An Exploration of Nurses' Experiences of Caring for People from Different Cultures in Ireland

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Student Name: Kathleen Markey

Student Number: 9441961

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ABSTRACT

This study aimed to explore the experiences of both student and qualified nurses of caring for patients from different cultures in one region of Ireland. In particular it explores the concerns and challenges experienced and how nurses dealt with them in their daily practice. Using a grounded theory approach, ten focus groups and thirty individual face-to-face interviews were conducted with student and qualified nurses. As data were collected, it was simultaneously analysed using the classic grounded theory methodological principles of coding, constant comparison and theoretical sampling.

This study described the different challenges nurses face when caring for patients from different cultures and the coping strategies adopted to deal with such challenges in their daily practice. It provides a comprehensive picture of the personal, professional and organisational factors that contribute towards culturally insensitivity. Lack of knowledge leading to uncertainty was the consistent main concern that emerged for informants. Feelings of ambiguity were further influenced by an awareness of potential ethnocentric beliefs, values and stereotypes and the culture of the organisation in which informants learn and work in. The data reveals how nurses used rafts of disengagement strategies as a means of dealing with their lack of cultural knowledge. The culture within the organisation facilitated the disengagement and allowed it to go unnoticed. Accepting less than perfect care and becoming indifferent to the needs of patients who are not Irish is evident in the data. This went unchallenged and consequently culturally insensitive and sometimes even discriminatory care was perpetuated.

This study has implications for nurse education and leaders and managers in clinical settings. Although this study specifically explored nurses' experiences of caring for patients from different cultures, the findings may have wider implications for nursing practice in Ireland. It highlights the need for nurses to understand themselves and the way in which they form relationships with patients from different cultures. It reiterates the need for greater consideration into how culturally compassionate competence development is taught, learnt and perhaps more importantly applied in practice. Although acknowledging the organisational constraints and education deficiencies that were evident, this study highlights the need for greater individual and organisational commitment to culturally competent care.

I, the undersigned declare that this PhD Thesis which I am submitting is all my own work and research which has not been submitted for another degree, either at Middlesex University or elsewhere.

Name: Kathleen Markey   **Student ID**: 9441961

Signature: **Date:**   28/09/2017

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TABLE OF CONTENTS

LIST OF TABLES

GLOSSARY OF TERMS

Asylum Seeker:

An Asylum Seeker is a person seeking to be recognised as a refugee under the 1951 United Nations Convention Relating to the Status of Refugees.

Culture:

Culture is characterised by behaviour and attitude and is variable and changeable. Culture is defined by how we think and behave. Culture should not be viewed as static.

Cultural competence:

Cultural competence is not an endpoint and should be seen as a continuous process of personal and professional development. In order to provide competent care in culturally sensitive way health care professionals need to develop their knowledge, skills and attitudes. This requires developing attitudes and practices that incorporate empathy and humility, cultural awareness and sensitivity and is underpinned by principles of social justice.

Discrimination:

Discrimination is defined as inequality where the treatment of a person in a less favourable way than another person is, has been, or would be treated, in a comparable situation.

Diversity:

The term diversity is used to describe the variety and wide range of cultural difference, nationalities and ethnic minority groups living in a host society. Diversity focuses on mainstreaming and includes aspects such as class, ethnicity, educational background, linguistic, mental health, political, or religious beliefs. In this way diversity is defined as difference within and between cultural groups.

Equality:

Equality in the context of this study refers to the state of being equal in opportunities, status and/or rights. In the legal and social context, equality is the term used for "Equal Opportunities", based on the legal obligation to comply with antidiscrimination legislation. Equality aims to protect people from being discriminated against on a number of defined grounds. Equality does not mean that everyone should be treated in the same

way but enables observation and measurement of how people are treated in comparison with other people.

Ethnicity:

Ethnicity should be viewed as a combination of both culture and race and therefore cannot be discussed in isolation. Ethnicity is characterised by a sense of belonging and therefore has an objective aspect and a subjective aspect. It is a set of shared social characteristics such as culture, language, religion, traditions, skin colour or physical appearance, that contribute to a person's or groups' identity. These characteristics may change over time and are symbolic markers of difference.

Ethnocentrism:

Ethnocentrism is the inherent tendency to consider and believe that one's own culture is superior to another. In this way either directly or indirectly, this assumes that that the other culture is inferior or in some ways undeserving. This is used as the standard against which all other cultures are judged.

Interculturalism:

Interculturalism is defined as the interaction between majority and minority cultures and seeks to foster ways of developing an inclusive society. It requires the State, majority and minority ethnic communities to work together to accommodate diversity, where all members interact, integrate and have equal opportunities.

Institutional Racism

The definition of institutional racism was defined by the Stephen Lawrence Inquiry as 'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in the processes, attitudes and behaviour which amount to discrimination through the unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'.

Indifference:

This is a term used to describe apathy, lack of interest and lack of commitment to respect cultural difference and provide quality care in culturally appropriate ways.

Migrant:

There are a number of understandings and interpretations of the term 'migrant' depending on context, i.e., social, political, cultural or economic. In general, the term migrant can be understood as any person who lives temporarily or permanently in a country where he or she was not born and has acquired some significant social ties to this country. Officially, the United Nations acknowledges that the term 'migrant' should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned for reasons of personal convenience and without intervention of an external competing factor. Therefore, this definition of migrant does not apply to asylum seekers, refugees or displaced people.

Migration:

Migration is generally considered the crossing of the boundary of a political or administrative unit for a certain period of time. The variations existing between countries, regions and areas indicate that there are no objective definitions of migration. It can involve a move from one area to another within one country or relocation of people between nations, often seeking employment or education opportunities.

Non-Irish National:

This is a term used at government and subsequent organisational levels to describe a person living in Ireland who is not classified as being Irish. The term 'foreign national' generally refers only to people who are not EU citizens. Non-Irish national seem to be the least problematic in terms of public use and understanding. However it has negative connotations as when using such terms people from different cultures are segregated and labelled as the 'other' and therefore inferior or in some ways undeserving.

Organisational culture:

It is a term used to describe the norms and practices within organisations. In this way it describes the attitudes and practices of individuals and collective groups of people working and learning within the healthcare setting. It captures the beliefs and values that influence the practices of healthcare professionals that become accepted as standards of practice.

Prejudice:

Prejudice involves 'pre-judging' by assigning negative, misinformed and ignorant attitudes towards an individual or certain groups, for example, religious or ethnic groups.

Race:

Race is socially constructed and should be seen as a social construct rather than a biological one. The term race is still widely used in legislation. In Irish equality legislation 'race' is described as "race, colour, nationality or ethnic or national origins".

Racism:

Racism is a specific form of discrimination and exclusion because of skin colour, nationality, ethnic or cultural background. Racism is a word that often has negative connotations to it and can be acted out in thoughts, actions or omissions. Racism can be direct or indirect, overt or covert and can be consciously acted or subconsciously. There is global and Irish legislation that prohibits any form of racism even if borne out of unwitting prejudices, thoughtlessness or ignorance.

Racial Discrimination:

Racial discrimination occurs when a person(s) receives less favourable treatment or outcomes than another person in the same situation would have received on the grounds of their 'race'.

Refugee:

According to the United Nations Convention Relating to the Status of Refugees (1951), a refugee is a person who has left their own country and cannot return due to a well-founded fear of persecution on the basis of their race, religion, nationality, political opinion or membership of a particular social group.

Resigned Indifference:

Resigned indifference is a term used to describe the individual and collective nature of accepting that providing less than perfect care to people from difference cultures was acceptable. As a consequence it went unnoticed and was perpetuated.

Stereotyping:

Generalising about particular minority ethnic groups and labelling them, thus creating false expectations that individual members of the group will conform to certain (often negative) traits or characteristics that have been attributed to the wider group or community.

Tolerance:

Tolerance assumes the superiority of the persons who tolerate towards the supposedly inferior group or person to be tolerated. In this way people are tolerated as opposed to valued and respected and seen as truly equal.

Traveller:

Travellers are an indigenous minority of people documented as being part of Irish society for centuries and may or may not be nomadic. Travellers have a long shared history and value system with their own language, customs and traditions. In March 2017, there was an announcement by the Irish Government to officially and legally recognise Travellers as an ethnic group after many centuries of canvassing for this.

Xenophobia:

Fear of people perceived to be from a different ethnic or cultural background, mainly associated with protecting their own way of life such as jobs and other opportunities being taken by people from other countries.

CHAPTER 1

INTRODUCTION

1. Introduction:

This thesis presents a research study which explored the challenges nurses' experience and how they deal with them when caring for people from different cultures. This chapter provides the background to this study and contextualizes the need to explore factors that influence nurses' attitudes and practices from an Irish perspective, when caring for patients from different cultures. In particular the major shifts in the demographic profile that have occurred in Ireland in recent years require consideration. This chapter explores the potential impact of such rapid developments on Irish healthcare services and professionals working within them. It aspires to identify potential Irish specific barriers to providing culturally sensitive and anti-discriminatory care. The chapter concludes with an outline of the thesis and highlights the aims of the subsequent chapters to follow.

2. Trends in Irish Migration:

Irish migration in the late 20th and early 21st century can be categorised as having had three major demographic shifts, which include; net emigration prior to the 1990's; increasing number of Irish emigrants returning to Ireland from the mid 1990s to the early 2000s and unprecedented levels of immigration since 2002. The turnaround began during 1991-1996, when small inflows of migrants entered Ireland, but this rapidly increased during 2002-2006, when 48,000 migrants entered Ireland (CSO 2012). This reflected the economic boom of the 1990s, transforming Ireland into a country of net immigration by the early 2000's (Ruhs 2009). The term migrant in this context is used loosely to describe people from other nationalities and ethnic groups who have immigrated to Ireland, and are classified by the state as 'non-Irish nationals'.

Net inward migration appeared briefly for the first time in Ireland in the 1970s, with an annual average of 14,000 immigrants entering Ireland between 1971 and 1979. This reverted to net outward migration again throughout the 1980s (CSO 2009). The turnaround began during 1991-1996, where there were small inflows of immigrants entering Ireland which lead to the peak net inward migration period of 2002-2006, highlighting that 48,000 migrants immigrated to Ireland during that period (CSO 2011).

In 2002, 224,000 'non-Irish nationals' (a term used by the state to describe people from other nationalities and ethnic groups) were counted in the census and four years later this number doubled to 420,000 (CSO 2006). The number of non-Irish people in Ireland has increased by 143% between 2002 and 2011 (CSO 2012) and now accounts for 555,000 or over 12% of the entire population (CSO 2016). In September 2008, the Irish Government announced that Ireland was witnessing a major economic crisis and entering a recession (Government of Ireland 2008). A sharp rise in unemployment occurred almost immediately. As a result, Ireland witnessed the return of high emigration rates again as the numbers of people emigrating in search of employment opportunities to other countries increased (CSO 2012). There was a widespread perception that migrants would return to their countries of origin as a consequence of the recession. However statistics from the most recent census (CSO 2016), demonstrates that immigration to Ireland continues albeit at a slower rate. Table 1 shows the trends of immigration and emigration between 2012 and 2016, highlighting the consistent gradual increase in the number of migrants entering Ireland legally mostly in search for education or employment opportunities. The 5.8% decrease in the number of people who emigrated from 80,900 to 76,200 between 2015 and 2016 is reflective of the encouraging economic shift and the recent return of economic growth in Ireland (CSO 2016). It is also important to note the increase in the number of immigrants to Ireland from 69,300 to 79,300 between 2015 and 2016, which represents an estimated increase of 15% (CSO 2016). This highlights how Ireland continues to appear a popular destination for migrants, which is expected to continue particularly in light of the uncertainty associated with Britain exiting the

European Union. The reduced emigration and increase in immigration statistics demonstrates how a return to net inward migration (+3,100) has resulted for the first time since 2009.

Table 1: Population and Migration Statistics:

	Year Ending				
	Apr-12	**Apr-13**	**Apr-14**	**Apr-15**	**Apr-16**
Immigration	52,700	55,900	60,600	69,300	79,300
Emigration	87,100	89,000	81,900	80,900	76,200
Net Migration	-34,400	-33,100	-21,400	-11,600	3,100
Natural increase	44,900	40,800	37,900	37,400	35,300
Population change	10,500	7,700	16,500	25,800	38,400
Population	**4,585,400**	**4,593,100**	**4,609,600**	**4,635,400**	**4,673,700**

Sources: CSO (2012; 2013; 2014; 2015; 2016)

3. The Context of Migration into Ireland

Although acknowledging that migration is a process rather than an end point, it is important to compare migration trends as a means of contextualising migration in Ireland. Over the past 15 years, Ireland has witnessed a rapid increase in the ethnic and cultural diversity of its population (Central Statistics Office 2006; 2011; 2016). Economic, political and cultural reform in the 20th century has seen the mass emigration to which Ireland was traditionally accustomed, replaced with net inward migration. Analysis of data from the national population census, which is held every five years helps explain the recent trends of migration in Ireland. The self-recorded responses to three key questions on the census form; such as place of birth, nationality and periods of time spent outside of Ireland help us understand the growing diversity of the demographic profile of the population. However, despite such unprecedented increases in immigration, the implementation of an ethnicity question on the Irish census only occurred for the first

time on the April 2006 census. This highlights the failure of the state to acknowledge that Ireland was changing from a relatively monocultural to a multicultural society. Ireland's pattern of inward migration is distinctly different to what has occurred elsewhere in Europe and the world in that the great bulk of our migrants come from within the European Union (EU) as opposed to other continents. The last four Census (2002; 2006; 2011; 2016) provide insightful information of the population of Ireland by nationality. Migrants to Ireland are a diverse group in terms of their country of origin. There were over 199 different nationalities living in Ireland as recorded on the 2016 census (CSO 2016). Table 2 highlights the shifts in the top ten national groups residing in Ireland from 2002 – 2016. It highlights how the majority of migrants living in Ireland have come from neighbouring EU countries such as Poland and the United Kingdom and are therefore currently free to move to, live and work in Ireland. It is also interesting to note that a significant proportion of migrants in Ireland are now Irish citizens. Around 8,600 Non-European Economic Area (EEA) adults acquired Irish citizenship in 2015, which represents around 7.5% of the adult non-EEA population (CSO 2015). Between 2005 and the end of 2015, a total of 93,610 non-EEA nationals aged 16 and over acquired Irish citizenship. This represents 45% of the estimated adult immigrant population of non-EEA origin resident in Ireland. Those recorded on the census as having dual nationalities has risen from 55,905 in 2011 census to an estimation of 104,784 in the 2016 census (CSO 2016). A significant proportion of migrants in Ireland are now Irish citizens, highlighting the level of complexity of cultural and ethnic diversity in Ireland, exceeding any previous trends. Vertovec (2007) refers to such growing trends as 'super-diversity'.

Table 2   Top Ten National Groups in Ireland (2002 - 2016):

Top Ten National Groups In Ireland (2002 - 2016)			
Rank	**2002**	**2006**	**2011**	**2016**
1	UK (117,095)	UK (126,068)	Poland (122,585)	Poland (122,515)
2	USA (17,519)	Poland (73,402)	UK (112,259)	UK (103,113)
3	Germany (10,196)	Lithuania (25,796)	Lithuania (36,683)	Lithuania(36,552)
4	Nigeria (9,229)	USA (19,308)	Latvia (20,593)	Romania(29,186)
5	France (8,772)	Nigeria (16,425)	Nigeria (17,642)	Latvia (19,933)
6	China (6,392)	Latvia (14,186)	Romania (17,304)	Brazil (13,640)
7	Spain (6,122)	Germany (13,028)	India (16,986)	Spain (12,112)
8	Australia (5,361)	France (11,950)	Philippines (12,791)	Italy (11,732)
9	Romania (5,247)	China (11,515)	Germany (11,305)	France (11,661)
10	Italy (5,180)	Philippines (9,873)	USA (11,015)	Germany(11,531)

Sources: CSO (2012; 2013; 2014; 2015; 2016)

4. Background to Study: Exploring the Impact of Migration:

When considering the history of migration in Ireland, the impact of social, economic, political and cultural change on Irish society must be considered. Global migration is a phenomenon affecting every country, bringing with it both challenges and benefits for sending and receiving countries. This rapid diversification of Ireland brings many challenges both for Irish people adapting to a multicultural society and for migrants attempting to integrate into mainstream society. Such challenges are not exclusive to Ireland. However, the rapidity, extent and newness of this demographic change at a time of economic and political instability present many challenges. Over the past 15 years Ireland has benefited from the effects of global migration. However, Irish society has struggled with newcomers and cultural diversity over many decades. This is set against a long history of conflict with incomers from the Vikings to the English and Scottish settlers in the 16th century. Irelands' history identifies that it has long been a country to

resist newcomers, dating back to the Viking invasions of Ireland (800 AD). The plantation period (1534 – 1961) saw English and Scottish settlers coming to Ireland. However, from this period on, sectarian conflict became a recurrent theme in Irish history, due to resistance to British rule in Ireland. Irish society has also struggled to integrate the Irish Travellers and for decades marginalizing Irish Travelling people has been evident (Vivian and Dundes 2004; Reid 2005). The long history of reported hostility in Ireland towards Travellers is significant and highlights the challenges with integration. However the reluctance of the Irish government to recognise Travellers as a unique ethnic minority until recently (March 2017) is further evidence of the resistance of the state to respect the cultural identity of Travellers. The number of Travellers residing in Ireland increased by 5.1% since the 2011 census as the numbers have risen from 29,495 in 2011 to 30,987 in 2016 (CSO 2016).

Given this historical backdrop to the ethno history of Ireland and the overt demonizing of Irish Travelling people for decades, it is not surprising that new migrant communities would face barriers to integration (Kennedy and Murphy-lawless 2003; McGinnity *et al* 2006; Fanning 2007). Over recent years, there have been increasing reports of intolerance (McGinnity *et al* 2016; Michael 2015), xenophobia, social tensions (Kelly 2005) and hostility (Fanning 2012) towards migrants in Ireland. Fears, intolerance of difference and hostility have motivated negative attitudes and behaviours towards migrants (Fanning 2007). The economic recession of 2006 has been particularly destructive, leaving Irish people increasingly anxious about employment, blaming immigration for the economic recession and the return of mass emigration. Recession and subsequent mass unemployment have fuelled negative attitudes towards immigrants (McGinnity *et al* 2016).

In response to the increased migration in recent years, Ireland promptly introduced policies and legislation aimed at addressing integration, discrimination and racism. The Employment Equality Acts (1998-2015) and the Equal Status Acts (2000) and (2011)

specifically prohibit any form of discrimination. The Irish Government also introduced a number of key policies aimed at further planning for cultural and ethnic diversity and integration in Ireland. The National Action Plan against Racism (Government of Ireland 2005) was timely and provided strategic direction to combat discriminatory practices and racism in Ireland. The National Action Plan for Social Inclusion 2007-2016 (Government of Ireland 2007) further demonstrated the Government's plans to build an inclusive society. This set out key priorities and strategic goals aimed at tackling poverty and social exclusion, highlighting the need to focus on vulnerable groups such as migrants, Travellers and members of ethnic minority groups. However despite legislation and policies, there are increasing concerns regarding the treatment of migrants and refugees in Ireland (Cahill 2009; Radford 2010; Michael 2015). McGinnity *et al* (2009) highlight discrimination in recruitment to employment in Ireland higher than in other European countries. Furthermore, this report illuminates that the majority of Irish employers were twice as likely to interview an Irish person as a 'non-Irish person' with precisely the same qualifications. Not disputing the concerning nature of such reports, in some ways it is not surprising given the rapid changes to the demographic profile of Ireland, highlighting how progress can be slow.

Ireland is now more diverse in terms of culture, race and ethnicity, which arguably it was unprepared for (Fanning 2007; King-O'Riain 2009). Irish people who have been brought up and educated with certain values and beliefs need to be aware of their own cultural perceptions. The lack of exposure to other cultures and traditions has led them to believe their own pattern of behaviour and expectations for behaviour as being "normal" and superior and anything different as being "wrong" or inferior. This ethnocentricity is additionally informed by Catholic discourses, relating to Irish missions abroad which became an integral part of Irish identity. Many Irish people will remember the "black babies", collection boxes with pictures of malnourished black children in every church, school and shop. Irish children were encouraged to help provide food and shelter for these children and "a penny for the black baby" was one of the first phrases learnt at

school, which may have contributed to ideas of racial superiority. Such views contribute towards the development of negative stereotypical assumptions of patients from different nationalities. However, Reid and Taylor (2007) suggests that ethnocentrism in an Irish context amounts to more than "cultural stereotyping" with inappropriate assumptions made based on the majority experience or negative stereotypical images. Pease (2010) argues that too much emphasis is placed on individual prejudices and suggests the need to address the complex wider social context in which values are learned, such as behaviour that is socially reinforced and normalised. Socially reinforced and normalised behaviour and attitudes must be identified, explored and challenged, if change is to occur.

5. The Impact of Global Migration on Irish Health Care Services:

Rapid inward migration challenges Irish healthcare settings, services and the professionals working within them to provide quality care that meets the needs of individuals from diverse cultural, ethnic and linguistic backgrounds (Lyons *et al* 2008; Tuohy *et al* 2008; Markey *et al* 2012). Although Ireland has been host to diverse cultural groups for generations albeit at a smaller scale, health services and the training of health and social care professionals were predominantly geared towards a relatively homogenous nation until recently. Ireland is now host to over 199 different nationalities (CSO 2016). However, healthcare professionals have not felt adequately equipped to respond to the needs of a diverse patient base (Tuohy *et al* 2008; Lyons *et al* 2008). There is significant evidence of culturally insensitive and discriminatory care to individuals from minority ethnic groups in Ireland (Cairde 2005; Equality Authority 2008; Lyons *et al* 2008; Ryan *et al* 2008; Radford 2010). In response to such reports, the Health Service Executive introduced the National Intercultural Health Strategy (HSE 2008), highlighting initiatives to promote culturally competent care.

Clearly, Ireland has come a long way in a short time in developing legislation and policies in response to moving from a relatively homogenous nation to increasing ethnic and cultural diversity. However, the evidence highlights that despite such developments,

reports of insensitive and racially discriminatory attitudes and practices continue. Therefore, there is a need to explore the factors which enable or hinder the way in which legal and professional directives are operationalised. Policies alone are insufficient to effect change and they take time to become embedded and to demonstrate effectiveness (Culley 2001). Ultimately the responsibility for legislation and policies lies with the Government and organisations, but the actual implementation relies upon the actions and attitudes of individuals. If staff lack motivation and are not adequately prepared and supported, change is unlikely. Despite the wealth of literature highlighting the various challenges for nurses globally when caring for patients from different cultures, little is known as to how they address such issues in their daily practice. Although there is some evidence exploring Irish nurses' experiences, there is no research to date highlighting how nurses respond to the challenges experienced when caring for patients from different cultures. Therefore this study is both timely and necessary as a means of gaining a greater understanding as to how nurses in Ireland address the challenges experienced when caring for patients from different cultures. It is anticipated that the findings from this study will contribute to a richer understanding of the development of cultural competence for nurses in Ireland.

6. Purpose of the Study:

The purpose of this study is to generate an explanatory theory that explicates how nurses' deal with their main concerns and challenges when caring for people from different cultures, in an Irish context. Through exploring the experiences of student and qualified nurses of caring for a multicultural patient population, a greater understanding of the potential Irish specific barriers to providing culturally sensitive care emerges. The uncharted nature of the factors that influence and hinder culturally competent practice in Ireland lent itself to a grounded theory approach. Therefore this study employed a grounded theory methodology based on the early work of Glaser and Strauss (1967) and Glaser's subsequent work, which constitutes the classic approach (1978). The classic

approach although no less rigorous than the other approaches, was favored as it emphasises allowing the problem to emerge from the informants' perspective. In keeping with the philosophy underpinning this research approach, it was exploratory in its quest to understand what is really going on when nurses care for patients from different cultures. In particular this study aimed to uncover the factors that influence nurses' attitudes, practices and behaviours in their daily practices. Through exploring such issues, the findings from this study will contribute to a richer understanding into the issues that enable and hinder culturally sensitive care, which has implications for nurse education and clinical practice.

The interest in the area of cultural competence commenced during my 15 years living and working in London during the times of the troubles in Ireland. I had insight into the stereotypical views of Irish people in London and had witnessed firsthand what it was like to be on the receiving end of hostility and to be segregated as an "outsider". I also had the opportunity to work with experts in the field of cultural competence and learned so much about the importance of being culturally aware and culturally sensitive both in the classroom and the clinical setting. However, the real impetus for this study commenced when I moved back to Ireland in 2007. At this time Ireland was entering into an economic recession and as a result anxiety and uncertainty was apparent. However, I was shocked at witnessing the extent of the ethnocentrism, xenophobia, racism and general hostility towards migrants openly portrayed in the media coverage of the sudden collapse of the Irish economy and amongst friends, families and work colleagues. Considering the ethno history of Ireland, I was perhaps naïve in thinking that Irish people were welcoming and would empathise with and understand the experiences of migrants trying to improve their lives. I have over the last number of years seen and heard overt and covert examples of racism at work, whilst socializing, shopping and at home. This sparked a need to explore at a much deeper level the influencing factors that enable and hinder culturally sensitive attitudes and practices, particularly in Irish healthcare settings.

7. Outline of Thesis:

This thesis is presented in nine chapters, beginning with this introductory chapter. Chapter two and three contextualises and provides a rationale for the study. The discussions within these early chapters are the result of a preliminary broad literature review undertaken before the study commenced, which was reviewed, refined and updated once the findings were finalised. However as asserted by Glaser (1978:32), this literature was not used as a theoretical framework for the study but instead provides a background and context to situate it. The intent was to locate the investigation within the broader context of current issues on cultural competence. Engagement with a more detailed literature review was directed by ideas, which emerged during the process of data collection and analysis. This is what Straus and Corbin (1994) refer to as the second phase of the literature review, which is presented in the findings and discussion chapters.

Chapter four presents the overall methodological approach for this study. This section discusses how the principles of a classic approach to grounded theory informed this study. Discussions will also focus on the philosophical and methodological positions underpinning this study and how they were utilised in this research. This chapter describes data collection, the constant comparative analysis of data, as well as ethical considerations. It also recounts the methodological, ethical and personal challenges encountered and how they were overcome within the context of this study.

Chapter five presents the main concern identified by informants, which describes how lack of knowledge led to uncertainty, when caring for patients from different cultures. Chapter six presents an overview of the various disengagement strategies nurses adopted to deal with their lack of knowledge and the uncertainty this entailed. It also highlights how the culture of the organisation allowed and sometimes facilitated disengagement on a daily basis. Chapter seven discusses the indifference of students and qualified nurses to the needs and vulnerabilities of patients from different cultures and personal and

organisational factors that contribute towards this indifference. Each findings chapter describes how the emergent data takes the researcher back to existing literature as a means of positioning and contextualising the findings. However, she is also drawn to wider bodies of research to explain the attitudes, behaviours and practices informants engaged in when they were uncertain about their ability to care for somebody from a 'non-Irish' background.

Chapter eight discusses the findings of this study and highlights how they contribute new knowledge, particularly in relation to Ireland but also to cultural competence in other contexts and settings. Chapter nine discusses the implications of the findings and makes recommendations for leadership, nurse education and clinical practice in particular. It also addresses the strengths and limitations of the study and makes recommendations for future research.

8. Summary:

This chapter has provided the reader with an overview of this thesis by introducing the study and its purpose. It sets the scene for chapter two and three which contextualises the study and justifies the need for this research and its potential significance.

CHAPTER 2

CONCEPTS

1. Introduction:

This chapter explores existing debates on some key concepts related to this study. In particular it examines concepts such as; culture, race, ethnicity, identity and cultural competence. Examining and understanding different perspectives regarding such complex concepts was useful in clarifying a position to take in setting the contextual background for this study.

2. Understanding the Complexity of Concepts: Culture, Race, Ethnicity and Identity:

Understanding the complexity associated with concepts such as culture, race, ethnicity and identity was fundamental in identifying a position and working definition with which to commence this study. These terms are used interchangeably and with varying diversity within the literature, which highlights at the very least their complex nature. However, in acknowledging the diverse interpretations of such important concepts Vandenberg (2010), highlights the importance of clarifying the working definitions and interpretations adopted in different contexts. Several authors criticise how these terms have sometimes been defined within transcultural nursing theory (Gustafson 2005; Culley 2006; Campesino 2008). Therefore it is important to understand and make explicit the positions and interpretations taken in operationalising complex concepts in both research and practice. When considering a position to take for this study, it was useful to explore how interpretations of culture, race and ethnicity have influenced the development of cultural identity in an Irish context. This helps set the contextual background for this study and in some ways illuminates some influencing factors that may contribute towards the attitudes and behaviours of nurses in Ireland.

There are varying contradicting definitions of culture within the literature, resulting in much uncertainty regarding the interpretation of culture. Earlier anthropologists define it as groups having set boundaries, beliefs, morals and customs that are somewhat static, difficult to change and are inherited or habits acquired (Geertz 1973; 145). Others define culture as socially shared beliefs and activities (Leininger 1988), implying it is a property of a group rather than an individual. When examining these definitions exploring other interpretations was important, as culture appears to be described as a collective phenomenon. From an Irish context, adopting such interpretations may be unhelpful as there is a danger of trying to identify what is typical of a certain culture which may lead to inadvertent stereotyping. Furthermore, Vertovec (2007) who writes from a United Kingdom perspective highlighted the need to re-focus such thinking and consider the "super diversity" that may exist. As Ireland has witnessed a rapid increase in the diversity of its population, it is important to acknowledge individual differences that exist within as well as between groups and societies. For the purpose of this study it was useful to adopt Fernandos' (2010) interpretation suggesting culture is characterised by behaviour and attitude but should be seen to be variable and changeable. Although acknowledging the needs of people from other cultures are similar to Irish people, the term 'people from different cultures' was used throughout this thesis as opposed to the exclusionary term 'non-Irish nationals' which is used in existing Irish policy. In taking this position it was acknowledged that although people may come from a different cultural background their needs may be similar to those of Irish people.

Understanding race and identity and how such concepts might be interpreted from an Irish context was also helpful. Where race is defined within some transcultural nursing texts, it at times is inadvertently presented in relation to biological characteristics, such as skin colour (Jones 2000). Although taking such a position is sometimes not the intention of the authors, it can further influence the categorising of groups. In examining the various interpretations of race within the literature, I adopted Fernandos' (2010) definition, which argues that race is socially constructed and should be seen as a social

construct rather than a biological one. Culley (2006) suggests that the ambiguity associated with defining race is related to a general discomfort when discussing the related concept of racism. However, Campesino (2008) highlights that racial categorisation and stereotyping occurs as a result of such lack of clarity.

Exploring the debates on interpretations of such complex concepts left me questioning the meaning of identity and ethnicity from an Irish context. The socio-cultural changes in Ireland over the past decade have influenced the development of our understanding and operationalisation of concepts such as culture, race and ethnicity. Williamson and Harrison (2010) warn that caution should be taken when classifying these concepts, as it has implications for approaches to cultural and ethnic diversity adopted. Understanding the meaning of identity formation and exploring the meaning of transnational identity are important factors, which are sometimes overlooked (Taylor *et al* 2013). This prompted me to consider the meaning of ethnicity. Again I found it useful to adopt Fernandos' (2010) position, suggesting that ethnicity should be viewed as a combination of both culture and race and therefore cannot be discussed in isolation. Ethnicity is characterised by a sense of belonging (Fernando 2010) and therefore has an objective aspect and a subjective aspect. The objective aspects refer to the external characteristics that people see such as dress, norms, practices and customs. However the subjective aspects require equal consideration such as feeling part of a culture and adhering to it to different degrees, maybe even in different contexts. This position is supported by Culley (2006) and Vertovec (2007) who suggest that ethnic identities are subject to change and ethnic groups are not internally homogeneous.

Ireland has experienced overwhelming transformation as a result of rapid social, economic, cultural and ethnic change over a short period of time. It is important therefore to identify the impact of such changes to the ethnic and cultural diversity of the demographic profile of Ireland, particularly in the context of Irish identity. Fanning (2012) and others (Lentin and McVeigh 2002; Watt 2007; King-O' Riain 2009) have

articulated that until recently Irish society considered itself a relatively indigenous and monocultural society. The inclusion of an ethnicity question on the Irish census introduced for the first time in 2006 is further evidence of this. However, the reality is that Ireland has always had cultural and ethnic diversity, albeit at a much smaller scale. However, there is evidence to suggest that Irish society has sometimes struggled to embrace cultural diversity and a denial of class differences also exists. One such example is the differentiation between people living in big cities versus rural parts of Ireland. People who live outside of Dublin are sometimes referred to as 'culchies' and are sometimes portrayed as farmers, ignorant and less glamorous than those living in the countrys' capital. Another such example is the long history of hostility shown towards the Irish travellers (Vivian and Dundes 2004). Despite the decades of canvasing for the recognition of Irish Travellers as a separate ethnic identity, this was only addressed by the state in March 2017, which demonstrates the lack of tolerance of people who do not conform to the 'norm'. If Irish society has found it challenging to integrate long-standing groups from different cultural backgrounds, it is hardly surprising that it is difficult to embrace new cultural groups and migrants.

Irish society is in a state of continuous transformation of cultural and ethnic diversity and it is struggling to reconstruct itself and its' identity. The reported resistance and resentment towards migrants since the economic downturn is further evidence of this (Fanning 2007; McGinnity *et al* 2009; Cahill 2009). Such transformations have influenced notions of what it means to be Irish. An example of this is the citizenship referendum in 2004, which resulted in the introduction of a citizenship criteria based on blood ties. Prior to the 2004 referendum, anyone born in the Republic of Ireland was automatically granted Irish citizenship. Arguably, this initiative may be seen to reflect xenophobic notions and resistance at government and societal levels to reconstruct Irish identity (Fanning 2012). Furthermore, despite the calls at national (HSE 2008; NAPAR 2007) and international levels (The Council of Europe 2008) for intercultural dialogue and integration, challenges with integration of immigrants in Ireland is an on-going

problem (Fanning 2007; Kuhling and Keohane 2007; Fanning 2012). Understanding such issues offers some background and context to this study and helps to conceptualize some of the findings that will be discussed later.

3. Integration in Ireland and Migrants:

Ireland has become an increasingly diverse country in terms of nationality, race, ethnicity and cultural and religious beliefs. Despite being host to long standing cultural groups such as Jews and Irish Travellers for decades, the migrant population in Ireland continues to grow, now representing over 199 different nationalities (CSO 2016). The rapid and unprecedented transformation of the demographic profile of Ireland goes some way to explain the term 'non-Irish national' which is currently used in government policies and documentation to describe individuals who have immigrated to Ireland. The 2016 census highlights that over 13% of the population is of migrant origin. There are a number of understandings and interpretations of the term 'migrant' depending on context, i.e., social, political, cultural or economic. In general, the term migrant adopted for this thesis is any person who was not born in Ireland but who lives here temporarily or permanently.

The migrant population is itself highly diverse in terms of nationality, ethnicity and religious beliefs. In adopting a loose definition of migrants, there are considerable differences between migrants in terms of their situation in Ireland, including whether or not they have the right to work here, and the manner in which they have come to Ireland. Migrants coming to Ireland generally have differing needs and opportunities depending on their circumstances. Integration allows immigrants to contribute to the economic, social, cultural and political life of their host country, and is important for social cohesion. Integration is also important for encouraging acceptance of immigrants by the host country population.

4. Cultural Competence:

In order to provide competent care in culturally sensitive ways nurses need to develop their knowledge, skills and attitudes. This requires developing attitudes and practices that incorporate empathy, cultural awareness and sensitivity (Papadopoulos *et al* 1998; Campinha-Bacote 2002) and is underpinned by principles of social justice (Douglas *et al* 2014). However, there are varying interpretations as to what constitutes cultural competence and how it can best be developed (Douglas and Pacquaio 2010). There are also variations of the terminology used in the literature to describe concepts such as; transcultural care, intercultural care and cultural competence. As evident from these varying debates and the ambiguity associated with the competence required to provide culturally appropriate care that meets the individuals' needs, the term cultural competence was chosen for the purposes of this thesis. While some scholars question the value of cultural competence in its broadest sense (Campesino 2008), others dispute the entire concept (Mahoney *et al* 2006), suggesting it is misleading as it implies developing technical skills only. Some critics suggest that the major problem lies in how culture is defined or interpreted in cultural care theories or cultural competence models (Gustafson 2005; Culley 2006; Williamson and Harrison 2010; Jenks 2011). Others are critical of cultural competence models as they appear to focus predominantly on the development of individual competence, to the detriment of developing the culture of the organisation (Vandenberg 2010; Hoskins and Sallah 2011). More recently, equipping nurses to practice in both a compassionate and culturally competent manner has emerged as an important concept (Papadopoulos *et al* 2016) and is an area that until recently has received little attention.

5. Models for Developing Cultural Competence:

A range of cultural competence models and frameworks are evident within the literature, which have played a significant role in nursing practice. They have been instrumental in

increasing the awareness of the need for cultural competence and provide various proposed structures for its development. Existing cultural competence models and frameworks have been developed in countries other than Ireland, such as the; USA (Leininger 1988; Purnell 2005; Campinha-Bacote 2002), United Kingdom (Papadopoulos, Tilki and Taylor 1998) and New Zealand (Ramsden 2002). Although they offer various perspectives and have some differing philosophical positions, the common goal is to strive for the development of the ability to care sensitively, respectfully and effectively for people from all cultural groups. Some models advocate alternative perspectives, such as cultural humility (Tervalon and Murray-Garcia 1998), cultural safety (Papps and Ramsden 1996) or frameworks based on social justice perspectives (Doughlas *et al* 2011). Although questions have been raised about the applicability of some cultural competence frameworks in their current format, both in nursing (Gustafson 2005; Lipson and Desantis 2007) and other professions (Ben-Ari and Strier 2010; Kirmayer 2012), few solutions have been proposed. Furthermore, there remains little evidence to support the use of such models and frameworks in practice. This is perhaps associated with the limited evidence to support how best they can be used in different contexts and countries.

The Papadopoulos Tilki and Taylor (PTT) model (Papadopoulos *et al* 1996) is an easy to follow model that was developed in the UK, in response to a growing multicultural society. It was one of the first cultural competence models to focus on racism and it attempts to address some of the deficits in earlier models such as social and political discourses (Culley 2006). It particularly highlights the similarities between different cultures and the differences within them and those from the host culture. It also focuses on the beliefs and values of the practitioner, and not just the patient. It is easy to understand and applicable to practice in different settings (O' Shaughnessy and Tilki 2008; Markey *et al* 2012). In moving through the four constructs of the model, cultural competence is not static but is developed on an on-going basis and varies in accordance with individual experiences and the context of the situation. A particular strength of the

PTT model is that it places equal emphasis on the impact that organisational and social structures have on the development of cultural competence (Papadoupoulos 2006).

There are however many critics of cultural competence models in general. Some are criticised for being too theoretical, complicated and for using terminologies that are far removed from practice (Kirmayer 2012). Others are criticised for being over simplified and can read more like guides then comprehensive frameworks for delivering culturally congruent care (Culley 1996; Swinny and Dobal 2008). These debates although present some of the criticisms of the philosophies underpinning cultural competence models and frameworks; they fail to explore reasons why challenges with their application continue. Jirwe *et al* (2009) highlights that they tend to relate to a particular country or healthcare system and they may be more specific in meeting the particular needs of the context and culture of the country in which they were created and may not relate as well to the needs in a different country. Some scholars argue that some of the current models do not deal adequately with the powerful complexities of racism and oppression (Culley 1996; Paradies 2006; Pease 2010). However, a common critique that consistently emerges is the broadly defined, but narrowly applied concept of culture (Gustafson 2005). This may be associated with the dissonance that can occur between the originators philosophical beliefs and the actual practices that are perceived to be advocated for when translating such models and frameworks into practice (Vandenberg 2010). It is exactly for these reasons that Gustafson (2005) and Kikuchi (2005) suggest that caution needs to be taken when adopting theories and models and consideration needs to be given to ways of how they can be effectively adopted. Hence, there is a need to fully understand what is happening in an Irish context and how best cultural competence can be developed. This lack of consensus within the existing literature illuminates the need for further research to explore the challenges experienced by nurses as well as what influences culturally sensitive actions and omissions of care in practice and how best cultural competence can be developed.

6. Summary:

This chapter explored some key concepts related to this study as a means of clarifying a position to take in setting the contextual background for this study. The next chapter presents the broad preliminary literature review (phase 1), which explores the gaps within the existing literature on cultural competence and provides a justification for the need for this study.

CHAPTER 3

LITERATURE REVIEW

1. Introduction:

This chapter provides the preface and contextual overview to this study as it explores some of the gaps within the literature at the time of starting this study. An overview of the complexities associated with cultural competence education and the reported challenges associated with caring for patients from different cultures are presented. Through examining the wider national and international literature for emerging themes and inconsistencies, a justification for this study is presented.

2. Sourcing and Reviewing Literature:

While engagement with existing literature prior to primary research is characteristic of most strategies of inquiry, Glaser (2002) argues against this in grounded theory, emphasising the need to enter the research process with as few preconceived ideas as possible. The argument against engaging with existing literature from the onset is based on the premise that such engagement may contaminate the data collection. Similarly, Chen and Boore (2009) agree that the literature should be used to explain the theory as opposed to the theory being derived from the literature review. However, there are those that argue against Glasers' perspective of avoiding undertaking the literature review before the theory has emerged. Reviewing the literature broadly but not extensively before data collection was seen to be important as a means of gaining some background knowledge to help contextualise the study. However, on a more practical level the researcher while undertaking a PhD study was required to complete a proposal which requires a literature review to identify the gaps in the evidence and provide a rationale for the study, including a justification for the research approach. Hence early in this study, the researcher did undertake a broad literature review in the general areas of transcultural

competence, transcultural education and issues from an Irish perspective in order to identify what work had been done and what knowledge gaps existed. The intent was to situate the research study within the broader context of the current issues on transcultural care, which provided a contextual nature to position the study. The researcher did however specifically avoid imposing a specific theoretical framework on the study at the onset. Engagement with a more detailed literature review and existing theories was directed by the concepts and ideas which emerged during the process of data collection and analysis, which is what Straus and Corbin (1990) refer to as the second phase of the literature review. In the current study, therefore existing theoretical concepts from different fields were identified and accessed as and when it was deemed necessary in order to progress the overall study. Indeed the resulting findings have directed the researcher towards areas of research and theoretical concepts which were not anticipated prior to the commencement of data analysis.

In keeping with Glasers' (1992) approach to searching and sourcing literature when undertaking a grounded theory study, this review of literature is presented in two phases. The first phase which is presented in this chapter is the result of a preliminary focused scan of the existing literature regarding the challenges nurses experience when caring for or learning how to care for patients from different cultures. Phase 1 was carried out in 2009/2010 and although a lot of research emerged after this study commenced, I explored and negotiated with this newer literature as data were analysed. The result of this initial review was a published peer reviewed paper, exploring some of the potential Irish specific challenges associated with providing culturally sensitive care (Markey *et al* 2012). The aim of doing this preliminary literature search was to identify knowledge gaps in the existing evidence as well as to contextualize this study within broader international literature. It was also required for the original research proposal and for ethical approval. This helped position, conceptualise and justify the need for this study. However, as data were collected, analysed and findings started to emerge, I reflectively zigzagged from

data to literature to position the findings of my study within the broader literature. I have referred to this as the second phase of literature searching and reviewing.

This second phase of exploring the literature is presented in the findings and discussion chapters and compares the findings of this study to existing relevant evidence as presented within the literature. In taking Glaser's position that "all is data" (Glaser 1992), this second phase of literature reviewing contributed as another source of data. It enabled the findings of this study to be paralleled and contrasted to existing theories and other sources of evidence. As findings were emerging, this guided a much more specific and focused search of the literature. As concepts and ideas emerged during the process of data collection and analysis, the literature was re-reviewed concurrently. However in seeking to further understand and provide possible explanations for the findings emerging, literature outside of the transcultural literature was sometimes required. This constant comparison of the emerging findings with other theories and evidence is a key principle of grounded theory analysis (Glaser 2002). Taking such a practical approach was seen to be particularly beneficial for this study as it allowed for interplay with the emerging findings and existing theories to make comparisons with.

This chapter presents phase 1 of the literature review, which provides a review of literature around; transcultural care, cultural competence, transcultural education and cultural diversity through a number of methods from using electronic databases and other available grey literature. Health strategies and policies were also reviewed. Research, such as primary studies and conceptual theoretical papers, were extensively accessed through comprehensive searches of electronic data bases such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, SCOPUS, PubMed, Medline, Wiley Online and Google scholar. A range of keywords and MeSH terms were used derived from the core category and associated sub core categories: 'cultural diversity', 'cultural care', 'cultural competence', 'transcultural education' and 'transcultural nursing'. These were then combined using Boolean operators through the 'track searches'

feature in the selected databases and terms combined for relevancy included; ("cultural diversity AND nursing"), ("cultural car* AND nursing"), ("cultural competence AND nur* "), ("transcultural education AND nur*"), ("transcultural nursing AND nur*").

The second phase of literature reviewing is presented at the end of each findings chapter. On identifying areas within the findings, the literature was reviewed again in light of emerging findings. MeSH terms, keywords and phrase searches were searched of "disengagement" "masking", "distancing", "fitting in" and "indifference". Then using Boolean operators through the 'track searches' feature in the selected databases. The terms combined include; ("disengagement" AND ' transcultural nursing'), ("masking" AND "transcultural nursing"), ("distancing" AND ' transcultural nursing"), ("fitting in" AND ' transcultural nursing"), ("indifference" AND "transcultural nursing").

Concepts found within each of these sections were then searched to provide a comprehensive search. Terms combined were duplicated through the simultaneous searches of multiple databases. The articles were filtered by English language. Titles and abstracts derived from these searches were read and scrutinised to identify relevance with the emergent findings. The decision to include articles was made considering their relevance and position for increasing understanding, if they met the specified criteria of displaying relevance to the emergent findings and the articles were peer reviewed. Some articles were rejected due to lack of relevance while others were found to have relevance to numerous categories. Sources with relevance to more than one section of the findings were stored and subsequently analysed. The search was supplemented by hand searching reference lists of retrieved publications and the help and support of the librarian was sought to ensure that the searches were thorough seeking out the databases for the most relevant literature to support this discussion.

Further information was accessed through books held in libraries through interlibrary loan. The aim initially was to logically review empirical studies, which reported on the

analysis of primary data collection on cultural competence and/or transcultural education. However, there was a general paucity of empirical studies, particularly within an Irish context. Therefore, other types of grey literature were accessed such as discussion papers, textbooks, government and non-government documents and publications, enhancing the discussion and adding to the body of knowledge on the areas of cultural care.

3. Themes That Emerged from Phase 1 of Literature Review:

The following themes emerged from this preliminary literature review.

3.1 Increasing Reports of Cultural Insensitivity:

Despite the wealth of published international literature on cultural competence, reports of culturally insensitive care in Irish healthcare settings have increased (Vivian and Dundes 2004; Reid and Taylor 2007; Lyons *et al* 2008; Ryan *et al* 2008). Such reports are not unique to Ireland as there is a wealth of evidence worldwide that suggests that the standard of care that is provided to patients from different cultures and diverse linguistic backgrounds is not meeting their needs (Cortis 2004; Gerrish *et al* 2004; Leishman 2004; Murphy 2006; Wachtler *et al* 2006). Such reports highlighted the challenges associated with adapting practices to respond appropriately, sensitively and effectively to patients from different cultures and backgrounds. However, they also highlighted the significant gap that remains in translating cultural competence theory to individual and organisational practices. On one hand the literature has been steeped with calls for the need for nurses to practice in a culturally appropriate way (Papadopolous *et al* 1998; Campinha-Bacote 2003; Mahoney *et al* 2006; Mixer 2008), but the continued reports of cultural insensitivity highlights the limited progress made. This illuminates the complexity of adapting practices to meet the diverse needs of a growing multicultural patient base as highlighted by Vertovec (2007), but also highlights the need to explore reasons for the continued reports of cultural insensitivity. Studies on the actual challenges nurses experience and more importantly how they deal with these challenges in their

daily practice are lacking in the existing literature. Further research in this area will assist to gain a deeper awareness of the challenges, whilst assisting to empower nurses to think differently about the strategies used to overcome them. Gustafson (2005) and Kikuchi (2005) argue the need to review existing cultural competence models to ensure they are meeting the needs of ever-changing and complex healthcare settings. However, there remains a lack of research-based evidence to support this assumption. Further research is needed to explore how nurses behave and what influences their behaviour when caring for people from different cultures.

Given the relative newness of cultural diversity in Ireland and the lessons that can be learnt from other countries, Ireland is in a position to influence change as it is still in the infancy stages of developing initiatives to address such issues. However, given the paucity of Irish research on cultural competence, there is a need to explore the contributing factors that influence and hinder cultural competence in Irish health care settings. Little remains known as to what influences the attitudes and practices of nurses in Ireland that ultimately result in culturally insensitive care. There is a need to fully understand what is happening in an Irish context and how best cultural competence can be developed. In particular, there is a need to gain a greater understanding into why nurses behave the way they do when caring for patients from different cultures.

3.2 Challenges of Caring for New Communities:

There is a wealth of evidence in the literature to suggest that nurses experience a range of challenges when caring for patients from diverse cultural and ethnic backgrounds (Gerrish *et al* 1996; Boi 2000; Cortis 2004; Jirwe *et al* 2010). These studies found several challenging areas of care for nurses particularly around communication barriers and professional preparedness. There are also increasing reports in the literature to suggest that organisational structures and services within healthcare settings can also be challenging (McGee 2009). However, there is a need to further understand how care is

organised in healthcare settings and how the culture of the organisation can enable or hinder nurses' ability to provide culturally competent care. Although these studies highlighted the different complexities associated with cultural competence, none of them identify the extent of the challenges experienced or explain in any depth how nurses address them in their daily practice. It is evident that it remains unclear how nurses prioritise care needs of patients from different cultures and what influences these priorities. Gaining such insights will provide a more comprehensive understanding of how care is provided and what influences actions and attitudes that underpin culturally insensitive care.

Irish society as a whole has struggled with ethnic and cultural diversity issues of new migrant communities (Kennedy and Murphy-Lawless 2003; Kelly 2005; Fanning 2007). The increase in immigration also presents a significant challenge for nurses to improve their knowledge of less common diseases and disorders and to provide culturally appropriate care. In response to the growing reports of culturally insensitive care (Lyons *et al* 2008; Ryan *et al* 2008), Irish health services are tasked with improving the services and care provided to patients from diverse cultural and linguistic backgrounds. This is evident by the introduction of the Intercultural Health Strategy (HSE 2008), albeit in an arguably limited fashion. However, there is little evidence to determine if the recommendations from this strategy have been advanced effectively. There is a need to understand the possible ways that nurses and organisations deal with cultural difference in Ireland, as there is a scarcity of current research in this area. Furthermore, current research exploring cultural competence in Ireland predominantly took place prior to the launch of the Intercultural Health Strategy in 2008, with less evidence of published research since then.

On synthesising the literature published up to 2010, language barriers, ethnocentricity and feeling ill prepared appeared the most common challenges discussed, with very limited research describing how nurses deal with such challenges. This highlights the

need for further research to explore not just the challenges nurses' experience but more importantly how they deal with them in their daily practice.

3.3 Language Barriers:

One of the essential aspects required for providing culturally competent care is effective cross-cultural communication. The language barrier that is presented ads to the challenges experienced for both the patient and the nurse, and is the most reoccurring challenge reported on within the literature. Gerrish (2000) and Bischoff and Hudelson (2009) highlighted the importance of addressing language barriers, as quite often they are ignored. Poor cross-cultural communication can result in cultural misinformation and misunderstandings, which can have a negative effect on patient care (Cohen *et al* 2005). There is evidence to suggest that nurses experience frustration and stress when communicating with culturally and linguistically diverse patients (Boi 2000; Cioffi 2005; Tate 2003). Similarly, Ozolins and Hjelm (2003) in an exploratory study of nurses' experiences of working with migrants in Sweden found linguistic barriers as the main challenge for nurses. Similar studies in the UK (Boi 2000), Australia (Cioffi 2005), Norway (Hoye and Severinsson 2008) and Ireland (Tuohy *et al* 2008) also found challenges related to linguistics and accessing interpreter services. Although the aforementioned studies highlighted frustrated nurse attitudes due to communicational disparities, they fail to explore how nurses' deal with such communication challenges.

The importance of ensuring strategies are introduced to overcome language barriers is well documented (Bischoff *et al* 2003; Bernard *et al* 2006), as the quality of patient care depends on good patient-professional communication. The value of using professional interpreters when a patient is not proficient in English is also well recognized in the literature, as a way of appropriately dealing with language barriers (Bischoff *et al* 2003; Bernard *et al* 2006; Karliner *et al* 2007). Despite such evidence, there is a wealth of evidence globally to suggest that professionally trained interpreters remain under used

(Hampers *et al* 1999; Flores *et al* 2003; Meddings and Haith-Cooper 2008). Instead there remains a heavy reliance on family members and bilingual health care professionals to translate (Gerrish 2000; Bischoff *et al* 2003). However, there is evidence to suggest that patients often feel more comfortable and prefer the use of professional interpreters (Hadziabdic *et al* 2009). This raises questions as to why nurses continue to fail to engage appropriately with professionally trained interpreters. When professionally trained interpreters are not used, connecting with the patient can be difficult (Nailon 2006), medical errors occur (Bischoff *et al* 2003; Cohen *et al* 2005) and patients receive inadequate care (Gerrish 2000; Hampers and McNulty 2002). Some reasons offered within the literature as to why interpreters are underutilised include; poor interpreting services available (Boi 2000; Gerrish *et al* 2004); lack of availability of interpreters (Cioffi 2003); lack of understanding and knowledge of interpreting services (Flores *et al* 2003; Gerrish *et al* 2004) and the role of the interpreter is not understood (Hampers *et al* 1999). However what appears to be missing from these studies is an understanding into how nurses deal with language barrier challenges if they decide not to use professionally trained interpreters. There is a need to understand what influences nurses' attitudes and practices in their dealings with challenges experienced when caring for patients with diverse linguistic and cultural needs.

3.4 Ethnocentrism:

Responding appropriately to culturally diverse patients' needs presents as a challenge for health care professionals daily. There is evidence to suggest that nurses' attitudes towards people from different cultures can influence behaviours and practices (Homer 2000). In particular ethnocentrism can hinder culturally competent practice (Husband 2000) and can have a negative impact on the health of people from different cultures (Burgess *et al* 2007, Kai *et al* 2007). Lee *et al* (2006) in an Australian qualitative study identifying the attitudes of physiotherapists towards clients from culturally diverse backgrounds acknowledged that perceptions of culture affected care delivery. There is a need to further

understand the implications of ethnocentrism in the context of delivering nursing care. Narayanasamy (2002) and Papadopoulos *et al* (1998) discussed the need for nurses to acknowledge their own cultural views and opinions as a means of addressing stagnant ethnocentric attitudes and cultural bias. However, what appears less evident within the existing literature is how nurses' deal with ethnocentric attitudes and how they influence individual practice and ultimately the care provided. Further research exploring the actual challenges nurses experience and more importantly how they deal with them in their daily practice is warranted.

There is evidence to suggest that nurses in Ireland have struggled to adapt to the over 199 nationalities that constitute the social make-up of the new unchartered multicultural Ireland (Reid 2007; Humphries *et al* 2008; Lyons *et al* 2008). Although Ireland has come a long way in a short time in dealing with the changes to the demographic profile of its population, little remains known as to how nurses deal with ethnocentrism. Drawing on Fannings' work (Fanning 2007; Fanning 2012) helps us to understand the influence of the socio-economic and complex political history of Ireland and its impact on nurses' attitudes towards cultural differences. However, Reid and Taylor (2007) suggest that ethnocentrism in an Irish context amounts to more than 'cultural stereotyping' with inappropriate assumptions made based on xenophobic undertones. Culley (2006) however warns of the complexity of having prejudices and that racism does not only arise from ethnocentrism. Nonetheless unaddressed prejudices can lead to damaging patient encounters (Burgess *et al* 2007), however the extent of which is relatedly unknown in Ireland due to the paucity of research in the area. Nurses working within Irish healthcare settings must recognise how ethnocentric assumptions can act as barriers to well-intended therapeutic relationships. However, this can be challenging as the structures and the care delivery approach in Ireland typically reflect attitudes, beliefs and values of the dominant culture (Polaschek 1998). On synthesising this literature, it is evident that there is a need to undertake more empirical research into factors that influence and hinder cultural competence. However, more specifically there is a need to understand how nurses in

Ireland deal with ethnocentric attitudes and values in their daily practice and how this might influence their ability or desire to care for patients of different cultures.

3.5 Feeling Ill Prepared:

Feeling ill prepared to care for patients from different cultures is also a challenge that is reported on globally. Studies carried out in Ireland (Lyons *et al* 2008; Tuohy *et al* 2008), UK (Narayanasamy and White 2005; Vydelingum 2006; Kai *et al* 2007), USA (Braithwaite *et al* 2006; Jirwe *et al* 2009; Starr and Wallace 2009), Australia (Pinikahana *et al* 2003), New Zealand (Whiteford and Wright St-Clair 2002) and Sweden (Momeni *et al* 2008), all highlighted the difficulties nurses face when they feel ill prepared to care for people from different cultures. This lack of preparation is often contextualised within the literature as a consequence of not having the appropriate knowledge or lacking experiences and opportunities to care for patients from different cultures. In particular these studies highlighted how nurses feel unsure of how to act and as a consequence are generally fearful of getting it wrong. However, these studies fail to explore how nurses deal with this lack of preparation. While there is an abundance of literature on cultural competence, there is a lack of empirical studies exploring how nurses develop cultural competence on a daily basis, suggesting the need for further research in this area.

Cultural competence education is the most commonly reported initiative recommended within the literature as a means of improving the care provided to patients from diverse cultural and ethnical backgrounds (Papadopoulos *et al* 1998; Mahoney *et al* 2006). This call is not unique to nursing, as there are also increasing calls for effective cultural competence education in the preparation of medical practitioners (Dogra 2004), occupational therapists (Whiteford and Wright St-Clair 2002) and physiotherapists (O' Shaughnessy and Tilki 2007). However, there remains a lack of consensus within the literature as to how this should be structured and organised, suggesting the need for further research in this area. Although there is a wealth of evidence within the literature

describing various approaches to delivering effective cultural competent education, there are those that question the effectiveness of some of these current approaches in nursing (Duffy 2001; Lipson and Dasantis 2007; Campesino 2008; McAllister *et al* 2006). Willen *et a*l (2010) emphasises that it is striking how little is known about the challenges, problems and pitfalls of cultural competence education. This further suggests the need for a deeper exploration into the challenges experienced for nurses when caring for patients from different cultures and how best they can be prepared to overcome such challenges effectively in practice.

3.6 The Complexities of Cultural Competence Education:

Preparing nurses to provide culturally sensitive and anti-discriminatory care is well documented in the international literature as being extremely challenging (Gerrish and Papadopoulos 1999; Duffy 2001; Tilki *et al* 2007). However, there is limited guidance regarding effective strategies to overcome such challenges. There are also debates presented in the literature that question the effectiveness of approaches frequently used in cultural competence education in increasing cultural sensitivity and understanding (Duffy 2001; Cortis and Law 2005; Gustafson 2005). However, little remains known as to why they are ineffective and how nurse education can support the development of nurses to practice in compassionate and culturally appropriate ways. Similarly, Lipson and Desantis (2007) argued that there is little consensus about what works and as such a variety of inconsistent approaches are used in the preparation of nurses. Following this review of the literature, it is evident that there remains contradicting views regarding what constitutes cultural knowledge. There are those that argue for the need to focus on the development of cultural specific knowledge in the preparation of nurses (Momeni *et al* 2008). However, increasing arguments are presented within the literature questioning the value of teaching nurses about the beliefs of various cultural groups, suggesting that this alone is not conducive to developing cultural competence (Gustafson 2005; Lynam *et al* 2007; McAllistair *et al* 2008). Culley (2006) deduces from such debates that an

approach to education that does not assume a common cultural need is required. However, further research and guidance regarding how this can best be achieved in different contexts is required.

Much of the contemporary, cultural competence education discourse advocates for the development of cultural generic knowledge in tandem with cultural specific knowledge. Implied within this approach is the need to develop cultural awareness, which involves the challenging of personal beliefs and values as a means of addressing ethnocentrism (Papadopoulos *et al* 1998; Kardong-Edgren and Camphina-Bacote 2008). However, little remains known on how nurses develop cultural awareness and what enables or hinders its development in their daily practice. Much of the literature explores curriculum content and structure, with less of an emphasis on how nurses learn and develop the knowledge, skills and attitudes required for cultural competent practice. There is also a dearth of studies exploring how nurses operationalise their learned knowledge, skills and attitudes in their daily practice. Tilki and Boyle (2008) suggest that sharing cultural information of any nature firstly requires practitioners to become more self-aware and questioning of their own practice, values and beliefs. There is a need to explore what challenges nurses face and how they deal with them as a means of gaining a deeper understanding of approaches that enable nurses to respond appropriately to individual's needs.

There is a wealth of literature that reports on the benefits of learning during cultural encounters in clinical practice (Koskinen and Tossavainen 2003; Kardong-Edgren and Camphina-Bacote 2008; Mixer 2008). Many scholars write about the usefulness and effectiveness of having coordinated, well supported and structured clinical experiences for students (Casey and Murphy 2008). Whiteford and Wright St-Clair (2002) in their phenomenological study exploring the experiences of student occupational therapists of learning to care for patients from different cultures, reported that their hands on experiences was perceived to be the most important feature of their programme. Clearly, the value of clinical learning is evident; however there are those that argue that such

positive learning depends on many factors such as positive role models (Begley and White 2003; Mooney 2007). Little remains known as to the learning process involved in the development of cultural competence in clinical practice. These debates reiterate the complexity associated with adequately preparing nurses to care appropriately for patients from different cultures, but also suggests that further research in the area is required.

4. Summary of the Gaps in the Current Literature:

On synthesising the literature published between 1996 and 2010, it is evident that much has been written on cultural competence and culturally competent education. However, culturally insensitive and racially discriminatory practice continues to be reported globally. There are varying recommendations presented within the literature as to how best to deal with such issues. However, there is little evidence currently available to suggest why nurses continue to find it challenging to implement the various recommendations that are evident within the literature. This suggests that perhaps it is timely to stop and take stock of the issues that nurses are facing in today's increasingly complex healthcare setting and thus rethink the future direction of new approaches. It is clear that there are many gaps and inconsistencies when ascertaining the experiences of nurses caring for patients from different cultures. The international stage is littered with strategies, discussions and initiatives that all positively contribute to increasing awareness of cultural competence and the need for social justice. However due to the complex and multifaceted nature of these sensitive issues it is vital that the experiences of front line staff are explored with a view to better understanding what enables and hinders cultural competent practice. There is limited literature specifically exploring the challenges and how they are dealt with by qualified and student nurses, when caring for patients from diverse cultural and ethnic backgrounds.

This broad review of literature highlighted that although there is a wealth of publications regarding cultural competence, there is a paucity of in depth studies describing nurses'

experiences of caring for people from different cultures. In particular, there is little evidence exploring the actual challenges nurses encounter and how they address them in their daily practice. However, the studies that have explored the experiences of nurses make reference to some of the possible challenges such as; language barriers (Boi 2000) and an associated anxiety of not having adequate knowledge and skills (Kai *et al* 2007). Whilst other studies make reference to the fears associated with acknowledging cultural difference (Jirwe *et al* 2010). However, none of these studies identify the extent of these challenges or do not explain how nurses overcome them in practice. There is also a paucity of literature exploring these experiences from an Irish context and it is now an urgent necessity for Irish research. Gaining such an insight would provide a more comprehensive understanding of how care is provided and what influences the actions and attitudes that underpin culturally insensitive care. This study aims to fill this gap through the use of a grounded theory methodology. It provides an in depth exploration into the challenges experienced by student and qualified nurses, when caring for patients from different cultures within Irish healthcare settings. Gaining a deeper understanding of the practices and behaviours of nurses and what motivates or influences them will provide some further insights into how best to prepare nurses. Therefore, the broad research questions that emerged as a result of identifying the gaps in the current literature include:

- What are the experiences of student and qualified nurses of caring for a multicultural patient population in Ireland?

- What are the main concerns and challenges experienced and how are they dealt with in their daily practice?

5. Summary:

To conclude, this chapter offers a contextual background, which positions this study and highlights the gaps and inconsistencies in the current literature on cultural competence and culturally competent education. It therefore provides a clear justification for the need for this study. The next chapter discusses how the undertakings of this study were operationalised.

CHAPTER 4

METHODOLOGY

1. Introduction:

This chapter details how the principles of a classic grounded theory methodology were adopted in this study. It begins with a review of the studys' aims and objectives and explores the philosophical positioning of the researcher, research study and how these propositions influenced the choice of methodology adopted. The ethical principles that required consideration during this study are also presented. Sampling, data collection and the process of constant comparative analysis of data during the various stages of coding are also described. The credibility of this study is discussed, incorporating Glasers' (1987:17) evaluation criteria for fit, relevance, workability and modifiability.

2. Research Aims and Objectives:

This study sought to explore the experiences of student and qualified nurses when caring for patients from different cultures, with a particular emphasis on the challenges encountered and how they were dealt with in daily practice. Based on a broad literature review carried out at the commencement of this study, the following are the objectives that this study started with:

- ➢ To explore individual experiences of student and qualified nurses of caring for a multicultural patient population in Ireland.

- ➢ To identify the main concerns and challenges as experienced by informants and determine how they deal with them.

- ➢ To generate an explanatory theory on how Irish nurses deal with the challenges experienced when caring for patients from different cultures.

Although, Glaser (2002) discourages commencing a classic grounded theory study with pre-determined research questions, taking such a position was felt to be unrealistic. Having broad research questions as a means of providing a starting point for this study was important. Furthermore, a requirement when submitting a PhD research proposal is the need to justify the study being proposed and to make explicit the specific research questions that ultimately emerge from a gap in the existing literature. While agreeing with Glaser who asserts that there is a need to enter the field with an open mind to enable informants to articulate their real concerns (Glaser 2002), I disagree that commencing a study with research questions prevents this from occurring. Listening carefully to informants' experiences and remaining open enabled an exploration of nurses concerns and how they are dealt with when caring for patients from different cultures.

3. Philosophical Positioning of Study:

When starting out on this research journey, a number of issues required consideration such as identifying a gap in the existing literature and deliberating over the various possible research designs that would best suit this study. The challenges experienced during these early stages were mainly associated with refining a research topic and deciding the most appropriate methodology to use. During discussions with supervisors and following deliberations on personal philosophical assumptions as well as the ontological and epistemological underpinning this study, a methodology suited to this study was chosen. The outcome of which formed the basis of an article published in Nurse Researcher, which outlined the various possible perspectives that required consideration (Markey *et al* 2014).

As ontology is concerned with the form and nature of reality, the need to focus on staying true to the data and capturing accurately and honestly what was being said was important. Mindful of the mechanisms that may be consciously or unconsciously contributing to culturally insensitivity in Ireland, this study is best positioned within a realist paradigm (Collier 1994; Searle 1995). In adopting Crottys' position (Crotty 1998) on subtle

realism, viewing reality as independent of mind or consciousness was necessary. Through a subtle realist approach, an understanding of how nurses resolve their everyday concerns when caring for patients from different cultures can be found. However, taking such a position was not without its challenges. Although acknowledging the necessity of exploring the conscious and subconscious beliefs and values underpinning practices, initially it was challenging to probe the subconscious thoughts underpinning actions and omissions of care. However, through guidance from supervisors and reflecting on at times poor interviewing skills, this got easier with time. Bergin *et al* (2008) suggests that maintaining a subtle realist ontological position is particularly important when studying factors that are not always capable of being measured. For example the subconscious assumptions and prejudices that impact on the care offered to patients from diverse cultural and ethnic backgrounds.

As epistemology is concerned with the nature of the knowledge and considers the relationship between the researcher and data, maintaining a non-judgmental positioning in understanding the attitudes and practices of nurses was important. As objectivism implies a belief that it is possible to separate the person doing the research from what is being researched (Lincoln and Guba 2000) and subjectivism incorporates the researchers' interpretation of events, this study was not positioned within either of these perspectives. Claiming absolute objectivity is unrealistic as personal unconscious biases may be evident and to claim total subjectivity suggests that findings may be interpreted based on personal views of the researcher. In taking the stance that it is not possible to view knowledge and knowledge production as disembodied and to rely on interpreting the data from the researchers' perspective has the potential to undermine the credibility of the finding, reading the work of Patton (2002) on 'empathic neutrality' was helpful. Empathic neutrality requires the researcher to adopt a position of neutrality, whilst being able to understand the position, feelings and experiences of others (Patton 2002). Hence, this study is positioned well within this perspective.

4. Deciding on a Methodology:

A number of methodological approaches were considered. Following a critical appraisal of the research objectives and personal values regarding the nature of knowledge, the role of the researcher and how we can validate what we know, a grounded theory methodology was seen to be the most suited to this study. Although other qualitative approaches were considered, grounded theory seemed to fit best for this particular study. It is a process-orientated methodology that advocates for exploring the conscious and subconscious beliefs and values, which is in keeping with the ontological position adopted for this study. The need to gain an explanation of what is actually happening in Irish health care services is the gap in existing research; as opposed to describing the idealistic and what should be happening. This focus is in keeping with the objectives of using grounded theory (Smith and Bailey 1997).

5. Origins of Grounded theory:

Grounded theory was developed in the 1960's by two sociologists; Anselm Strauss and Barney Glaser (1965; 1967), while undertaking a study on dying in hospitals. The ideas and practices developed during this study were subsequently formalised into a methodology. These researchers came from two different philosophical positions. Strauss came from the University of Chicago, which has a long history and tradition in qualitative research methods. In contrast, Glaser received his training at Columbia University, where the main focus was on quantitative research. After developing their method of grounded theory through their studies, there was a split in their thinking. As a result the diversification of grounded theory emerged and researchers could now choose how to use grounded theory as a research method. These choices come from a deep understanding of the different versions of grounded theory, including Glasers' classic approach (Glaser, 1992), Strauss and Corbins' (1990) later approach and in recent years Charmazs' (2006) constructivist approach. Strauss and Corbin (1990) advanced a different version of grounded theory, which they considered to be the result of concerns

raised about the classic approach (Annells 1996). However, Glaser (1998) disputes these claims and accused Strauss and Corbin of no longer doing grounded theory, arguing that it encouraged forcing of the data rather than allowing it to emerge. Charmaz (2006) proposed a new dimension to grounded theory, which aims to create a sense of partnership between informants and the researcher in the construction of meaning. However these developments were strongly contested by Glaser (1992). Glaser, Strauss and Corbin and Charmaz are consistent with the view that generating grounded theory is a way at arriving at a theory suited for its supposed users. However, Annells (1996) suggest that there are many distinct differences in the various approaches, particularly within the philosophical underpinnings. Glaser (1996) argues that the emphasis of grounded theory from a classic grounded theorist's perspective should be on emergence of data, without influence by the researcher. In contrast, Strauss and Corbins' view to their modified approach or Charmazs' constructivist approach acknowledge the views of the researcher when analysing data.

6. Types of Grounded Theory:

Chen and Boore, (2009) suggests that the researcher should not be limited by the methodology and should choose an approach pertinent to the aims of the particular study. However, many questions have been raised about the diffusion and dilution of the grounded theory method (May 1996). Becker (1993) and Wilson and Hutchinson (1996) are all critical of the lack of adherence to the essential aspects of grounded theory. In contrast, Cutcliffe (2000) does not regard researchers' adjustments with a given methodology as problematic, as long as any deviations are justified to avoid 'method slurring'.

Once deciding that grounded theory was the best fit for this study, choosing a suitable approach to grounded theory was important. I was initially drawn to Charmazs' (2000) constructivist version of grounded theory, mainly due to her writings on the application of her approach, which appeared logical and had procedural steps outlined. Charmaz

(2006) proposed that constructivist studies are derived and expanded from interpretive approaches which calls for the 'imaginative understanding of the phenomena under study' (p.126), resulting in additional knowledge of the subjective experience of people. On experimenting with this approach in the early stages of this study, I liked the concept of having my own personal opinion acknowledged during the research process, as Charmaz advocates for seeking both informants' and researchers' meaning and interpretation of the phenomena being explored. However, I later dismissed the suitability of this approach for this study as my at times lack of patience and empathy when hearing informants stories and their acceptance of insensitive and sometimes even discriminatory attitudes and practices, may have biased the findings as opposed to understanding the influencing factors. I acknowledged the importance of remaining open and neutral to the meanings experienced by the informants, but I also acknowledged that I needed an approach that would help with doing this.

Following consideration of Strauss and Corbins' (1990) approach, I found the more prescriptive and overwhelming detailed approach to coding, memoing and analysis unwieldy. The steps for analysis appeared complicated and quite rigid, which appeared over procedural and unmanageable. This is a view that has also been reported elsewhere within the literature (Benoliel 1996; Melia 1996; McCallin 2003). I was drawn to the classic approach (Glaser 1978) because of the flexible and systematic nature of pragmatically explaining relationships and connections emerging in the data. A particular strength of the classic approach is the emergence of the main concern and ways of dealing with it from informants themselves, allowing for a greater understanding of what is really happening on the ground floor, which is in keeping with empathic neutrality (Patton 2002).

7. Classic Grounded Theory

The classic approach is emergent, with the researcher entering the field open to exploring a substantive area and allowing the concerns of informants to guide a deeper exploration

into how they deal with their concerns. Furthermore, the open-ended approach with this approach was seen to be a particular strength. Although I had some understanding of the challenges of cultural competence development while working in the United Kingdom, I lacked insight into Irish specific issues. Therefore I needed a research approach, methods and questions to be as flexible as possible until greater insights were developed. The goal in classic grounded theory is not to control what is going on in the data but to help keep theoretical control over what is emerging (Glaser 1978). As a result, the classic approach, although no less rigorous than other grounded theory approaches, the structured and comprehensive process, which enables researchers to gain a true picture of issues emerging was particularly valued. Nonetheless taking the time to explore the various versions of grounded theory proved invaluable, as it created a greater awareness to the risks of potential method slurring.

Although acknowledging this approach appeared the best fit for this study, it is not without its critics. There are those that view the remodeling of grounded theory as a productive evolution to the methodology (Strauss and Corbin 1990; Annells 1997; Charmaz 2000). However, there are those who argue that much of the criticism associated with this methodology is associated with the over dilution of grounded theory (May 1996). Others argue that the growing body of literature on grounded theory that often lacks adherence to what is seen to be essential aspects of the method is also a concern (Becker 1993; Wilson and Hutchinson 1996).

8. How Classic Grounded Theory was Used:

The procedural steps of Glasers' approach (Table 3) offered useful guidance on using the research design, although appeared daunting at first. Initially I struggled with understanding the process as there is minimal guidance on the practicalities of operationalising the methodology. The extensive writings of Glasers' procedures of grounded theory were essential readings and assisted to clear the muddy waters (Glaser 1978; 1992; 1993; 1994; 1995). It was also helpful to attend two classic grounded theory

seminars organised and hosted by Dr. Barney Glaser in San Francisco (in 2009) and New York (in 2010), where I presented my work in progress. Listening to fellow grounded theory researchers and attending trouble-shooting workshops facilitated by Dr. Glaser proved beneficial. The insights gained from sharing ideas assisted with the confidence development required. Thus following Glaser's step of classic grounded theory I was able to conceptualise the findings to offer a broader and more comprehensive view of nurses' experiences of caring for patients from different cultures in Ireland.

Table 3. Steps of Classic Grounded Theory:

		Classic Grounded Theory
1.	**Preparation**	Minimizing preconceptions. Requires having a broad research topic, but no predetermined research "problem". No in-depth literature review as to do so may add pre-conceived ideas.
2.	**Data Collection**	All is data - any type of data can be used. Data collected explores patterns of behaviour Theoretical Sampling -Initial analysis determines where to go and what to look for next in data collection. Analysis and data collection continually inform one another.
3.	**Analysis: Constant Comparative Analysis**	Data analysis involves relating data to ideas, then ideas to other ideas. Data is compared and contrasted to other data for similarities, differences and differing properties. Three key steps **Open Coding -** Coding for anything and everything. Invivo coding patterns of behaviour. Three questions are asked of the data: A. "What is this data a study of?" B. "What category does this incident indicate? C. "What is actually happening in the data?" **Selective Coding -** Usually occurs when trends start emerging in data and similarities or variations amongst codes appear. Collapsing codes to see how they fit to categories occurs.

		Theoretical Coding - conceptualize how the categories and their properties may relate to each . What connects the data. Use of coding families to assist to weave fractured data back together.
4.	**Memoing**	Memos are the write-up of ideas and data emerging. It helps keep analytical distance from data whilst looking for connections about codes and their relationships.
5.	**Sorting and Theoretical Outline**	Conceptual sorting of memos and ideas and mapping the categories and how they connect, showing relationships between concepts and categories.
6.	**Writing Up**	First draft of write-up of findings.

Source (Glaser 1978; Glaser 2001)

9. Ethical Considerations:

Ethical approval was sought and granted from two separate ethics committees; the University ethics committee (see appendix A) and the Hospital ethics committee (see appendix B). Anticipating and addressing issues of ethical considerations was fundamental in carrying out this study and the following ethical issues were considered and addressed:

9.1 Informed Consent:

Before participating in the study potential informants were advised both verbally and in writing of the research purpose, process, intended outcomes and details regarding participation. Informants were fully informed about the study before they agreed to take part, with particular emphasis placed on the fact that they could withdraw from the study at any time with no consequences. These details were specifically described in participant information sheets for student (see appendix C) and for qualified nurse informants (see appendix D). An open and honest disclosure regarding the purpose, process and potential implications of the study, potential risks/benefits and rights of the informants was provided both verbally and in writing. Once informants were happy to proceed, they were

then required to sign a written consent form (see appendix E). Throughout the process the researcher remained honest and clear about the expectations of informants.

9.2 Voluntary Participation:

The need for research informants to have a choice regarding their participation in a research study is a fundamental obligation in relation to respect for autonomy. Therefore ensuring interested informants were fully informed and their decisions to participate were voluntary and without coercion, was imperative for this study. As qualitative data in the form of individual face to face interviews and focus groups provided the data for this study, the voluntary participation of informants was essential to elicit the richness of data required.

9.3 Minimising Harm and Maximising Benefits for the Informants:

Researchers have a duty to minimize harm and to maximize benefits for informants, while adhering to the right of protection from harm. Being aware of the need to remain cognizant of any potential harm or discomfort that could befall informants was essential. As I was a lecturer within the University that informants studied in or worked with when planning student placements, there was a fear that informants may be reluctant to remain open and honest about their experiences. Furthermore given the sensitivity of the topic, informants may have feared the implications of their practice being questioned. Strategies were introduced to addresses such fears, such as starting each focus group and interview with mutually agreed ground rules. Throughout each of the focus groups and interviews I was particularly sensitive to gestures, silences and facial expressions that may allude to potential feelings of discomfort. I remained alert and aware for any signs of discomfort throughout the process. Particular attention was also paid to the sensitivity and appropriateness of questions asked during the process. An informal debriefing session was offered after each interview and focus group. This meant that any potential psychological harm was minimised.

9.4 Maintaining Confidentiality and Anonymity:

There is a need to ensure informants are made feel comfortable and are assured that confidentiality and anonymity will be maintained at all times. I endeavored to consider informants as true partners and aimed to develop a foundation of trust and empathy. I respected informants' right to anonymity and confidentiality and ensured their contribution remained confidential. All interviews and focus groups were tape recorded with permission from informants and were later transcribed but informants' names were not used during the audio recordings. Furthermore, all transcripts were coded so that only the researcher knew which transcript belonged to which participant or from which focus group, to ensure no connection could be made to the informants. To further ensure confidentiality was maintained, the tape recordings and transcripts were stored in a locked filing cabinet in the researchers' office. The electronic data was stored in a password-protected file, which was encrypted. After this study reaches its full completion all of the audio-recordings and transcripts will be destroyed. Paper data will be shredded and electronic data will be deleted.

10. Study Population:

A total of 452 undergraduate students on the nursing programmes were eligible to participate at the time this study commenced. Although, when using grounded theory pre-determined population prior to data collection are not required (Strauss and Corbin 1990), However at the onset of this study the researcher was required to complete a PhD proposal, which requires identifying a target population, and to demonstrate ethical approval has been granted. It would be impractical to wait for data to be collected and analysed before deciding what other data to collect and from whom. As a means of pre-empting possible delays associated with having to go back to ethics committees when data dictated the need for more or different informants, I projected a possible sample frame. This involved deciding, which available data sources could provide the richest and most relevant information and I then applied in advance for ethical approval. Although

unsure as to what would emerge from the analysis of the initial data collection and what leads I would need to follow, as a precaution I applied for ethical approval to involve student and qualified nurses in this study. Although this practical approach wa discouraged by Glaser (1978), more recently Glaser (2002) acknowledged that in the initial stages of a study, researchers will go to groups where they believe will maximise the possibilities of obtaining data. This reiterates the need for the researcher to have some idea early on in the research process of where to sample, but not necessarily what to sample for.

11. Sampling and Sample:

Although acknowledging that Glaser asserts the need to solely use theoretical sampling, this was not possible at the early stages as initial data collection needed to occur before emerging findings guided further data collection. Therefore, the sampling approach for this study was sequential in using purposive sampling initially, which was then superseded by theoretical sampling as concepts began to emerge. Benoliel (1996) warns that a theory that is solely developed from purposive sampling will lack conceptual depth. Although unsure as to what direction the study would take, it seemed logical to commence this study exploring the experiences of student nurses. This decision was based on the premise that they would have experience of both providing care to individuals from diverse cultural and ethnic backgrounds and of learning about such concepts both in theory and practice. Morse and Field (1996) concur with this view, suggesting that there is a need in grounded theory to choose individuals who have the most experiences. As a growing understanding of the data, concepts and their properties emerged; theoretical sampling was operationalised to determine areas that required further in-depth exploration. It became clear that students' development of cultural competence was largely influenced by qualified nurses on the ward, hence signposting the researcher to invite qualified nurses to participate in this study. All informants worked in the same region but as their main concerns and ways of dealing with their challenges became clearer, variations were sought in informants' age, experiences and ethnicity.

This helped with the comparative analysis for this study as it allowed the exploring of similarities and differences of opinions and experiences.

12. Recruitment of Informants:

Students on the undergraduate nursing programmes at one University in the mid-west region of Ireland and registered nurses at the two local acute general service hospitals were invited to participate in this study. A letter of invitation (see appendix F) and a participant information sheet was placed on notice boards and sent electronically to all undergraduate nursing students studying at one institution. These invitations requested volunteers to participate in a focus group and/or individual interview. Furthermore, a letter of invitation (see appendix G), together with participant information sheets seeking registered nurse volunteers to participate in a focus group and/or individual interviews, were placed on notice boards in local acute hospitals. The participant information sheets described the informants' right to ask questions, the right to refuse to take part in the study and the right to withdraw at any time from the study. Opportunities to seek clarity and ask questions were also welcomed. The voluntary aspects of their participation and the freedom to withdraw from the study at any time were particularly emphasised.

13. Data Collection:

Data were collected using a combination of focus groups and individual semi-structured interviews with both student and qualified nurses. Data collection continued until theoretical saturation was achieved (Saks and Allsop 2007).

13.1 Focus Groups:

Focus groups were used as a means of exploring opinions and attitudes towards people from different cultures. In total ten focus groups were conducted between 2009 and 2010. See table 4 for focus group profile of informants. Each focus group lasted between 72 and 98 minutes and the number of informants who participated in each focus group ranged from six to nine. Eight of the focus groups were with student nurses, which consisted of

two focus groups for each year of the four-year undergraduate nursing programme. This was useful to compare and contrast perspectives from students at various stages of their development. Two focus groups with qualified nurses working in the acute general hospitals that provide clinical placements for the undergraduate nursing students were also facilitated. A separate semi structured focus group schedule was used for the student focus groups (see appendix H) and the qualified nurse focus groups (see appendix I), which became more structured as categories began to emerge. Probing questions helped explore opinions, experiences, attitudes and behaviours. I acted as the focus group moderator and facilitated each of the focus groups, managed discussions and encouraged engagement. A colleague assisted by acting as a co-moderator, taking notes, observing group dynamics and interactions. All focus groups were tape recorded with permission from informants and were transcribed verbatim. Through exploring, comparing and contrasting informants' similar as well as different views and perspectives, a broad variation and understanding of the challenges experienced and how they are dealt with was obtained.

Table 4. Focus Groups Demographics and Profile of Informants:

		Work Area	**Gender**	**Position**
Qualified Nurses	Focus Group 1	Medical (2) Surgical (2) Specialised (4)	Female (8)	RGN *(5) CNM I *(3)
	Focus Group 2	Medical (3) Surgical (1) Specialised (2)	Female (5) Male (1)	RGN *(4) CNM I *(2)
Student Nurses	Focus Group 1	Programme Y1 (6)	Female (6) Male (0)	1st Year Student
	Focus Group 2	Programme Y1 (5)	Female (5) Male (1)	1st Year Student
	Focus Group 3	Programme Y2 (9)	Female (7) Male (2)	2nd Year Student
	Focus Group 4	Programme Y2 (6)	Female (4) Male (2)	2nd Year Student

	Focus Group 5	Programme Y3 (6)	Female (6) Male (0)	3rd Year Student
	Focus Group 6	Programme Y3 (7)	Female (7) Male (0)	3rd Year Student
	Focus Group 7	Programme Y4 (9)	Female (7) Male (2)	4th Year Student
	Focus Group 8	Programme Y4 (9)	Female (8) Male (1)	4th Year Student

RGN* Registered Nurse
CNM I * Clinical Nurse Manager 1

13.2 Semi-structured Individual Interviews:

Semi-structured interviews helped explore personal views, attitudes and experiences, as well as further exploring issues that emerged during focus groups. In total thirty semi-structured interviews were carried out with 20 student nurses and 10 qualified nurses between 2009 and 2011. A separate semi-structured interview schedule was used for student informants (see appendix J) and qualified nurse informants (see appendix K). See table 6 for individual interview demographics and profile of informants. Each interview lasted between 32 and 75 minutes. All interviews were recorded with permission from informants and were transcribed verbatim. The audio transcripts were further supplemented by written field-notes to maximise data collection, which is an approach advocated by Montgomery and Bailey (2007). The interviews provided opportunities for informants to reflect on experiences, recall accounts and explanations of their experiences that may not have been previously considered. Developing appropriate interviewing skills was important as the quality of the interview is dependent on the questions of the interviewer and the honesty of the interviewee (Savin-Badden and Howell-Major 2013). Every effort was made to remain open and establish a rapport with informants throughout the interview process. In particular measures to establish an atmosphere of trust was a priority to ensure informants felt comfortable to share their experiences, thoughts and feelings. Remaining sensitive to participant gestures and facial expression throughout the interviews was also equally important due to the sensitivity associated with this study.

Table 5. Interview Demographics and Profile of Informants:

	Age	**Gender**	**Position**
Registered Nurses	22 – 29 (4) 30 – 39 (2) 40 – 49 (3) 50 – 59 (1)	Female (10)	RGN *(8) CNM I *(2)
Student Nurses	17-23 (16) 24-40 (4)	Female (16) Male (4)	Programme Y1 (4) Programme Y2 (4) Programme Y3 (7) Programme Y4 (5)

RGN* Registered Nurse
CNM I * Clinical Nurse Manager 1
CNM 11* Clinical Nurse Manager 2

14. Rationale for Using Focus Groups and Individual Interviews:

The purpose of combining focus groups and individual face to face interviews for this study allowed for complimentary views to be explored. Focus groups are practical and are often useful when exploring sensitive topics as informants question each other, empathise or even attempt to out-do each other. They were particularly useful to monitor interactions and observe how informants explained and justified their opinions and defended their positions as they were challenged. The benefits of using focus groups in qualitative studies have widely been reported (Lambert and Loiselle 2008; Redmond and Curtis 2009; Doody *et al* 2013). Although focus groups were useful in gaining group opinions, informants may have been hesitant during focus groups to disclose personal sensitive views and experiences, for fear of been negatively judged by peers (Redmond and Curtis 2009; Doody *et al* 2013). Therefore individual interviews afforded some safety and structure, encouraging the sharing of honest opinions. They are frequently used in classic grounded theory studies (Duffy *et al* 2004; Lambert and Loiselle 2008). They afforded the opportunity to explore sensitive issues, which might have been

uncomfortable or embarrassing for some people in the group setting. Adami (2005) and Lambert and Loiselle (2008) advocate the combining of different data collection methods in grounded theory as a means ensuring a comprehensive understanding of the issues being explored. The initial intention was to firstly gather data from the focus groups and then later verify with findings from interview. However, for practical reasons some of the interviews were conducted over the same period as the focus groups.

15. Analysis of data:

Constant comparative analysis was simultaneously carried out during data collection and analysis. As data and codes emerged, comparisons were made to determine if similarities or differences in experiences, interpretations and behaviours were consistent or if variations occurred in different contexts. Memoing and taking field notes assisted with this process. In line with classic grounded theory, data were analysed using the framework advocated by Glaser (1992), which incorporated open, selective and theoretical coding.

15.1 Open Coding:

Data analysis began with line-by-line invivo coding, where key phrases as used by informants own words were noted (Glaser 1992). As soon as interviews were transcribed they were coded in the right hand margin with keywords summing up what informants were sharing. Examples extracts of coded transcripts are provided in appendices (see appendix L). The data were coded in every way possible, by asking the following questions; what is actually happening in the data? What is the main concern faced by informants? How do informants deal with their concerns? Glaser (1992) advocates the use of these questions to keep the analyst theoretically sensitive and transcending. In open coding, everything is coded so as to find as many codes as possible without consideration of relevance (Glaser 1978). However after coding eight transcripts, I had over 180 codes. I feared omitting something important, however with so many codes, it left further analysis of the data difficult as I was becoming consumed with the codes.

During a workshop with Dr. Glaser, I realised that I had 'over-fractured the data' and was aiming for 'theoretical coverage' and as a result had omitted the important step of constant comparative analysis (Glaser 2004). Once I made this discovery, I went back to re-code the data, ignoring the volume of codes that were unrelated to the challenges experienced and instead began identifying patterns of behaviour as advocated by Glaser (1978). For example, one continuous pattern of behaviour throughout all interviews was how nurses avoided encounters, delayed care, staying away and focusing mostly on physical care (Table 6). Cognisant that codes are independent of people time and place, which makes them enduring these codes were grouped together as they all referred to the same pattern of behaviour of avoidance, which collectively was conceptualised as distancing.

Table 6. Example of Conceptualisation:

In-vivo code	Initial Category Coding	Conceptual Category
Avoiding encounters Delaying care, Avoiding providing care Focusing on physical care alone Staying away. Passing responsibility Getting in and out Getting by	Avoiding	Physical Distancing.

The aim of open coding is to identify initially the main concern and then the focus turns to exploring the underlying way in which informants deal with their concerns. However during this process, I experienced many challenges with naming categories. It took some time before the 'ah ha' moment occurred in seeing that everything connected to lack of knowledge leading to uncertainty. However, through grappling with my confusion, dialoguing with supervisors, frequently going back to data and re-drafting of chapters, I realised that nurses use a variety of disengagement strategies, which are underpinned by resigned indifference. Through asking key questions on what informants described doing as well as what they are not doing and why, assisted with this process. Charon (1995)

suggests that understanding people in terms of both their overt and covert minded behaviour is important when undertaking a grounded theory study.

15.2 Selective coding

Simultaneously with validating informants' main concern and how they deal with this in their daily practice, I progressed to selective coding. This meant that I went back to the data collected and re-coded it for issues relating to disengagement and indifference, whilst de-limiting codes that had no relevance (Glaser 1978). For example once disengagement was identified as the way nurses deal with their main concern when caring for patients from different cultures, the study was delimited by selectively coding for issues regarding and relating to disengagement, the related sub categories and what influenced disengagement (see appendix M). As a result the analysis became more focussed and categories were developed and saturated through a process of constant comparison. Eaves (2001) suggest that this constant comparative analysis is indeed a central feature of grounded theory. It also proved beneficial for the researcher to compare issues within the data to explore, under what conditions does disengagement occur? What are the consequences of disengagement? What influenced attitudes and behaviours? And what strategies are used to disengage? In the final stage of selective coding, theoretical sampling and theoretical memo writing assisted in saturating categories and their properties (Glaser 1978). Theoretical saturation was reached when no new properties of the categories were found in the data.

15.3 Theoretical Coding:

The main objective in grounded theory is to synthesise emerging categories by creating theoretical links between them. Glaser (1998) refers to this process as theoretical coding. Manual mind mapping helped with this process, with codes and categories written on movable sticky notes and placed on a wall (see appendix M). Movement around of these codes and categories helped clarify thinking and connections within data and presenting these in a diagrammatic way was useful (see appendix N). Cutcliffe (2000) suggests that

it is this theoretical coding that can provide the full and rich understanding of the social processes and human interactions, which are being studied. The open and selective coding stages fragmented the data but provided dimensions and variations within each of the categories. During the theoretical coding stage, particular connections between each of these categories were studied. Theoretical coding helped weave back together the fractured data through the systemized use of a coding framework as guided by Glaser (1992). Glaser in his writings provides a number of coding families that can assist to begin relating codes and their properties. However, having a working knowledge of these theoretical coding families proved beneficial. A theoretical code in its broadest sense is what relates the categories to each other in a clear and distinct way. It emerged within the data that nurses use a number of disengagement strategies to deal with their lack of knowledge which is underpinned by a resigned indifference. When further seeking connections between the categories and properties of the categories, it became apparent that other theoretical codes were also evident. Theoretical codes from several theoretical coding families may emerge as being relevant in specifying the emergent relationships between categories but the real theoretical code is the one that overall specifies the relationship between the categories. Through much deliberating with the data, through the use of mind maps and the sorting of memos, it became clear that the strategy family emerged as the final theoretical code because of its fit as it was able to illuminate the relationship of all the categories.

16. Field Notes and Memoing:

Field notes were taken throughout data collection and analysis. There were no set criteria for taking these notes, other than observations made during or reflections after the interview or focus group. In particular interactions, observations of both verbal and non-verbal communication during data collection as well as a brief synopsis as to how data emerged compared with other data collected was considered (see appendix O)

Memos were written along the way recording thoughts, questions, relationships between interviews and specific themes that emerged (see appendix P). The memos helped to develop the characteristics of categories that emerged and how data compared to other data collected. Ghezeljieh and Emami (2009) suggests memo writing provides a tool that provides ongoing dialogue for the researcher, which helps to clarify what is happening in the field, and what is explicit and implicit in the data. Glaser (1978) suggests memoing raises the data to a conceptual level, develops the properties of each category and begins to locate the emerging theory. However he also argues that memo writing should not be constrained by prescriptions and rules, and should adopt a totally free approach (Glaser 1998).

Despite the emphasis that Glaser (1978;1992) attributes to memo-writing, only in the actual process of data analysis did the importance of memoing to the overall process become clear. The process of open coding produced many independent memos detailing the researchers emerging thoughts. While memoing was relatively unstructured during open coding it became more structured and productive during selective coding and theoretical coding. In particular the decision to write memos on a category by category basis encouraged the defining of each category and the exploring of relationships between codes within each category. Indeed, Glaser (1978:85) suggests that writing memos will force the researcher to theoretically code. Memos written throughout the study were sorted. During sorting each memo was placed into the pile into which it belongs, based on the code or category to which it refers.

17. Reflexivity:

Remaining reflexive throughout data collection and analysis was essential for the development of this study. Reflecting on methods and approaches used during data collection was fundamental for personal development, but it also ensured the quality and credibility of the findings. Glaser (1992) refers to the role of the researcher during data collection as one that can 'instill and spill', suggesting that informants openly share their

attitudes and experiences. However, I personally found it challenging to keep the discussions flowing and the story coming. Informants were at times hesitant to share personal experiences due to the sensitivity associated with discussing individual practices. Quite often the positive reinforcements I initiated such as allowing time for informants to gather their thoughts, nodding and smiling encouraged informants to tell their story. Through reflection and discussions with my supervisors, I appreciated the need to consider the complexity of power relations during data collection and analysis (Alex and Hammersmith 2008). As I am a lecturer responsible for student development, I was aware that this might affect my relationship with informants and their decisions on what experiences they chose to share. I realised very early on during data collection that I needed to be aware that some informants may tell me what I want to hear (Glaser 1992), whilst others may choose to withhold views as a means of self-protecting their image. I realised the need to empathise with informants and the challenges they experience, create an open and honest dialogue and remain non-judgmental in all verbal and non-verbal communications. Discussing my own challenges when working as a nurse also proved beneficial in setting the tone that nobody is perfect and it is important to understand meanings, experiences as well as what influences actions and omissions of care. However, incorporating vague prompts to bring the discussion back to the participant, without as Charmaz (2000) refers to as 'interrogation', was equally important. Dwyer and Buckle (2009) refer to this as adopting an 'insider perspective'. However the challenge in taking such an approach was to ensure that the potential for bias or molding the discussions didn't occur. Valentine (2007) refers to this as maintaining empathetic distance. However, this was not without its challenges. I struggled to remain non-judgmental when hearing accounts of how nurses showed little regard to the vulnerabilities of patients from different cultures. My initial reaction was to challenge the attitudes and practices described. However, I reflected on these thoughts and opinions and was constantly reminded of the need to maintain empathetic distance and professionalism during the research process. I soon realised that for many, their involvement in this study was the first time they had an opportunity to think or talk about

their attitudes and practices and therefore the realisation of the impact of care provided was only starting to occur. This reassured me in some ways but also made me more determined to complete this study and create awareness for others of the need to provide space to think about practices.

During data collection and hearing the attitudes and experiences of informants, I found myself reflecting on my own journey, which commenced as an Irish woman studying and working in the United Kingdom for many years. I realised that I was lucky as I had opportunities to work with excellent role models and was encouraged to think about my own attitudes and how they impacted on my practice early on in my career (Markey and Tilki 2007). I also completed a transcultural competence online module in 2009 (at Middlesex University), which increased my cultural awareness and sensitivity and helped me re-consider my attitudes and values. I realised how inappropriate it was to therefore judge others, who perhaps have not had the same opportunities or supports that I received. Following debriefing sessions with my supervisor, I adopted various approaches during data collection that allowed me to maintain a balance between empathetic distance and neutrality. I attentively listened to informants, whilst observing for any signs of distress, discomfort or hesitancy. I was careful not to interrupt or break silences to enable informants to reflect on their experiences and compose themselves in times of ambiguity or hesitancy. Being receptive to body postures, picking up on non-verbal cues indicating possible unease and listening to tones and silences were also essential. I also became acutely aware of silences or long pauses during interviews and at such points I asked questions to seek further meaning of issues being discussed. Charmaz (2006:33) advocates such an approach when interviewing in grounded theory as it provides an opportunity to investigate the taken for granted aspects of meanings.

The chief aim of data analysis is to organize, provide structure and elicits meaning from the data (Polit and Beck 2004). In line with classic grounded theory, data were analysed using the procedural steps as advocated by Glaser (1992), which incorporated open,

selective and theoretical coding. As Glaser and Holton (2004) suggest adhering to the principles of coding and constantly comparing the data supports theoretical sensitivity ensures findings emerging derive from the data. Constant comparative analysis was carried out simultaneously with data collection and analysis, as a means of exploring underlying uniformity, contradictions and its varying conditions within the findings. However, I struggled initially with data analysis because of a lack of confidence and experience in using a classic grounded theory approach to analysis. To assist in navigating through these swampy lands, I developed strategies that worked for me, such as; renaming codes and categories many times; dialoguing with my supervisors and others who have used grounded theory and reading and re-reading classic grounded theory books (Glaser 1992; 2002; 2004; 2006) and publications.

To help keep focused Glaser's questions were written on the top of every page of transcripts and field notes until familiarity with the questions was achieved. Confidence slowly developed in naming codes and concepts. Using the interview transcripts initially available, a grid was made where columns were made to the right of the main text on each page. This allowed for codes to be put beside text explaining what was going on in the data.

18. Credibility of the Study:

Glaser (1978, 1998) recommends four criteria for evaluating and judging the credibility and rigour which are; fit, workability, relevance and modifiability. Glasers' criterion appeared to fit best with the methodology and is widely used by researchers who use grounded theory. However, Glasers' criteria has many similarities with evaluating criteria identified by other scholars such as; Morse and Field (1996) and Shenton (2004), who consistently refer to evaluating trustworthiness in terms of credibility, transferability, dependability, conformability and recurring patterning.

According to Glaser (1998), fit refers to whether or not the categories adequately capture issues that emerged within the data. The findings of this study fit as the categories

presented in this study were carefully derived from the data through the process of open, selective and theoretical coding. Although time consuming, mind-mapping and manual coding and re-coding strategies provided a trail of my analytic work, which were often the focus of discussions with my supervisors. However, this was not without its challenges as discussed in Markey *et al* (2014). The most difficult challenge was naming the categories to ensure they accurately reflected the data, as opposed to being influenced by my anxieties of generating findings that presented the nurse in a negative light. However, constant questioning during supervisory discussions ensured a continuous self-correcting process occurred, where coding and re-coding of the data was carried out numerous times, until they accurately reflected the data.

The criterion of workability is established through informants' acknowledgement and affirmation of the usefulness of the findings in their own practice (Glaser 2001). Following identifying lack of knowledge leading to uncertainty as the main concern, identifying how informants dealt with this in their daily practice became the focus of analysis. This evaluation criterion explores the confirmability of the findings. Strategies were used to help minimise my own personal biases and ensure that the experiences and ideas of informants were presented in an objective and accurate manner. Maintaining a reflexive approach and having debriefing sessions with supervisors were fundamental as they provided a sounding board for ideas and helped to identify flaws in thinking and my own biases and preferences.

The findings of this study demonstrate relevance as lack of knowledge leading to uncertainty and the varying ways of dealing with it is something that all health and social care professionals can relate to. They offer a rationale into why care provisions is the way it is. Ensuring the relevance of the findings of this study is something that was considered from the onset of the study as opposed to waiting until its completion. In particular, sharing emerging findings during two grounded theory Summer Schools facilitated by Dr. Glaser and International conferences was a means of checking for relevance. It also

provided opportunities to receive feedback from nurses globally which also assisted to improve my thinking.

The criterion of modifiability refers to the flexibility of the findings. This is mainly concerned with the extent to which the findings can be applied to other situations, as well as how they can be modified if circumstances or contexts change (Glaser 2001). The uncertainty, disengagement and resigned indifference that emerged in the findings of this study is a reflection of where nurses are currently at in an Irish context, particularly considering the rapid diversification of the demographic profile in Ireland. However, as new developments occur in Irish health care settings and nurse education, the findings are capable of being modified in light of these developments and nurses' attitudes and practices may evolve. In essence this study captures the 'here and now' but if developments occur the attitudes, behaviours and practices may also evolve.

19. Summary

This chapter has explored the main ontological, epistemological and methodological propositions that have influenced this research study. Drawing on ideas presented regarding the methodology, methods and the practicalities of operationalising them, this chapter has explored the challenges experienced and strategies adopted to overcome them in the conduct of this study. The following chapters present the findings from this study under the following categories; lack of knowledge, disengagement and resigned indifference.

CHAPTER 5

FINDINGS: LACK OF KNOWLEDGE

1. Introduction:

This study explored the experiences of student and qualified nurses of caring for patients from diverse cultural and ethnic backgrounds. In keeping with the goals of grounded theory, this study specifically sought to explore the main concern for nurses and how they deal with them in their daily practice. This chapter presents the main concerns as articulated by the informants when describing their experiences of caring for people from different cultures. This chapter will finish with an overview of how these findings compare with and are contextualised within extant literature and existing theories and research. Dunne (2011) recommends this as a practical approach to re-reviewing literature as findings emerge in classic grounded theory studies. The term 'different cultures' is used in this thesis to describe cultures which are not Irish as I am uncomfortable with the term 'non-Irish', which is used in current policy and legislation in Ireland.

2. Lack of Knowledge:

Student informants consistently articulated how they lacked the appropriate knowledge to care for patients from different cultures.

> *"...well personally I don't have enough knowledge to understand the needs*
> *of such patients. I just wouldn't have a clue. My experiences of caring for…*
> *like Polish patients is that I just didn't really know what I was at".*
> *(Student Focus Group 2)*

Qualified nurses also consistently expressed a lack of cultural knowledge as exemplified by the following extract.

"I find when I am working on the wards that we don't know enough about their actual…their background, their beliefs or their…their religious beliefs. That's a big challenge. Because you don't know …even down to what they eat….to order for…for lunch and that kind of thing."

(Qualified Nurse Interview 1)

Nurses expressed their anxieties because of their lack of cultural knowledge. However, their focus was on the difference in care needed by culturally diverse patients, rather than exploring the similarities they shared with other patients. Although informants suggested that this is associated with a lack of knowledge, it is perhaps more about a lack of preparation of how to use the knowledge they already have or apply it to different contexts. There was inability to think about the similarities of care needs for any ill patient.

"Sometimes, we are worried about not knowing enough and as a result you are worried about messing up if they are from a different country...It is just their needs are different."

(Qualified Nurse Interview 2)

Feelings of unease, embarrassment and inadequacy were expressed as a result of feeling ill prepared during professional training.

"Sure we didn't have a notion. Maybe if we had been given a bit more on their religion, things like that, we could be more prepared and this makes you feel uneasy in a kind of a way."

(Student Focus Group 4)

While this is an appropriate comment, informants failed to recognise the responsibilities of the nurse to get answers by asking the patient or colleagues. They made no reference to using intercultural resources which are readily available on the internet and offer guidance on caring for people with various cultural and religious beliefs. Although,

awareness of the potential implications of their lack of knowledge was demonstrated, such as mutual cultural misunderstandings, there was a general failure to find solutions to the problems identified.

> *"I suppose that you would find it weird at the start and because of that, you are always worried about saying the wrong thing and putting your foot in it. Because you don't have the nitty gritty of the knowledge required."*
>
> *(Student Interview 11)*

Fear of being misunderstood as a result of lacking cultural knowledge consistently emerged from participant data.

> *"like you would misinterpret them ...or if you did something on them that they didn't want you to do…or…. they might misinterpret you."*
>
> *(Student Interview 10)*

Some students welcomed and valued lecturers' attempts at discussing cultural aspects of care, during their theoretical programme.

> *"I mean…yes, but kind of in the lectures we are dealing…or the lectures are dealing with different cultures. I mean they are talking about it ...you know, they are relating to it, which is great."*
>
> *(Student Interview 1)*

However, other students felt that attempts to discuss cultural aspects of care were only addressed in one specific lecture. Although such input was valued by the students, it appeared that the particular focus involved solely exploring the differences between cultural and religious beliefs. Clearly this knowledge is important but it is not surprising that as a consequence nurses found it difficult to see the similarities of care needs of all patients regardless of cultural or religious beliefs. Although acknowledging the newness of cultural diversity in Ireland and beyond the scope of this study, this raises questions

regarding nurse lecturers' confidence and commitment in supporting cultural competence development.

> *"It was talked about…but it would have been within the context of one module …and maybe even in the context of one lecture which focused only on the differences or beliefs and religions."*
>
> *(Student Focus Group 2)*

More senior students felt that cultural issues were addressed in an ad hoc manner, rather than learning incorporated across all modules. Perhaps this is more associated with a focus on content delivery as opposed to considering how nurses learn and more importantly apply such learning to practice.

> *"We really do need more information…on a more continuous basis... and ..maybe about ….we will say African people, and how to deal with them and…more of what we should and shouldn't do…you know what are the things we should do…steps we should follow."*
>
> *(Student Interview 14)*

Although the students reported having specific modules on psychology, sociology and communication where cultural aspects of care were discussed, biological sciences, diseases and practical skills appeared to take priority. Cultural aspects of care were rarely discussed within sessions such as those on hygiene, monitoring vital signs, wound or pressure area care. Acquiring biological knowledge is important. However in the context of practice, this knowledge did not enable or empower informants to incorporate cultural insights within nursing practice, as exemplified by this student extract.

"Yes the science stuff like that is mostly what we have done so far (year 2)...the stuff that....that aren't really that relevant when you go out on placement like...and meet all these patients who have different beliefs and values."

<div align="right">

(Student Interview 2)

</div>

Students appeared to value didactic approaches to learning and teaching, adopting a false premise that if it was not taught then it was not learned. Despite calls from informants for a greater focus on cultural specific knowledge during their professional preparation, they need to have the curiosity and motivation to find the information they need as well as applying what they know in different contexts. There is a need to focus the learner on how to problem solve and most importantly find answers where there are knowledge deficits. Although arguably not unique to transcultural nursing, it does highlight the importance of paying attention to carefully planning learning and teaching approaches that prepare nurses for an increasingly complex and demanding healthcare setting.

"But it (cultural aspects of care) was just literally touched on in the lecture ...and I mean touched on like mentioned. For example blood transfusions and we are told there are certain religious beliefs that need consideration when giving blood transfusions and that's it nothing about who or what they are or how you should deal with it".

<div align="right">

(Student Interview 3)

</div>

3. Uncertainty:

As a consequence of their lack of knowledge, feelings of ambiguity and uncertainty were consistently expressed by both student and qualified nurses. This resulted in feelings of vulnerability, a sense of anxiety and hesitation when in contact with people from different cultures, as exemplified by this junior student.

"I still would be very anxious because do you know if you approach them in any way…like even though you wouldn't mean to like…they mightn't think that…they mightn't know that you didn't mean to em….offend them. You…yes, you would have a real fear of doing something wrong".

<div align="right">

(Student Interview 2)

</div>

Such feelings were also consistently reported by senior students and qualified nurses with varying levels of experience. Not knowing what to expect and the worry associated with causing offence to patients was consistently expressed. This was often described as fearing the unknown, which arguably is not unique to caring for patients from different cultures. It would be interesting to explore nurses concerns in general and how they deal with them when caring for any ill patient.

"We really don't know what to expect and often subconsciously we might cause offence……..I…I think sometimes we…we em….don't deal with it all that well. I think em….sometimes we shy away from …..you know….difference. To some extent we harbour a fear of the unknown ourselves…."

<div align="right">

(Qualified Nurse Interview 7)

</div>

Nonetheless, this uncertainty resulted in vulnerability and a sense of helplessness, which clearly impacted on nurses' actions and omissions of care. However, despite feeling anxious and worried about causing unintentional offense to patients, they carried on regardless and hoped for the best.

"I mean like… you do try your best ….under the circumstances to care for them and not do anything wrong …but you just can't help worrying that you might get it wrong. You really do just feel so helpless.. and you just can't help being so worried. But what can you do….."

(Qualified Nurse Interview 10)

The discomfort associated with asking the patient questions about their cultural and religious backgrounds was consistently articulated. There was a sense that when uncertainty was experienced in such circumstances that informants felt unable to clarify, ask questions or acknowledge knowledge limitations. This was often described as feeling worried about exposing their lack of knowledge. However, informants described feeling more comfortable to ask questions and seek clarity when caring for Irish patients. For many their lack of exposure to cultural difference and the limited opportunities to role play cross cultural encounters in the classroom, contributed to their general uncertainty.

"it's just it is so foreign to us…..and if you don't know what to do for an Irish patient you feel ok to ask but with a non-Irish patient if you don't know you don't feel you can ask because of the sensitivity of being seen as ignorant."

(Qualified Nurse Interview 8)

A general sense of unease was observed during interviews when informants began describing their perceptions and experiences of caring for patients from different cultures. For example as exemplified by the quote below; hesitating before speaking, with many silences and breaks in sentences. This obvious discomfort that was consistently observed, further demonstrates the extent of the uncertain ground experienced, which arguably is not surprising considering the rapid and unprecedented widening of cultural diversity in Ireland.

"But do you know to have a… a mm…..conversation like with em…with em…..them, I would be kind of mmmm…..afraid nearly to…bring up some ……things, because I …..don't know what…what they…. find….like wrong…. with what I might say or do …..or whatever...you are really worried about messing it up."

3.1 Ethnocentricity and Stereotyping:

Informants consistently demonstrated awareness of conscious or unconscious ethnocentric beliefs, values or stereotypes, which contributed to their uncertainty. However, the acknowledgement of having stereotypes and biases were discussed in the context of the newness of cultural diversity in Ireland.

"It's just we haven't seen much of it (different cultures), as Ireland has only recently become a multicultural Ireland, so really hand on heart we can say we just haven't had much exposure to them and their beliefs. It wasn't seen as important for us because it wasn't really an issue until recently."

There was limited acknowledgement of the long-standing cultural and religious diversity in Ireland, albeit at a much smaller scale. Although the Irish Travellers were consistently acknowledged, they were not classified by informants as a different cultural group with particular cultural needs. Instead, when discussing multiculturalism, informants sometimes described this in the context of nationality. Arguably this is not surprising, given that Travellers in Ireland have only recently been formally recognised as a distinct ethnic group.

"Yes well I guess we have always had Irish Travellers……but in some ways that's different…the issues are different….but only recently have we had other nationalities such as Africans and Polish for example and I really wouldn't have a clue of how to deal with them…."

<div align="right">

(Student Interview 20)

</div>

In other situations, cultural difference was described in the context of skin colour. This demonstrates a narrow understanding of culture, race and ethnicity, which clearly contributed to the ethnocentricity and stereotyping described. Given the newness of cultural diversity it is likely that Irish people classify differences in skin colour as a particular factor, seeing diversity only in terms of ethnicity, failing to appreciate the changing nature of global migration and shifting cultural identities. Irish people are challenged to reconstruct their identity but this will take time. It is therefore not surprising that such narrow views are mirrored in Irish healthcare setting.

"I think they were maybe….you know, brought up when there was White people in Ireland, no Black people…you know. And it's…it's a pity really. I mean…you know. But…no, it's just we are not really used to it".

<div align="right">

(Student Interview 1)

</div>

Nonetheless, there was a real awareness of ethnocentric values and beliefs and possible stereotypes that may have been developed at an early age and went unchallenged. However, opinions and attitudes towards the Irish Travellers or people from lower socio-economic groups were more openly disclosed.

"Um. We…you know, this is how we have learned and grown up. So when it comes to Travellers then…well they….they are different norms to us. If it comes to people who perhaps are from a less …em…economic…socio-economic background…oh…I am…I mean I am the same. I remember my mother not allowing me pal around with a girl….because she lived in a housing estate."

(Qualified Nurse Interview 8)

In particular, examples of negative stereotypes and prejudices towards Irish Travellers were openly expressed during focus groups, because a lack of understanding and appreciation for their particular cultural heritage. These views went unchallenged by other informants but instead were affirmed by nodding or verbal comment. Perhaps this reflects the concerning wider social values of deep-rooted hostility against those identified as Travellers.

"You don't want to upset anybody. You know, you don't want to lose your job by being rude to a Traveler because you don't like Travellers. They are rude…. you always have suspicions about them and be sort of slower to give the same level of care as you would to normal people like or….."

(Student Focus Group 2)

Fewer examples of prejudices towards people from other cultures were as overtly portrayed. This was sometimes associated with the perception that stereotypes and prejudices about other cultural groupings were less acceptable.

"Because other nationalities aren't as rude and they have more regard for us than the Travelling community. I have never had any issues with any other culture here in Ireland except for the Travelling community. I have never witnessed anything like them…."

(Student Focus Group 8)

Nurses do not enter into the profession in a vacuum. Informants described socialization into Irish values, highlighting how their upbringing influenced them.

"Yes I agree….It is a lot what you hear at home….and your parents saying…."

(Qualified Focus Group 9)

Learning beliefs and values during upbringing and from parents was seen as a fundamental component to personal development. At times such learning had a positive influence on informants' beliefs and values regarding cultural diversity, as exemplified by the following.

"It wasn't really an issue for me growing up as my parents seemed to have a positive outlook on people in general and always seemed to see the best in people regardless of where they were from or the backgrounds that they came from."

(Student Interview 20)

The majority of informants described being influenced by the family. This was described as being similar to picking up an accent, which illuminates the difficulties experienced in unlearning such attitudes.

"…. that's what they grew up with you know hearing things from your parents about Blacks or the English for example, you know, they would have negative attitudes and beliefs towards them and you can't help but learn them too. It's like well you learn an accent from your parents, you too learn their beliefs…weather they are right or wrong."

(Student Focus Group 3)

Such ethnocentricities and stereotypes were reinforced by Irish society where people from diverse backgrounds are unconsciously labelled as 'non-Irish', and as such othering, problematising and only focusing on cultural differences. This is not surprising, considering this is a term used in Irish government policy but it does highlight how wider Irish social values impact on nurses' attitudes and behaviours.

"That's the …influence of society and effect on sub conscious. You know, you…you hear society …or the media coverage, and it always referred to the foreigners or the non-Irish and the Irish. We do it all the time without thinking."

(Qualified Nurse Interview 9)

Some informants were unaware of their ethnocentric views before the interview, as nothing or nobody appeared to challenge them. Clearly acknowledging ethnocentric attitudes and practices cause discomfort but failing to so allow them to go unnoticed.

"You mightn't be aware of issues in your head…but they be there indirectly…because you do hear stories of ….we'll say Polish people attacking and…I mean in our town there were two Polish guys who raped a girl. So automatically you have this stereotype…that is in your head even though you might be unaware of it…oh they are dangerous, you know….it is sometimes always there at the back of your head."

(Student Interview 19)

Other informants were unaware of ethnocentrism until something challenged them.

"You already have these views and regardless of how you have got them they are there……you sometimes are not really aware of them until you do something wrong…..and then it hits you like a bang."

(Qualified Nurse Interview 10)

There was a genuine fear of being perceived as racist. Informants consistently acknowledged that they wanted to be liked and at times this required them to collude with rather than challenging stereotypes, prejudices and biases.

"Well I…I suppose people don't like people seeing that they are racist either…a lot of the time, so you would hide your cards with that."

(Student Interview 11)

The impact of the media coverage on racism in Ireland appears to make nurses more fearful of being thought of as racist.

"Um….um. Or….you know, you talk about …em…you know, I suppose….in some ways, fearful of….of neglecting them, because we might forget about them or we might be fearful of…of offending them……..or maybe being accused of being insensitive or being racist in undertones. And so I think we are…we are very fearful of these accusations, particularly in today's climate with all the coverage on racism and things….which I think summarizes the challenges."

(Qualified Nurse Interview 5)

The following interview extracts illuminates fears of being negatively judged by the researcher and being seen in a negative light. However fears of accusations of racism took precedence over taking the time to get to know people from other cultures and learning from such interactions. Clearly racism is a complex term but in the absence of having opportunities to explore and discuss such factors, it is not surprising that nurses were so fearful of being labelled racist.

"You will think oh God ….you ….are going to think I am a racist. We are afraid of what we don't know and worried that we might offend or be accused of being racist."   *(Student Interview 11)*

The discomfort associated with even saying the word was frequently articulated and portrayed.

"I hate to use the word (racist) cos it's such a strong…..negative….horrible word….and would be terrible if you were associated with it…."

(Qualified Nurse Interview 6)

Examples of practices, negative views and attitudes towards people from different cultures were frequently witnessed by informants. "They", "she" and "them", were words used, which assisted informants to disassociate from any involvement with insensitive attitudes and behaviours. This eased the personal discomfort associated with the

standards of care described. However, there was a failure to accept personal responsibility and accountability for their own inaction and lack of challenging of racist attitudes or culturally insensitive care.

> " I would definitely say she had huge issues about having to care for them....I would even go as far to say ...yep...she was racist."
>
> *(Student Interview 18)*

However, the following participant articulates clearly that racism is never intended but practices may be seen as racist as a result of lacking knowledge.

> "I think we should be educated really about things like that [how to care specific knowledge]. So..em..you could be seen then as being sort of ...racist against certain people...or holding something against them like if you weren't...if you hadn't the knowledge like, do you know. It would be just...being ignorant....sure you would be ....because you would just...wouldn't have the knowledge like."
>
> *(Student Nurse Interview 2)*

Through the course of such discussions, it became evident there was a lack of awareness as to what constitutes racism.

> "But I am quite open-minded. I would hope that I am not racist....it's hard to know but if I was it would definitely not be intentionally...it's hard to box in what racist practice is... which for some then causes more anxieties and we are extra careful."
>
> *(Qualified Nurse Interview 2)*

It became obvious that this was the first time some informants had ever thought about ethnocentricity and racism and several were uncomfortable and upset by their enlightenment.

"It's …it's only when you are here today asking those questions, that you stop to think…yes, yes …God. Was I really that bad? That is hurtful and upsetting to think that the care provided was racist but I never intended it to be."

<div align="right">

(Qualified Nurse Interview 6)

</div>

While other informants remained oblivious to personal beliefs and values that may have contributed towards culturally insensitive actions or omissions of care. The limited opportunity to meet people from other cultures in Ireland has clearly contributed to such complacency.

"I have nothing against any other nationality at all…..so that really does not come into the equation when I am caring for them. It really has nothing what so ever to do with it… But I do think it's because we have been alone for a while… oh how do we deal with these people….they are not Irish…they are different from us. They have a different language…different way of doing things."

<div align="right">

(Student Interview 16)

</div>

3.2 Culture of the Organisation:

Informants consistently described the influence the culture of their workplace had on them, which further contributed to the uncertainty experienced. For some this ambiguity was associated with hierarchical structures and feeling pressurised to follow instructions unquestionably. For others, fearing rejection by peers and colleagues was significant.

Both student and qualified nurses consistently described a hierarchical organisation. Those in positions of power had the ability to influence others, either in a positive or negative way. Informants were fearful of going against the wishes of those in powerful roles, such as managers.

"I am afraid to say ....but we still very much work in a very hierarchical structure...in that your boss is your boss....and you do as they say without hesitation....if your CNM says to do something a certain way you do it without question....it is just the way it is...."

<div align="right">*(Qualified Nurse Interview 4)*</div>

Student informants frequently discussed the power relationship between the student and qualified nurse, who assesses their clinical practice. The following excerpt summarises the fear amongst students of failing their practice assessment, if they deviate from routines perceived as acceptable.

"I am glad now I didn't question it or rock the boat, because I am going back to the same place and if I had of said something she could have got her own back on me with my competencies [practice assessment]."

<div align="right">*(Student Focus Group 8)*</div>

Qualified informants also feared being rejected by peers if they questioned practices that formed part of the accepted routine in clinical practice. Having a routine to follow helps nurses put some order to their chaotic working day particularly as nursing is a practice based profession. However the challenge occurred when such routines were seen as rigid and ethnocentric in nature.

"We want to fit in...we want to kind of...don't want to be labelled as the kind of awkward nurse...or the one who is always challenging or questioning."

<div align="right">*(Qualified Nurse Interview 7)*</div>

Nurses were fearful of being rejected by the team if they were seen to lack knowledge, skills and were particularly worried about being seen as incompetent.

"....it's like nurses have a fear of kind of exposing what they don't know to their colleagues."

<div align="right">*(Qualified Nurse Interview 6)*</div>

Student informants acknowledged that attempts were made during the theoretical aspects of their programmes to prepare them to provide culturally sensitive care, albeit at a superficial level. However, what was learnt in the classroom was not always observed in the practice setting. This theory practice gap described although not unique to transcultural care is something that requires consideration.

"Because yes, learning is one thing about the culture, but actually caring for that particular culture is different...what you learn in the classroom and often what you see done is different and sometimes you have just got to go with the flow..."

<div align="right">*(Student Focus Group 1)*</div>

During time spent in clinical practice, students were exposed to both the culture of the organisation and role models that influenced learning. As a means of surviving and getting through their placement, students reported following the practices of their preceptors and peers, even if they knew it wasn't the best way.

"You know you're just following the preceptors...their cues really...regardless if they are good or bad."

<div align="right">*(Student Focus Group 2)*</div>

Sometimes, the absence of role models, capable of engaging in and questioning practices in a respectful and culturally appropriate way, left student informants feeling uncomfortable when caring for culturally diverse patients. Despite at times knowing that practices were inappropriate, the students in particular followed their peers in an attempt to feel socially accepted. This raises questions regarding accountability and commitment

to provide quality care for patients from different cultures but may not be unique to this group of patients, where nurses are feeling over-burdened, under resourced and undervalued. However nurses felt ill equipped to question attitudes and practices that are accepted as part of the routine, therefore change is unlikely to occur.

> *"A bad experience I suppose ...it will teach you bad things to do ...you will pick it up and...do you know, trying to unlearn it ...would be...I suppose be more difficult."*
>
> *(Student Focus Group 1)*

4. Positioning and Contextualising Findings with Existing Theories and Evidence:

This section positions and considers the findings in this chapter to existing theories and other evidence presented within the wider literature. The main concern as identified by informants in this study when caring for people from different cultures is lack of knowledge which leads to uncertainty. Drawing on the wider literature helps position these findings within broader healthcare literature and contextualises the impact of lack of knowledge leading to uncertainty in any caring context. These findings led to exploring broader theories on uncertainty as a means of trying to understand the attitudes, practices and inactions of nurses towards patients from different cultures. Although, much has been written about the concept of uncertainty in nursing practice in general (French 2006; Penrod 2007), few studies explore the impact of such feelings of uncertainty in practice. The literature clearly provides a theoretical definition of uncertainty and its meaning (French 2006; Penrod 2007; Cranley *et al* 2009). However from re-reviewing the literature, it is evident that there are very few studies exploring nurses' experiences of dealing with uncertainty in their daily practice. The discomfort associated with being unsure of how to act has perhaps wider implications for caring practices in any context.

Drawing in particular on two different theories of uncertainty; the uncertainty reduction theory (Berger and Calabrese 1975), which is s a communication theory and the theory of uncertainty in illness (Mishel 1988), some parallels can be made. Firstly, uncertainty is intrinsic in every basic human experience and is unique to the individual experiencing it, depending on variations of contexts and circumstances (Penrod 2007). However, the findings of this study suggest that there are variations into how uncertainty is both experienced and responded to. For example in some contexts, nurses seek appropriate answers when they are uncertain, however they do not seek the information they need when caring for patients from different cultures. Secondly, in both of these theories, individuals appraise their uncertainty, its causes and then initiate coping strategies to resolve it. This is in contrast to the coping strategies adopted by informants in this study, which will be discussed in the following two chapters. The uncertainty reduction theory (Berger and Calabrese 1975) which explores the underpinning issues that affect initial interaction with others, asserts that people need information about each other to reduce their uncertainty. However, the findings of this study highlight the failure of informants to engage with and explore beliefs, values and wishes of patients from different cultures. It raises questions that remain unanswered in the existing literature, as to why nurses feel it is acceptable to choose to do nothing about their lack of cultural knowledge and the uncertainties which follow.

The lack of knowledge to care for people from different cultures fits with the wider literature (Momeni *et al* 2008; Taylor *et al* 2013). Re-reviewing the literature at this stage, highlighted that many international studies report on the ambiguity and apprehension experienced by healthcare professionals when preparing for cross-cultural encounters (Cioffi 2003; Vydelingum 2006; Jirwe *et al* 2010). Although the lack of knowledge and ignorance identified in this study is consistent with the wider transcultural care literature, there is limited research which explores why nurses fail to take responsibility for their limitations. Arguably, this study raises questions as to why nurses still felt ill-prepared and lack cultural knowledge despite the extensive literature

highlighting these issues over the years. Informants in this study appeared to view their role as nurses through a particular knowledge lens. They saw the need for greater input on cultural specific knowledge and felt this was more important than ethical knowledge or experiential knowledge. So the contradiction arises in that although they felt ignorant and uncertain, they failed to seek answers and continued to do things that they sometimes knew to be incorrect. They failed to use the patient, themselves or their families to answer questions. In this regard, the findings of this study add to the existing body of knowledge but extend them in describing how nurses deal with their lack of knowledge on a daily basis. However, they raise other questions with regards to why nurses fail to take responsibility for knowledge limitations and the uncertainties this generates. It also questions why nurses choose to seek help in addressing uncertainty in some situations, but not in relation to caring for patients from different cultures.

5. Summary:

This chapter provides an overview of how lack of cultural knowledge leading to uncertainty consistently emerged as the main concern for informants in this study. The culture of the organisation also contributed to the uncertainty experienced and this is congruous with theories of uncertainty. This chapter through illustrating nurses' voices can help to create a deeper understanding with regards to how lack of cultural knowledge can impact on the care provided to patients from different cultures. However what remains unclear is why nurses do not seek the information they need when caring for patients from different cultures. The following chapter describes how informants dealt with their lack of knowledge and subsequent uncertainty.

CHAPTER 6

FINDINGS: DISENGAGEMENT

1. Introduction:

This chapter describes how nurses deal with their lack of knowledge when caring for patients from different cultures. The uniqueness in this study lies in the description of how nurses use a raft of disengagement strategies as a means of coping with their lack of knowledge and subsequent uncertainty. These have been categorised into 'masking', 'distancing' and 'fitting in'. The culture of the learning environment also had a role to play, as it at times facilitated disengagement. This chapter will finish with positioning and contextualising these findings with extant literature and other relevant theories and research.

2. Disengagement:

Disengagement refers to the strategies that nurses used in different circumstances as a means of dealing with their lack of transcultural knowledge when caring for people who are not Irish. Informants described how they masked personal beliefs and knowledge limitations, using a range of distancing strategies as a means of avoiding uncomfortable encounters and generally kept a low profile to avoid conflict during their working day. Although nurses in this study did not intentionally set out to provide substandard care, by adopting disengagement strategies, culturally insensitive and even at times unethical practices were sometimes described.

3. Masking:

Masking refers to the way informants disguised their personal beliefs, values and knowledge limitations. It explains the dissonance between how nurses think and how they act with patients and peers. Different masking approaches were described, which

may have helped ease the personal discomfort associated with being unsure of how to behave but consequently attitudes and knowledge deficits went unresolved. Different types of masking occurred in different contexts, including disguising personal beliefs, concealing knowledge limitations and mirroring the attitudes and behaviours of peers as a means of preventing rejection.

3.1 Masking Personal Beliefs and Values:

Nurses consistently acknowledged the possibility of having conscious or unconscious personal stereotypes, prejudices or biases. Informants were aware of the potential impact that this might have on patient care if they were portrayed, albeit as a result of thoughtlessness or ignorance. However, instead of acknowledging and addressing ethnocentricities, informants described how they learnt to put such attitudes aside (albeit temporarily) as a means of getting through the day, as exemplified by the following quote.

> *"I do think we do stereotype in our heads…we may not……..act it out. I was thinking it in my head. Now …I didn't let it affect my care, I put my own views aside."*
>
> *(Student Interview 4)*

However, this was only a temporary measure where ethnocentricities, xenophobic attitudes and sometimes even racist opinions were described as being "left at the door" and collected again on the way home. This demonstrates the dichotomy between what nurses' think at a personal level and what they feel they need to do as professionals. In taking such an approach, ethnocentric values, stereotypes and prejudices remain unchallenged and unaltered, subsequently contributing to the complacency and acceptance of the substandard care described.

"You have values and beliefs, but you have to leave like your personality and personal views at the door or in your car because you have to act in a certain way. You can collect them again on your way out. It's the only way we can ensure the patient care is not affected."

<div align="right">

(Student Interview 6)

</div>

Others described being dishonest about their personal opinions and disguising them, therefore limiting the meaningful engagement that can occur during patient encounters and the subsequent learning afforded during meaningful cross-cultural communication. However, nurses in this study genuinely believed they were not doing anything wrong when disguising ethnocentric attitudes. Nonetheless the failure to acknowledge and sensitively address such opinions and attitudes either directly or indirectly clearly impacted on the care of patients who were not Irish.

"I suppose it's like the Jehovah's Witness…you are kind of being two-faced a bit. You have…one opinion in your head and you are leaving him with another opinion that you kind of have of him."

<div align="right">

(Student Interview 16)

</div>

Overall, there was a reluctance to acknowledge personal prejudices and stereotypes as demonstrated by the language sometimes used by informants. A general avoidance of personal pronouns such as "I" or "my" was demonstrated. Instead, informants placed themselves vaguely in the midst of a larger working group. Frequently using words such as "they", "nurses" and "we" were used, therefore minimising personal responsibility or involvement.

"They can…em….certain degrees of concealment in terms of how …how they are going to manage …caring for somebody that's different from them…em….. I think …we make attempts to hide them…you know, we don't intentionally go out to… expose our prejudice or…or our personal views that …might be quite stereotypical."

<div align="right">

(Qualified Nurse Interview 7)

</div>

Many reasons were identified for disguising personal beliefs and values. The majority of informants acknowledged that a nurse can dislike a patient on a personal level, but have a professional obligation to provide appropriate care for them at the same time. However questions are raised as to how nurses in Ireland define appropriate standards of care or interpret professionalism as evident by the descriptions of care described that went unchallenged.

"..because we have a nurses uniform ….but really deep down I don't like you, but I am not going to tell you I don't like you, but I am here to do a job. I don't know where it came from…but I was a nurse and you….you have to act professionally."

<div align="right">

(Qualified Nurse Interview 5)

</div>

A misunderstanding of professionalism and what acting professionally means was clearly demonstrated. As opposed to discussing their professional responsibilities to care in a safe, ethical and effective way, there was a tendency to describe professionalism in the context of appearances of nurses, failing to acknowledge the need for commitment to quality and safety and accountability for actions and omissions. In particular, they described adapting their persona and posture to appear more formal and businesslike, in a naïve attempt to appear professional. Arguably nurses in this study were pre-occupied with how they were being perceived and although wanted to be seen to do a good job, appeared less concerned with fulfilling their moral, professional and legal obligations.

"I think we just continue in our professional mode and .... My professional mode is something else....I am straighter ...the chin is up......the tone is down...I am being professional...you are the patient...and you are the family...."

(Qualified Nurse Interview 4)

The ability to disguise personal beliefs and opinions was a behavior that was learnt and developed during their upbringing.

"Like ...growing up we were always told to bite our tongues ...you don't say what's on your mind if it is going to be perceived wrongly."

(Qualified Focus Group 2)

This ability to disguise opinions was further reinforced during professional education. Informants described being taught to put aside their own values, as opposed to acknowledging and challenging them, during their training. Therefore it is not surprising that nurses in this study felt uneasy, uncomfortable and helpless as they were unsure of how to deal with conscious or subconscious ethnocentric and xenophobic attitudes and values.

"Stereotypical assumptions that might have been based on our upbringing or our going to school or our own cultural heritage .... I think we.... have ways of concealing that, because we have been taught to put our prejudices aside. So it's part of our education, you know, put your prejudice aside and ....let's get in… ...and do what you have to do. You are a nurse now, focus on that."

(Qualified Nurse Interview 7)

Nurses in this study were generally well intended as in the majority of circumstances, masking was used to prevent personal stereotypes and prejudices impinging on care delivery. In the absence of having opportunities to think about, explore and challenge

89

personal ethnocentricities, nurses tried to conceal them as that was the only coping skill that they knew.

> *"I also think that nurses make attempts to …. disguise or to ...not reveal those prejudices or inabilities, because they want to be good nurses and they want to provide this quality care."*
>
> <div align="right">*(Qualified Nurse Interview 7)*</div>

However for others, disguising personal beliefs and values was a coping strategy used to get through the day and "get the job done" with as little conflict as possible, with little reference made to the need for compassion or quality care. Arguably this complacency that went unchallenged contributed to the acceptance of substandard care described for patients who were not Irish.

> *"It's like we have learned to wear this mask when we put our uniforms on, we must act and be seen to act in a certain way…this means never showing any true feelings that might be problematic….and therefore getting done what has to be done."*
>
> <div align="right">*(Student Focus Group 6)*</div>

3.2 Masking Knowledge Limitations:

Both student and qualified nurses consistently reported their lack of knowledge, skills and confidence to care for people from different cultures. An awareness of such limitations was clearly demonstrated and this resulted in feelings of vulnerability. As a consequence, the informants learned quickly how to disguise their lack of knowledge during encounters with patients. However there were limited attempts to seek answers or clarity when unsure and as a result culturally insensitive care was described albeit as a result of ignorance and thoughtlessness. Clearly nurses felt embarrassed and uncomfortable with not knowing what to do. Nonetheless, as a result of choosing to hide

knowledge deficits as opposed to seeking help raises questions regarding nurses' commitment.

> *"We don't tell them we don't have enough knowledge. We disguise that bit."*
>
> <div align="right">*(Qualified Nurse Interview 5)*</div>

Informants described their fears with having their practice observed and questioned by the patient. This increased their vulnerability as they were fearful of the personal implications of having their knowledge limitations exposed. Instead of looking for solutions for their ignorance, some informants masked their deficits by spending longer with the patient. However, this suggests being physically present, as opposed to meaningfully connecting and engaging with the patient. Spending more time with a patients does not necessary equate to providing quality and compassionate care in culturally appropriate ways.

> *"I probably would try and give them better care …you know that bit of extra time at least… because I would feel more that I am being watched maybe by them.. and you need to make sure that they don't know that you haven't a clue what you are at."*
>
> <div align="right">*(Student Interview 13)*</div>

Other informants described how they did something for the patient that perhaps they wouldn't normally do, as a means of masking knowledge limitations. Many informants referred to this as providing "more professional care". However, there was a discrepancy in the informants understanding of the meaning of professional care and the role and responsibility of nurses. The examples offered did not always demonstrate that the care provided exceeded the expectations and responsibilities for a nurse, as laid out in the code of conduct and ethics (NMBI 2014).

"Em…. like you probably would give more professional care. And I think a lot of it would be as well….you would feel more uptight in the room... you would take the time you know to really fluff up their pillows…"

(Student Focus Group 4)

This was described as a dissonance between what nurses think and how they act. Despite having a limited understanding of professionalism, maintaining a professional image and fulfilling their professional role was seen as important. They did not want to let the side down but were genuinely unsure of how they should adequately deal with ethnocentric and xenophobic attitudes and values.

"...letting down the professional side….doing the wrong thing, saying the wrong thing…fear of offending, because I am a nurse I shouldn't do that. ….but I am smiling at you…but you don't know I don't like you."

(Qualified Nurse Interview 5)

Other informants described putting on a smile, as a means of compensating for actions, omissions and knowledge limitations. However, instead of trying to find answers for themselves and take measures to provide the best care, they attempted to hide behind a smile. In this regard there was a deliberate attempt to conceal deficits and at times ethnocentric and culturally insensitive practices that occurred at both individual and organisational levels. Despite moral, professional and legal obligations to provide safe and quality care, unethical decisions were made. Instead of rectifying the knowledge limitations and subsequent poor care provided, informants described doing nothing. This failure to take appropriate action was underpinned by an indifference to which nurses appeared resigned. This will be discussed in the following chapter.

"Anything to disguise I suppose the wrong act or the bad act or thoughts or any other ....care ...that they do, do you know... it's like a little bit of extra ...when they put that smile on."

<div align="right">

(Qualified Nurse Interview 3)

</div>

3.3 Masking with Preceptors and Peers:

The nurses in this study consistently described how they took measures to disguise their ignorance in front of their preceptors and peers. They described the fears of being judged as incompetent or inadequate by their preceptors and peers. Therefore, when uncertainty was experienced, instead of seeking clarification or answers from colleagues, they masked their deficits. Impressing peers was seen to be more important than accepting that it is ok to not know everything.

"You'd always be worried that they (the preceptor) might think. You don't have a clue and then fail your competencies (practice assessment), so you pretend to them that you have the underpinning knowledge when 9 times out of 10 you don't have a clue."

<div align="right">

(Student Interview 17)

</div>

Although in most instances it was students who took measures to hide their lack of knowledge from preceptors, qualified nurses also reported the need to be seen as knowledgeable and competent. Furthermore qualified nurses felt there were extra pressures on them to demonstrate expert knowledge and competence and were uncomfortable at not knowing and were fearful of being humiliated in front of peers.

"You know it's not that we don't want to do a good job or that we intentionally set out to treat them differently but sometimes we are so afraid of ourselves that we feel the need to disguise parts of ourselves...and of course what we don't know.. if you get me... We are under pressure to be seen as that good nurse who is extra knowledgeable and competent and knows what they are at...not just by the patient but by our colleagues too....so you do what you have to, to get the point across."

<div align="right">

(Qualified Nurse Interview 6)

</div>

However, in other circumstances, masking from colleagues involved complying with others and knowingly delivering substandard care as a means of avoiding conflict. Although acknowledging what they should be doing, informants described acting in certain ways which were often inappropriate, in order to seek approval from peers. Although they acknowledged that they sometimes knew what they should be doing, they colluded with insensitive and sometimes even racist attitudes and practices as a means of avoiding peer rejection.

"We do... change our behaviours...it's almost like we mask our own thinking...so I know what I should be thinking....the correct thinking...so I know what I should be doing but I put a mask over it... because I am here.... I need to adapt...I need to fit in here with what goes on in the ward and I need to get along with these colleagues... which I think is what is happening. So it's not an individual thing. Its, I think a bigger thing. It's tackling an organisation."

<div align="right">

(Qualified Nurse Interview 1)

</div>

One informant refers to being part of a team, which involves sticking together, and not challenging or exposing the substandard care of peers.

*"But we also have a professional culture…which is that…learning how to
be a nurse.. and we stick together. You don't go against your colleagues."*

<div align="right">*(Qualified Nurse Interview 7)*</div>

Whilst the majority of informants described their discomfort in challenging the practices of peers, they also described the measures taken to avoid peer rejection. The need to acknowledge and challenge attitudes and misinformation underpinning culturally insensitive practices was noted. However, the incidents they described demonstrated that instead of acknowledging and questioning them, they disguised concerns and turned a blind eye. The absence of discussions on self-awareness of stereotypical or ethnocentric values both at an individual and organisational level perpetuated the masking strategies. It appeared easier to disguise beliefs, values and practices as opposed to challenge and question them.

*"We put on this act…but I think …that we have learned those adaptive skills
…that when it comes to situations then outside of our work where we are in
a situation where perhaps we don't know somebody…and we don't feel
totally comfortable, we go into that mode again."*

<div align="right">*(Qualified Nurse Interview 4)*</div>

4. Distancing:

Distancing describes the avoidance strategies adopted when situations and encounters made nurses feel uncomfortable. Arguably the discomfort during cross cultural encounters is not surprising due to nurses' limited exposure to cultural difference as a result of the rapid nature of the widening of cultural diversity in Ireland, which only recently occurred. As a result, nurses physically and/or psychologically distanced themselves from the patient, failing to appreciate the learning and confidence that occurs as a result of cross-cultural engagement. Psychological distancing explains how informants made minimal attempts to connect with and form a rapport with patients from

different cultures. This ultimately had a negative effect on the ability to communicate with patients and subsequently develop therapeutic relationships. Physical distancing explains how nurses avoided having contact with patients, which resulted in unmet patient needs. This resulted in the provision of culturally insensitive care, which was either directly or indirectly provided, quite often as a result of a general lack of confidence.

4.1 Psychological Distancing:

The difficulties experienced when trying to connect with people from different cultures were consistently described. Although language barriers were the most frequently discussed challenge, feelings of social awkwardness were also described. Despite informants acknowledging the importance of connecting with the patient and building a therapeutic relationship, distancing strategies were repeatedly described.

4.1.1 Feeling Awkward:

The informants consistently described the difficulties they experienced when communicating and engaging with people with diverse linguistic needs. Not surprisingly, language barriers consistently emerged as the biggest challenge.

> *"And it was very hard to kind of explain to him you know anything about any of even the basic nursing procedures. We spoke different languages and he didn't understand me…so that one to one just couldn't happen."*
>
> *(Student Focus Group 1)*

As a consequence, there were particular challenges experienced when trying to find commonality and a connection with the patient. Connecting and having some common ground as a starting point was seen as fundamental in building a rapport. The small talk that occurs during patient encounters was highlighted as important. The need for commonality was acknowledged, suggesting some common ground is needed to

stimulate a sense of curiosity to want to find out more about the patient. The lack of cultural understanding and the discomfort with not knowing what to say whilst acknowledging and respecting difference was problematic.

> *"You would be more…I don't know….more at ease and make better attempts to get along with them, there would be more rapport with them, because you have more in common with them….you are interested and want to learn more about them."*
>
> *(Qualified Nurse Interview 5)*

The majority of informants felt this connection was much easier if the patient was Irish, as they felt more comfortable when communicating. It is not surprising that communicating with somebody with similar cultural beliefs and norms and cultural heritage was easier. However as a result of becoming pre-occupied with cultural differences, nurses were unable to consider possible similarities between and across cultures and as a result general caring discussions were minimal. Clearly communicating with any ill patient regardless of culture requires nurses to assess and plan person centred care and therefore there is arguably similarities of communication needs for all patients.

> *"I suppose because you know a little bit of Irish culture, you know the jokes, you know the usual conversation that you might have to connect with the patient because you are Irish – there is some commonality."*
>
> *(Student Focus Group 1)*

However, where informants had prior experiences of caring for diverse cultural and ethnic groups, they reported less anxiety during cross cultural encounters.

"Because we had a really good bond. Em.. I would have been used to working with a lot of Phillippino nurses in Canada. So I understood this complete thing of denial, denial… right up until the very end…. she had three children, similar ages to my own. So we had a link there as well."

(Qualified Nurse Interview 10)

Other informants who were not Irish, reported feeling at ease when communicating with patients from different cultures and with diverse linguistic needs. As a result of their own personal experiences of migration, they felt they were sensitive to the possible challenges patients might experience. This connection made the rapport building and therapeutic engagement easier.

"Em… but I know I felt comfortable as I grew up in London so I would have more of an understanding of what it is like to come from a different country and what might happen …. And I … and I am not saying they had not tried to communicate with her (patient)… because they were very kind and caring to her but they couldn't seem to make inroads with her."

(Qualified Nurse Interview 6)

However, when language barriers were present, small talk did not occur and the development of therapeutic relationships was minimal. In the majority of circumstances this was described as feeling unable to communicate or understand each other, due to language barriers. As a consequence feelings of social awkwardness were described.

"I hated that kind of silence, you know like...there is nothing ....you know,
you would say 'hello' and he kind of...understood that ...but after that there
was no kind of conversation, it was just awkward like."

<div align="right">*(Student Focus Group 1)*</div>

However, some informants suggested that the language barrier is sometimes overused as an excuse for failing to meaningfully engage with the patient. When language barriers were evident, it made disengagement with the patient less discomforting.

"Probably because they [nurses] could be busy and so it's actually better
for them not to spend too much time with a patient who doesn't understand
them. This may then be just used as an excuse as to why the care provided
was not to the right standard. "

<div align="right">*(Student Focus Group 1)*</div>

When probed further during interviews, the majority of informants admitted to feeling socially awkward around people from different cultures, suggesting language interpretation was not the only barrier.

"Yes, well it's also a fact of social awkwardness. You know, because you
can't ... communicate, you know. It's...even...even if you like from being
Irish to English, you know, there is a different way of going on. You just
don't know how you should be around somebody from another place."

<div align="right">*(Student Focus Group 2)*</div>

However, despite acknowledging social awkwardness, there were minimal attempts at alleviating this. Instead there was a widespread acceptance that nothing could be done to improve the situation

"And you know, I notice that… the person because they can't engage in small talk communication, communicating with them tends to be avoided or they are avoided altogether."

(Student Focus Group 2)

The effects of this perceived inability to communicate with patients had various effects on informants. Some informants expressed their fears of language barriers, but did little to overcome it such as using professionally trained interpreters. Clearly language is a barrier, but nurses are required to use different communication skills in different caring contexts, other than the spoken word.

"I guess…. I am afraid of the language barrier and being misunderstood."

(Student Interview 15)

Other informants felt guilty as a result of feeling unable to communicate effectively with patients. However, minimal attempts to overcome the communication problems and language barriers were described.

"You feel bad… you are left wondering is he lonely then, because you can't communicate with him."

(Student Focus Group 1)

Anger was expressed at the organisation for not providing adequate professionally trained interpreters. Shifting the blame onto the organisation made the disengagement more comfortable, but also meant that nurses took no responsibility for their failures to try different ways to communicate effectively.

"It's not our faults, what they expect to happen if they don't provide us with the staff or interpreters to help us to communicate appropriately with the patient."

(Qualified Nurse Interview 8)

Despite the discomfort consistently expressed, there appeared little focus on how to overcome and resolve the problems identified. Only two informants discussed how professional interpreters were sometimes used or seen to be used.

"Like for different languages, em…there is an interpreter brought in which is good."

(Qualified Nurse Interview 1)

However, the majority of informants reported never using a professional interpreter, as exemplified by the following interview extract.

"My own service, I know, have never used an interpreter …in all the… people that we have had in from different cultures, they have never used one."

(Qualified Focus Group 2)

Instead family members were frequently used. This was rationalised by discussing the limited access to professionally trained interpreters in the workplace.

"Because …sad to say, we would have actually used quite a lot of family members …because we didn't have access to interpreters."

(Qualified Nurse Interview 2)

4.1.2 Focusing on Physical Care:

As a consequence of the discomfort described during cross-cultural encounters, informants described focusing on physical aspects of care only. This was often described

in the context of carrying out tasks and as a result the holistic needs of the patient were clearly jeopardised.

> *"We're not going to be doing small talk, so we just …we move on…we make*
> *his bed…. do his observations.. but we never really get to know him."*
>
> *(Student Focus Group 2)*

This helped to rationalise and minimise the personal discomfort associated with not engaging in a meaningful way with the patient. There was a sense that if the physical care needs were met, then it was acceptable. However, such acceptance of just doing enough to get by, demonstrates how moral, professional and legal obligations were breeched.

> *"So kind of in and out basically…focusing on just the physical care and not*
> *spending too much time with her ….so you don't feel so bad or awkward*
> *around her because she can't understand you and you are doing your bit."*
>
> *(Student Interview 10)*

The tasks frequently described involved bed making, attending to hygiene needs and monitoring of vital signs, but the opportunities for meaningful engagement during these encounters were not adequately utilised. Instead, the priority was on getting out of the patients' room as quickly as possible. The perception that extra time was required when engaging with people from different cultures emerged consistently as an issue. Clearly time is precise in a busy and under resourced healthcare setting. Instead of considering ways of using time effectively, the focus was on doing enough to get by. This further demonstrates how focusing solely on cultural difference, othering and problematising the patient can result in over estimating the time needed to provide care to patients from different cultures.

"I am sorry to say but if you know it's going to take so long you just avoid going in. If eventually you have to, then you go in, you focus on doing their physical care you know…the vital signs; wash them; make the bed and do enough to get by and pretend you know everything and then get out of there as quickly as possible……"

(Qualified Nurse Interview 2)

As a consequence of focussing only on the physical aspects of care, the psychological care and the rapport building with the patient was seen as less important. However, despite acknowledging the importance of connecting with the patient, there was a general disinterest in making attempts to get to know and understand the patient and their individual needs.

"There is a greater focus on physical care but because we have little in common their psychological care or that building of a rapport doesn't really happen and that is just it."

(Student Focus Group 4)

4.2 Physical Distancing:

Whilst some nurses focused on physical care, others opted to employ a strategy of physical distancing which is the distance that the nurse creates between themselves and the patient. The physical distancing approaches described incorporated avoidance techniques. There was a tendency to avoid contact with the patient to protect themselves from getting the care wrong, which took precedence over taking what they knew to be the right course of action.

"My worry of offending someone is taking over from my ability to care for them.. so often I avoid having contact with them as a precaution."

(Student Interview 13)

Sometimes avoidance strategies were intentionally used, whilst other times a lack of awareness of the implications of actions or omissions of care were evident.

"There is a distance there between us I don't know why or how but it is just there. Sometimes we are more aware of it than other times."

(Qualified Nurse Interview 9)

Delaying care was an avoidance used to respond to the uncertainties nurses experienced. Sometimes informants' delayed engaging with the patient unintentionally. However, in other circumstances it is the consequence of a learnt and accepted behavior that goes unchallenged.

"You don't think about it but sometimes…it just happens without knowing …you would delay going into them and then when eventually in with them you wouldn't stay long and converse with them, because you are just too fearful that you might do or say the wrong thing and upset the patient."

(Qualified Nurse Interview 1)

Passing responsibility was another approach described. Informants described how they pass the responsibility to care for people with different cultures to other colleagues.

"You are trying to pass the responsibility…"

(Qualified Focus Group 2)

Some informants felt that responsibility for culturally sensitive care was frequently passed to them, because they had worked in another country or were of a different nationality. The following nurse born and brought up in England felt she was frequently

allocated patients from diverse ethnic backgrounds because other colleagues felt incompetent.

> *"It was presumed that I would go. And the girls would wait actually, if I happened to be on annual leave they would… pencil my name in for it that I was going to her….they would say to me , you might call to this lady because we can never seem to make in-roads with her."*
>
> *(Qualified Nurse Interview 6)*

Student informants felt that the responsibility was quite often passed over to them, despite being quite junior.

> *"They [qualified nurses] pass the job to you to see could you understand and I guess pass over that responsibility as you are more junior."*
>
> *(Student Focus Group 4)*

5. Fitting In:

A culture of care within the organisation that facilitates and allows disengagement to go unnoticed was described. This was often described in terms of day to day practices that become part of a routine that is accepted but was often described as rigid, traditional and ethnocentric. Although having a routine helped provide some structure to the working day and helped ease the uncertainty of not knowing what to expect, this becomes problematic when they are ethnocentric and rigid. Treating "all patients the same" was also described as a means of fitting in with the accepted practices of the organisation. Although, adopting such approaches to care reflected the good intentions of nurses to maintain equality, the consequences of not acknowledging difference resulted in inadvertently providing culturally insensitive care, albeit as a result of thoughtlessness, ignorance and ethnocentricity.

5.1 Keeping to the Routine:

Informants described following traditional routines that are accepted in many clinical areas as a means of fitting into the culture of care, within their workplace. However, the routines described were generally ritualistic in nature.

> *"I think just personally I am working …in…a bit of an old-fashioned ward*
> *where you stick to the routine. That's the culture of the ward…the care that*
> *is provided is based on a routine of certain practices…certain things need*
> *to be done by a certain time."*
>
> *(Qualified Nurse Interview 1)*

Not surprisingly, nurses described how routine provides a sense of security at times of uncertainty. It offered guidance to the management of their day-to-day duties and ability to carry out procedural based care. However, such practices were often task orientated, as opposed to valuing opportunities during cross cultural encounters to plan holistic and patient-centered care. Hiding behind such routines further facilitated and permitted disengagement to go unnoticed.

> *"So that's fine. That's a routine …..a tick box system and it's straight*
> *forward because you just follow that and do all those tasks required at the*
> *given time...and then you have no worries."*
>
> *(Qualified Nurse Interview 2)*

Cultural care is not seen to be an integral part of the accepted routines described. As a consequence the provision of culturally sensitive care is not seen as a priority. For many participants this was often associated with lack of exposure to cultural difference.

"… so it's routine… everything is routine and….culture doesn't fit into it."
(Qualified Focus Group 1)

The physical care needs of patients were seen to be the most important element of the accepted routines. Set times were identified for certain procedures or practices. Nurses perceived that evaluation of the care provided was often based on observable features such as how the patient looked, with minimal attention given to rapport building or the importance of developing therapeutic relationships. This eased discomfort associated with disengagement but allowed them to go unrecognized and unchallenged. The focus on keeping to the routine took precedence over listening to the wishes of the patient.

"So by day three, I hate to say it, but despite her (patient) not wanting a wash we dragged her out of bed. Not that we physically lifted her out…but we got her out of the bed, got her showered, got her all freshened up…made sure the baby was happy….looked after the baby, changed the baby's nappy. We felt we had done an absolutely fantastic job as that is the routine and now people can see we were good."
(Qualified Nurse Interview 2)

Providing care perceived as part of the accepted routine was a priority, regardless of the patients' wishes or personal beliefs. Some students acknowledged that routine practices might be underpinned by ethnocentricity and therefore go against patients' wishes. However, they still felt it important to ensure that practical aspects of care were provided, as they were seen as fundamental to the accepted routine. Taking such a position infringes patients' autonomy and fails to acknowledge the patient as the ultimate decision maker. It raises questions about why obtaining consent when caring for different cultures is not regarded as an absolute requirement and a lack of awareness of the failure to do so constitutes unlawful touching.

"And you know it's really hard as they probably have different views but it just needs to be done. They need to understand that certain care must be carried out, regardless.....You have to be washed either way, so like do you want to get your hair washed or....but either way you are going to be washed. End of. It has to be compulsory."

<div align="right">*(Student Focus Group 6)*</div>

Care based on routine practices where the Irishness of the organisation is unstated and taken for granted was frequently described. There were many examples of practices that were steeped in ethnocentric values and Hibernocentric norms. However, this was accepted and went unchallenged, thus further demonstrating how such practices are sustained.

"When bacon and cabbage is on the menu today and at least one day a week....you have to eat that...there is no two ways about it like do you know. It's our way or no way... If you know what I mean."

<div align="right">*(Student Interview 2)*</div>

The impact the Catholic religion had on developing the norms that became deeply rooted in everyday practices was also discussed. It was accepted that these were the norm and anything outside of that was seen to be abnormal.

"We already have a routine – like if a patient dies – we act as if they are all practicing Catholics..quick, get the candles, get the priest...that is how things are just done on the ward."

<div align="right">*(Qualified Focus Group 1)*</div>

For others, keeping to the routine was used as a means of disguising the nurses' lack of knowledge rather than encouraging them to find out what they didn't know.

"If I keep to the routine and do as everyone else is doing then it is less likely

to illuminate or highlight the bits I don't know or have a clue about."

<div align="right">

(Student Interview 19)

</div>

5.2 Treating all Patients the Same:

Nurses described feeling more comfortable when caring for Irish patients. This was often the result of feeling that professional education focused more on preparing nurses to care for Irish patients, with minimal attention to different cultures. As a consequence, care was mostly underpinned by Eurocentric or sometimes even Hibernocentric norms. Numerous incidences were described where the care provided was based on the needs of white Irish Catholic patients. Although nurses in this study did not intend to provide less than perfect care, the limited opportunities to think about ethnocentricities or engage with cultural difference resulted in a lack of awareness and sometimes even complacency.

"I suppose you… care for so many Irish people that you base your care
around that kind of care…you talk about providing care to Irish patients in
the class. You know what to do if Mrs. Murphy [Irish patient] had blah,
blah, blah…"

<div align="right">

(Student Focus Group 4)

</div>

This reflected the culture of care that informants described, that indirectly encouraged the treating of all patients the same, regardless of their cultural or ethnic backgrounds. Instead of listening and acting on the individuality of patient needs, patients appeared to be cared for in the same way. In this regard, there was misconception that all patients were being treated equally, which resulted in culturally insensitivity although not necessarily consciously or intentionally.

"It is a given that the care provided would be the same and everybody abides with that rule..well mostly anyway...you would treat everybody the same. You can't treat them differently...em...just because they are a different religion or a different culture...you know, you treat them the same."

(Qualified Nurse Interview 1)

This demonstrates that the nurses are often well intentioned when treating all patients the same. However, despite acknowledging that care was based on the needs of Irish patients, little was done to adapt practices. This was rationalised by suggesting that everybody is treated equally regardless of ethnicity, cultural or religious beliefs. Students experienced this culture of care in practice, and although often had reservations about such standards of care, it was easier to mirror these practices than to question them.

"Yes I was on placement in November. There was a lot of ... Polish women. More than we will say African or whatever. And basically from what I could see they were all treated the same... well I guess the same as Irish people."

(Student Interview 1)

However, the implications of treating all patients the same failed to acknowledge the individuality in cultural and religious beliefs. The following summarises the attitudes of the majority of nurses who wanted to treat all patients equally, but failed to acknowledge the similarities and differences amongst diverse cultural groups.

"Because they are a different religion or a different culture...you know, you treat them the same.. well I know for me, I treat all patients the same. There is no difference in individual people just because of their religion or culture."

(Qualified Nurse Interview 1)

Treating all patients the same, was based on a false assumption that the care was not discriminatory.

"You would...you might have a bit of a worry that you would offend them or something, but I think you would have to treat them all the same...if you could. Yes treat them like as one of your own as we like to say."

(Student Interview 2)

Some students acknowledged that treating patients the same in all situations was not appropriate. However, despite acknowledging the poor care they had witnessed, minimum effort was made to challenge or change practices.

"It was still explained the same way as it would be to an Irish woman. But there was no extra information given, and there was ...you know big words.... Big English words that the woman wasn't going to understand anyway. There was kind of no effort made to make it simple for the women to understand."   *(Student Interview 1)*

Other informants acknowledged that by treating all patients the same, their lack of knowledge or level of competence was less likely to be questioned. It was felt by some informants that to ask patients about their beliefs, values and customs might further expose their knowledge limitations.

"I treat them the same…I don't ask them about their beliefs…I don't ask them about their religion really. What message would that give them if I ask them questions…that I am incompetent really isn't it?"

(Qualified Nurse Interview 1)

However, the following interview extract illuminates the ethnocentric beliefs that can underpin such approaches as well as a lack awareness of personal ethnocentricities, but this went unquestioned and often even unnoticed.

"She explained (to a mother) about burying her baby and she said ok I will ring my husband and see what he says…and then she said I can't attend my baby's funeral because my husband said so. And well it was said to her that she must go. It's your baby's funeral you have to go….and well she was kind of looked down on her from then on."

(Student Interview 2)

6. Positioning and Contextualising Findings with Existing Theories and Evidence:

It is not surprising that a lack of knowledge and the subsequent uncertainty caused informants to lack confidence in their ability to care for patients who were not Irish. This is in keeping with the small amount of research in Ireland to date (Kennedy and Murphy-Lawless 2003; Tuohy *et al* 2008; Lyons *et al* 2008; Tobin and Murphy-Lawless 2013; Boyle 2014) but is not unique to this country (Jirwe *et al* 2010). However, the lack of motivation to find appropriate solutions to the knowledge limitations and uncertainties described was not anticipated. Returning to the literature as these findings were emerging was useful as it helped in some cases to understand the reasons for some decisions made. In particular, it highlighted that although lacking cultural knowledge is a consistent theme that emerges in the transcultural literature, there is little evidence to describe how professionals deal with this lack of knowledge. Given the lack of confidence and fear of

112

showing their ignorance, nurses adopted strategies to disguise their ignorance from patients, supervisors and peers. The strategies they adopted to deal with anxiety are similar to those described by Menzies in the 1960s and others since (Smith and Lorenzton 2005; Gabriel 2010; McHugh *et al* 2011). The consistent theme that emerges from the findings of these studies describes how nurses minimise contact with patients and adopt task based routines as a means of coping in a stressful working environment. It is clear from the data that the organisational culture where rituals and routines take precedence over individualised care, further facilitate disengagement. It would appear that the rituals and routines described by Walsh and Ford (1989) although are very dated, are still evident in this study. Although there was some admission that following standard procedures and/or going against the patient's wishes led to unsatisfactory, insensitive and sometimes even unethical care, little was done to improve the care provided. It was easier to comply with unacceptable practices than to risk being rejected or suffer the consequences of challenging those in authority. This correlates with other studies exploring reasons for students' conformity during clinical placement and the measures taken to avoid conflict within a team (Lewett-Jones and Lathlean 2009). This raised further questions as to what influences nurses inertia to provide quality meaningful care in culturally appropriate ways.

The extent of the disengagement adopted led me to delve into a broader literature to try to understand the decisions made. The experiences and views expressed by informants could at least in part be explained by some theories of uncertainty (Kai *et al* 2007), whereby nurses feel disempowered and therefore self-preserve in times of ambiguity. However, the evidence from this study contradicts the views of several writers who hypothesise that people are generally motivated to find answers and solutions when they experience uncertainty (Cioffi 2005; Kai *et al* 2007; Penrod 2007). It was clear that the nurses in this study were unable but sometimes unwilling to learn or find solutions. It is evident from reviewing the literature, that there is a particular gap in our understanding of strategies employed to respond to and resolve uncertainties experienced in healthcare

practices. Other scholars have also identified this gap and specifically highlight the need to understand nurses' uncertainty (French 2006; Cranley *et al* 2009; Vaismoradi *et al* 2011).

While acknowledging the discomfort and anxiety experienced by students and qualified nurses as a result of a lack of cultural knowledge, gaining an understanding as to why nurses felt it acceptable to disengage with patients and fail to challenge culturally insensitive care. Bandura's moral disengagement theory offered some explanations. Bandura (1996) hypothesises that moral disengagement occurs when individuals engage in habitual self-regulatory behaviour when intentionally detaching themselves from a situation. This theory helps explain how informants took measures to disengage from the patient but rationalised it for themselves, thus reducing the personal discomfort associated with providing sometimes less than perfect care. He further suggests that people who have morally disengaged do not worry about implications of their actions or omissions. They deactivate the self- regulation to do the right thing and therefore experience less guilt. In this way they detach themselves by hiding the harmful effects of their actions, justifying their behaviour and imagining the harmful action is in some way deserved. Clearly the lack of resources and time and limitations in knowledge contributed to nurses' actions and omissions of care and blaming organisational constraints and professional preparation eased discomfort but also contributed to sustaining accepted standards of practice that weren't always underpinned by caring values. This is in keeping with other research in the wider literature on moral disengagement (Barsky 2011).

7. Summary:

The psychological defence mechanisms described are not unusual and nurses and doctors adopt them when they are unsure (Menzies 1960; Smith and Lorenzton 2005; Curtis *et al* 2012) and organisational customs often facilitate them (Gabriel 2010). It is evident that the culture of the clinical areas investigated condoned sometimes less than satisfactory

care, albeit unintentionally in the majority of circumstances. On reflection, it would have been good to explore whether nurses adopted similar actions when caring for people with conditions with which they were not familiar or where they lacked the skills needed to provide a particular treatment. This raises questions as to why the student and qualified nurses in this study appeared to take so little responsibility for care, which was not meeting the needs of certain patients. It also raises questions as to why the culture of the organisation not just allows but sometimes facilitates disengagement and why such approaches to care go unnoticed and remain unchallenged. This will be explored further in the next chapter.

CHAPTER 7

FINDINGS: RESIGNED INDIFFERENCE

1. Introduction:

Nurses in this study often knew what they should be doing, but felt unable or at times unwilling to do what was right and appeared to become resigned and indifferent to the needs of patients from different cultures. This indifference was made easier by working in organisations that had no expectation that culturally sensitive care would be provided. Rigid routine ethnocentric practices and task focussed care was the norm which often allowed culturally insensitivity to go unnoticed. Although, the majority of informants witnessed culturally insensitive practices on a regular basis, they did not attempt to challenge them but instead admitted to 'turning a blind eye'. They went to great lengths to rationalise their own and others actions or omissions. Rather than challenging inappropriate attitudes, actions and behaviours they appeared to develop a resigned indifference about the needs of non-Irish patients. This chapter presents these findings and contextualises them within the broader literature to further explain the resigned indifference described.

2. Individual Indifference:

Informants consistently articulated an awareness of the need for culturally sensitive care. This was often described in the context of witnessing a new phenomenon resulting from unprecedented changes to the demographic profile of Ireland.

"I mean it is new to Ireland… so we now see more frequently patients who are not Irish....and there is a need to ensure that the care provided is quality care to all patients...."   *(Qualified Nurse Interview 2)*

Despite such awareness, examples of culturally insensitivity were described, albeit often as a result of thoughtlessness or ignorance. Examples of cultural misunderstandings were frequently described, due to lack of knowledge of the similarities and differences amongst patients from different cultures. The following extract illuminates this point, but also highlights the importance of opportunities for nurses to reflect on, make sense of and question practices.

"I made a judgement…a wrong judgement we'll say as she wanted to wait to ask her husband his opinion first...but I kept pushing her cos I just couldn't understand why she had to confer with her husband....it is only recently that I learned that …that was actually part of her culture and I just wasn't aware of that."   *(Student Interview 4)*

Although informants consistently articulated that culturally insensitive care was rarely intended, there was a general failure to take action to improve the care described.

"But it's kind of subconscious….well that is what I think anyway nothing bad is intended"   *(Student Focus Group 2)*

In the majority of circumstances, awareness of the moral implications and consequences of care that was not always to the highest quality was demonstrated. However, a lack of motivation and willingness to do anything about what they knew to be wrong was also described.

"It can be compromised sometimes, but not intentionally.. sometimes we just do not know what to do or at times we just don't have the resources."

(Student Interview 11)

In other circumstances a lack of interest was sometimes described when witnessing discriminatory practices, but nurses appeared to do nothing about them. Such views were accepted, went unquestioned, thus perpetuating indifference at individual and organisational levels.

"We know it's wrong but we don't do anything about it."

(Qualified Focus Group 2)

Many students articulated a better understanding of what they should be doing, with particular reference to sourcing answers to uncertainties.

"I definitely want to look into them more like because you can't….like once you have…once I would see a religion like I would have to definitely go off and research it, because I wouldn't know them off the top of my head. And I would be just afraid in case you didn't insult someone or say something that just isn't done in their religion."

(Student Focus Group 6)

Paradoxically, the actions described by the majority of students did not involve actively looking for answers to their uncertainties. Finding answers when unsure when caring for patients from different cultures was not seen as a priority.

"It really isn't an issue, we don't see finding out about their religion as a priority and it is something that just doesn't' happen. Nor it doesn't get taught or reinforced while on placement."

(Student Focus Group 1)

The following interview extract illuminates the extent of indifference that some informants demonstrated. Knowingly providing minimum care to patients from different cultures was a finding that consistently emerged. However, this was often described in the context of feeling unable to provide the care they wanted due to a lack of time and resources. Perhaps more concerning was the acceptance that such less than perfect care was tolerable. Although, not disputing the pressures nurses are feeling in an increasingly demanding role, taking measures to disguise the substandard care appeared to take precedence over trying to improve it.

"I just ignored him…..I just didn't tell anybody and I just….tried to communicate the least amount with the guy, just did the bare minimum for the person…"

(Qualified Nurse Interview 5)

Apathy was described and demonstrated in different ways and for different reasons. For some the frustrations associated with feeling ill prepared to care for different cultures was clearly articulated. However, instead of actively finding answers to their ignorance, disengagement strategies were adopted. Despite acknowledging the negative implications of such actions and omissions of care, informants felt unable to do anything about them.

"We don't really bother with them ….if I am truthful about it we tend to avoid dealing with them if we can because we just don't know enough about providing care to them…."   *(Qualified Nurse Interview 2)*

For many informants, the indifference was the result of working within an organisation that was under resourced. As a consequence of organisational constraints, informants felt

comfortable to acknowledge fatigue, which resulted in careless behaviour and a disregard for patient dignity, blaming exhaustion and feeling unsupported when working with challenging issues.

> *"But then you will come onto the wards and like…I know even I don't do it anymore…I…because you are too busy or it's just…you run out of steam…you just don't bother….."*
>
> <div align="right">*(Qualified Nurse Interview 1)*</div>

Complacency was also demonstrated. Many nurses failed to question their own practices and didn't see anything wrong with their actions and omissions. They did not appear to engage in reflective practice or modify their practices accordingly in light of their experiences.

> *"You know they did the same with every woman, explained everything the same. It didn't matter whether the women understood or not, but they were told and that was it, you know. They were trying the best they could but regardless it was obvious the care provided wasn't right."*
>
> <div align="right">*(Student Interview 1)*</div>

The indifference and lack of compassion towards non-Irish patients appeared to be influenced by wider xenophobic attitudes and opinions.

> *"You know you just can't help it you know feeling resentment towards them. Ireland was doing fine before the immigration flood gates were opened…which resulted in a free for all."*
>
> <div align="right">*(Qualified Nurse Interview 7)*</div>

Such attitudes influenced the decisions and actions taken. Many examples of how people from different cultures were treated less favourably than Irish patients emerged in the data. This partly reflected the over focus on cultural difference and anything that deviated

from the norm was subsequently classified as abnormal. This allowed nurses to rationalise less than perfect care which clearly eased discomfort. At times, racially discriminatory views and attitudes were openly portrayed as exemplified by the content and the language of the following student interview extract. However, more concerning was the acceptance that these attitudes and practices were satisfactory and therefore went unchanged.

"You always have suspicions about them and be sort of slower to give the same level of care as you would to normal people like or … …. do you know you wouldn't give them the same level of care as you would for your own….Irish people like…Its just our perception of them…like that… they are not one of our own."

(Student Nurse Interview 2)

However, in other incidences such views were less overt, instead they 'othered' or problematised patients from different cultures. 'Othering' explains how nurses focus on differences between cultural and ethnic groups, as opposed to identifying the similarities of care needs. This helped reduce the personal discomfort associated with culturally insensitive care.

"I don't know really why but I guess they are different. They have different backgrounds and different views than us. They expect and believe certain things that are often very different to our views. They are just different really."

(Qualified Nurse Interview 9)

Either consciously or unconsciously, informants differentiated individuals from diverse cultural and ethnic backgrounds, using language such as "they" and "them" as different from "us" as highlighted in the above interview extract. However, some students were

aware that there were fewer differences than nurses assumed but felt helpless to do anything about it.

> *"When dealing with we will say…. Irish white people and you know getting on with the normality. And then when you see this maybe black person…you know….come in, and they kind of…they (nurses) see it as strange I think, you know….still….which…you know is kind of….not right. They see them as different and therefore act differently with them…but what can you do…you are only a student."*
>
> *(Student Interview 1)*

Labelling and subsequent 'othering' often occurred before patient encounters. Many examples where patients were labelled at handover or during discussions at the nurses' station were described.

> *"Before they told us her symptoms you know, like she was a traveller. It was the first thing we were told; not her name or anything other than she is a traveller."*
>
> *(Student Focus Group 3)*

Listening to what others say had an influence on the images and perceptions they developed about patients before coming into contact with them and therefore influenced their interactions.

"At report in the mornings, like you pick up negative vibes off other nurses…you know they are trouble or are hard going and that can influence you."

<div align="right">

(Student Interview 4)

</div>

3. Organisational Culture of Indifference:

An organisational culture of indifference was also described, which eased the personal discomfort associated with culturally insensitivity. The collective nature of how culturally insensitivity went unchallenged highlights the general inability to question practices and arguably the inertia to take action. However, devolving personal responsibility for influencing changes to practice was a recurrent finding. The following extract summarises the views of many informants, where culturally sensitive care was not seen as important and therefore frequently omitted.

"But maybe I am the type of person that unless I have to do something I won't do it. But it might be useful …and maybe…maybe that's….that's a point. That single-handedly how am I going to do anything? That if I feel that it's not a priority then single-handedly why would I be breaking my neck trying to change the world when it's not seen to be an issue for…I suppose for others."

<div align="right">

(Qualified Nurse Interview 1)

</div>

The collective nature of indifference resulted in the failure to challenge culturally insensitive practices. Some informants described a weariness associated with constantly trying to do the right thing in times where resources were minimal and an increase in the demands on nurses. However, as a consequence of working with colleagues where there were no repercussions for any level of substandard care, taking shortcuts was easier. Seeing others get away with providing less than perfect care had a domino effect and influenced the lack of motivation and commitment to do the right thing. Although this

study specifically explored attitudes and practices when caring for patients with different cultures, the findings may have wider implications as questions are raised regarding morale, accountability and organisational commitment to provide quality care.

> *"it's just sometimes well its hard….cos you… get tired of trying so hard …when your other colleagues might not be doing so and nobody says anything to them….so what's the point…"*
>
> *(Qualified Nurse Interview 9)*

The influence of the organisation can also impact positively on individual practices and behaviours, if the environment is one that promotes quality standards of care in culturally appropriate ways. The following interview extract from an Irish nurse working in Canada for a period highlights the positive effect of seeing a colleague provide culturally competent care, suggesting that such practices can then become normalised and repeated.

> *"And then your other nursing colleagues, the Canadian nurses you are working with, it [culturally sensitive care] was all really normal to them. So then you…it becomes really normal to you."*
>
> *(Qualified Nurse Interview 6)*

Although acknowledging the value of such positive influences, there were however minimal examples of positive role modelling described. Such perceptions may be associated with the general overburdening felt as a result of working in an increasingly complex healthcare setting but may also have eased the discomfort with acknowledging the impact of certain attitudes and practices. It was easier to blame individual behaviour on others or constraints that were felt to be beyond the control of individual nurses. Nonetheless, despite acknowledging the importance of evidence-based practice, learned values and skills to deliver dignified care, culturally insensitivity was often described. It was easier to mirror practices that were seen to be acceptable than to challenge them. Therefore, despite knowing what should be done, it appeared that it was easier to do what

everybody else was doing and not just by student nurses. Through blaming others, nurses in this study general failed to take any responsibility for their role in less than perfect care described and as such practices went unquestioned and cultural insensitivity perpetuated.

"And will just end up doing the same thing everyone else does….and forget all the evidence based practice…and….that they are supposed to be doing that."

(Qualified Nurse Focus Group 9)

In particular, the student nurses' fear of failing clinical assessments as a consequence of upsetting preceptors took precedence over doing the right thing by their patients.

"Students will definitely not question or challenge poor practices as that would mean their competencies would be at risk if you know what I mean."

(Student Interview 1)

Student informants articulated a good understanding of their roles, responsibilities and expectations. However, the practice they described did not demonstrate how they fulfilled such responsibilities. Instead a dissonance was described where they knew what they should be doing, but failed to do so in order to get through their placement with as little conflict as possible. For many, surviving the placement required a change in mentality, to the detriment of providing quality dignified care. Some described becoming hardened or having to accept that nothing can be done to improve standards of practice. Thus the collective nature of indifference impacted on nurses who were aware of what they should be doing. As a coping mechanism they do not see the person they are caring for as an individual with feelings and individual needs, but instead often as an object or task needing to be done.

"And I guess you just have to…to toughen up and go in and do it …like and…although you mightn't have the time to spend with them at least if you do the tasks that are required such as the obs. and make the bed, then you are still doing your job."

<div align="right">*(Student Interview 13)*</div>

Stereotypical attitudes, prejudices and biases were frequently witnessed. However, despite being aware that these were inappropriate, the majority of informants described going along with them as a means of fitting in and being accepted by peers. It was easier to conform to such attitudes and practices than to challenge and report them. However, ethnocentric attitudes and practices went unchallenged and unchanged and as a consequence nurses were more likely to become resigned to indifference.

"Because I think it's important that we do want to fit in.   And…and sometimes that means getting involved with this group who are up there talking racist…."

<div align="right">*(Qualified Nurse Interview 3)*</div>

At times such views and attitudes were openly displayed and discussed. However, they were described as being witnessed and blamed on colleagues and other people, rather than taking personal responsibility for their own involvement. In doing so they failed to acknowledge the duty of care on all professionals to challenge and report such practices.

"I have encountered it I think…some nurses would wear their…nearly wear their prejudices on their sleeve and would be very up front about…their real views…how they really dislike them…they probably don't even try to disguise it anymore."

<div align="right">*(Qualified Nurse Interview 7)*</div>

The following nurse describes how overt racist comments were sometimes encountered, but went unchallenged. Clearly, the complexity of racism and fears and discomfort

associated with it is challenging in any context. However this unease and sense of helplessness increases when limited opportunities are afforded to explore appropriate ways of acknowledging and dealing with racist attitudes. Clearly nurses in this study were often well intended but felt unable and uncomfortable to deal with witnessing racism. The recent negative publicity on racism in Ireland perhaps contributed to the increased fears as on one hand it made them more aware but did not equip them with the tools to deal with it. Nonetheless as a consequence, such attitudes are perpetuated and practices sustained.

> *"I never challenged one of them....I never stopped them in their tracks and said, hang on a second, what are you talking about...that's quite a racist comment you have given....you know, I wouldn't dare. And I...and I wondered, was it because I didn't want to be labelled as the person who...was being awkward or for siding always with them...."*
>
> *(Qualified Nurse Interview 6)*

Although this highlights a general lack of will to challenge uncomfortable matters, it also highlights the extent to which nurses go to be accepted as part of the team. Nurses described their fears of being labelled as the "awkward" colleague, who is in the minority if they challenged attitudes and behaviours of others. Therefore, fitting in sometimes required conforming to some practices that they know to inappropriate. Although beyond the scope of this study, these sometimes disturbing findings warrant the need for further exploration into the extent of such conformity. Questions are raised as to how widespread this is or is it just specific to some nurses when caring for patients from different cultures.

"We want to fit in...we want to kind of...don't want to be labelled as the kind of awkward nurse...or the one who is always challenging or questioning."

(Qualified Nurse Interview 7)

Many informants described knowing what to do, whilst turning a blind eye to the attitudes and practices happening around them. Although acknowledging the discomfort associated with challenging poor practice in any context, there appeared to be little consideration of individual and organisational moral, professional and legal responsibilities to take appropriate action in such circumstances.

"We know the right thing to do. But when we go into practice we don't do it. Or we see somebody not doing it...and we....just don't feel able to challenge it. Yes we want to fit in which is maybe why we don't challenge but the rest I am not sure about it's like we close our eyes. ...."

(Qualified Focus Group 2)

Informants described how people just wanted a peaceful life when they went to work.

"So...you don't want to be rubbing anybody up the wrong way."

(Student Focus Group 8)

As a consequence, they took measures to avoid conflicting encounters and situations with colleagues and peers.

"You are trying not to…em…you are trying not to cause any conflict really…you know, with your fellow workers. You don't want to rock the boat".

<div align="right">*(Qualified Nurse Interview 1)*</div>

Therefore, questioning and challenging others did not occur. Instead accepting sometimes less than perfect care was often seen as the easier option.

"In general, nurses just don't like to be questioned so it is I guess a hidden rule that they are not questioned… I guess nobody challenges anybody really…..not really, no. we just become accepting of it."

<div align="right">*(Student Interview 11)*</div>

Instead of having the courage to speak out or do what they knew to be right, complying and agreeing with the majority took precedence. This demonstrates the impact the collective nature of an organisation can have on individual practices.

"Nurses have a lot of peer pressure and…the talk at the back of the nursing stations do you know …although you mightn't agree with certain issues that arise, you still have to nod your head and …do you know, kind of agree to the majority of what they are saying."

<div align="right">*(Qualified Nurse Interview 2)*</div>

However, there was a hidden admiration for those who did speak up and challenge others, but there was also a clear awareness of the possible repercussions for those who do speak up.

"If you do speak up for yourself you know what I mean you are…you are…you are going to be that person….who…fair play to you for …for standing up for yourself, but now look what you have dug for yourself….you have dug yourself a hole. You live then with that label and the consequences of it and…but it's not your fault."

<div align="right">

(Qualified Nurse Interview 1)

</div>

4. Resigned Indifference:

The term 'Resigned indifference' is used to describe how nurses were sometimes aware of the implications of the attitudes and practices described, but they became resigned to it and had a series of reasons to excuse themselves. This involved creating a justification for individuals' actions and omissions, as a means of easing the discomfort associated with the care described. In this way, attitudes, behaviours and practices were maintained and culturally insensitive practices sustained. During focus group discussions and recounts of incidents from practice, informants reflected on the impact of their actions and non-actions. For many, this was the first opportunity to really think about their practices and the impact of the decisions they made, which unveiled many emotions and reactions. For some, the regret associated with doing nothing and allowing practices to go unchallenged, was expressed. Despite awareness of the inappropriateness of some attitudes and practices, nurses felt ill-prepared to deal with it.

"I didn't challenge her and I felt awful and dreadful because of that."

<div align="right">

(Student Focus Group 2)

</div>

A sense of sadness was also described.

"It saddens me now and I regret it and feel terrible for not doing anything about it. Maybe because the woman wasn't Irish...you know. And I ...its terrible thing to say like....but ...I think it is true. It saddens me now and I regret it and feel terrible for not doing anything about it....."

(Student Interview 1)

For others, feelings of embarrassment and frustrations were expressed, as a result of feeling unable to provide the care required.

"You just don't have the knowledge.....it is something that just doesn't get covered....and your real fear is you do something wrong....become an embarrassment to the profession....and you have to go home and try and sleep at night knowing you didn't do your best. It's frustrating...."

(Student Interview 20)

However, notwithstanding the feelings of guilt and sadness associated with providing culturally insensitive care, an inability and sometimes unwillingness to do anything about it was consistently expressed. Consequently, there was a general failure to learn from such experiences and change practices.

"We are afraid to admit that what we might have been doing ... wrong...and that is hard...a hard thing to admit...and although you can't help feeling guilty, I don't know if there is anything different that we would do."

(Qualified Nurse Interview 8)

The informants used the third person to describe the culturally insensitive practices rather than having any ownership through terms such as "I" and "me". This suggests that minimal personal responsibility for the sometimes compromised care described was taken.

131

"If...sure I am sure if there was a nurse/midwife on the ward and she was ...if she had a habit of stereotyping and ...if for instance she had....knew someone who was out of a job she could easily blame say the foreign nationals...and this indirectly will influence how she sees them and how she cares for them...if you know what I mean."

(Student Focus Group 1)

During the course of discussions, informants began to recognise that the practices and attitudes described were not always congruent with their moral, professional and legal responsibilities. As a consequence, informants began sharing a number of explanations and justifications as to why this occurred. This often involved blaming others, professional education and/or organisational constraints that they felt were out of their control. However, the ease at which informants blamed others and absolved themselves from personal involvement or responsibility for culturally insensitive care was more concerning. They were comfortable to identify that they felt ill prepared to work in today's complex healthcare setting, as this was out of their control. But there was also a failure to acknowledge personal responsibility for their limitations and doing something about it.

"It's not our fault.... It just wasn't covered in our training as to be honest it wasn't really an issue."

(Qualified Nurse Interview 10)

Blaming professional training for failing to adequately prepare nurses with the questioning and assertiveness skills consistently emerged within the data.

> *"Maybe we are not taught enough to stand up for ourselves. Maybe in college...in our training."*
>
> <div align="right">*(Nurse Interview 1)*</div>

There was also a tendency to blame the organisation, for their inability to always provide high quality care but there was limited sense of personal responsibility for the less than perfect care sometimes described.

> *"So it's not that nurses aren't wanting ...trying to do the best care. But through no fault sometimes of their own...and sometimes the fault is the system....or the organisation in which they work....that's sometimes what happens."*
>
> <div align="right">*(Qualified Nurse Interview 9)*</div>

Notwithstanding the pressures of working in an increasingly demanding healthcare setting that is under resourced and increasingly busy, it appeared too easy to blame the organisation for the failure to provide adequate resources.

> *"I suppose we still don't really have a workable system in place to deal with people from different cultures, like even what we were doing there about translators. We still ....I don't think we have a good enough system at the moment ....where I work anyway.....which is kind of frustrating."*
>
> <div align="right">*(Qualified Focus Group 2)*</div>

Informants consistently referred to the pressures that they feel nurses are under in an environment where they feel under resourced, understaffed and overworked. The following interview extract summarises how the majority of informants acknowledge that they could have done more despite the constraints described, but instead chose to justify not doing so.

"The problem is that we are just so busy and under pressure to get everything done…but I just felt that that extra little bit of time to explain you know could have been taken and I know it wasn't their fault. I mean there is so much to do…its crazy in there."

<div align="right">

(Student Interview 19)

</div>

The time needed to communicate with patients who are not proficient in English was perceived as an extra encumbrance. There was a perception that the care needs of patients from different nationalities are more complex and time consuming.

"We perceive a non-English speaking patient as an extra burden, which means spending more time with them….time we don't have."

<div align="right">

(Student Focus Group 3)

</div>

Many informants feared how colleagues perceive them if they were seen spending their time building a rapport with patients, when they felt overwhelmed with the volume of work to get through. Spending time chatting to patients was not seen as a priority when they felt pressurised to get certain tasks done. In this way, there was a general failure to appreciate the value of planning person centred care and the learning that can occur during cross cultural engagement

"You get a name for being too particular or always spending too much time with them when there are other things to be doing."

<div align="right">

(Qualified Focus Group 1)

</div>

Spending time with patients from different cultures and developing therapeutic relationships was perceived as particularly unimportant and irrelevant, in an increasingly busy practice setting where observable measures of quality care appears to take priority. Despite having awareness of the importance of being with and talking to patients, it was sometimes not done.

"And as well if you're seeing…sitting down kind of talking to the patient, you'll feel that they'll think you're lazy, that you're not working, you're just sitting there talking…."

(Student Focus Group 2)

As a result, many examples of care that could have been better were described. The business of the ward and lacking time were presented as justifications for their failings.

"I think it would have just taken too much time (to explain burial procedures to a mum) that's all and we sometimes just do not have the time to spare to do so….even though we want to."

(Student Interview 1)

Instead of exploring ways to improve practices and the care provided, informants became resigned to and accepting of the standard care given to patients from differed cultures.

"We treat all our patients the same regardless…. And it's….I think we are doing an OK job."

(Qualified Nurse Interview 6)

Failure to take action to improve care appeared to mirror wider social xenophobia. For example blaming immigration for the economic downturn in Ireland consistently emerged during interviews.

"I think at the moment in Ireland that…it's just…it's the problem with so many foreign nationals coming into the country and trying to get jobs. And Irish people feeling, oh they are taking away our jobs and… It can escalate any tensions."

(Student Interview 6)

This reflects the narrow attitudes of wider society regarding immigration and the changing demographic profile of the population of Ireland. Informants shared many

examples of negative views of immigration portrayed through the media, which had a destructive effect on them as healthcare professionals caring for a culturally diverse patient population base. The following quotation summarises the impact of such influences:

"And there is a lot of coverage on blaming ...how did the country let in so many people to work and now there are no jobs you know. It is a big issue at the moment. It affects you even if you don't want it to or aren't aware of it....And everyone knows a couple of people who are out of work. So....they could definitely.... ...almost like blame the...the patient like you know, as one of them like."

(Student Focus Group 1)

This labelling made it easier to decide to do nothing about the sometimes deficient care described. It was a way of further easing the personal discomfort associated with delivering care that was not always holistic, person centred or evidenced based.

"Yes, it's almost like that's our justification. its ok if.... if I have limited time with the patient, because I have labeled them into this foreigner em...it's a way of protecting ourselves....yes. It's almost like that's our justification."

(Qualified Nurse Interview 4)

5. Positioning and Contextualising Findings with Existing Theories and Evidence:

Many obstacles to the development of transcultural caring relationships are reported in the international literature (Jirwe *et al* 2009; Ayaz *et al* 2010; Arieli *et al* 2012; Adamshick and August-Brady 2012). However, there is limited research to date from an Irish perspective within the current literature. This highlights the need to comprehensively explore the circumstances which lead to the culturally insensitive care,

as reported by Tuohy *et al* (2008), Lyons (2008), Tobin and Murphy-Lawless (2013) and more recently Boyle (2014). The findings of this study echo previous Irish studies highlight the deficiencies in care for people who are not Irish, but extend them by explaining the factors that influence nurses resigned indifference. It was also useful to explore the wider literature to help position and contextualize these findings. In particular the body of literature exploring normalisation process theory (May and Finch 2009) was particular useful in unpicking the issues that may have been influenced by wider professional and social values in an Irish context. This body of literature although written from a broader aspect helps explain some of the reasons why practices become embedded, sustained and accepted as the norm that form institutionalised practices. The 'Irishness' of the organisation goes unnoticed and is rationalised into the day-to-day perceptions of normality. There is a need for a greater focus on leadership (McGee 2009), not only to question the whiteness (Husband 2000; Purwar 2001) and ethnocentric values embedded in institutions (Polaschek 1998; Allan *et al* 2004) but to embed the rights of minority groups to standards of care. Although such literature is useful in understanding the resigned indifference described, they do not go far enough to explain why nurses know what they should be doing, but choose not to take action.

Despite articulating awareness of the moral, professional and legal responsibilities on nurses to provide quality care, sometimes less than perfect care was described. While acknowledging the individual contexts and the constraints experienced, I needed to understand why and how informants justified the indifference demonstrated. The findings also raise questions as to why nurses feel it acceptable to provide less than perfect care to patients from different cultures. This led me to delve into a new body of research literature that included but transcended the literature on transcultural care. Reviewing such literature raised other questions such as why nurses both individually and collectively continue to provide culturally insensitive care, albeit sometimes as a result of thoughtless, ignorance or routines that are somewhat rigid and ethnocentric. The uniqueness in this study lies in the explanation of how and why nurses deal with lack of

cultural knowledge. Participant data also raises questions as to why the culture of the organisation allows the resigned indifference to go unnoticed. Seeking answers to such issues led to exploring the broader literature on moral decision-making and institutional racism, as a means of offering some further explanations for attitudes, practices and behaviours described in this study.

Reviewing wider theories and broad literature on moral decision-making helped explain some factors that contribute to the resigned indifference reported. Most of the literature on moral decision-making highlights the complexity of moral distress experienced by nurses, which impacts on decisions taken and care provided. Although informants in this study did not always demonstrate distress when caring for people from different cultures due to mostly ignorance and thoughtlessness, awareness of knowingly providing or choosing to ignore sometimes deficient care was evident. This is in keeping with how some define moral distress as occurring when the ethically correct action is known but not taken due problems that arise and confront nurses (Gallagher 2010; Musto and Schreiber 2012). Although there is some conceptual fuzziness regarding the definition of moral distress (McCarthy and Gastmans 2015), this has sparked calls for the need to understand the moral dilemmas nurses face in their day-to-day practice. Some argue that organisational constraints such as lack of resources result in nurses feeling unable to do what they know to be right (Jameton 1984; Deady and McCarthy 2010). However, notwithstanding the reality of organisational constraints, participant data sometimes demonstrated that these limitations were on occasions over-used as excuses for not fulfilling moral, professional and legal obligations. Others such as Gallagher (2010), acknowledge external and organisational constraints, but identify internal factors such as the lack of courage to do the right thing. The findings of this study support what is known about moral distress in the literature, as it highlights that both individual and organisational factors contribute to nurses failing to do the right thing. As a means of easing personal discomfort associated with sometimes knowingly failing to follow the

ethically correct action, nurses went to great lengths to rationalise their own and others actions or omissions.

It was useful to draw on Testers' (2002) theory of indifference, which explains how commitments to principles of human rights can co-exist with a lack of care or inaction to the suffering of others. He conceptualises indifference as a condition of seeing the patient as different and classifying them as he refers to it as "it-ness", which is similar to the "othering" referred to by informants in this study. Othering is a concept that also emerged in other literature (Johnson *et al* 2004). However, this theory refers solely to the individual, failing to acknowledge the impact or role the organisation has on contributing to (resigned) indifference. This raised questions which signposted me to re-look at current literature on racism and in particular institutional racism to try to explain the attitudes, practices and behaviors described in this study.

It was useful to draw on sociological perspectives and psychology literature where arguably there has been a stronger emphasis on conceptualising and understanding the complexities of racism. The findings of this study highlight the subtlety with which sometimes insensitive and sometimes even discriminatory practices were demonstrated despite being rarely intended or explicit. Participant data also illuminate the discomfort associated with naming practices as racist. As a result, this creates a false illusion that racism is not an issue for nurses in Ireland, further highlighting the psycho-emotional aspects associated with discussing racism. Such findings correlate with other conceptualizations of racism (Essed 1991; Cortis and Law 2005). This is not surprising as there is denial within Irish healthcare settings to accept the term racism to describe discriminatory practices and acknowledge that culturally insensitive practices can be racist (Ryan *et al* 2008; Fanning 2012). Although not unique to Irish healthcare (FRA 2012), denial stems from Irish social and political debates, which are reluctant to use the term racism to describe the prejudices and intolerance experienced by ethnic minorities in Ireland. Instead the term xenophobia, described as "fear of the stranger" is used to

explain prejudice and intolerance in Ireland. Fanning (2012) argues for a broader definition of racism in Ireland to include xenophobia. New racism according to Johnstone and Kanitsaki (2009) is subtle discrimination that occurs in everyday talk and is not recognized as racism. However, the findings demonstrate that the reluctance to acknowledge and discuss racism increased the uncertainty experienced.

Drawing on Jones's (2000) definition of racism it was useful to consider how it can manifest at personal and institutional levels, which is classified as the norms that sustain racial division and inequality. Many of the examples of culturally insensitive and at times even discriminatory were often unintended and often borne out of thoughtlessness, ignorance, and unwittingly Hibernocentric values embedded in organisation cultures. These are characteristics of institutional racism as defined by the Macpherson inquiry (Macpherson 1999, s. 6.34). Although the concept of institutional racism is criticized by some (Holdaway and O' Neill 2006), for the purposes of this study it captures the complexity associated with personal attitudes and behaviours, which are facilitated and amplified by the culture of the organisation.

6. Summary:

This chapter describes the resigned indifference demonstrated, highlighting how culturally insensitive practices are sustained and perpetuated in Irish healthcare settings. Although the findings do not imply that informants were weak willed and unable to think for themselves, the culture of the organisation is one that does not encourage or support assertiveness or the challenging of colleagues. Existing theories and literature on moral decision making, indifference and institutional racism offers some explanations as to why resigned indifference occurs. They help to bridge the gap in our understanding of nurses' attitudes, behaviors and practices, as well as what influences them. However, they do not go far enough to explain why nurses choose to provide less than perfect care, do enough 'just to get by' or 'turn a blind eye' to cultural insensitivity. The findings of this study

help us understand the influencing factors and barriers to cultural competence in Irish healthcare settings and although not generalizable may have wider implications.

CHAPTER 8

DISCUSSION

1. Introduction:

This chapter discusses the findings of this grounded theory study as they relate to the wider literature, whilst contextualising them within deeper cultural issues in Irish society. This study describes the ways in which nurses in Ireland deal with their lack of knowledge on a daily basis when caring for culturally diverse patients. It helps explain how the culture of the organisation and professional socialisation contributes to nurses' attitudes, practices and behaviours when responding to cultural difference. Although these findings offer explanations specific to an Irish context, they may also contribute to more global discussions on cultural competence and nursing care in general. To help in framing discussions within the literature, focus is placed on where the findings of this study are viewed to have a strong contribution to the existing debates on nurse education and healthcare management and leadership.

2. Contribution to Knowledge:

Informants in this study unanimously agreed that lack of cultural knowledge and feeling ill prepared to care for cultural difference was their main concern. A range of disengagement strategies was used as a means of dealing with their lack of knowledge and subsequent uncertainty. This is the first study that explores how and why Irish student and qualified nurses deal with their lack of knowledge about people from other cultures. To date, only a small number of Irish studies exploring the experiences of nurses of caring for patients from different cultures have been published (Tuohy *et al* 2008; Lyons *et al* 2008; Ryan *et al* 2008). These studies highlight some of the challenges experienced when caring for patents from diverse cultures. However they do not comprehensively explore how nurses deal with such challenges on a daily basis and what influences their decision making. Although these studies contribute some understanding

of the position of transcultural care in Ireland, they were mostly small qualitative descriptive investigations exploring only the experiences of qualified nurses. Using a grounded theory approach was useful in exploring how both student and qualified nurses' deal with their concerns and challenges, whilst allowing the data emerge from informants rather than exploring specific gaps in evidence. The findings help explain nurses' attitudes and behaviours, as well as what influences them when dealing with cultural difference on a daily basis.

The findings of this study mirror Papadopoulos *et al* (1996) almost two decades ago in highlighting how the organizations in which nurses learn and work, shape individual experiences and impact on care delivery. The data demonstrates that hierarchical structures, organisational cultures and ward routines facilitated a raft of disengagement strategies. Consequently, culturally insensitive care was frequently described, but the organisational culture and structures facilitated an acceptance of low standards of care through daily routines that become taken for granted and rarely questioned. This data shows how and why nurses accept ways of working that are ritualistic, task orientated, unreflective and where the 'Irishness' was implicit. Similar to Husband (2000), these findings re-iterate the need to question such Eurocentric norms and values, which are often embedded in organisational culture, practice and care provision. The collective nature of the disengagement strategies adopted, that went unchallenged and sometimes even unnoticed, explain nurses' attitudes and practices in a way that has not previously been explored.

This study adds new perspectives to the existing body of knowledge on cultural competence as it highlights how nurses become accepting and resigned to indifferent care. The data highlights how the norms of many clinical settings, organisational cultures and Irish social and political ideas collude with ignorance and allow nurses to ignore and arguably become indifferent to the needs of people who are not Irish. While there are real problems regarding staffing, constrained resources and the variety of cultural groups

newly arrived in Ireland, the findings add to our understanding of how culturally insensitivity is sustained. Several studies identify that care provided to patients from different cultures is not meeting their needs (Ryan *et al* 2008; Brondolo *et al* 2009) and culturally insensitive care continues to be reported on in Ireland (Boyle 2014) and globally (Murphy 2006; Williamson and Harrison 2010; Hart and Mareno 2014). This study is original in explaining how nurses become resigned and indifferent to the needs of their patients and sustain the disengagement used to deal with their lack of knowledge. The findings call for what Campinha-Bacote (2003), refers to as 'cultural desire' both at individual and organisational levels, as pivotal to cultural competence and surmounting the challenges experienced in daily practice. It was easier to comply and fit in with practices that were deemed acceptable than to find answers when unsure or challenge attitudes and practices that jeopardised patient care. Culturally insensitive care is perpetuated through indifference and facilitated by the culture of the organization, in which nurses learn and work. Although this study was carried out in one region of Ireland and is therefore not generalizable, the issues emerging are applicable to other parts of Ireland and more widely.

3. Lack of Transcultural Knowledge

The lack of knowledge described in this study and the dissatisfaction associated with feeling ill equipped to care for patients from different cultures resonates with existing evidence from the UK (Narayanasamy 2002; Vydelingum 2006; Kai *et al* 2007) and more globally (Braithwaite *et al* 2006; Momeni *et al* 2008; Jirwe *et al* 2009; Starr and Wallace 2009; Taylor *et al* 2013; Hart and Mareno 2014). The findings also echo work carried out in Ireland to date (Lyons *et al* 2008; Tuohy *et al* 2008; Ryan *et al* 2008; Boyle 2014), but extend them in explaining how both student and qualified nurses respond to their lack of knowledge, and how professional attitudes and organisational cultures impact on nursing practice. Clearly, if those providing the care lack the necessary knowledge and feel ill-equipped, engaging with patients from different cultures can be uncomfortable. Some writers suggest that cultural specific knowledge has limited utility

in today's nursing practice (Gustafson 2005; McAllister *et al* 2006; Vandenberg 2010; McAllister 2015). This study adds to such debates, highlighting the need to recognise that although there may be differences within and between cultures, people who are ill or distressed have common needs.

Ireland has witnessed many economic, political and cultural changes over the last fifteen years. As a result, a rapid and unexpected increase in cultural and ethnic diversity occurred (CSO 2002; CSO 2016), which arguably Ireland was unprepared for (Fanning 2007; King-O'Riain 2009). Unlike other countries where cultural diversity occurred at a slower pace, Ireland has moved from a relatively monocultural to a more diverse multicultural society within a short time frame. Therefore, it is not surprising that informants in this study viewed differences in nationality, language, religious beliefs or cultural norms challenging and reported feeling unsure of how to act due to limited exposure to cultural difference. Ireland is now far more diverse in terms of culture, race and ethnicity (CSO 2016). Consequently, Health services and the training of health and social care professionals were geared towards a relatively homogenous nation within the norms of the dominant culture (Polaschek 1998). Although different in terms of experience and levels of responsibility, the findings demonstrate similarities between both student and registered nurses' lack of knowledge and subsequent uncertainty when caring for patients from different cultures. The lack of exposure to cultural difference, limited opportunities for cross cultural encounters and inadequate transcultural education and continuous professional development, offers some explanations for the challenges of caring for people they knew little about. Nurse education and healthcare organisations must now, more than ever, challenge the Irishness implicit in practice and reflect the widening diversity and multicultural makeup of the Irish population.

4. How Nurses Deal with their Lack of transcultural Knowledge:

The uniqueness of this study lies in explaining how nurses in Ireland deal with their lack of knowledge during patient encounters. Informants described how they used a raft of

disengagement strategies to deal with their lack of knowledge and protect themselves from the uneasiness of not knowing. Disengagement allowed nurses to disguise their limitations and reduce the fears associated with doing or saying the wrong thing. However, as a consequence there were limited opportunities for learning from patients and transcultural situations, thus never dealing with and even perpetuating problems. The actions of nurses in this study echo the disengagement described in the wider nursing literature when nurses experience uncomfortable situations (Arieli *et al* 2012; Fida *et al* 2015). Because of their disengagement, there was a particular failure to appreciate that cultural knowledge can be enhanced through encounters and engagement with patients from various cultural backgrounds. These findings echo Papadopoulos *et al* (2015) call for culturally competent compassionate practice and highlight the dearth of existing literature on this area within nursing.

Data demonstrates that cultural knowledge was predominantly viewed in terms of particular beliefs and practices relating to specific ethnic groups. In the absence of feeling able to recite culture specific information about various ethnic groupings, informants were uncertain of how they should act. While there were clear deficits, nurses appeared unable to draw upon their wider caring knowledge or skills, because they invariably saw cultural aspects of care as separate. There was little emphasis on understanding their own values or their impact on the nurse/patient relationship with people from different cultures. Arguably the lack of knowledge demonstrated, might be expected of student nurses because of limited clinical experience or opportunities to apply learning in the clinical environment. However, lack of knowledge was consistently reported by the qualified nurse informants who felt there were greater demands on them to demonstrate competence, leaving them uncomfortable and embarrassed to acknowledge their limitations. They too have had limited exposure to cultural difference, minimal continuous professional development and until recently few cross-cultural opportunities in clinical practice. Student informants' fears of exposing knowledge limitations were associated more with fear of failing their clinical practice assessment rather than

providing substandard care. Despite the calls from informants for a greater focus on cultural specific knowledge during their classroom education, the findings suggest that this type of information will fall on fallow ground if prejudices, ethnocentrism and indifference are not adequately addressed. The data clearly demonstrate the need to emphasise and respect for cultural and individual preferences rather than trying to know everything about diverse cultural groups. Although nurses made few attempts to learn facts about various cultural or religious groups, they particularly failed to utilise the opportunities to explore cultural preferences and meaning with the people they were caring for.

Both student and qualified nurses described how they disguised their knowledge deficits and distanced themselves from the patient in order to ease their discomfort. Students generally kept a low profile as a means of fitting in with the culture of the clinical setting, where there was little encouragement to ask questions. Informants described doing just what was needed to get through the day with as little conflict as possible and this is consistent with strategies addressed within the wider literature, such as masking (Smith and Lorentzon 2005; Montgomery 2006; Mackintosh 2007), distancing (McGrath and Boore 2003; Pavlish *et al* 2015) and fitting in (Levett-Jones and Lathlean 2009; Anderson and Edberg 2010). This study brings together these different concepts to explain how nurses dealt with their lack of cultural knowledge and the uncertainties this caused. More worryingly the data demonstrated how nurses became indifferent to people they knew little about and appeared resigned that this was acceptable, thus perpetuating cultural insensitivity.

This study highlights the role the healthcare organisation has in shaping individual nurses' experiences and approaches to care. Irish health services have endured many changes in recent years and continue to undergo wide ranging reforms in response to the evolving healthcare needs and shifting demands on the service. Despite the calls for safe, high quality, compassionate care and value for money in recent healthcare policy,

informants in this study report that the healthcare system remains under resourced. The recent slow-down of the Irish economy has impacted on the finances allocated to healthcare and clearly the embargo on nursing staff recruitment significantly contributed to reduced staffing and increased workload pressures. There is evidence in the wider literature highlighting how work environments including staffing levels influence staff morale and ultimately patient outcomes (Schubert *et al* 2009; Rochefort and Clarke 2010; Aiken *et al* 2014), and this is echoed in the findings of this study. Although this study was carried out in one region in Ireland, there is evidence to suggest that nurse staffing levels is an issue for healthcare services in other regions of Ireland (INMO 2012). In a study commissioned by the Irish Nurse and Midwifes' Organisation (INMO 2012), nurse staffing levels were found to be significantly lower in Ireland when compared with England, resulting in compromised patient care, higher mortality rates and increased adverse events for patients. Understanding the extent of such organisational constraints helps us understand some of the external factors that influence nurses' attitudes, behaviours and practices in Ireland. Clearly in the current climate with cutbacks and staff shortages, informants reported feeling undervalued, unsupported, over-stretched and overwhelmed with the increasing expectations on them. Informants consistently described their frustrations associated with lack of resources and time constraints and feeling unable to carry out their caring role to the best of their ability.

5. **Organisational Culture Facilitating Disengagement and Indifference:**

Although increasing workload pressures and deficiencies in nurse education clearly contributed towards the culturally insensitive attitudes and practices described, this alone is insufficient to explain the reluctance for some nurses to engage with patients from different cultures. The data provides a rich description of gaps in care that student and qualified nurses commonly encountered during the course of their everyday practice. Informants described their unease and discomfort when caring for patients from different cultures because of their limited exposure to cultural difference and as such feeling ill

prepared. Therefore, it is not surprising that nurses reported feeling unsure how to act during cross cultural encounters but they felt embarrassed to acknowledge their limited knowledge or to seek clarity.

The culture of care described in clinical practice was based on routine practices and norms. This eased their discomfort about being unsure, but allowed and even facilitated the disengagement strategies they adopted. Having a routine and structure to follow helped nurses plan and organise their working day. However the challenges occurred when these routines were ritualistic and ethnocentric, through thoughtlessness and ignorance, but were perpetuated by clinical settings that allowed them to go unchallenged. The routine practices described by nurses were rigid and ritualistic rather than tailored to the needs of the patient. These findings echo fifty years old literature which demonstrated how organisations developed systems and mechanisms, to protect professionals against anxiety (Menzies 1960), but without meeting the needs of patients. Ethnocentric attitudes and routines were engrained in everyday practice with little attention to the needs of many patients, but which disproportionately disadvantaged people who were not Irish.

This study captured the process whereby nurses' ethnocentric attitudes and practices are acceptable and their obligations to provide quality, person centred care are sometimes ignored. This clearly reflects the complexities of translating healthcare reform policy to an increasingly busy and under resourced clinical setting where nurses feel ill-prepared and overwhelmed. Over time, routine practices that are ethnocentric become so acceptable they are deemed normalised and go unquestioned, even if they go against the wishes of the patient. The findings echo Campinha-Bacote (2011) and McGee and Johnson (2014) in demonstrating that keeping to accepted routines took priority over thinking critically about practices that were not person centred. Although not generalisable, these findings may have wider implications for nursing practice in general as evidenced by increasing calls for compassionate care in nursing (Dewar *et al* 2013;

Papadopoulos *et al* 2016). The nurses appeared to have little encouragement to develop courage, commitment and confidence to learn, to ask questions, discuss tensions and challenge threats to patient safety. These findings suggest an absence of the leadership which McGee' (2009) calls for to model quality and enforce high standards of nursing care in which are culturally appropriate.

The data also reveals how culturally insensitive attitudes and practices were witnessed but went unchallenged. When culturally insensitive attitudes or sometimes even discriminatory were observed, both student and qualified nurses failed to challenge them. Instead, nurses in this study appeared to turn a blind eye or were sometimes even oblivious to them, further contributing to a collective acceptance of insensitive care. These findings mirror Husbands' (2010) description of 'moral professional complacency' and Horsburgh and Ross (2013) account of 'institutionalised negativity'. The failure to challenge and being content to comply with indifferent attitudes and practices was fuelled by a desire to fit in and conform to what was accepted within clinical settings. However nurses in this study were not just passively tolerating insensitive practices, but in doing so were active in perpetuating cultural incompetence. Echoing Murray (2010) and Curtis (2014), they described how it was easier to comply with accepted practices on the ward, even if that went against what was taught in the classroom. Drawing on a seminal work by Festinger (1957) who refers to this as 'cognitive dissonance' where individuals feel compelled to comply with practices despite knowing what they should be doing, was useful. Almost sixty years later it would appear that this is still evident in today's nursing practice. There is now a greater need than ever to focus on developing courage to challenge practices, make unpopular decisions and take risks, as a means of transforming the care of people from culturally different groups (Alpers *et al* 2013; McAllister 2015). Courage is a state of mind that enables nurses to dare to do something challenging (Thorup *et al* 2012). Nurses in this study generally lacked critical reflection and had not learned to challenge values and insensitive or inadequate practices adequately, so the

harmful effects of ethnocentricity, routines and rituals in healthcare were hidden and are therefore at risk of continuing to operate in powerful ways.

6. Focussing on Difference and Neglecting Human Similarities:

The data reveals extensive evidence of how nurses become pre-occupied with cultural differences as opposed to appreciating the need to explore similarities of beliefs and care needs. Informants were often oblivious to and accepting of how they were 'othering', 'stereotyping' and ultimately problematising the needs of patients from different cultural backgrounds. Despite the labelling of patients as "popular" versus "unpopular" first reported on in 1972 (Stockwell 1972), the findings of this study demonstrate that it is still very relevant in Ireland today. Nurses in this study consistently described the time pressures required to carry out their responsibilities and manage their workload in an effective way. Lack of time to carry out nursing duties and responsibilities is a consistent challenge in nursing literature (Chan *et al* 2013, Clarke and Holt 2014). However the data suggest that nurses may have overestimated time needed to provide care, because of their focus on cultural difference.

Nurses in this study articulated their desire to provide quality and safe care for all patients. However they found it challenging to bring together different aspects of nursing knowledge, caring skills and empathic attitudes in culturally appropriate and acceptable ways. Instead they appeared fixated on cultural differences and pre-occupied with cultural specific knowledge rather than what might be common to all patients. Although, informants criticized the lack of cultural specific knowledge within undergraduate curricula, findings raise questions about nurses' self-awareness, commitment and ability to think critically. This mirrors Fanning (2007; 2013) and Burgess *et al* (2007), who argue that focussing solely on cultural difference, contributes to damaging cross-cultural encounters. Although not condoning the focus on difference or the construction of people who are not Irish as "other", the tendency to do so reflects Irish political and social discourse. For example, the term used in government documentation to describe

refugees, asylum seekers and migrants is "non-Irish Nationals" (CSO, 2002; 2016; HSE, 2008). This labelling at government level segregates and positions cultural groups as different or "other", rather than as people. Such views are overtly portrayed in the media and political discourses. Vertovec and Wessendorf (2005) suggest that over attention to cultural identity, which emphasises difference has the potential to distance minority groups, as they are constructed as the "other". It is not surprising that "othering" filters down to society in general and into Irish healthcare settings. Gustafson (2007) and Husband (2010) argue that attitudes to outsiders are underpinned by notions of tolerance and a belief that those with perceived undesirable characteristics are not only seen as different but inferior. Similarly Fanning (2012), highlights that inferiority is particularly explicit in an Irish context due to cultural heritage, xenophobic ideologies and more specifically the ethnohistory of Ireland. Despite being quick to develop policies in Ireland, the Irish government has been less active in enforcing their policies around integration, social inclusion, equality and diversity. Neither have they been honest about the positive impact of migrants in the economic, social, political and cultural life of their communities.

The way that nurses focused on difference, othering and problematising patients from different cultures contributed to their inability or disinterest in communicating effectively, as avoidance took precedence over spending time with patients. Informants unanimously agreed that the language barrier presented as a real challenge for both nurses and patients. Despite acknowledging the value of professionally trained interpreters, they were rarely used, a finding which concurs with other studies (Meddings and Haith-Cooper 2008; Jirwe *et al* 2010; Tavallali *et al* 2014, Boyle 2014). As a result there was clear evidence of cultural misunderstanding and difficulties connecting with patients due to patients' lack of proficiency in English. Nurses clearly experienced difficulties relating to patients from different cultures on a basic human level because of language problems. This fits with Boi (2000) and Jirwe *et al* (2010) who found that nurse-patient relationships were difficult to construct if the 'small talk' element was

replaced with no spoken word. However nurses regularly communicate with patients who can't speak or communicate for other reasons, raising questions as to why there was disinterest in seeking different ways to build therapeutic relationships with patients who are not proficient in English. Communicating effectively and sensitively during cross cultural encounters is essential in reducing the risk of compromising the quality of care provided, (Cioffi 2003; Bischoff and Hudelson 2009). However the findings indicate significant room for improvement, in particular the importance of other mechanism for communicating when language barriers exist. Nurses in this study were more concerned with practical tasks, than engaging with the patient, thus minimising the learning that can occur during cross-cultural encounters. Although not disputing the challenges associated with emotionally connecting with patients which are well documented in the wider nursing literature (Jackson and Stevenson 2000; Moyle 2003), nurses did not see the educational value of spending time with patients whose cultures were unfamiliar .

7. Justifying Indifference:

Some nurses in this study argued that they treated all patients the same, showing no preference for people who were not Irish. However they were also aware that the disengagement adopted resulted in less than perfect care and sometimes even discriminatory. This made them feel uncomfortable and embarrassed but they felt ill equipped to deal with such issues appropriately. Nursing routines were essentially ethnocentric so the appropriateness of care was never questioned and culturally insensitive practices are sustained. It was easier to ignore cultural insensitive practices and follow what they knew was inappropriate, rather than challenge colleagues and do what they knew to be right. The Council of Europe (2008), International Council of Nurses (2008) and the World Health Organisation (2012) make explicit the global perspective regarding nurses' obligations from a human rights perspective. Such positions are also evident in an Irish context, as NMBI (2014; 2016) and DoH (2017) clearly highlighting nurses' accountability for the provision of competent, safe and compassionate person centred care. However, nurses need time to think about attitudes

and practices, explore and identify ethnocentricities as a means of developing critically and gaining the courage and confidence to question the Irishness engrained in routines. These findings may explain the perpetuation of traditional ritualistic practices, carried out without thinking, but raises questions as to why culturally insensitive and sometimes overtly discriminatory care is allowed to persist.

Although informants were aware that the care provided was sometimes not meeting the patients' individual preferences or needs, they went to great lengths to rationalise their actions or omissions to themselves as a means of easing their personal discomfort. Instead of taking measures to improve the care provided and taking responsibility for not challenging, nurses coped by blaming the system and problematising the patient. Justifying and having a range of excuses for sometimes substandard care helped ease their discomfort but also perpetuated the acceptance of culturally insensitive care. Blaming culture as a means of self-preservation is receiving much attention in the wider literature in recent times (Crigger and Meek 2007; O' Connor *et al* 2011a; O' Connor *et al* 2011b). However, Jones *et al* (2016) argues that the acceptance of poor nursing care has received little attention. This study helps explain how nurses in Ireland become complacent, immune and tolerant of indifference towards patients from different cultures. Although the findings represent the views, attitudes and practices of nurses in one region of Ireland, it is possible that they could broadly be applicable in other contexts and countries.

The increasing reports of culturally insensitive both globally and in Ireland has led to a number of health service initiatives such as the National Intercultural Health Strategy (HSE 2008). However, these alone are insufficient and take time to work. Culley (2001) argues that legislation in isolation fails to tackle values and discriminatory attitudes which persist in the 'hearts and minds' of institutions and health and social care professionals. Ultimately the responsibility for introducing legislation and policies lies with the institution, but the actual implementation relies upon the actions and attitudes of

individual staff members. However the challenge occurs when nurses feel ill-equipped to challenge attitudes and practices that are taken for granted and where the cultural appropriateness of care is rarely questioned. Student informants in particular described feeling unable to deal with the poor practice they witnessed. They acknowledged that care provided was on occasions unprofessional and at times even unethical but they lacked the courage and confidence to challenge it. The data also provides evidence of how registered nurses and preceptors in clinical practice also felt ill-equipped for their role modelling responsibility. This study highlights the challenges in preparing nurses for the realty of practice. The findings mirror the recommendations of others who suggest didactic approaches to teaching that predominantly present culture as a list of traits are ineffective if used in isolation (Vandenberg 2010; Williamson and Harrison 2010; Taylor *et al* 2013). Instead the findings call for a greater focus on critical self-awareness, self-inquiry and the courage to challenge as the cornerstone for transforming ethnocentric and indifferent attitudes.

8. Task Oriented Not Patient Centred Care:

Informants consistently admitted to 'just doing enough to get by'. This was often described in the context of taking measures to meet patients' physical needs, such as monitoring vital signs and administering medication. This study mirrors and extends the findings of recent research by Boyle (2014) who also found that community nurses in Dublin were content at doing 'just enough to get by' when caring for patients from different cultures. This allowed them to get through the day in a busy and demanding environment, where there was unanimous agreement that getting tasks done quickly carried a higher value than providing person centred care. In this way, informants described being present to patients in a role focussing on completing tasks, as opposed to the interpersonal "being with" presence, described by writers such as, Barker and Buchman-Barker (2005). Such findings are contrary to the beliefs underpinning therapeutic relationships as reported within the broader literature (Moyle 2003; Barker and Buchanan-Barker 2005) but are equally applicable during cross cultural encounters.

With the increasing focus on improving quality and safety in healthcare in Ireland, auditing and measuring standards of care are now part of everyday practice. However, nurses appear to interpret quality care in terms of measurable and observable tasks such as hygiene, medications and vital signs measurement to the determent of engaging with the patient in a culturally appropriate way. Care was prioritised in terms of tasks, rather than being holistic and person centred, thus allowing nurses to 'just do enough to get by'. This is clearly substandard practice, which went unchallenged by nurses who were busy, and equally ignorant or unconcerned for the individual needs of patients from different cultures. Over time this becomes acceptable and standard practice, echoing Jones *et al* (2016) who found cutting corners in acute nursing care in Australia of growing concern, but is an under investigated characteristic of general nursing practice. Although such reports are not unique to caring for diverse cultures (Francis Report 2012), the findings of this study illuminate the process whereby nurses become resigned and indifferent to the needs of patients from different cultures.

This study highlights how nurses focus more on getting the task done, than the actual experience and engagement opportunity afforded when planning care to meet the needs of patients. The commitment to auditing practice as a means of driving quality and safety care has increased awareness of quality but may have inadvertently led nurses to prioritise physical care without consideration of emotional or cultural appropriateness. There is evidence in the literature to suggest that nurses find it difficult at times to provide emotional care in general and as a result tend to focus more on the physical aspects of care provision (McGrath and Boore 2003; Jirwe *et al* 2010). This study echoes these findings but extends them in explaining how nurses use distance and avoidance strategies as a means of coping with fear of failure, embarrassment and situations in practice that cause anxiety and general discomfort. Although not disputing the busy workload and increasing demands on nurses, however nurses in this study genuinely believed they did nothing severely wrong. Rituals, routines and lack of reflection facilitate culturally insensitive care in the clinical setting. However, the lack of

accountability at professional or organisational level allows nurses to become complacent and sometimes even immune to substandard care for these patients. Arguably, the limited attention in professional codes, local healthcare polices and lack of consequences for providing substandard care may have influenced this acceptance as cultural care is deemed unimportant. These findings concur with others (McGee and Johnson 2014; Blanchet Garneau and Pepin 2015; McCalman *et al* 2017) highlighting the importance of culturally competent organisations but extend them in explaining how complacency occurs when norms and practices go unquestioned. There were few opportunities for nurses to think aloud about cultural dilemmas that occur in practice. As mentioned elsewhere, the research was the first time many participants had thought about cultural issues. As such there was no pressure to debate concerns, consider ethical or legal issues or to deliberate over strategies to address issues and or generate the skills and courage to challenge insensitivity and discrimination.

9. Resigning to Indifference:

These findings raise questions as to why nurses feel it acceptable to provide substandard care to patients and why they ignore and comply with indifference towards cultural difference. Although nurses in this study intentionally adopted a range of disengagement strategies to get through their day with as little conflict as possible, they did not intentionally set out to jeopardise patient safety or provide culturally insensitive care. They were content with taking measures to meet physical care needs and maintenance of physiological safety, but were less concerned with psychological and cultural needs. This narrow view of how nurses in this study interpret and define quality and safety is echoed by others (Jones *et al* 2016). However, the uniqueness of this study lies in its explanation of the process of how nurses become immune to ethnocentricity and complacent with providing care that was not always of high quality. Ethnocentricity and biases are clearly primary barriers to providing culturally sensitive patient care (Cong-Wong *et al* 2009). However this alone is insufficient in explaining the indifference that was widely demonstrated and went unquestioned. Drawing on Tarliers' (2004) classification of

deserving and undeserving patients and exploring the cultural context in which Irish nurses develop attitudes towards cultural difference helps explain the attitudes, practices and behaviours that go unquestioned. While acknowledging the contexts and constraints experienced, the ease of doing 'just enough to get by', complacency at providing substandard care and disinterest in providing quality culturally sensitive care are significant findings that warrant consideration.

This study echoes findings from other international studies (Jones *et al* 2016; McCalman *et al* 2017), highlighting the important role healthcare organisations have on shaping care delivery, setting standards for nursing practice and approaches to cultural competence. It particularly adds new perspectives on how cultural insensitivity is sustained and goes unnoticed. Data demonstrates how the rituals, routines of clinical settings and wider organisational cultures, militate against culturally sensitive care. This is consistent with Boyles' (2014) findings in community nursing in Dublin, but involves student and qualified nurses. This study highlights how collectively nurses became content with providing sometimes substandard care and even oblivious at times to the consequences for the people they were caring for.

This complacency, failure to take action to improve standards of care and general acceptance of less than perfect care was perpetuated by a culture in clinical settings which appeared to have minimal repercussions for nurses. Insensitive or at times even discriminatory behaviours went unnoticed or were tolerated as there appeared to be at times low expectations that people from different cultures would receive quality care. These findings highlight the need to prepare the wider healthcare organisation to explore practices that are ritualistic, Eurocentric norms and become normalised to the point they get unnoticed, as argued by others (Culley 2001; Gustafson 2007; Husband 2010; McCalman *et al* 2017). The data demonstrate that raising concerns or suggesting improvements were not everyday practice so there were few opportunities for nurses to develop the courage, confidence and skills required to do what is right even through it

might not be popular with peers. There appeared to be minimal evidence of an environment of trust where critical reflection occurs, blame is avoided, risk managed and new ideas developed, tested and evaluated. This requires focussing on the need to develop a workforce that is better able to firstly acknowledge the need for change, adapt to change and implement developments to practice that are continuously evolving.

Many nurses in this study believed (or failed to question) that treating everybody the same, as opposed to appreciating the patient as a unique person, was sufficient in meeting their needs. The unconscious features of promoting equality are underappreciated and anxiety, fear, guilt and uncertainty lead to avoidance and denial of practices that are painful or threatening. The findings emphasise the need to help nurses rehearse the skills of questioning, thinking about and challenging individual and collective attitudes and practices, when something is not right. They need to understand ethical, legal and professional imperatives and develop courage to challenge ethnocentricity and individual and collective indifference. The challenge for nurse educators is to find the balance between developing knowledgeable doers and emotionally intelligent practitioners that have a greater self-awareness of individual and organisational attitudes that may hinder culturally sensitive care. Taking responsibility for learning and development must replace the ease at shifting the blame and self-rationalising behaviour. However the findings also raise questions regarding the standards of care in clinical practice that become accepted and unchallenged and sometimes even unnoticed. It was easier to comply with accepted practices even if it resulted in substandard care than to risk being rejected or suffer the consequences of challenging those in authority. Although the findings do not imply that participants were weak willed and unable to think for themselves, the culture of the organisation is one that does not encourage or support assertiveness or the challenging of attitudes and practices. Consideration needs to be given not just to the content of nursing curricula in nurse education but also educational philosophies and learning and teaching methodologies both in the classroom and during clinical placements. This does not necessarily require major structural changes but instead requires a shift in thinking such

as a "little and often" approach within curriculum design (Taylor *et al* 2013), that focus on developing culturally compassionate care (Papadopoulos *et al* 2016). Focussing on self-examination, questioning practices, contextualizing knowledge to different caring circumstances and a commitment to meeting individual patient needs is essential if we are to grow nurses who can become change agents. These findings help explain how nurse education and the culture of the organisation can hinder nurses' ability to provide culturally competent care.

10. Wider Irish Societal Values:

Nurses do not work in a vacuum as the culturally insensitive, indifference and uncaring attitudes and practices described in this study reflect wider social attitudes towards minority ethnic groups. This study highlights how nurses assimilate such values and attitudes of wider society, which in Ireland is largely anti-immigration. Although not acceptable, it does highlight that wider social discourses can influence nurses working in Irish healthcare settings. While sudden and rapid immigration to Ireland might explain ethnocentricity and institutional racism, Ireland also has a poor record when dealing with any type of difference. For example, the long history of hostility towards Travellers, which was evident in this study but is also reflective of the views of wider Irish society (Vivian and Dundes 2004). The slowdown of the Irish economy in 2008 resulted in increasing reports of resentment towards migrants due to the reported rise in unemployment and emigration (McGinnity *et al* 2006; Fanning 2007; McGinnity *et al* 2016). It may be argued that migrants were tolerated while the economy was booming, but tensions escalated when competing for job opportunities that were on the decline during the recession (Fanning 2012). This study demonstrates how attitudes in Irish society transcend into healthcare services and professionals working within these services. Unless nurses are consciously aware of the personal, social and professional values that inform their attitudes and practices, their ability to become culturally competent will be at the best superficial.

Compared to many other countries, Ireland must be acknowledged for the fast pace in their developments of new legislation, policies and strategies, to address approaches for intercultural integration and to tackle racism (Mladovsky *et al* 2012). However, like other countries racism is an issue that continues to cause concern in society in general but is becoming increasingly evident in Irish healthcare settings (Reid and Taylor 2007; Lyons *et al* 2008; Sheridan *et al* 2011; Migge and Gilmartin 2011; Boyle 2014). This however does highlight the complexity of changing practices to meet the diverse needs of a growing multicultural patient base and suggests that quick-fix solutions imposed from the state do not necessarily provide the answers required. Data provides evidence that nurses are fearful of the negative connotations, emotions and legal and professional implications associated with being seen to be racist. Fear of being labelled racist as a result of not knowing how to act further contributed to disengagement, mirroring many international views that report that racism is euphemised, denied or negated and inadequately addressed in nursing curricula (Cortis and Law 2005; Culley 2006; Tilki *et al* 2008). The data also provides many examples of more subtle discriminatory practices, which often occurred in everyday talk at the nurses' station, but was unrecognised as racism. This is not surprising as there is reluctance within Irish social and political debates to use the term racism to describe the prejudices and intolerance experienced by ethnic minorities in Ireland. Instead there has been considerable emphasis on the concept of xenophobia, 'fear of the stranger' to explain such prejudices and intolerance in Ireland (Fanning 2007). The data resonates with Johnstone and Kanitsaki (2009) who suggest that this is a type of new racism. Fanning (2012) suggests that there is a need to have a broader definition of racism in Ireland to include xenophobia which relies upon an unexpressed subtext of racial beliefs and assumptions.

Combating this denial of racism in an Irish context may be challenging as Irish people in general pride themselves as having a culture of "welcoming", which can further suppress acknowledgment and confrontation of racism. The data provides some evidence of the impact of the recession in Ireland, highlighting how Irish people were increasingly

anxious about employment opportunities and these anxieties are further fuelling negative attitudes towards immigrants. Nonetheless, Irish people need to be aware of the reality of racism in Ireland that too often cloaks itself in the rhetoric of national identity and xenophobia (Fanning 2012). As Essed (1991) states racist practice is not always intended or explicit because it originates in socialised attitudes and behaviours enacted through familiar practices. As was evident in the data feelings and misunderstandings were ignored, conflicts remained unresolved, solutions were not found and complacency escalated. The findings suggest that as Culley (2001) argues racism contextualised as an intolerance arising from ignorance cannot be cured by education alone. The nurses were denied opportunities to explore misunderstandings in an open and transparent way in a spirit of learning. The organisations, clinical learning environments and cultures did not provide the nonthreatening environment suggested by Burgess *et al* (2007) where learners felt comfortable to share stereotypical or racial views, in an attempt to address them.

The lack of commitment to provide quality care to patients from different cultures that appeared to become accepted, unquestioned and at times even unnoticed is a particular area requiring consideration. Although beyond the scope of this study, it would be interesting to explore if this lack of initiative to provide quality person centred care would be tolerated when caring for Irish patients. Although not unique to Ireland, this failure to question those perceived in positions of power perhaps is more evident in Irish society than in other countries. The Ryan report in 2010 provides volumes of evidence of neglect and the physical, psychological and sexual abuse of children in orphanages and industrial schools in Ireland. More significant than the abuse was the culture of concealment between the Church and State and the unquestioning attitude of professionals who suspected or even knew the cruelty meted out by the clergy. The Lourdes Inquiry in 1996 highlights how a consultant obstetrician carried out a large number of unnecessary Caesarean hysterectomies without the knowledge or consent of the women. Despite professionals having an awareness of such disturbing practices, they went unquestioned

and unchallenged. More recently, the Tuam Baby Inquiry in 2016 further highlights the extent of a culture of non-questioning and arguably a culture of silencing as unmarked graves containing skeletons of babies at a site at a home for unmarried mothers in Tuam, co. Galway. The majority of these Irish specific cases centre on religious structures and processes highlighting the powerful influence of the Irish Catholic Church (Fanning 2012) that ran hospitals and care homes. However, widespread poor nursing care and failure to challenge substandard care is reported on globally (Francis Report 2012; Traynor and Buss 2016; Jones *et al* 2016). Although these findings offer explanations specific to an Irish context, they may also contribute to the wider discussions on cultural competence. While Ireland has changed and is changing it is possible that a culture of not challenging the status quo is still at large (Fanning 2012).

11. Summary:

The findings of this study mirror other studies exploring cultural competence from a European (Jirwe et al 2010; Hart and Mareno 2014) and Irish context (Lyons *et al* 2008; Tuohy *et al* 2008; Ryan *et al* 2008; Boyle 2014). The lack of compassion and accountability for actions or omissions in care is a global phenomenon in nursing that has received a renewed focus in recent years, in light of increasing reports of substandard nursing care that becomes accepted (Francis Report 2012; Keogh Report 2013; Jones *et al* 2016). These recent scandals highlight the need for a collective commitment to quality, safe and compassionate care. Similar recommendations were echoed in the Health Service and Health Information and Quality Authority investigations into the death of Ms. Savita Halappanavar in Ireland. Although media coverage of this case focused predominantly on abortion laws in Ireland, other issues such as the inappropriate management of an individual with sepsis and the ethnocentric and cultural insensitivities were demonstrated. Sadly the findings of this study demonstrate how poor care, ethnocentric and cultural insensitivities often go unnoticed. They also support McGees' (2009) calls for the need for the development of leadership to challenge professional boundaries that hinder quality care and consider new ways to work collectively in the

best interest of the patient. The findings highlight the need for cultural compassion (Papadopoulos *et al* 2016) to address the poor patient care in for all and not just those who are culturally different.

CHAPTER 9

CONCLUSIONS, RECOMMENDATIONS AND REFLECTIONS

1. Introduction:

This chapter discusses how the research aims were achieved and presents some concluding reflections summarising the significance of personal and professional developments achieved during the PhD journey. The strengths and limitations are explored and recommendations for future research in the area are proposed. Finally the chapter ends by discussing implications of the research, making recommendations and a plan of action for nurse education government policy, the Nursing and Midwifery Board of Ireland, healthcare organisations' and nurse education.

2. Conclusions:

This study describes how nurses in Ireland use a range of disengagement strategies as a means of dealing with their lack of cultural knowledge and the uncertainty this entails when caring for patients from cultures with whom they were not familiar. Although nurses in this study took measures to protect themselves from the discomfort of not knowing, this investigation generated significant evidence to suggest that culturally insensitive care was common but went unchallenged. The data provides a rich description of factors that influenced nurses' actions and omissions but also highlights that consequently over time, substandard care becomes acceptable and often unnoticed. Organisational constraints, competing workload demands, ethnocentricity and deficiencies in education are challenges that warrant attention, but the acceptance of doing 'just enough to get by' raises questions as to how nurses become complacent and even immune to substandard care.

Before embarking on this study I would have argued that the failure to provide sensitive culturally competent care to people who were not Irish was because of the lack of knowledge caused by inadequate educational preparation. I still believe this is so but I am

saddened to find that this is not the only cause. The sampling and methods gave voice to the views of students at different points in their training and to qualified nurses working in different clinical settings. Despite this diversity the accounts of students and qualified nurses in focus groups and interviews, were very similar and on many occasions reflected xenophobic media discourses in Ireland at the time. The perceptions and challenges were not dissimilar to those reported in other countries but there were differences, which are arguably specific to the Irish experience.

The sampling might have anticipated the lack of knowledge or confidence and had I not been trying to keep an open mind I might have predicted that nurses would have adopted strategies to protect themselves against anxiety. However, the findings point to individual, cultural and organisational factors, which I had not anticipated. I was surprised to find the extent of the ways in which students and qualified nurses limited or avoided contact with patients from different cultures. I had not thought about how routines and rituals in some clinical areas, which were ethnocentric in nature and went unquestioned, facilitated this. Although I was not surprised to find that nurses felt ill equipped to care for people who were not Irish, I did not envisage the complacency and the lack of concern about how this impacted on patients. I was not totally surprised by the ethnocentricity and racism, which came across in interviews and focus groups, but was shocked by the accounts of racial discrimination reported by the informants. More worrying was the evidence of ethnocentricity, the pervasiveness of racism and the failure to challenge it.

The study has helped illuminate the context of cultural competence in Ireland. A multiplicity of factors contributes to the insensitivity experienced by people from different cultures as they use the health care system. It is easy to blame nurses and their preparation in university, but their clinical learning, the cultures and environments in which they undertake placements and the practices they are exposed to all play a part. The society they live in (and where they are mostly socialised) and the organisations they are attached to influence their attitudes and help shape indifference or at best tolerance of

166

outsiders. The failure of Government and regulating bodies to implement appropriate policies and actions to address racism and discrimination perpetuates the problems. Gaining a clearer picture is fundamental when considering how to promote culturally sensitive care. While nurse educators have a big role to play, it will take a whole organisational if not societal commitment to ensure justice, fairness and quality of care for people who are not Irish.

The term 'resigned indifference' captures and explains the attitudes and practices of the nurses investigated. It helps explain how student and qualified nurses feel it acceptable to behave ethnocentrically, insensitively or not to challenge the neglect of patients from different cultures may experience. The research has implications for nurse education in both the classroom and clinical areas. The findings have implications for professional practice, as questions are raised about the competence of registered nurses and their expectations and supervision of students. In particular they may add to existing debates on caring and compassionate practice.

Nurse participants used a range of disengagement strategies to compensate for the uncertainty caused by their lack of knowledge about caring for patients from different cultures. Students were critical of their lack of theoretical preparation and although they appeared to want information, they made few attempts to find out for themselves. Despite an awareness of the moral, professional and legal obligations, informants often ignored and sometimes collude with unacceptable behaviour. Although students may have lacked confidence or were fearful of questioning colleagues, especially their seniors, the evidence suggests their reticence was as much to do with a lack of concern. It is also a reflection of the collective failure of health services and higher education institutes in Ireland to address ethnocentrism and discrimination.

Although data was collected over five years ago, the continued and growing reports of racism in Ireland (Michael 2015) suggest that attitudes of Irish people have changed little. The findings concur with international evidence, which signals the need to improve the care offered to people from different cultures. In particular they offer insights into

specific barriers that require attention in Ireland and possibly elsewhere. They highlight the need for nurses to understand themselves better and critically consider how they connect, empathise and create relationships with patients who are not Irish. Some of the barriers to culturally sensitive care relate to how nurses protected themselves from anxiety when uncertain. Others reflect a lack of preparation during nurse education and a dearth of culturally competent leadership in clinical practice. Perhaps the main barrier was the collective indifference demonstrated towards patients from different cultures that went unchallenged in the classroom and in clinical practice.

Clearly cultural knowledge is important, but the findings demonstrate that information alone will not make a difference. The indifference, lack of courage to question and lack of commitment to act in accordance with ethical imperatives and professional and legal directives require a greater focus in the undergraduate curriculum. It also highlights the need for ongoing professional development for qualified nurses. This has implications for the way nursing is taught in the classroom and how it is learned and modelled in clinical areas. Unless strategies to address the individual and collective nature of ethnocentric and indifferent attitudes are carefully planned, culturally insensitive practices will continue operating in subtle ways.

The findings of this study have the potential to inform nurse education and clinical practice by offering a unique explanation of why nurses provide culturally insensitive care. They make visible the impact of individual and organisational ethnocentricity, xenophobia and indifference towards different cultures. Understanding both student and qualified nurses' perspectives of how and why they behave as they do emphasises the need for change. The findings highlight the need to develop culturally competent education, leadership and practice in Ireland. Clearly these findings question how the values underpinning professional nursing, as laid out by the Nursing and Midwifery Board of Ireland (NMBI 2014) are applied in daily practice. They also highlight the lack of commitment and negligence demonstrated at government, organisational and individual levels to address the indifference towards people form diverse cultural and

ethnic backgrounds. Although acknowledging the need for a whole systems approach, this chapter will focus mainly on recommendations for nurse education, which includes clinical practice, as change more widely will take time.

3. Strengths and Limitations of the Study:

This study provides a comprehensive understanding of the attitudes, practices and behaviours of nurses when encountering cultural difference. The uniqueness of this study lies in its explanation of how nurses deal with lack of knowledge on a daily basis. A key strength of this study is the contribution it makes to a deeper understanding of the relatively under acknowledged focus on doing 'just enough to get by', in nursing care. Understanding how and why a raft of disengagement strategies are adopted and accepted as well as the implications of adopting such approaches to care for quality care and patient safety, can influence change. This study extends the limited evidence on cultural competence from an Irish context and although not generalisable as it was carried out in one region of Ireland, the explanations of factors that influence nurses' attitudes and behaviours may resonate with others. Expressing the voices of nurses responsible for care delivery affords new insights into the personal, professional, socio-cultural and organisational barriers to culturally competent care in Ireland but may also be applicable to other countries. Adopting the principles of a classic grounded theory approach was particularly useful in providing a framework that encouraged the behaviors of practicing nurses on the ground and the realities of practice experienced, emerge from informants. Constantly comparing data from both student and qualified nurses and interviews and focus groups extends other Irish studies provides a more comprehensive understanding of the issues emerging.

Chapter four highlights how the various methodological challenges were overcome. However, there are limitations associated with this qualitative inquiry that must be acknowledged. This study took a retrospective view of informants' accounts and relied on a recollection of actual views and experiences, suggesting that informants may have been influenced by recall bias. Furthermore, the findings reported are based on

informants' self-reported behaviour, and are based on an assumption that interviewees report their true thoughts, experiences and behaviours. While there is no reason to believe that informants were not being honest, the researcher cannot say with certainty that their recollection of events truly reflected the experiences they described. In many instances informants were constructing their thoughts about cultural matters, attitudes and practices they might hold or have witnessed for the first time. Although different data collection methods were used, in the absence of direct observations in practice, it is possible that informants' accounts of how they acted and behaved in practice may have been different in reality. The impact of the researcher on informants' responses also needs consideration. The researcher is a nurse lecturer and is therefore known to both student and qualified nurses. She has also published articles on cultural issues. Hence, there may have been times that informants were not truly honest because of possible discomfort associated with owning and taking responsibility for poor practice or the implications of exposing their ignorance. However the evidence from different student groups and qualified nurses is very consistent and it is troubling to think that informants might have played down the care described, given the collective insensitive care described. The data was collected over five years ago and it is possible that changes and new developments have already occurred and attitudes and practices could have changed.

4. Recommendations for Further Research:

There is a need for further research to explore nurses' and other healthcare professionals' experiences in the region where the study was undertaken as well as in other parts of Ireland. Focused research is needed to explore the extent to which disengagement and indifference is evident, when caring for Irish patients or when nurses are faced with uncertainty about clinical conditions, new treatments or procedures. Given the extent of the insensitive and racially discriminatory care described by nurses in this study, there is a need to compare such perspectives with that of patients from different cultures receiving care in other parts of Ireland. A qualitative research study exploring issues from

the patient's or family's perspective and their overall experiences of care, is urgently warranted.

Informants' perceptions of the failings of nurse education were clearly articulated. There is a need to undertake a study exploring the views of lecturers who teach on nursing programmes regarding their experiences of curriculum development and their confidence in teaching the care of patients from different cultures. Equally, it would be helpful to examine how confident qualified nurses and especially nurse mentors/preceptors are, and to identify what training and support they need to direct and supervise care in Ireland's multicultural society. Such studies should help obtain a more comprehensive picture of the issues emerging in this study.

5. Implications and Recommendations:

This study has highlighted a number of challenges to the delivery of culturally compassionate competent care in one region of Ireland. It described the impact of unchallenged personal and collective ethnocentrism, stereotypes and unwitting prejudices on nurses' attitudes and practices that often went unnoticed. The data provides evidence of how nurses are? professionally socialised into particular ways of thinking and behaving, which are influenced by wider societal views towards migration and cultural difference in Ireland. However there were limited opportunities in the classroom and in clinical practice to address such issues, leaving nurses to often think on their feet and learn as they go. Clearly nurses felt ill prepared and self-preserved in times of uncertainty and discomfort. However the extent of ethnocentric attitudes and insensitive care that lacked compassion raises questions regarding the commitment to provide quality care in a culturally meaningful and appropriate way. The routine ethnocentric practices and insensitive care that went unchallenged manifested into an unconscious resignation and acceptance of substandard care and indifference to patients. As a consequence, culturally insensitive and occassionally discriminatory care are accepted to the point that they are sustained and become normalized. Although acknowledging the busy work environments, structural and organisational constraints and knowledge limitations, the

complacency, ease at doing 'just enough to get by' and the acceptance of substandard care to people who are not Irish has wider implications. Although beyond the scope of this study it does question whether such attitudes and practices would be tolerated for Irish patients. Consideration is needed to consider ways of operationalising a truly intercultural inclusive society and culturally competent healthcare organisation, at a time when cultural diversity in Ireland is increasing and reports of racism continue to rise. This requires a whole systems approach but wider societal attitude change takes time. Therefore for the purposes of this thesis, particular focus will be placed on recommendations for nurse education and clinical practice as a means of influencing direct and achievable change to nurses' attitudes, behaviours and practices thus enhancing outcomes for patients. In particular concise recommendations in the form of an action plan will be presented.

6. Implications for Nurse Education:

The data provides extensive evidence of how nurses lacked knowledge and felt unable to apply generic caring values to cross-cultural encounters. The findings highlight that there is a need to be mindful that cultural knowledge in isolation does not ensure sensitivity, however a lack of knowledge can contribute to insensitive and discriminatory care. Whilst the findings clearly highlight the need to improve nurses' knowledge, they also demonstrate that cultural information alone will not dispel ethnocentricity, acceptance of substandard care, complacency or indifference. The nurses in this study appeared oblivious to the impact of their own attitudes on their relationship with patients from different cultures and were oblivious to the factors that influenced them, highlighting the need for developing self-awareness as well as thinking about individual identity and how it has been shaped. There is clearly a need to move beyond curriculum content and address the unwitting prejudices and stereotypes which unconsciously impact on relationships with patients. It is important that this is addressed in a spirit learning, which avoids blame and draws upon the strengths and knowledge which already exists. It is important that a whole system approach is adopted rather than singling out any one

section of the organisation as problematic. However, learning and teaching approaches need to take some risks and embrace transformative learning approaches within a continuum of intercultural learning and cultural competence development. This requires exploring taken-for-granted frames of reference, ways of thinking or mind-sets to generate new beliefs and opinions. Transformative learning involves deep, powerful emotions or beliefs and can be uncomfortable for teachers and students. However the challenges associated with incorporating such approaches in learning and teaching strategies need to be acknowledged and adequate support and guidance for nurse lecturers and their leaders.

The data provides evidence of how both student and qualified nurses were insensitive to the needs of patients from different cultures, whilst ignoring or accepting the indifferent care they were offered. Seeing patients' nationality, ethnicity or cultural differences before their individual care needs played a part in this. Nurses need help to acknowledge and respect difference but appreciate similarities in care needs and not seeing culture as separate. The need to be curious, motivated and proactive in seeking answers, solutions and resources to deal with the challenges of nursing must be embedded. They need to feel confident to admit what they don't know, take risks rather than avoiding situations, ask patients or families for information, apologizing and learning when they get it wrong. This requires a move away from didactic and linear methods of teaching and learning that focus on knowledge as the outcome, towards a more non-linear, student-centered approach. In this context, there is a need to replace the focus on knowledge, to knowing how to access information efficiently. Nurses need support in appreciating how culturally competent compassionate care is quality care, which will benefit all patients and can be highly satisfying for both nurses and patients.

This study generated evidence that highlights how students observe insensitive care during clinical placements. However, in the absence of feeling able to challenge, they chose to ignore it despite knowing it was wrong. Informants did not consider themselves racist; however, ignorance, unwitting prejudice and stereotyping were woven into

173

individual and collective practices. Instead of taking responsibility for their own involvement, informants had a range of excuses for insensitive care and colluded with a culture of blame. This may have eased their discomfort but the re-thinking of practices did not occur. The findings of this study further demonstrate that it is no longer adequate to focus on developing individual cultural competence but nurses need to develop the courage and skills to challenge insensitive organisational and professional values and practices. Developing cultural awareness should be about being aware of what is taken for granted in the profession or the organisation and focusing on the self as a means of transforming thinking. It should be about questioning beliefs and values underpinning attitudes and practices and allowing a greater awareness of the implications of choosing to turn a blind eye or collude with culturally insensitive and racially discriminatory care. Working through and discussing real practice scenarios, role-playing how to deal with different challenges experienced in practice and the use of debate as a means of encouraging a more questioning approach to attitudes and practices is required.

The national drive at increasing international education and incoming student mobility and the growth in people migrating to Ireland in recent years have rapidly broadened the cultural and ethnic diversity within the nursing classroom. The intercultural classroom provides an engaging opportunity for students to learn with, from and about students from different backgrounds. The nursing classroom is a microcosm of the clinical environment where people from diverse cultures bring different experiences, strengths and skills, together and work with each other to achieve particular learning goals. However care and attention is required to ensure such learning opportunities are maximised but done sensitively to explore similarities whilst respecting different ways of seeing things. This requires creating an environment where students feel comfortable to ask questions, challenge their own and others thinking, use intuition as a guide, stand up for beliefs and feel comfortable to advocate for others. Developing such critical thinking and assertiveness skills in a safe environment will assist to prepare nurses to fulfil their professional and legal responsibilities, whilst appreciating the realities of clinical practice setting.

These findings have relevance for nurse educators and qualified nurses who act as role models for students during their clinical placements. Adopting the four constructs of the Papadopoulos, Tilki, Taylor (PTT 1998) cultural competence model and the Papadopoulos (2015) culturally compassionate competence model, provide a framework from which to implement the recommendations from this study for nurse education for both undergraduate nurses and continuous professional development for qualified nurses. In particular, the findings emphasise the need for nurses to explore their own personal beliefs and values, which influence their attitudes and behaviours. They also need help to rehearse the skills of questioning, clarifying and challenging when something is not right. They need to understand and develop the commitment and confidence to apply ethical, legal and professional imperatives to their daily work.

7. Implications for Clinical Practice:

The data provides evidence of the collective indifference demonstrated and highlights how culturally insensitive attitudes and practices can become rationalised into day-to-day normality and embedded in organisational cultures and practices. They demonstrate the power of the clinical environment in shaping attitudes and practices of students and registered nurses. These findings have implications for managers and leaders within healthcare settings and highlight the need for questioning and transforming the attitudes and values underpinning the philosophy of care. The culturally and linguistically appropriate services (CLAS) standards of the Federal Office of Minority Health and Human Services in the USA (Office of Minority Health 2013) stipulate the importance of respecting and responding to diverse patient's health needs and cultural and language preferences. These standards provide a framework highlighting the importance of cultural and linguistic competence for healthcare staff and organisations as a means of providing equity, dignity and quality care for all. There was evidence of cultural complacency, cultural misunderstanding and cultural imposition which clearly impacted on approaches to care and care delivery.

National and international healthcare policies and strategies make explicit the need for compassionate care in plans for healthcare reform, suggesting it lies at the heart of healthcare delivery. For this to become a reality, it requires a commitment from nurse educators and managers in healthcare settings to explore how compassionate care can be nurtured, developed and sustained through education and practice. The findings of this study highlight the need to develop strategies to strengthen the capacity to provide compassionate care in a culturally appropriate way. To date, there is minimal evidence in the literature on the importance of connecting cultural competence and compassion (Papadopolous and Pezella 2015). This study illuminates the need to interweave these concepts as compassionate care cannot be operationalised without exploring cultural values and beliefs. The culturally competent and compassionate practice model (Papadopoulos *et al* 2015) is a welcome framework that prompts nurses to understand the meaning of compassion and ways of developing it with patients and families from diverse cultures.

The findings highlight the need to replace the culture of non-questioning and doing nothing, with a culture of courage, confidence and commitment to constructive criticism. Empowering nurses to challenge ethnocentricity and racism amongst colleagues requires sensitivity and skill and staff need support to develop this. Continuous professional development should particularly focus on providing a safe space for nurses to recognise their ethnocentricity and how this impacts on nurse – patient interactions. There is a need to recognise diversity within any group and to acknowledge the similarities between different groups (Papadopoulos *et al* 2015). The need to feel comfortable about not knowing all the answers and a realistic appraisal of strengths and limitations is required. It is also important to recognise that people from all cultures have similar needs for comfort. A particular focus should be supporting nurses to learn how to challenge negative attitudes and practices. Learning, teaching and assessment approaches must focus more on self-directed and enquiry-based approaches to learning as a means of increasing the independent, questioning and critical thinking required.

176

There is a need for managers to communicate a clear message of the responsibility to provide quality person centered, compassionate and culturally sensitive care. This message needs to be explicit in mission statements, policies and procedures at both organisational and departmental levels. Time and space needs to be given for nurses to celebrate and share good practices but also there needs to be a greater focus on addressing individual responsibilities for their role in substandard care. There needs to be a clearer message that substandard and insensitive care will not be tolerated and this requires having more explicit accountability and repercussions.

8. **Implications for the Irish Government and Nursing Midwifery Board of Ireland:**

In a rapidly globalising Irish society there is a need for more open discourse on the characteristics, aspirations and experiences all humans share, whilst respecting difference and celebrating diversity. Government discourse and media presentations must acknowledge the contribution of migrants to Ireland, drawing similarities with the vast contribution to other societies by the Irish diaspora over generations. The government should legislate to prevent sensational inaccurate and racist coverage of cultural issues in Ireland. The media should play a greater role in promoting more positive discussions on interculturalism. The Government should lead by example; ensuring policies embed an inclusive intercultural approach.

Nursing education and practice is guided by the Nursing and Midwifery Board of Ireland (NMBI) standards and policies. There is a need for the NMBI to send a clearer message of the expectations for nurses and nurse educators through the code of conduct and other documentation laying out standards of nursing attitudes and practices in Ireland. Curriculum Development is therefore guided by requirements and standards for nurse and midwifery education programmes (NMBI 2016). The explicit development of cultural competence appears to have received little attention in these national standards, despite the widening of cultural diversity that continues. It is therefore not surprising that nursing departments in Irish HEI's do not fully appreciate the need for cultural competence and

cultural competent nurse education. There is clearly a need to include the development of culturally competent compassionate care as one of the core requirements for undergraduate and postgraduate curriculum approval and their annual review criteria.

9. Recommendations in the Form of an Action Plan:

Nurses were aware of their ignorance and the organisation provided ample opportunities to hide it through routines, blaming the system and there was no pressure to demonstrate cultural competence. Many nurses felt so bad about their actions or omissions but it was easier to hide within the system, which didn't encourage openness, questioning, asking patients or families for advice or apologising for getting/saying something wrong. This has implications for how we address such issues at organisational, qualified staff and student nurse levels.

Table 7: Recommendations in the Form of an Action Plan

Recommendations for Nurse Education (acknowledging importance of learning in classroom and clinical practice)				
Action	**Objective**	**Rationale**	**Responsible person/Body**	**Timescale**
To report the findings of this study to the Nursing Midwifery Board of Ireland and to the wider nursing and nurse educator population.	Summarise key findings in a report format and send to the Chief Education Officer, Nursing and midwifery Board of Ireland, who is responsible for approval and maintenance of educational standards for nurse education and guidance to the professions. Submit a summary of the findings to the Director of the Nursing Midwifery Practice Development Unit and centres of nurse education in clinical practice and the Directors of Nursing within the acute services within the region.	To encourage a greater understanding of the factors that act as barriers to culturally competent care. To advocate for local and national initiatives aimed at setting appropriate standards of care for people who are not Irish. To create greater awareness of the realities of cultural competence in an Irish context that may be applicable to other contexts and countries.	Kathleen Markey	February 2018

179

	Publish the findings in the Irish Nurses and Midwives Organization journal and newsletter and attend and present findings of this study at the annual INMO conference in 2018.	To highlight the importance of making more explicit cultural competence development.		
	Present findings at local research seminars organised by the nursing department and local acute healthcare services and national/international conferences.			
	Publish findings of study in peer reviewed journals that attract a broad readership of student and qualified nurses and nurse educators.			
Review the undergraduate curriculum and critically examining ways of re-	Adopt the constructs of the PTT model as a framework to guide the development of	Critically look at how curriculum is designed to actively build on and support	Department of Nursing and Midwifery –	September 2018

shaping the core values underpinning curriculum design, to ensure a continuous commitment to compassionate and culturally appropriate attitudes, behaviors and practices.	cultural competence across the curricula.	continuous cultural competence development.	curriculum development team	
	Form a steering group with representatives' from; community groups working with migrants, service user representatives, international council for international students, clinicians, student representative, course directors and faculty within the department of nursing and midwifery.	Curriculum design must begin with the development of cultural awareness and culturally sensitive and compassionate attitudes, before skills can be learned and students supported to apply them in clinical practice.		
	Carry out mapping exercises of curricular content and aspects of modules where cultural care can is addressed across the four year nursing programme.	Focus on adopting a "little and often approach" as opposed to a complete curriculum overhaul.		

Review educational philosophies, learning and teaching approaches both in the classroom and during clinical placements.	Critically examine learning, teaching and assessment strategies to ensure their appropriateness for continuous development of both individual and collective cultural competence.

Incorporate learning and teaching approaches and activities aimed at creating greater self – awareness, personal growth, self-regulation and therapeutic use of the self are recommended as a means of encouraging nurses to understand themselves, whilst respecting difference.

The use of approaches such as scenario based activities, real patient and nurse stories, may assist in developing the openness to new experiences | There is a need to review not just what is taught but how cultural competence is learnt and more importantly applied in practice.

Developing critical thinking skills, assertiveness, questioning and independent learning skills will help equip nurses to work in an increasingly complex practice setting, where rigid ethnocentric routine practices are engrained.

Discussing uncomfortable attitudes and practices sensitively in the safety of a supportive environment will encourage nurses to think about and acknowledge ethnocentricity, xenophobia and racism whilst collectively | Department of Nursing and Midwifery – teaching and learning committee | November 2018 |

182

| | and personal developments required. In particular practice scenarios that challenge explore political and media discourses on migration and integration.

Use learning and teaching approaches that encourage students to think about their attitudes and practices, whilst exploring the meaning on discrimination and the complexity of racism.

Map assessments across curriculum to ensure they encourage the gradual progression and development of critical and independent thinking, curiosity to learn and relating theory to practice and competent practice that is provided in culturally | thinking about appropriate ways of dealing with it sensitively and progressively. Learning with and from others experiences will help break down some of the barriers associated with discussing racism and blame avoided. | | |

	appropriate ways for example, reflection, projects and case studies. Encourage more sociological input in curriculum to challenge ignorance, understand value of migrants whilst critically exploring factors that may indirectly influence nursing attitudes and practices as a means of acknowledging indifference and more importantly dealing with it.			
Co-ordinate cultural competence education and training for nurse mentors/preceptors and lecturer/faculty.	The principles of continuous professional development should focus on developing cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Developing the knowledge and skills to discuss uncomfortable issues in a sensitively and	Nurse educators and those responsible for supporting students learning in clinical practice need to appreciate the value of exploring ethnocentric and racist attitudes and practices, feel comfortable to admit to not knowing everything whilst	Centre for nursing practice in acute healthcare settings in collaboration with department of nursing and midwifery	July 2018

184

	proactive way is essential in influencing change to practice.	being open to learn with and from student experiences.		
Review structure, content and focus of nurse mentorship and preceptorship programmes.	Within the role as link lecturer/faculty support in practice, support cultural competence training and development for mentors/preceptors. Establish mechanisms and forums for staff to share good practice as well as forums to enable staff to communicate concerns around culturally insensitive care in an open manner. Offer guidance and support with assessing cultural competence in clinical practice as well as ways of dealing with a poor performing student.	Providing opportunities for mentors/preceptors to think about their attitudes and practices and creating safe space for nurses to think about cultural dilemmas and prepare them for their leadership roles.	Centre for nursing practice in acute healthcare settings in collaboration with department of nursing and midwifery	Sep 2018

185

	Encourage and facilitate action learning sets for trained staff or ward based tutorials			
Provide support and skilled facilitation for students, mentors/preceptors and lecturers/faculty.	Co-ordinate group discussions and guided group reflection where opportunities are provided within small groups to explore stereotypes of particular groups and the truth or myth within them. Adopting the principles of clinical supervision, provide time and space for individuals to come together in a safe environment, to be facilitated to think about and discuss attitudes and practice dilemmas. Provide opportunities to explore how prejudices are	Such opportunities provides space for nurses to think about their own culture, cultural heritage and how it affects their understanding of others, as a means of recognizing its impact on cross-cultural encounters. This requires skilled facilitation and sensitivity as discussing stereotypes, prejudices and biases are sometimes uncomfortable, for both the student and the facilitator.	Centre for nursing practice in acute healthcare settings in collaboration with department of nursing and midwifery	May 2018

	developed, whilst also acknowledging how they impact on relationships and care provided as a means of providing meaningful direction for future practice.			
Developing cultural knowledge should focus on supporting nurses to find answers when they are unsure and adapt general caring principles and modify their skills to respect the social, cultural and psychological needs of patients.	Encourage students to self-appraise their knowledge, whist developing learning logs and contracts as to how they will increase their understanding is recommended. Plan opportunities where students learn to actively build on, rather than passively consume knowledge and develop independent learning and critical thinking skills. Using the same clinical or decision making issue, whilst	Nurses need cultural guidance but there is a need to acknowledge and respect difference and individual preferences.	Department of Nursing and Midwifery – teaching and learning committee and curriculum design team	Sep 2018

	changing the cultural or ethnic background of patients should allow nurses to compare how general care should be adapted for people of different cultures.			
Greater attention to similarities of needs and the values of compassionate practice is required during learning and teaching approaches both in the classroom and practice setting.	Work with non-government organisations such as Dorus Luimni and AkiDwA in planning learning and teaching activities and patient scenarios. Invite service users, people from different cultures and experts in the area such as healthcare professionals working in asylum seekers/refugees health centres, to share experiences is recommended.	Encourage the realities of practice are reflected in all learning, teaching and assessment strategies. Appreciating the realities of practice and vulnerabilities of people of different cultures as this will strengthen their capacity to provide compassionate care whilst respecting difference Encourage students to anticipate how it might feel for patients receiving care and role playing within the classroom can assist create	Cultural competence steering group	April 2018

188

		this awareness. The need for nurses to really think about the importance of caring for patients in a way that they want to be cared for is essential.		
Maximise on the opportunities for intercultural learning as a result of the increasing diversity of the student population	Capitalising on such cultural encounters in a safe and developmental learning environment where students have opportunities to learn with, from and about each other has the potential to provide the foundation and confidence for developing cultural competence. Practice questioning techniques in the more culturally diverse classroom allowing for opportunities to question values, beliefs that influence individual attitudes and practices.	Use learning and teaching approaches that equip students with the confidence to question and speak out are critical in developing these skills. For example, debates as learning tools, where students are required to articulate a perspective that may be unpopular to others, will assist in developing the confidence to question others' attitudes and practices. Provide opportunities for students to develop a mind-set of enquiry rather than unthinking acceptance of	Cultural competence steering group	July 2018

		ritualistic practices that further facilitate the un-noticing of insensitive practices.		
There is a need to support nurses to learn how to identify insensitive thoughts and attitudes, thus enabling them to be addressed before uncompassionate behaviour is acted out.	Provide opportunities for nurses to discuss their practice, to think about what they do and question the effectiveness of their care is essential. Incorporate caring conversations in our daily work and learning, and focusing on how we interact and meaningfully engage with patients as opposed to the task are essential. Providing opportunities for students to explore the meaning of compassion and how compassionate care can be provided in a culturally appropriate way requires a	Providing opportunities for nurses to recognize and acknowledge personal discomforts, challenging individual ethnocentric attitudes and exploring ways to respond and act appropriately to deal with them is fundamental.	Cultural competence steering group	July 2018

	more student led and student centered approach to their learning where the student voices, interpretations and experiences of compassionate practices are equally important in the learning process.			
Recommendations for Leadership and Management				
Action	**Objective**	**Rationale**	**Responsible person/Body**	**Timescale**
Develop organizational management and leadership structures and systems that promote the implementation of the standards for culturally and linguistically appropriate services within organisations	To review skill mixes in light of national and international skill mix Review practice audit tools that are routinely carried out in clinical practice to ensure they incorporate cultural competence as a criterion against which practice is judged, cognizant of the CLAS standards and Intercultural Health strategy as a guiding framework. Such audits should	There is a need for greater investment in preparing managers and leaders adequately for their transformational role, supporting them with management, leadership and cultural competence training. Ensure mission statements and organizational values encompass the need for courage, compassion, cultural sensitivity, integrity,	In collaboration with the practice development units and practice development Co-ordinators with in each acute services within the region.	November 2018

191

	highlight the need for improvements, resources and education and training. Review organisational and departmental values and mission statements. Consideration needs to be given to equality in fairness in considering, devising and operationalising human resource policies with regards to employment and promotion of people from different cultures who are eligible and have all required qualifications and experience as stipulated.	dedication to person-centered care and respect for diversity.		
Provide institutional cultural awareness and skilled anti-racist training.	These should be mandatory with annual attendance to updates compulsory. I would want to avoid blame and although I think it should be	This should help to address the subtle everyday discrimination, thoughtlessness and ignorance that this study demonstrated.	In collaboration with the practice development units and	May 2018

	compulsory, it needs to be done by experienced people and not just used as a tick box. There is a need to ensure culturally appropriate mechanisms for patients and their families to provide feedback about their healthcare experience and this training should be based on this feedback.		practice development Co-ordinators with in each acute services within the region	
Promote quality standards of care and address substandard care in an appropriate yet sensitive way.	Review assessment tools to ensure they explicitly encourage nurses to explore cultural, sexual and religious beliefs. As well as continuing and learning from Health Information and Quality Authority (HIQA) announced and unannounced inspections	This should embed a philosophy which encourages being more pro-active in engaging with patients in exploring cultural beliefs and care preferences. This should ensure the development for cultural compassion competence is explicit within standards of	In collaboration with the practice development units and practice development Co-ordinators with in each acute services within the region	Ongoing

	of clinical settings to determine compliance with quality standards, recommend to NMBI that they undertake annual quality and safety assessments of both HEI's and clinical placements to ensure they are compliant with their standards and guidelines ensuring standards for culturally and linguistically appropriate services are explicit.	care.		
Create an awareness of the findings of this study at a national level	To summarise key findings of this study and their implications in a report format and send to the Office for the Promotion of Migrant and Integration, Department of Justice and Equality; Chief Nurse, Department of Health; the Health Service Executive and Diane Nurse, National Lead for Social Inclusion. Link with the HSE Social	Creating awareness is the first step in facilitating change.	Kathleen Markey	January 2018

	Inclusion Unit volunteering to sit at national and local forums to canvas for a greater commitment for the operationalization of intercultural strategies and policies. Recommend that the HSE move forward with the review of the National Intercultural Health Strategy and indicate a willingness to engage at all levels with the support of this. Recommend the use of "othering" terminology used in existing policies and national strategies such as "non-Irish nationals" to be reviewed.			

10. Concluding Reflections:

This PhD journey has provided opportunities for personal and professional developments, whilst enabling greater insights and understanding and generating and dealing with new knowledge fit for practice. Such new awareness and insights has assisted with transformational developments to my daily practices as a nurse, researcher and academic. With the support and guidance of my supervisors, I now have a deeper understanding of the rationale for research processes and feel more comfortable in questioning philosophies underpinning research methodologies and appreciate that a methodology should not constrain the process of generating new knowledge. The initial interest in this research area commenced whilst undertaking research exploring racism in the classroom (Tilki *et al* 2007; Markey and Tilki 2007), this was further ignited in 2008 following completion of an online cultural competence module at Middlesex University. However, the real impetus for this study was the xenophobia, intolerance and prejudice I observed on moving back to Ireland. I realised that in order to shape the practices of nurses in Ireland, I needed to understand nurses' attitudes and values and examine what influences them to think and behave the way they do. From listening to informants' descriptions of the extent of the ethnocentricity and indifference that went unchallenged, I realised that despite all my prior learning, I too had become complacent and content at doing little. The findings reminded me of the need for a change in thinking and the need for continuous cultural competence development. This renewed awareness has enabled me to appreciate that nurse educators need to take time out from their own practice to question their attitudes and values and reflect on their teaching practices. The individual and collective nature of the attitudes and practices described has enabled me to open my eyes and ears in continuing my own journey of self-discovery. We must all take responsibility for our part played in the culturally insensitive and racially discriminatory care that is sustained. I have become much more in tune with issues raised in this study and acknowledge the winding journey ahead for me as an individual, for the profession, and Irish society in general. I now however have the confidence to raise questions and I feel

comfortable to admit not having all the answers. The following quote summarises my journey travelled during the past 7 years.

"It's rather like climbing a mountain, gaining new and wider views discovering unexpected connections between our starting point and its rich environment. But the point from which we started out still exists and can be seen, although it appears smaller and forms a tiny part of our broad view gained by the master of the obstacles in our adventurous way up"

(Albert Einstein 1921)

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214

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APPENDICIES

APPENDIX A - ETHICAL APPROVAL (UNIVERSITY)

Kathleen.Markey

From: Anne.OBrien
Sent: 28 October 2010 16:07
To: Kathleen.Markey
Subject: RE: EHSREC09-05

Dear Kathleen

The extension for this research project (EHSREC09-05) has been approved until Sept 2012.

Regards

Anne O'Brien
Administrator to Education and Health Sciences
Research Ethics Committee

From: Kathleen.Markey
Sent: 14 October 2010 15:58
To: Anne.OBrien
Cc: Kathleen.Markey
Subject: RE: EHSREC09-05

Dear Anne, many thanks. Please see attached my previous application form, as there have been no amendments made. I would appreciated if this could be considered to extend my ethical approval period for another year (until Sep 2012). I will pop in the post today a signed hard copy.

Many thanks
Kind regards

Kathleen

Kathleen Markey
Lecturer
Department of Nursing and Midwifery
Faculty of Education and Health Sciences
Health Science Building
University of Limerick
Limerick
Ireland

Email: kathleen.markey@ul.ie
Tel: 061 - 23 4355

APPENDIX B - ETHICAL APPROVAL (ACUTE LOCAL HOSPITAL)

Ms. Kathleen Markey,
Lecturer,
Department of Nursing & Midwifery,
Faculty of Education & Health Science,
Health Sciences Building,
North Bank Campus,
University of Limerick,
Castletroy.
LIMERICK.

Re/   **Protocol Title**
        "The learning experiences of students, lecturers, clinical practitioners of teaching or learning about providing culturally sensitive care – a grounded theory approach".

Dear Ms. Markey,

The Ethics Research Committee at the Mid-Western Regional Hospital, Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Ethics Research Committee:

Application to the Research Ethics Committee	Approved
Appendix 1: Consent Form	Approved
Appendix 11: Participant Information Leaflet	Approved

This approval is valid for one year from the date(s) accepted above unless otherwise noted on this document.

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions.

Yours sincerely,

Marie O'Keeffe

Mary Donnellan O'Brien,
Business Manager, Medical Directorate.
(For and on behalf of the Ethics Research Committee).

224

APPENDIX C – PARTICIPANT INFORMATION SHEET FOR STUDENTS

Study Title: The experiences of student and qualified nurses of caring for patients from different cultures

Researcher: Kathleen Markey (MSc, PGCHE, BSc, RGN)

You are invited to take part in the above research study. Before you make your decision, it is important for you to understand why the research is being carried out and what it will involve. Please take the time to read the following information carefully and discuss it with others or myself if you wish. Please do ask me, if there is anything that is not clear or if you would like further information. Please take the time to decide whether you wish to take part.

Thank you for taking the time to read this.

What is the study about?
Ireland has undergone rapid social, economic and political changes over the past ten years. As a result, Ireland has seen the development of a new phenomenon, where a predominant monocultural society has now become a multicultural society. The aim of this study is to generate an explanatory theory that describes the attitudes and practices of nurses caring for patients from different cultures. Ethical approval from the University of Limericks' Ethics Committee has been granted. I would welcome the opportunity to hear about your experiences of providing care to patients from different cultures and your views and opinions regarding the preparation you receive in your nurse training. The study will attempt to identify your main concerns and challenges and determine how you deal with them, in your daily practice. It is envisaged that the findings of this study will contribute new knowledge, which will support the development of cultural competence education and clinical practice in Ireland.

What will I have to do?
You will be invited to participate in a focus group discussion with other students to discuss your views of learning about providing culturally sensitive care and your experiences of how you do this in clinical practice. The focus group will consist of up to 8 students from your cohort and will take up to 60 minutes. It is envisaged that these focus groups will assist the researcher to gain insights into the experiences of BSc nurse students being prepared to care for a multicultural population and how they deal issues experienced in clinical practice. You may later be contacted and invited to participate in a face-to-face individual interview, which may last up to 90 minutes. Confidentiality and anonymity will be maintained. Your opinions and views are fundamental to this study, which is envisaged will contribute new insights into the area.

225

What are the possible benefits of taking part?
Your participation in this study will contribute towards the generation of an explanatory theory, which will describe what influences nurses' attitudes and practices when caring for patients from different cultures. It is envisaged that the findings of this study will contribute new knowledge, which will support the development of cultural competence education and clinical practice in Ireland. You will also benefit from seeing how the research process is operationalised in a research study, which will further contribute to your personal and professional developments.

What are the potential risks?
There are no potential risks associated with participating in this study.

What are the alternatives?
It is up to you to decide whether or not to take part. Your participation in this study is completely voluntary and you are free to withdraw at any time. You are not obliged in any way to participate.

What if I do not want to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason for doing so. A decision to withdraw at any time, or a decision not to take part, will not affect any of your final grades in any way. Participation in this study will take place at the end of the semester so will not impinge on any assessment processes in any way. Your participation in this study is completely voluntary.

What happens to the information?
All information that is collected during the course of this research study will be kept strictly confidential. Paper data will be stored in a locked filing cabinet in the researchers' office. The electronic data will be anonymous and data will be stored in an encrypted storage drive. Interviews will be tape recorded with your permission but will be deleted after they have been transcribed verbatim.

Who else is taking part?
Qualified nurses in the clinical setting and all students currently enrolled on the BSc nursing programmes will be invited to participate in this study.

What happens at the end of the study?
The contributions you make may be used in the research report or any publications that follow. However your identity will not be revealed and measures will be taken to conceal any other characteristics, which may identify you. This study is part of a PhD that I am

doing at Middlesex University, where I am under the supervision of two experts in the field.

What if I have more questions or do not understand something?
Before you make your decision, it is important for you to understand why the research is being carried out and what it will involve. Please take the time to read this information sheet carefully and discuss it with others or myself if you so wish. Please feel free to ask anything that you are unclear about before you have reached your decision. Take the time to decide whether or not you wish to take part. If you have any queries please do not hesitate to contact the researcher undertaking this study (please see contact details below):

What happens if I change my mind during the study?
If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you or your final grade in any way. Your participation in this study is completely voluntary

Contact Details:
Kathleen Markey
HS3 – 028, Department of Nursing and Midwifery,
Health Science Building,
University of Limerick,
Limerick,
Ireland

Email: Kathleen.markey@ul.ie
Telephone: 061 23 4355

If you have concerns about this study and wish to contact someone independent, you may contact:
The Chairman of the University of Limerick Research Ethics Committee,
C/O Vice president Academic and Registrar's Office,
University of Limerick.
Tel: (061) 202022

A copy of this information sheet will be given to you to keep.

Many thanks for all your help and participation in this research study.

APPENDIX D – PARTICIPANT INFORMATION SHEET FOR QUALIFIED NURSE INFORMANTS

Study Title: The experiences of student and qualified nurses of caring for patients from different cultures.

Researcher: Kathleen Markey (MSc, PGCHE, BSc, RGN)

You are invited to take part in the above research study. Please take the time to read the following information carefully and discuss it with others or myself if you wish. Please do ask me if there is anything that is not clear or if you would like further information.

Thank you for taking the time to read this.

What is the study about?

Ireland has undergone rapid social, economic and political changes over the past ten years. As a result, Ireland has seen the development of a new phenomenon, where a predominant monocultural society has now become a multicultural society. The aim of this study is to generate an explanatory theory that describes the attitudes and practices of nurses caring for patients from different cultures. Ethical approval from the Ethics Committee at the hospital in which you work has been granted. I would welcome the opportunity to hear about your experiences of providing care to patients from different cultures and your views and opinions regarding what influences nurses' attitudes and practices. The study will attempt to identify your main concerns and challenges and determine how you deal with them, in your daily practice. It is envisaged that the findings of this study will contribute new knowledge, which will support the development of cultural competence education and clinical practice in Ireland.

What will I have to do?

You will be invited to participate in a focus group discussion with other nurses to discuss your experiences of caring for patients from different cultures. In particular you will be asked about the challenges experienced and how you deal with them in your daily practice. The focus group will consist of up to 8 nurses working in clinical practice and will take up to 60 minutes. It is envisaged that these focus groups will assist the researcher to gain insights into the experiences of nurses of caring for patients from different cultures. You may later be contacted and invited to participate in a face-to-face individual interview, which may last up to 90 minutes. Confidentiality and anonymity will be maintained. Your opinions and views are fundamental to this study, which is envisaged will contribute new insights into the area.

What are the possible benefits of taking part?

Your participation in this study will contribute towards the generation of an explanatory theory, which will describe what influences nurses' attitudes and practices when caring for patients from different cultures. It is envisaged that the findings of this study will contribute new knowledge, which will support the development of cultural competence education and clinical practice in Ireland. You will also benefit from seeing how the research process is operationalised in a research study, which will further contribute to your personal and professional developments.

What are the potential risks?

There are no potential risks associated with participating in this study.

What are the alternatives?

It is up to you to decide whether or not to take part. Your participation in this study is completely voluntary and you are free to withdraw at any time. You are not obliged in any way to participate.

What if I do not want to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason for doing so. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way. Participation in this study will take place at a time that is mutually convenient and in a location of your choice. Your participation in this study is completely voluntary. No financial compensation will be given for participation in this research.

What happens to the information?

All information that is collected during the course of this research study will be kept strictly confidential. Paper data will be stored in a locked filing cabinet in the researchers' office. The electronic data will be anonymous and data will be stored in an encrypted storage drive. Interviews will be tape recorded with your permission but will be deleted after they have been transcribed verbatim.

Who else is taking part?

Other qualified nurses working in clinical practice and all students currently enrolled on the BSc nursing programmes at the University of Limerick, will be invited to participate in this study.

What happens at the end of the study?

The contributions you make may be used in the research report or any publications that follow. However your identity will not be revealed and measures will be taken to conceal any other characteristics, which may identify you. This study is part of a PhD that I am doing at Middlesex University, where I am under the supervision of two experts in the field.

What if I have more questions or do not understand something?

Before you make your decision, it is important for you to understand why the research is being carried out and what it will involve. Please take the time to read this information sheet carefully and discuss it with others or myself if you so wish. Please feel free to ask anything that you are unclear about before you have reached your decision. Take the time to decide whether or not you wish to take part. If you have any queries please do not hesitate to contact the researcher undertaking this study (please see contact details below):

What happens if I change my mind during the study?

If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way. Your participation in this study is completely voluntary

Contact Details:
Kathleen Markey
HS3 – 028, Department of Nursing and Midwifery,
Health Science Building,
University of Limerick,
Limerick.

Email: Kathleen.markey@ul.ie
Telephone: 061 23 4355

If you have concerns about this study and wish to contact someone independent, you may contact:

The Chairman of the Scientific Research Ethics Committee,
Limerick Regional Hospital,
Dooradoyle,
Limerick.

A copy of this information sheet will be given to you to keep.

Many thanks for all your help and participation in this research study.

<div align="center">**APPENDIX E – CONSENT FORM**</div>

Study Title: The experiences of student and qualified nurses of caring for patients from different cultures

Researcher: Kathleen Markey (MSc, PGCHE, BSc, RGN)

<div align="right">**Please initial box**</div>

I confirm that I have read and understand the information
   sheet dated ....…….for the above study and have
  had the opportunity to ask questions.   ☐

I understand what the project is about, and what the results
   will be used for   ☐

I am fully aware of all of the procedures involving myself,
   and any of the risks and benefits associated with the study
  free to withdraw at any time, without giving any reason.   ☐

I understand that my participation is voluntary and that I am   ☐
   free to withdraw at any time, without giving any reason.

I am aware that my results will be kept confidential   ☐

I agree to take part in the above study.   ☐

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Researcher   Date   Signature

<div align="center">1 copy for participant; 1 copy for researcher;</div>

APPENDIX F – LETTER OF INVITATION TO STUDENT INFORMANTS

Dear student,

You are invited to take part in a research study (which will involve participating in focus groups and/or individual interviews), which aims to explore your experiences of caring for or learning how to care for patients from different cultures. The aim of this study is to generate an explanatory theory that describes the attitudes and behaviours of student and qualified nurses when caring for people from different cultures. We are therefore seeking your views and wish to hear of your experiences of caring for and learning how to care for patients from different cultures. It is envisaged that the findings of this study will contribute new knowledge, which will support the development of clinical practice and cultural competent education in Ireland.

You will benefit from participating in this study as an individual, as you will have experience of engaging in the research process, which will assist you in developing your research skills. Your contributions will also benefit nurse education and clinical practice as we hope to unravel what influences nurses' attitudes and practices when caring for patients from different cultures. Can you please let me know if you are interested in participating in this study and sharing your views and experiences.

If you would like to know more about this study and possibly participate, please let me know by email and I will contact you with further details of this study. Please see attached the participant information sheet and consent form.

Kind Regards,
Kathleen Markey

Kathleen Markey
HS3 – 028, Department of Nursing and Midwifery,
Faculty of Education and Health Sciences
Health Science Building,
University of Limerick,
Limerick,
Ireland

Email: Kathleen.markey@ul.ie
Telephone: 061 23 4355

APPENDIX G - LETTER OF INVITATION TO QUALIFIED NURSE INFORMANTS

Dear nurse,

You are invited to take part in a research study (which will involve participating in focus groups and/or individual interviews), which aims to explore your experiences of caring for patients from different cultures. The aim of this study is to generate an explanatory theory that describes the attitudes and behaviours of student and qualified nurses when caring for people from different cultures. We are therefore seeking your views and wish to hear of your experiences of caring for how to care for patients from different cultures. It is envisaged that the findings of this study will contribute new knowledge, which will support the development of clinical practice and cultural competent education in Ireland.

You will benefit from participating in this study as an individual as you will have experience of engaging in the research process, which will assist you in further developing your research skills. Your contributions will also benefit nurse education and clinical practice as we hope to unravel what influences nurses' attitudes and practices when caring for patients from different cultures. Can you please let me know if you are interested in participating in this study and sharing your views and experiences.

If you would like to know more about this study and possibly participate, please let me know by email and I will contact you with further details of this study. Please see attached the participant information sheet and consent form.

Kind Regards,
Kathleen Markey

Kathleen Markey
HS3 – 028, Department of Nursing and Midwifery,
Faculty of Education and Health Sciences
Health Science Building,
University of Limerick,
Limerick,
Ireland

Email: Kathleen.markey@ul.ie
Telephone: 061 23 4355

APPENDIX H - FOCUS GROUP SCHEDULE FOR STUDENTS

Study Title: The experiences of student and qualified nurses of caring for patients from different cultures

Researcher: Kathleen Markey.

Introduction:
  Participant information sheet
  Voluntary participation and other ethical considerations
  Opportunity to ask questions and seek clarification
  Introduction to interviewer and Confidentiality issues addressed
  Mutually agree ground rules

Prompts:

  Have you had experiences in practice of caring for individuals form a diverse range of cultural, ethnic, religious backgrounds? How did you cope? What issues emerged for you.

  Tell me about these experiences?

  What are your views/opinions about caring for and/or learning how to care

  patients from different cultures?

  What has influenced/influences your attitudes and behaviours?

  Do you feel the programme assists you to develop the knowledge and skills to provide culturally sensitive care to a diverse population. Discuss/Observe interaction

  Discuss the main concerns and challenges experienced by student nurses when caring for or learning how to care for patients from different cultures?

  How are they dealt with? What influenced you to follow that course of action?

  Is there anything else you would like to share?

APPENDIX I - FOCUS GROUP SCHEDULE FOR QUALIFIED NURSES

Study Title: The experiences of student and qualified nurses of caring for patients from different cultures

Researcher: Kathleen Markey.

Introduction:
      Participant information sheet
      Complete demographic form
      Opportunity to ask questions and seek clarification
      Introduction to interviewer and Confidentiality issues addressed
      Mutually agree ground rules

Brief prompts:

Tell me about your experiences in practice of caring for individuals form a diverse range of cultural, ethnic, religious backgrounds?

What issues emerged for you? How did you cope?

Tell me more about your experiences.

Discuss your main concerns and challenges when caring for patients from different cultures.

How did you deal with these. What influenced you in your course of action?

In your opinion, how can these be dealt with/resolved?

APPENDIX J - INTERVIEW SCHEDULE FOR STUDENT INFORMANTS

Study Title: The experiences of student and qualified nurses of caring for patients from

different cultures

Researcher: Kathleen Markey.

Introduction:
      Participant information sheet
      Opportunity to ask questions and seek clarification
      Introduction to interviewer and Confidentiality issues addressed
      Mutually agree ground rules
      Complete demographic form

Brief prompts:

Tell me about your experiences of learning how to care for patients from different cultures. Tell me more.

How important do you feel it is to learn about and develop the knowledge and skills to provide culturally sensitive and anti-oppressive care? Why?

What experiences have you had of providing care or witnessing the provision of care to patients from different cultures. What influenced you to think or behave the way you did/do?

Tell me about your experiences of caring for individuals from different ethnic/cultural backgrounds. Do you feel you had/have the appropriate knowledge and skills?

What were your main concerns and challenges when caring for patients from different cultures?

How did you deal with these challenges in your daily practice? What did you do to deal with these challenges? What influenced you to take that course of action? Do you feel it was the right course of action? Is there anything you would have done or could have done differently? Tell me more….

Is there anything else you would like to add?

INFORMANTS

Study Title: The experiences of student and qualified nurses of caring for patients from different cultures
Researcher: Kathleen Markey.

Introduction:
>   Participant information sheet
>   Opportunity to ask questions and seek clarification
>   Introduction to interviewer and Confidentiality issues addressed
>   Mutually agree ground rules
>   Complete demographic form

Brief prompts:

Tell me about your experiences of caring for patients from different cultures. What influenced you to think or behave the way you did? Is there anything you could have done or should have done differently? Tell me more…..

What were your main concerns and challenges when caring for patients from different cultures? Why? Tell me more…..

How did you deal with these challenges in your daily practice? Was there anything else going on? What did you do to deal with these challenges? What influenced you to take that course of action? How do you feel about the care provided?

What influences your attitudes and actions when caring for patients from different cultures? Why? How? Is there anything you could or should do differently? Tell me more….

How do you support student learning to develop cultural competence in clinical practice?

What challenges are there and how do you overcome them?

How important do you feel it is to learn about and develop the knowledge and skills to provide culturally sensitive and anti-oppressive care? Why?

Is there anything else you would like to add?

Researcher	*So what else do you think they might have been fearful of?*	*Incidence*	*Initial Code*
Practitioner interviewee 6	I guess all the …the legal things…that in nursing…that we would be nervous that you are missing a major symptom. You know, the patient tries to tell you, but you don't understand and therefore then there could be implications and….you know, there's a perception….I am sure there's a perception that somebody would rather go into the house of Mr. Smith with prostate CA, this lovely old Irish granddad and that communication is perceives as being much easier to assess their symptoms. It's less stressful. I mean we would see that anyway in nursing. But anything that's going to take a little bit more time is difficult, whether it's dealing with somebody who is intellectually disabled or…or blind or….has physical….so	Professional shielding Fearing implications Seeing patients as a burden	Professional shielding
Practitioner interviewee 6	I am just thinking…the….the first lady I went to that was from Latvia, I probably….once I had raised my hand to say that I would go to her, because I was the most junior member in the team, that was probably a factor as well….I am sure….related to…the whole of allocation really isn't it…anyway in a way. But anyway….its like nurses have a fear of kind of exposing what they don't know	Being obliged to volunteer Fearing being exposed	Accepting responsibility Professional shielding
Researcher	*Do you think that is what is happening?*		
Practitioner interviewee 6	Oh yes…I am sure. . ….we would go off and we would…we train as nurses in a graduate diploma, but now we have … care has been extended…extended …that there's a lack of skill you know…		

## APPENDIX M - EXAMPLE OF TABLE WITH CATEGORIES, CODES AND THEIR PROPERTIES

Lack of knowledge leading to Uncertainty			
Lack of knowledge	**Uncertainty**	**Ethnocentricity and stereotyping**	**Culture of Organisation**
Not knowing Not knowing what we don't know Feeling anxious Lacking cultural knowledge More about being unable to use knowledge Feeling ill prepared Ad hocly addressed – over focus on ologies Not seen as important Valuing didactic approaches – not taught not learned	Feeling ambiguity Fear of causing offense Not knowing how to act Not knowing what to say Not knowing what to expect Feeling helpless and disempowered	Awareness of ethnocentricities and stereotypes Awareness of early age learning Overt discrimination of travellers Fewer examples of overt towards other cultural groupings for fears of … Some aware of ethnocentricities, others not Fear of racism accusations Lacked understanding Lacked opportunity to discuss Feeling upset Others remained oblivious Focussing on difference	Hierarchical structures Fearing rejection by peers Power of preceptor Questioning frowned upon Theory practice gap – didn't know how to handle Getting through placement Surviving placement Mirroring practices Take the easier option Wanting social acceptance

Masking	Distancing	Fitting in	Resigned indifference
Masking personal Beliefs and values Fearing different beliefs Identifying differences Faking smiles Putting on face Getting on with job Playing the game Disguising beliefs Parking them at the door (collect them on the way out) Hiding temporary Not showing beliefs Acting Getting out quickly Limiting conversations	*Psychological distancing (difficulties connecting – despite knowing):* *Disconnecting:* Seeking commonality Connecting challenges Feeling uncomfortable Social awkwardness Easier to do if not Irish Lacking small talk Less discomforting if poor English Not overcoming social awkwardness Blaming organisation *2.Focusing on physical care:* Focussing on tasks Focusing on physical care Focusing on measurable care Reduced personal discomfort with not connecting Getting in and getting out Doing what has to be done Getting the job done Timing pressures Business of ward Rapport building not important	*Keeping to the routine:* Following traditional routines Rigidity of accepted routines Needing security Task focussed Feeling compelled Cultural care not part of routine Importance Vs unimportance Our way or no way Failing to respect patient Taken for granted care Irishness of organisation wishes Fitting in Mirroring poor practices **Treating all patients the same:** Feeling uncomfortable Being cautious Fearing accusations Seeing difference BUT Failing to acknowledge difference Failing to respect difference Falseness of equality Appearing well intended Our way or no way	*Individual indifference:* Failing to take action Awareness of responsibilities and implications Lacking motivation Lacking willingness Going with the flow Taking the easier option Lacking interest Choosing to do nothing Accepting Knowingly providing sub standard care Disguising substandard care Blaming Being complacent Not questioning Othering Being influenced by others

Masking knowledge limitations:	Physical distancing		Organisational Indifference:
Disguising lack of knowledge Overcompensating (wouldn't normally do) Maintaining a professional image Living with dissonance Lacking understanding of professionalism	Avoiding (consciously) Avoiding (sub consciously) Delaying care Delaying engagement (intentionally and unintentionally Passing responsibility Omitting engagement Ignoring Burdening		Eased personal discomfort Failing to challenge Not being challenged Inertia to take action Weariness Mirroring poor practices Going with the flow Doing enough to get by Choosing to do nothing Task focussed Routinising care Conforming Wanting belongingness Turning a blind eye Not wanting to rock the boat Avoiding conflict Admitting those who do speak up
Masking with preceptors and peers: Disguising ignorance Needing to be seen as knowledgeable Complying with poor standards Turning a blind eye Getting on with it Feeling unable to challenge Taking the easier option			*Resigned Indifference:* Aware of responsibilities Blaming Self-rationalising Range of excuses Easing discomfort Emotional turmoil but Feeling disempowered and helpless Feeling unsupported Being allowed Business Lacking time, resources Labelling and othering
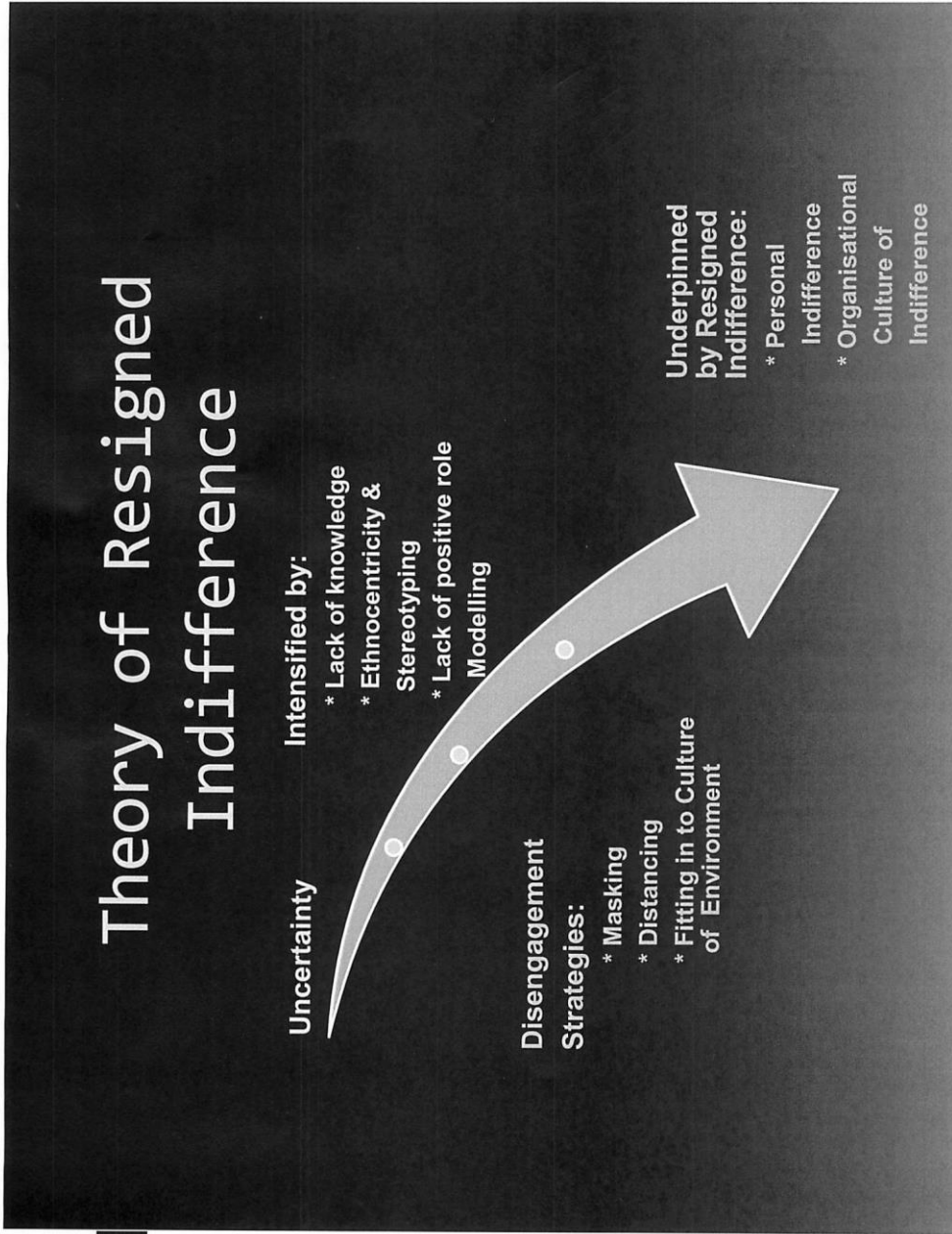
APPENDIX O - EXTRACT OF FIELD NOTES

Field Notes/ note taking – Practitioner interview (I. 4d)

Interview took place in informants home (as per their wishes)
Interview lasted 55mins

Initially informant felt cautious about sharing views and opinions but as strategies introduced to promote comfort and reassurance, informant appeared more relaxed.

Fears of being racist in discussions "hope not racist" hence ? does not know what constitutes racism

There was a general discomfort observed when using the term racism in discussions – repositioning in seats, many pauses, look at the floor and not maintaining eye contact

The challenge in caring for different nationals is the different traits – focus on looking at differences in other cultures towards the Irish culture – "our country" – there appears to be an over focus on cultural differences as opposed to seeking commonalities - this is an issue that appears to be consistently emerging in data.

Lacking of info; need for direction and need for research to guide direction

Avoidance of cultural care as focus more on medical problems and safety to mam and baby

Feeling horrifies at bad practice but did not know any better – an issue that consistently appears to be emerging. It is worth interviewing more registered nurses and exploring if this is an issue that is consistent?

Cultural issues not addressed in practice with students:
    Don't know curriculum
    Don't know if cultural issues addressed in competencies - "not top of my list"
    Time is an issue that consistently emerges – busy and no time – no time for "dauling"
    Lack of direction
    Not seen as a priority
    Not on radar
    Means to an end – "healthy mam and baby"
    Presuming care required
Not intentionally leaving it out or providing insensitive care
Interpreting of competencies – depends on who is assessing and their views

APPENDIX P - EXTRACT FROM MEMOES

16th September 2009
The main challenge that appeared to be identified is the issue with regards to having a prescribed syllabus from ABA and trying to fit it all neatly into a box; prioritising the prescribed syllabus but ensuring that evidence can be provided that key prescribed syllabus is evident. This almost suggests a regimental process of ticking boxes, as opposed to thinking broader about the needs and how cultural issues can be delivered. This would also suggest that the main focus is on teaching curricula content specifically; despite the acknowledgement during the interview that cultural development needs to be facilitated and can't be taught. Should the focus in 3rd level education be on teaching content or facilitating students to meet learning outcomes?

18th September 2009
Developing the knowledge and skills to become competent practitioners to care for a diverse range of cultural needs, appears to not be seen as a priority – although acknowledgement is given to the increasing importance. It would appear that it is seen as not fitting into the current curriculum – despite acknowledgement given to the growing importance of being transculturally aware. It would appear that as a concept it is seen as an "ad on", something extra with more workload (hence perhaps not seen as part of role). It is viewed as something that could be given time outside of modules – which raises questions about the value given to such concepts. Is it a tokenistic gesture? Is this as a result of a lack of awareness? It almost appears to be suggested that this is somebody else's role; a group of interested people needed to get buy-in; responsibility of others – might this be because of fears of lack of knowledge/insight? Or is this as a result of learned behaviour – such as we don't need to spend time teaching students to care for needs of "foreigners" (a word used within the interview)? Could this be viewed as a form of racism perhaps borne out of thoughtlessness or ignorance? (Or am I speculating this, in light of my own views and opinions?)

24th September 2009
There is a possible suggestion that some lecturers are more culturally aware than others. Furthermore it is suggested that a greater awareness comes with prior experience and exposure in working in other countries. Does this automatically suggest that those lecturers who have worked in other countries have a greater awareness, expertise? Have they learned appropriate behaviour? Was their practice appropriate? This suggestion is possibly questionable, although no evidence of this at present.

20ᵗʰ October 2009
It would appear that there was an emphasis to develop a specific post graduate transculturally competent module, however it is starting to appear evident that there is minimal specific/explicit Transcultural issues addressed within in the theory of the BSc programme – although early days yet to be stating this.

9ᵗʰ Sep Being cautious – student interview 2
It would appear that this element of being cautious is an issue that is starting to come out stronger in the interviews, although eluded to in the student focus groups. Their defence to this is although they don't always say they are being cautious; what they are doing is treating all patients the same for fear of accusations. Care was explained "the same" as it was to an Irish patient. Using "big words and all" – but this didn't bother the midwives. They did appear to real lack the ability to question themselves – doing a routine

18ᵗʰ Sep Being accepting of Bad practice - not challenged or questioned – student interview 5
Care is not being explained properly and this is accepted or resigning to the fact and not questioned. They know what they should be doing and no what should not be doing but become complacent . Justifying that its not their faults that "its crazy out there" Are they being <u>complacent ? This came up in focus groups too – what will qualified nurses say?</u>

9ᵗʰ Dec Getting the job done
This is something that comes a lot. They see culture as kind of an add on. There is a clear focus that there are constraints such as time, resources etc but they focus on getting in and out; focussing on doing the physical care only

4ᵗʰ Jan Not bothered
The nurses appear to be uninterested or blasé about it – this is something that emerges within the focus groups but is starting to emerge stronger -why not? Mostly because not being challenged or questioned

9ᵗʰ Jan Accepting of poor practcies
Accepting of own poor practices as "nobody would do anything if black person challenged me"

12ᵗʰ Jan Complacency
Patients do not challenge poor practices – so are they saying then it is ok not to challenge self or others???

9ᵗʰ Feb Carrying on acting as normal
Lacking insight as when not questioned then "we carry on acting as normal" -is this <u>customary practices</u>?????