to bring to the forefront long-held stereotypes that unjustly affect clients and other health care professionals (Tullmann, 1992). Tatum (1992) identifies three sources of student resistance to talking and learning about racism: considering race a taboo topic; believing in the myth of a just society; and denying racism within oneself. With such insights about student resistance, educators can be prepared for both resistance and

passionate emotions in such discussions (Britzman, Santiago-Valles, Jimenez-Munoz, & Lamash, 1993).

To further explicate a process focus in education, it is useful to consider Banks's (1992) vision of a transformative curriculum for empowerment. To empower, a curriculum must "help students to develop the knowledge, skills, and values needed to become social critics who can make reflective decisions and implement their decisions in effective personal, social, political, and economic action" (Banks, p.159). Such an educative process in nursing could encourage a critical stance and equip future nurses with the skills necessary for personal and collective action directed at eradicating individual and institutional racism from health care.

Nurse educators are in a position to influence students with racist attitudes. However, in recognition of the persistent and embedded nature of racism, one must acknowledge that nursing education may not realistically be able to ensure that all racist attitudes are abolished. Professional standards for actual nursing care offer direction in such situations; minimal standards of nursing care must be maintained. Nurse educators can appeal to the Canadian Nurses Association Code of Ethics for Nursing (1991) that states:

Factors such as the client's race, religion or absence thereof, ethnic origin, social or marital status, sex or sexual orientation, age, or health status must not be permitted to compromise the nurse's commitment to that client's care. (p.1)

It seems, then, that when students' racist attitudes are resistant to change, nurse educators must insist on the provision of culturally sensitive care, irregardless of underlying attitudes.

Along with nursing education, administration in health care agencies could take a clear stance in addressing both individual and institutional racism. Several participants in this study believed that institutions should be visible and deliberate in establishing policies promoting multiculturalism. Further, they maintained that institutions should take a firm stand to enforce the policies, to the point of disciplining nurses who do not show respect for other cultures. Malone (1993) emphasizes the correlation between hospital policies and culturally sensitive care and discusses the importance and the challenge of evaluating the cultural and racial sensitivity of individual nurses. "The tolerance and acceptance of the behavior (racism) by nursing administration represent silent approval and encouragement for the culturally and racially insensitive behavior to continue" (p.24). Malone recommends that cultural and racial sensitivity be an actual line item on each worker's evaluation form. By establishing and enforcing clear policies regarding multiculturalism, administrators could play a key role in eradicating individual racism from health care settings.

Administrators could also take responsibility in identifying and intervening in institutional racism. Inflexible and inaccessible institutions, catering to the dominant groups of society, may contain numerous barriers to culturally sensitive care. This study's findings made a clear case for the positive influence of a culturally diverse staff in bringing about a higher level of cultural sensitivity throughout the institution. Culturally diverse staff interpreted language and cultural practices, but also fostered openness and flexibility in the staff. A heterogeneous staff is more likely to appreciate a diverse client population. The need for a diverse staff and affirmative

action in hiring practices so that participation reflects the ethno-cultural diversity of communities is a core recommendation in the recent Discussion Paper on a Multicultural Health Policy Framework (BC Ministry of Health and Ministry Responsible for Seniors, 1995).

The participants in the study identified the lack of resources (e.g., client education resources, translation services, dietary services) as a constraining catalyst in the provision of quality care to culturally diverse clients. Specifically, the unavailability and under-utilization of translation services is an institutional barrier to culturally sensitive care. The findings of the study point to an apparent incongruity in the merit and use of formal translation services in hospitals. The participants described several situations (i.e., client education, informed consent, and accurate assessments) in which the quality of care for non-English speaking clients was inhibited by the language barrier; yet, formal translation services were rarely sought. The reasons for not seeking formal translation services must be carefully examined. The nurses in the study tended to use family members and other health care providers (usually nurses) for translation. Although the participants commonly acknowledged that the family "filtered" information, only two of the participants alluded to possible disadvantages in using family as translators because of this filtering practice. Only one participant voiced concern about using translators who were not familiar with medical terminology and practices. Thus, the primary reason for not seeking formal translation services appears to be the convenience and ready accessibility of using informal translators (i.e., family and other health care providers). A related reason seems to be the inconvenience and inaccessibility of the formal or

organized translation services. Most commonly, the formal services consisted of a list of hospital employees speaking various languages, available from the switchboard. The participants were vague in their descriptions of this service and only two of them had ever employed the services. Reasons for not using the services included the lack of access in other than daytime hours and the time-consuming nature of phoning for assistance.

The findings of this study, then, present the issues of translation to be predominantly those of convenience and accessibility. However, such an approach to translation can be seen as too simplistic. Masi (1992) warns that "the random acceptance of a person to provide translation based solely on convenience or expediency belittles the importance of the translation in meaningful communication between the physician and patient" (p.1161). When nonprofessional translators are used, information may be distorted because of their values (Durst, 1993; Haffner, 1992; Hartog & Hartog, 1983). For example, in order to prevent personal embarrassment, family members may diminish the client's complaint. On the other hand, these ad hoc interpreters may unnecessarily emphasize or exaggerate the situation to procure needed services (Durst). The issue of confidentiality is also central when family members or untrained hospital staff are used to translate (Durst; Masi, 1989). Non-English speaking clients have the same right to confidentiality as any other client. These matters of screening and confidentiality are further complicated by the involved nature of translation. In the report of a field study exploring the nature of translators' work in community health settings, Hatton (1992) points out the complex nature of the seemingly simple task of translation. Appraisals

of the task, client, provider, and information are interrelated; "the work with words was secondary, of primary importance was the interpretation of the social world that proceeded concomitantly with verbal translation" (p.57). Haffner (1992) maintains that proper medical interpretation requires a "firm grasp of two different and complex languages to achieve immediate, highly functional, and accurate translation, often at times of high stress and in critical circumstances, plus an ability to communicate effectively in each language at many different educational levels" (p.258). Translation in the health care field represents a complex process of translating highly specialized language (i.e., medical terminology) and interpreting cultural and social values while ensuring confidentiality. It is unlikely that untrained interpreters and/or family members can adequately overcome language barriers to guarantee equitable and culturally sensitive health care. Rather, it would seem that trained interpreters, meeting accepted standards for interpretation, should be available on a 24-hour basis in health care settings. The fact that the nurses in this study did not evidence awareness of the complexities involved in translation remains somewhat puzzling. Perhaps family members generally do provide adequate translation, or, on the other hand, perhaps this lack of awareness by the nurses is further evidence of the subtle presence of insensitive care and institutional racism. Further research is needed to explore the matter of translation from the perspectives of the client and the health care provider.

In summary, this study uncovered racism in health care settings, both at the individual and the institutional level. Canadian society views itself as tolerant and multicultural and does not commonly admit to racism. Similarly, little information is

found in the literature regarding racism in Canadian health care. The disturbing presence of racism must be addressed. Analysis of the study findings suggests that education and administration could significantly influence racism in health care. Institutional barriers to culturally sensitive care, including inadequate and inaccessible translation services, are an important component of racism in health care. The presence of racism in Canadian health care settings contributes significantly to the complex challenge of caring for culturally diverse clients and seriously threatens the quality of care received by these clients.

The Development of Resistant, Competent, and Impassioned Nurses

In addition to the issue of racism in Canadian health care, another key finding in the study carries direct impact for the quality of care received by culturally diverse clients. A conceptualization of a continuum of levels of commitment to cross-cultural nursing emerged from the data analysis. The levels of commitment, varying from being resistant to competent to impassioned, reflected the nurses' philosophical stance toward cultural diversity, intellectual processes, and nursing practice. Further exploration of this conceptualization is pertinent in light of the link between the level of commitment to cross-cultural nursing and the quality of nursing care provided to culturally diverse clients.

Understanding the Nature of the Continuum

The study findings suggest that nurses generally practice from a certain point along the continuum. That is, while there is a degree of fluidity in a nurse's position on the continuum (i.e., temporary movement due to personal or contextual influences or more permanent movement due to a turning point such as an immersion

experience in another culture), there appears to be a tendency or propensity toward a particular position on the continuum.

In order to ensure culturally sensitive care, all nurses should ideally fall into the competent or impassioned categories. The reasons for this are quickly apparent. Resistant nurses do not provide an acceptable quality of care for culturally diverse clients and efforts must be made to bring them to a competent level of commitment, or, at the very least, they must suspend their beliefs regarding cultural diversity in order to provide care that meets a minimum standard. Competent nurses, while providing an acceptable standard of care, perpetuate the status quo and are not involved in bringing about change to the larger health care system. In order for competent nurses to address the injustices and inequities in the system, they must move to a level of impassioned commitment to cross-cultural nursing.

Facilitating movement along the continuum represents a considerable challenge, considering the relative propensity of nurses to practice from a certain position. Further, commitment to cross-cultural nursing and the acquisition of cultural sensitivity may not follow a predictable, uniform, sequential development. Rather, the study findings suggest that the development of cultural sensitivity is influenced by the nurse's philosophical stance toward cultural diversity; that is, a nurse's starting point on the continuum influences future development of cultural sensitivity. For example, whereas competent and impassioned nurses noted the role of experience with cultural diversity in bringing about improved skills in cross-cultural nursing, resistant nurses were described as becoming "burnt out" by their repeat experiences with culturally diverse clients. The acquisition of cultural

sensitivity is further influenced by personal and contextual events that may result in temporary movement in either direction on the continuum. For example, cultural conflicts or the demands of a busy day could nudge a competent nurse toward resistance.

Insight into the determinants of starting points on the continuum must be sought in order to influence movement along the continuum. The participants speculated that the position of resistance was the result of little interaction with or exposure to diversity during formative years, generally characteristic of a homogeneous lifestyle. As such, resistance is likely deeply embedded and not easily changed. It seems that, as with the resistant nurses, nurses in the competent position are also products of their environments and represent the "norm" or predominant world view. Majumdar & Hezekiah (1990) elaborate on the predominant world view that exposes health professionals as unbiased and aspiring toward the ideal that "everyone should be treated in the same way." A "cult of efficiency" (Leininger, 1978) exists concurrently in the health care profession in which nursing activities are performed quickly and in a similar way for everyone. These descriptions of the predominant health care world view and the "cult of efficiency" parallel the philosophical stance of the competent nurses in the study who dealt with cultural diversity by applying the credo of "common respect for all." The finding that the majority of nurses likely practice from the competent position further supports the postulate that competent nurses typify the predominant world view of an "egalitarian ideal, underscored by a concern to avoid favoritism, and accompanied by the expectation of efficient care" (Majumdar & Hezekiah). Finally, impassioned nurses

reached their position on the continuum through an awakening experience in which they caught a vision of the nature of the minority experience. These nurses felt that such a distinct awakening experience was necessary in order for them to take on their impassioned commitment to cross-cultural nursing. Day-to-day experience would not likely bring about such a discrete turning point. The study findings of

- a) varying levels of commitment to cross-cultural nursing,
- b) a relative propensity toward a position on the continuum,
- c) the existence of specific predisposing determinants of that position,
- d) the association between quality of care and position on the continuum, and
- e) the link between the starting position on the continuum and acquisition of cultural sensitivity

provide the foundation for the following exploration of means by which to facilitate movement along the continuum.

Facilitating Movement Along the Continuum

Much of the literature regarding multicultural education and the development of cultural competence seems to assume that culturally sensitive care will easily result from a correct address of attitudes, knowledge, and skills. Nursing literature also falls into such a pattern, perhaps influenced by the traditional pedagogical view held until recently that delivery of content results in changed behaviors. The findings of this study, however, warn against such a simplistic approach and alert us to the obdurate nature of beliefs and practices regarding cultural diversity. The uncovering of the various levels of commitment to cross-cultural nursing provides a new orientation for nursing education. It seems that, to date, the bulk of nursing education has focused on educating nurses for the competent level of cross-cultural nursing. Education has

not been aimed at the resistant group of students who hold racist views; neither has it sought to awaken students to an impassioned stance. The status quo has been perpetuated by applying a consistent method of education to all students, regardless of their philosophical stance toward cultural diversity. The study findings suggest that attention might be variously directed at each level of commitment when seeking to bring about substantive changes in cultural sensitivity.

Developmental models (Carney & Kahn, 1984; Friesen, 1993; Hoopes, 1979; Ministry of Social Services, 1992) explicating the process of cross-cultural training, from the disciplines of psychology and education, offer further insight into the conceptualization of a continuum of commitment to cross-cultural nursing. These models are both helpful and limiting in understanding movement along the continuum from the resistant to the competent to the impassioned nurse. They share the assumption that the development of cultural competence is a sequential process beginning at the point of either cultural destructiveness or tolerance for multiculturalism, and progressing to the place of endorsing and encouraging diversity. The counselor development model, developed by Carney and Kahn (1984), is presented here because its themes are particularly relevant to the discussion of the study findings. The model outlines five stages of trainee development regarding cultural competence. In stage one, the trainees possess little, if any, knowledge of other cultures; the knowledge they do have is based on stereotypes. They push toward assimilation and resist participation in cross-cultural awareness programs. In stage two, the trainees begin to recognize their embeddedness in their own cultural views but lack an organized view of cultural differences. Subtle expressions of

stereotypic and ethnocentric thinking can be seen. Feelings of uncertainty and guilt characterize the trainees in stage three. Their ethnocentrism prompts an attitude of "colorblindness" expressed in a) an active attempt to deny cultural differences or b) an effort to become immersed in another cultural group. In stage four, the trainees selectively blend the particular cross-cultural knowledge, attitudes, and skills of their cultural reference group with those of other cultural groups to form new self-identities. In stage five, the trainees evidence an excitement about their capabilities, a desire to continue learning, an acceptance and celebration of cultural differences, and a commitment to effect change in society.

Several observations can be made in comparing Carney and Kahn's model to the study's continuum of commitment to cross-cultural nursing. First, the trainees in stage one resemble the resistant nurses and the stage five trainees correspond with the impassioned nurses. The link between the competent nurses and the trainees in stages two to four is not as obvious but it could be suggested that the competent nurse represents any number of variations or combinations of these three stages. Second, the Carney and Kahn model, as other developmental models, assumes linear, unidirectional movement through the stages to achieve a final place of cultural proficiency. The study findings, on the other hand, suggest a propensity toward a certain position with substantive and permanent movement resulting from distinct turning points. Finally, the Carney and Kahn model stands alone among the developmental models in offering instructions regarding appropriate learning environments for each stage (generally, the developmental models lack specific detail as to how development is facilitated). Of particular interest to this study are the

recommendations regarding stage one. Carney and Kahn posit that trainees at this stage are likely to experience the dilemma of wanting to maintain their ethnocentric views while simultaneously embracing the professional value that emphasizes the appreciation of cultural and lifestyle differences. If this dilemma is challenged by moralizing or confronting, the trainees are likely to leave the program. Therefore, the learning environment should be highly structured and supportive to encourage the exploration of diverse views. These recommendations for working with the stage one trainee may apply to the resistant nurse who is also likely to become defensive if his/her views are directly challenged. This brief overview of the cultural competency development models has validated the finding that not all nurses approach cross-cultural nursing in a like manner. The models are limiting, however, in assuming that everyone follows a unidirectional, sequential development of cultural competence.

The construct of varying levels of commitment to cross-cultural nursing has not been found in the nursing literature, although reference is made to the acquisition of cultural competence. Carpio and Majumdar (1993) present a process model used for the introduction of cultural sensitivity to nursing students at McMaster University, adapted from the work of Pedersen (1988) and Hoopes (1979). Pedersen's three-stage process proposes that learners progress from awareness of assumptions regarding behavior, attitudes and values to knowledge regarding cultures to skills in interacting with people of different cultures. Hoopes's intercultural learning process posits that the development of multicultural awareness follows a sequence of: ethnocentrism; beginning awareness; acceptance/rejection; appreciation/valuing;

selective adaptation; and, finally, the endpoint of assimilation, adaptation, biculturalism, or multiculturalism. This model for education emphasizes process rather than content as a means of influencing the development of culturally sensitive practitioners and, therefore, relies on experiential learning.

The role of exposure in encouraging the movement of resistant nurses toward competence and competent nurses toward an impassioned stance requires a more in-depth examination. The participants in the study emphasized the benefit of exposure to different cultures. According to the study findings, competent nurses become more confident in cross-cultural nursing with exposure to cultural diversity. In suggesting educational approaches, many of the participants recommended that students be assigned to culturally diverse clients and be given other opportunities to experience another culture (e.g., by visiting the home of a culturally diverse client). They suggested that clinical teachers not "protect" students from the challenge of caring for culturally diverse clients. Furthermore, cross-cultural immersion facilitated the awakening experience characteristic of the impassioned nurses.

Students might well benefit from working with role models who appreciate diversity and provide culturally sensitive care. Tullmann (1992) observes the impact of role modeling in which implicit cues are passed between individuals as part of a society's normal patterns. Students may feel threatened and uncomfortable in cross-cultural situations and should, therefore, be given faculty support and encouragement. Finally, reflection on the cross-cultural experiences and the resultant feelings, both individually and in groups, will likely promote learning as students link their experiences with theoretical knowledge.

While competent and impassioned nurses benefited from exposure to other cultures, this did not seem to be the case with resistant nurses. Rather, as mentioned earlier, they were described as being "burnt out" by repeated experiences with culturally diverse clients. Resistant nurses appear to be more difficult to move along the continuum and may not respond positively to exposure or immersion experiences. Therefore, special attention must be given to resistant nurses; indeed, the very existence of resistant nurses underlines the shortcomings of educational models that assume a uniform sequence of acquisition of cultural sensitivity. On the basis of the study findings (i.e., a lack of positive response to exposure to cultural diversity) and the strategies suggested by Carney and Kahn (1984), it appears that a better approach with resistant nurses might be to provide them with structured and supportive opportunities to explore their beliefs and values away from heterogeneous environments with the hope of broadening their world views. However, a realistic view of the impregnable nature of racism makes one cautious in expecting change in the resistant nurse. Perhaps a more viable solution is to insist that the resistant nurse put aside his/her racist attitudes while at work by strictly enforcing antiracist policies. Such an approach admits the resistant nature of racism but does not tolerate culturally insensitive care. Moving resistant nurses along the continuum remains a perplexing problem that clearly requires further study.

Nursing literature is consonant with the study findings in recommending experiential learning as a key method in multicultural education (Barton & Brown, 1992; Bartz, Bowles, & Underwood, 1993; Carpio & Majumdar, 1993; Lipson, 1988). Two research studies presented in Chapter Two found that exposure to different

cultures brought about changes in racial perception. Bernal and Froman (1992), in their study of community health nurses, concluded that "exposure, even when not through one's own ethnic group membership, is related to enhanced efficacy" (p. 29). Frenkel et al. (1980) found both favorable and unfavorable shifts in racial perception resulted from direct nurse-patient contact, leading them to comment on the importance of experiential learning and the resistance of racist attitudes to change. The Frenkel study leaves one to speculate whether the unfavorable shifts occurred in nurses who would fall into a resistant position on the continuum.

Support can also be found in the literature for the immersion experience that brings about an awakening to the mandate of cross-cultural nursing. Tournishey (1989) describes a course that required students to experience being strangers in an unfamiliar cultural setting. This experience consistently resulted in raising the students' consciousness about their own cultural values and beliefs. The experience also provided them with greater insight into the probable effects of being a "dependent stranger" within a health care institution. Exchange programs also raise the consciousness of participants. Bachner and Zeutschel (1990) state that approximately 85% of all respondents in a German and American exchange program indicated that the experience caused an attitudinal change, as a result of which they began to individualize people rather than stereotype them by nationality. An on-campus conversation partner program with students of different cultures resulted in substantive knowledge gain and an increase in global perspective. Participants were less ethnocentric and less prejudiced following the experience (Wilson, 1993). These examples suggest that the experience of being a minority in another culture brings

about considerable change in attitudes. Nursing education should seek to create such minority or immersion experiences for students with the goal of moving them to an impassioned level of commitment to cross-cultural nursing.

In summary, nurses' levels of commitment to cross-cultural nursing are directly related to the quality of care provided to culturally diverse clients. In order to ensure culturally sensitive care, all nurses should fall into the competent or impassioned categories. Facilitating movement along the continuum is a challenging task because of the propensity of nurses to practice from certain positions. Moreover, resistant nurses may not respond positively to exposure to cultural diversity. Nonetheless, cultural sensitivity can be encouraged by providing for experiences that expose students and nurses to cultural diversity. Immersion experiences often awaken nurses to the complexity and mandate of cross-cultural nursing. The conceptualization of a continuum of commitment to cross-cultural nursing offers insight into and direction for the development of nurses who provide culturally sensitive care.

Summary

In this chapter, salient findings of the study were discussed. The findings regarding the experience of caring for culturally diverse clients went beyond the descriptions presented in the literature, particularly in highlighting the complexity of cross-cultural nursing, in uncovering the presence of racism in Canadian health care settings, and in conceptualizing a continuum of commitment to cross-cultural nursing.

Both individual and institutional racism are present in our health care system and threaten the quality of care provided to culturally diverse clients. According to the findings, both overt and covert racism are practiced. In a nation that prides itself

on multiculturalism and tolerance, racism is not easily admitted and may, therefore, be disguised under a veneer of politeness and token support of multiculturalism. The presence of racism presents considerable challenge to nurses at several levels. Not only do they find it difficult to address racism among their colleagues, they must also be vigilant to institutional racism that is perhaps even more difficult to overcome. Nursing education and administration are two routes by which to address the monumental task of eradicating racism. A more critical approach exploring social structures and their interactions may be needed, rather than the commonly accepted descriptive approach of learning about different cultures. The establishment and enforcement of clear antiracist policies by nursing administration were also presented as means of addressing racism. The issue of inaccessible and inappropriate translation services served as one example of institutional barriers that must be overcome. I concluded that the presence of racism in Canadian health care settings contributes significantly to the complex challenge of caring for culturally diverse clients and seriously threatens the quality of care received by these clients.

The conceptualization of nurses along a continuum of commitment to cross-cultural nursing was explored in order to understand how movement along the continuum (i.e., acquisition of cultural sensitivity) might be encouraged. This exploration revealed that the acquisition of cultural sensitivity should not be understood as a unidirectional, uniform, and sequential process. I posited that the traditional approach to multicultural education, that assumes that culturally sensitive care will easily result from a correct address of attitudes, knowledge, and skills, is inadequate in moving resistant nurses to competence and competent nurses to

impassioned stances. Resistant nurses appear to be very difficult to move along the continuum. I speculated that structured and supportive approaches addressing values and beliefs that begin away from direct contact with cultural diversity may nudge resistant students and nurses toward more open attitudes. For students and nurses who acknowledge the role of cultural diversity (i.e., competent nurses), cultural sensitivity can be encouraged by providing for experiences that expose them to cultural diversity. Immersion experiences often awaken nurses to the complexity and mandate of cross-cultural nursing. Thus, the conceptualization of a continuum of commitment to cross-cultural nursing offers direction for the development of nurses who provide culturally sensitive care.

CHAPTER SIX: SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary

The purpose of this study was to explore the descriptions of recently graduated nurses regarding their experiences of caring for culturally diverse clients in order to gain an understanding of both the nature of the experiences and the factors influencing the experiences. The increasing diversity in the cultural composition of Canadian society has presented the nursing profession with the challenging imperative of culturally sensitive care. The nursing profession is responding to this imperative; the theory of cross-cultural nursing is growing, nursing associations are beginning to reflect the importance of culturally sensitive care in their policy statements, and nursing curricula are moving to include cultural content despite existing barriers. Nonetheless, evidence suggests that culturally diverse clients may receive a lower standard of nursing care. A gap existed in nursing knowledge as to the actual care of culturally diverse clients, factors influencing this care, and the experience of nurses in caring for these clients.

The literature reviewed as fore-structure to the study represented the experience of caring for culturally diverse clients as predominantly one of challenge and frustration. Sources of difficulty (e.g., cultural differences in values, beliefs, and customs; communication difficulties; and barriers from within the environmental context) and nurse-related factors influencing the experience were identified in the literature. While several studies addressed the matter of caring for culturally diverse

clients, these were generally inadequate in explicating the experience of recently graduated nurses in caring for such clients in Canadian hospital settings.

A descriptive-exploratory design in the qualitative (naturalistic) tradition was selected to address the Level I question. The question necessitated a design that allowed for the anticipated multiplicity of experiences by nurses while identifying shared themes and elements. The design took some direction from the phenomenological objective about understanding lived experience, but broadened that perspective to focus upon the shared elements within the specific experience of caring for culturally diverse clients.

Eight recently graduated nurses were interviewed for the study. The unstructured interviews were audio-taped and subsequently transcribed verbatim. The data analysis proceeded simultaneously with the interviews through a process of constant comparative analysis. Thematic analysis occurred as I moved between the transcripts to identify commonalties and variations within the emerging themes. Ultimately, a description of shared themes, across participants, within the experience of caring for culturally diverse clients resulted.

The findings of this study revealed the experience of caring for culturally diverse clients as one of considerable complexity and persistent challenge. On the basis of the participants' varied descriptions, the nurses were conceptualized on a continuum of commitment to cross-cultural nursing, ranging from being resistant to being competent to being impassioned. While the nurses demonstrated a propensity to practice from a particular position on the continuum, their level of commitment at any given point might be influenced by personal or contextual factors that moved

them toward either end of the continuum. Most notably, the impassioned nurses all described an experience of awakening to the complex imperative of cross-cultural nursing that came out of specific situations in which they were sensitized to the experience of being a minority in a foreign culture.

In order to provide culturally sensitive care, the participants implemented creative and flexible efforts in connecting with the client, working with the family, and accommodating for cultural practices. Despite these efforts, there were inevitably situations that left them dissatisfied or frustrated with the outcome of care. The nurses dealt with these feelings of dissonance by balancing their expectations, not in expecting less of themselves, but in accepting a less than ideal outcome.

The nature of the experience for the nurse and the quality of care provided to culturally diverse clients was also influenced by certain contextual factors, or catalysts, beyond the control of the nurse. The catalysts identified were: the setting of health care; the support of colleagues; the commitment of the institution; and the foundation of education. The nurses gave varying appraisals regarding the effectiveness of their education in preparing them to care for culturally diverse clients. However, four criteria for effective nursing education emerged from the data: 1) exposure to culturally diverse clients, 2) presentation of theoretical and factual information regarding cultural groups, strategies, and skills useful in providing nursing care, 3) opportunity to examine values and attitudes, and 4) preparation to address racism and hegemony in the health care system.

Most significantly, the study uncovered the presence of racism in health care settings. The most obvious examples of racism came in the descriptions by the

participants of the resistant nurses but other examples included inequities at the institutional level. The presence of racism presented considerable challenge to the participants at several levels. Not only did they find it difficult to address racism in their colleagues, they also needed to be vigilant to institutional racism that was perhaps even more difficult to overcome.

Conclusions

The study findings suggest the following conclusions:

1. The experience of caring for culturally diverse clients is complex and challenging due to the interrelatedness of multiple personal and contextual influences.
2. Nurses appear to have varying levels of commitment to cross-cultural nursing, ranging from resistant to competent to impassioned. The nurses' philosophical stances toward cultural diversity, intellectual processes, and nursing practice vary according to their level of commitment.
3. While a nurse's commitment to cross-cultural nursing appears to be relatively stable, personal and/or contextual factors may temporarily or permanently move him/her in either direction on the continuum. Situations in which nurses are sensitized to the experience of being a minority in a foreign culture may awaken them to the imperative nature of cross-cultural nursing.
4. Competent and impassioned nurses put substantial effort into caring for culturally diverse clients. In doing so, they employ strategies of connecting with the client, working with the family, accommodating for cultural differences, and balancing their expectations.

5. Culturally diverse clients may receive a lower standard of care in some situations. The quality of care is dependent on a) the nurse's level of commitment to cross-cultural nursing, b) the strategies employed by the nurse, and c) the influence of contextual catalysts.
6. Racism appears to be present to a perceptible degree in Canadian health care settings. Racism may be expressed by individual nurses and/or by institutions that provide inadequate and inappropriate services.
7. Nursing education is effective in preparing nurses to care for culturally diverse clients to the extent that it provides a) exposure to culturally diverse clients in clinical settings, b) theoretical and factual information regarding cultural groups, strategies, and skills useful in providing nursing care, c) opportunity to examine values and attitudes, and d) preparation to address racism and hegemony in the health care system.

Implications for Nursing

The findings of this study carry implications for nursing practice, education, administration, research, and public policy. The resulting recommendations are motivated by the mandate of ensuring a high standard of health care to culturally diverse clients.

Nursing Education

Nursing curricula throughout Canada have moved toward the inclusion of cultural content. However, this inclusion has been inconsistent and has tended to become lost in overcrowded curricula. The finding that most participants did not feel that their education had prepared them to care for culturally diverse clients is

disappointing. On the basis of the study findings, nursing curricula must consistently incorporate education for cross-cultural nursing. Specifically, the tasks of nursing education are to prepare nurses to 1) provide culturally sensitive care, and 2) address racism. To accomplish these tasks, nursing education must be process-oriented, rather than content-driven. Exposure to culturally diverse clients is mandatory; practical, immediate learning in the clinical setting is central to multicultural education. Toward this end, teachers must not "protect" students from clients who are perceived as more complex (e.g., someone who does not speak English). Encounters should also be planned that sensitize the student to the minority experience. Examples of such encounters include international travel, visits to core areas of the city, home visits to culturally diverse clients, and participation in non-English health classes. Students may feel threatened and uncomfortable in these unfamiliar settings and must be given faculty support and encouragement.

In order to benefit from this experiential learning, students must also learn theoretical and factual knowledge regarding patterns of cultural beliefs and habits. Care must be taken to avoid generalizations and stereotyping; this information must be viewed as a background against which to provide culturally sensitive care. Nursing education must emphasize the skills necessary for cross-cultural interaction (e.g., collaboration, accommodation and negotiation, and working with a translator).

Self-examination of attitudes and values must also be fostered. This should be encouraged as an ongoing process in the clinical settings. Faculty should encourage students to reflect on their experiences in cross-cultural situations with the aim of understanding their own responses and developing strategies to promote culturally

sensitive care. Journalling is one avenue by which to encourage such reflection. As well, seminars that are structured, supportive, and accepting may be ideal settings in which to discuss personal attitudes and biases. Racism should be openly acknowledged as being present in the health care setting and in society at large. Educators should be prepared for both resistance and passionate emotions in such discussions.

Students must be equipped to identify and address racism in health care settings. Self-awareness, critical thinking, and empowerment are necessary skills for personal and collective action directed at eradicating individual and institutional racism. It is conceded that these complex skills may only be acquired to a beginning level during baccalaureate nursing education and that the impregnable nature of racism makes it difficult to address. Nonetheless, sensitivity toward the issue of racism is an important first step in preparing nurses to deal with the problem.

Nurse educators must be alert to the students' varying levels of commitment to cross-cultural nursing. They cannot assume that all students will follow a predictable sequence in the acquisition of cultural sensitivity. Learning activities must be matched to the student's level of commitment. Students who are resistant to cultural diversity must be approached in a supportive and honest manner that challenges them to reflect on their biases and judgmental attitudes. Educators must carefully plan the timing of exposure to cultural diversity, remembering that early and unsupervised exposure might reinforce the discriminatory attitudes of resistant students. Similarly, students who acknowledge the role of culture must be nudged

toward awakening experiences that sensitize them to the mandate of culturally sensitive care.

Finally, these recommendations for nursing education carry implications for faculty preparation. Faculty must engage in the process of self-examination regarding attitudes toward cultural diversity. They must also be convinced of the mandate of culturally sensitive care and must be comfortable with the corresponding strategies for such care. Additionally, faculty must be prepared in the principles of anti-racist education.

Health Care Administration

According to the study findings, health care administration carries a considerable responsibility for the provision of culturally sensitive care. Health care administration must provide the resources and environment conducive to a high quality of care for culturally diverse clients. The philosophies and policies of health care agencies must clearly support cultural diversity; organizational objectives at all levels must state a commitment to culturally diverse groups. The intent of these policies (i.e., culturally sensitive care) must be enforced where necessary. For example, employee appraisals should address the ability to provide culturally sensitive care. Visiting policies also reflect an institution's commitment to culturally sensitive care. A 24-hour visiting policy acknowledges the important role of family members for the culturally diverse client. Similarly, signs in common languages contribute to an environment that welcomes diversity.

The study findings have pointed to the benefits of a culturally diverse staff. Through hiring practices, health care administrators should aim for diversity in their

agencies that reflects the cultural diversity of the community. This recommendation also carries implications for nursing education in recruiting and retaining students from minority groups and for the professional licensure bodies who evaluate the foreign credentials of immigrant nurses.

Finally, health care administration must attack racism at all levels. Organizations must be carefully examined for institutional barriers that result in inappropriate or inadequate services. Nurses in the study reported situations in which culturally sensitive care was constrained due to a lack of resources. Health care administration needs to consider the provision of the resources of translation services, client teaching resources, and dietary services responsive to cultural diversity. Due to the present era of cost constraints in the health care system, agencies may be hesitant to expand these services. However, the lower quality of care provided to culturally diverse clients demands some response. Cost-efficient, creative, and flexible solutions must be sought. Translation services need to be expanded to provide services that are accessible and appropriate. Trained interpreters, meeting accepted standards for interpretation, should be available on a 24-hour basis in health care settings. This might be accomplished by expanded services that include an on-site language assistance department with trained interpreters speaking the most common languages of the area. The services of such a department could be complemented by a roster of bilingual staff and a telephone interpreter service (Headley, 1992). Collaboration and cost-sharing among health care agencies in the provision of these services is needed. At the same time, health

care providers must be made aware of the potential pitfalls of using family members as translators and must be encouraged to use formal translation services.

Nursing Practice

When caring for culturally diverse clients, the nurse needs to develop open, supportive relationships by creative, flexible approaches. Efforts need to be made to connect with the client who is experiencing an isolating and frightening hospitalization. The presence of a language barrier may complicate this connection between the nurse and the client, necessitating the nurse to take more time and effort in non-verbal communication. The nurse must acknowledge and facilitate the involvement of families. For example, families should be encouraged to participate in the care of the client as appropriate. The identification of a family spokesperson, especially in the case of many concerned family members, will improve communication. In terms of accommodating for cultural differences, the nurse needs to seek information from the client to clarify the meaning of the cultural practice for the client and then must seek to negotiate a consensus or plan. When accommodating for differences, the nurse may be in a position to advocate creatively and courageously on behalf of the client. Given this process of information-seeking and negotiation, the nurse must then suspend moral judgment regarding the final decision. When nurses employ these strategies of connecting with the client, working with the family, and accommodating for difference, they will likely experience the positive aspects of caring for culturally diverse clients. However, nurses must also be prepared to balance their expectations in situations when, in spite of their diligent efforts, a less than ideal outcome results.

Nurses need to consider how they might develop a unit milieu that fosters culturally sensitive care. Supporting each other in frustrating situations, enjoying each others' successes in cross-cultural nursing, sharing resources such as books and articles, and discouraging negativism and discrimination will contribute to such a milieu.

The need for client education resources in different languages represents another challenge for nursing practice. Culturally sensitive teaching programs need to be developed by coordinated, concerted efforts that involve minority communities. For example, a cardiac teaching program for IndoCanadian clients might be coordinated in a community setting. Similarly, preadmission clinics should offer some teaching in various languages, whether by video or in-person translation. Pamphlets translated into various languages are another avenue of client education, although literacy levels must be considered. Nurses must be aware of the rationale for involving medically trained interpreters, rather than relying exclusively on family for translation.

Nurses also face the difficult task of addressing racism. Collective efforts will ease the burden of this task. The creation of a positive unit milieu, as discussed above, and the establishment of task forces or discussion groups on cultural diversity and racism will likely generate support and ideas. The aggregate voice of nursing is needed to identify and overcome institutional racism. Finally, nurses should consider professional development activities that expand their world views. For example, nurses might consider short term nursing assignments in developing countries.

Nursing Research

The findings of this study suggest the need for further research in several key areas. First, the uncovering of racism in Canadian health care settings, that has been minimally documented in the health care literature, requires further study. Race relations in health care services need to be evaluated. The perspectives of culturally diverse clients must be sought in order to understand the extent of racism and develop appropriate anti-racist strategies. Additionally, research should examine the difficult challenge of addressing racism in staff, with the aim of providing concrete solutions.

Second, the conclusions about resistant nurses are based upon information provided by their committed and impassioned colleagues. Therefore, it is necessary to validate that information with direct input from representatives of the resistant group.

Third, this study should be repeated with more experienced nurses who graduated longer than two years ago. As recently graduated nurses, most of the participants in this study had received some cultural content in their education. The inclusion of cultural content is a fairly recent development in nursing curricula. It is likely that nurses who graduated some time ago did not receive any education regarding cross-cultural nursing. Therefore, nurses with more experience may not be as aware of the need for culturally sensitive care. It would also be helpful to study the development of commitment to cross-cultural nursing.

Fourth, further research regarding translation services is required. The relationship between quality of care and translation needs to be explored from the

perspectives of the client and the health care provider. An assessment of formal and informal translation, including translation by family members, should be included.

Finally, the methodology of nursing research requires careful consideration. This study design did not follow any one of the popular qualitative methodologies currently used in nursing research (i.e., phenomenology, grounded theory, and ethnography) because none of these methods fit the research question. Rather, a descriptive-exploratory design that took some direction from the phenomenological objective about understanding lived experience and from the data analysis processes of grounded theory (e.g., constant comparative analysis) was implemented. As a novice researcher, it was challenging to design this study without guidance from an established methodology. This experience confirmed for me that nursing requires its own tradition of naturalistic inquiry (Thorne, 1991).

Public Policy

In recent years, the focus of multiculturalism has begun a shift from the "niceties" of cultural diversity (e.g., the celebration of language and culture) to the challenges of access, participation, and equality of opportunity, outcome, and success (McLeod, 1992). That is, multiculturalism has matured to see beyond the more superficial celebration of differences to a grappling with deep-rooted attitudes, inequities, and power structures. This shift must be reflected in overt policy statements regarding racism. Health policies at federal, provincial, and local levels need to acknowledge racism and promote antiracism.

In conclusion, this study has explored nurses' descriptions of the experience of caring for culturally diverse clients. The findings illuminate the complexity of the

experience and the interrelated influences on the quality of care provided to culturally diverse clients. The study, thus, provides direction for promoting culturally sensitive care through nursing practice, education, administration, research, and public policy.

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APPENDIX A: PARTICIPANT INFORMATION LETTER

I am a Registered Nurse and a student in the graduate program in nursing at the University of British Columbia. I am interested in understanding the experience of caring for culturally diverse clients in hospital settings. As Canadian society becomes increasingly diverse, more culturally diverse clients will be requiring the care of nurses. I am aware that caring for these clients may pose unique challenges to nurses. Therefore, the purpose of the study I am asking you to participate in is to understand what it is like to care for clients whose culture is different from your own. I am particularly interested in talking with nurses who have graduated within the last two years because I would like to know how your nursing education has prepared you to care for these clients.

Your participation would involve two meetings, approximately one hour long, at a place and time convenient for you. I will ask you questions about your experiences of caring for culturally diverse clients. Meetings will be tape recorded with your permission and only myself, two professors overseeing my study, and a typist will have access to the tapes. Your name will not be mentioned on the tape or on written material – your identity will be protected. You are under no obligation to participate in my study. Furthermore, should you decide to participate, you have the right to withdraw your consent at any time. I will be happy to share the findings of this study with you. As well, the results will be reported in my master's thesis, in a professional publication, and at professional conferences.

I hope you will consider participating in this study which will contribute to an understanding of the experience of caring for culturally diverse clients. If you are interested in participating or would like more information about this study, please phone me at xxx-xxxx or my thesis supervisor, Professor Sally Thorne at xxx-xxxx. Thank you for considering participation in this study.

Sincerely,

Sheryl Reimer, RN, BScN

APPENDIX B: CONSENT FORM**Nurses' Descriptions of The Experience of Caring for Culturally Diverse Clients**

I understand that this study is looking at the experiences of recently graduated nurses in caring for culturally diverse clients. I am aware that I will be asked to describe my experiences in caring for such clients as well as factors I perceive as influencing the nursing care I give.

I understand that there will be approximately two one-hour interviews with the researcher, Sheryl Reimer, at places and times that are convenient for me. I consent to having these interviews tape recorded and transcribed by a typist. I know that I can ask the tape recorder to be turned off at any point in our conversation or can have the tape erased if I wish.

I understand that Sheryl, two of her professors, and a typist will have access to the tapes. I understand that my identity will be protected throughout the study – my name will not be mentioned on the tape or written material, the tapes will be kept in secure place, and a pseudonym will be used in the research report. I understand that I can ask questions of the researcher throughout the study and that the results of the study will be shared with me. I also understand that the results will be reported in Sheryl's master's thesis, in professional publications, and at professional conferences. I am aware that I can withdraw from the study at any time and can refuse to answer any of the questions. I also understand that I face no risks in participating in this study – my participation will not negatively affect my job. My signature below shows that I have agreed to be in the study and that I have received a copy of this consent and an information letter about the study.

Signature of Participant

Signature of Researcher
Sheryl Reimer (xxx-xxxx)

Date

Faculty Advisor: Dr. Sally Thorne (xxx-xxxx).

APPENDIX C: INTERVIEW GUIDE**Questions:**

Tell me about what it is like for you to care for culturally diverse clients.

Tell me about an experience of caring for a culturally diverse client that stands out for you. How did you feel in caring for this patient? What were some problems you encountered, if any? What were the rewards for you? What contributed to make this the experience it was? Why did you choose this experience to tell me?

Tell me about what influences you in caring for culturally diverse clients. What helps? What makes it more difficult?

How did your nursing education prepare you for the experience of caring for culturally diverse clients?

Is there anything else you wish to say?

Prompts:

Can you tell me more....

In what way....

So what you're saying is....

What were your feelings....

What were you thinking when that happened....

What was that like for you....

APPENDIX D: NURSE INFORMATION SHEET

Name _____ Code # _____

Age _____

School of Nursing _____

Date of Graduation _____ Diploma _____ Degree _____

Type of nursing you are presently employed in _____

Full-time _____; Part-time _____ Hours/week _____;

Casual _____ Hours/week _____

How long have you been in this nursing position? _____

What is your ethnic origin? _____

What experience have you had in culturally diverse settings? _____

APPENDIX E: LEVELS OF COMMITMENT TOWARD CROSS-CULTURAL NURSING

	Resistant	Competent	Impassioned
Philosophical Stance	Ignore or resent diversity - Negative problem - Expect assimilation	Acknowledge & accommodate for diversity - Non-issue - Common respect for all	Accommodate & appreciate diversity - Big issue - Personal commitment clearly articulated **AWAKENING**
Intellectual Process	Negative stereotypes - Avoid education & knowledge Attribute any negative or foreign behavior to culture	Stereotypes & generalizations - Seek facts & strategies - Emphasize global approaches (i.e., respect, information-seeking) - Begin to see predictability and familiarity in cultures - See patterns in diversity - Little reflection on cultural issues	Complexity & ambiguity - Theorize & conceptualize - Analyze & reflect to identify biases in self & others - See diversity in patterns of culture - No assumptions - See broader picture of societal issues - Plan personal and professional development to improve cross-cultural skills
Nursing Practice	Racist practices - judging - ignoring - complaining OVERT & COVERT Frustrated with patient & family - "what this means to me" Threatened or resentful Task-focused - Rigid - Seek control & ownership - Block efforts of colleagues - Resistant to change	Passive participation in racist practices - May identify racism but choose to put up with it - Empathize but not empowered Frustrated with barriers to nursing care (e.g., language) - "what this means to getting the job done" Uncertainty, anxiety Competent care - Appreciate family - Effective in cross-cultural communication - Avoid cultural conflicts	Identify systemic, institutional, and individual racism - Advocate & negotiate - Empowered Frustrated with quality of care - "what this means to my patient" Confidence, enjoyment Partnership - Increased effort to connect and accommodate. May push hospital norms. - Thoughtful about conflicts - Enter into dilemmas of care