A PHENOMENOLOGICAL EXAMINATION OF QUALIFIED NURSES' PERCEPTION, MEANING AND EXPERIENCE OF CULTURE WORKING IN THE HSE WEST.

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Abstract

Abstract

This Research Study sets out to examine qualified nurses' perception, meaning and experience of culture working in the HSE West. The research was conducted utilising a Qualitative Phenomenological Husserlian Framework.

An in-depth review of the sociological and nursing literature was carried out. This revealed that culture is a multifaceted, dynamic and non static term which is difficult to define (Tovey & Share, 2003). Nursing is immersed in Culture complete with its philosophies, models and theories which embody the very essence of culture values, beliefs, attitudes and behaviour (Bashford & Slevin, 2003). The nurse is a cultural dweller who has been socialised at a personal level and at a professional level. Nursing subscribes to the practice of Holism yet for many nurses faced with difference in society a tick-the-box essentialist perspective is preferred which is at variance to this very constructivist ideal (Gray & Thomas, 2006).

Having the Map is not sufficient to deal with the diversity in Irish society the literature forwards cultural competence models with Madeleine Leininger (1995) at the fore front of the development of Transcultural nursing theory. Papadopoulos, Tilki & Taylor, (1998) have forwarded a transcultural care model which focuses on the development of transcultural skills and has identified four main concepts cultural awareness, knowledge, sensitivity and competence required in order for this to occur.

The hunch was formulated by the Researcher,

"That working abroad broadened the value and belief systems of nurses and increased tolerance to diversity".

A purposive sample of eighteen nurses was chosen who met the required generic and specific participant selection characteristics. The data was gathered via four focus group interviews comprising of the eighteen participants. The rationale in choosing the focus group interview as the method of choice is that it provides the Researcher with in-depth descriptions and collective interactions of the experiences of the participants in an informal natural setting (Krueger & Casey, 2000). An audiotape was used for the duration of the interview to ensure that all information was captured. The interview transcripts were then verbatim typed and analysed using Colaizzi's (1978) seven step procedural tool.

This elicited three themes, Rediscovering culture and Irishness, Nursing Culture workplace practices and issues and cultural competence models are they appropriate or useful?

Firstly, the findings revealed that nurses had a difficulty defining culture with as a result multiples of interpretation. O'Hagan (2001) warns that to leave individuals to attempt to define culture, something that we are not overtly aware of until we encounter *'others'* has the potential to lead to a limited, imbalanced, even negative perception of culture.

Secondly, the findings revealed that nurses are cultural dwellers with their own personal and professional culture which in turn provides each nurse with a meaning filled experience that in turn ascribes to ethnocentric assumptions. The research revealed that having worked abroad only served to reinforce negative value and belief systems and controversially revealed that the experiences gained abroad left many of the participants more racist than if they had never left. The statements indicated feelings of resentment, and intolerance with has not been helped by the current economic crisis. The predominate attitude to difference identified was that of *'them and us'* fitting in and treating everyone the same – the one size fits all.

Finally, given the current demographic changes in Ireland diversity is firmly parked on our doorstep the participants highlighted the need for post registration education to address the multi ethnic Irish society. The findings clearly demonstrated a dearth of knowledge with regard to cultural care models and the need for continuing education which will equip the nurse with the essential knowledge, skills and attitudes to care for and work with different ethno cultural groups. This is not suggesting that nurses will have expert knowledge about culturally diverse groups but instead will ensure greater cultural flexibility.

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Abbreviations

Abbreviations

ABA	=	An Bord Altranais
ANA	=	American Nurses Association
CNE	=	Centre of Nurse Education
CNME	=	Centre of Nursing & Midwifery Education
CA	=	Clinical Area
CPD	=	Continuing Professional Development
CSO	=	Central Statistics Office
DJELR	=	Department of Justice Equality & Law Reform
DoH&C	=	Department of Health and Children
EA	=	Equality Authority
EIW	=	European Intercultural Workplace
EU	=	European Union
FGI	=	Focus Group Interview
HCW	=	Healthcare Workers
HRB	=	Health Research Board
HSE	=	Health Service Executive
HSEA	=	Health Service Employers Agency
IHSMI	=	Irish Health Services Management Institute
INC ECF	=	Irish National Committee European Cultural Foundation
INMO	=	Irish Nurses/Midwifery Organisation
MA	=	Masters
NCCRI	=	National Consultative Committee on Racism and Interculturalism

NCNM	=	National Council for the Professional Development of Nursing and Midwifery
NMC	=	Nursing and Midwifery Council
NPAR	=	National Action Plan against Racism
ONSD	=	Office of the Nursing Services Directorate
PFGI	=	Pilot Focus Group Interview
PPPG's	=	Policies, Procedures, Protocols and Guidelines
RGN	=	Registered General Nurse
RNID	=	Registered Nurse Intellectual Disability
RM	=	Registered Midwife
RNT	=	Registered Nurse Tutor
RPN	=	Registered Psychiatric Nurse
RSCN	=	Registered Sick Children's Nurse
SRN	=	State Registered Nurse
UK	=	United Kingdom
UN	=	United Nations
UNESCO	=	United Nations Economic and Social Council
WIN	=	World of Irish Nursing

Chapter 1

Introduction

1.1 Introduction

Recent publications would suggest that Ireland is fast becoming a truly multicultural society (Lee et al, 2006; Eastern Regional Health Strategy, 2004; Boyle, 2000). *"This is another age a different reality. People now come to live and work in Ireland and their presence affects the way in which things are done here"* (ECF, INC, 2006, p 7).

As with global and European trends Immigration has now become an issue for Ireland, this is in turn creating increased demand on resources and in so doing changing the political, social, health and economic landscape (Tovey & Share, 2003). This movement of the *'other'* challenges the existing frameworks of traditional Irish society, in effect the exotic is now firmly camped on our back door (Tovey & Share, 2003).

Given these international and national developments, nurses as health care professionals need to be responsive to the change in population trends as nursing is *"... one of the cornerstones of the modern Irish health service"* (The Commission on Nursing, 1998, p 3), yet it is widely acknowledged that the individual needs of minority ethnic groups are not being met in our now multiracial society (Flowers, 2009; Cortis & Law, 2005; Gannon, 2004; Boyle, 2000; Alleyne et al, 1994). With the emergence of the trend of consumerism

this will no longer remain an acceptable societal norm as Flowers, 2009, p 48 suggests the development of a *"... consumer mandate for culturally competent care in an increasingly diverse multicultural society".*

Historically, nursing as a profession has continued to develop and respond positively to these changing needs and environments (O'Shea, 2008; HSE, 2006; The Commission on Nursing, 1998). From an Irish perspective the evidence to support the potential to change stems form two developments the first being the transfer of Pre-Registration Nurse Education to Higher Education Institutes and the second, the changes in the role, structure and function of the Health Services i.e. the Health Service Reform Programme (HSE, 2006). The former has seen through the implementation of Registration/Diploma programmes (DoH&C, 1996) and the subsequent transfer of pre-registration nursing programmes to Third Level Colleges in 2002 (HSEA, 2002). The latter is notably the Health Service Reform (2005) and Transformation (2007 - 2010) processes, in which nurses have embraced the move towards nationally consistent health services (HSE, 2006). Nursing has been dynamic and has demonstrated its commitment, by continuously embracing and adapting to a wide range of stimuli (Flowers, 2009).

In order to keep pace with the radical changes of the movement of Ireland as a mono-cultural society to one which is comprised of groups with diverse cultural perspectives, nurses as health care professionals need to examine their understanding of culture and diversity and in turn embrace the notion of cultural competence. As McGee (1994, p 3) suggests that *"... in order to*

reach out to each patient and establish a therapeutic relationship, the nurse must have some knowledge and understanding of individual and cultural differences". The Researcher would like to caution that *"... in today's society culturally competent care cannot be offered to all patients unless nurses have a clear understanding of diverse cultural backgrounds"* (Flowers, 2009, p 48). It is the nurse who is charged with this responsibility as the Code of Professional Conduct requires that he or she *"... recognise and respect the uniqueness and dignity of each patient/client"* (ABA, 2000).

1.2 Research Question

Aims and Objectives of the proposed programme of Research

In this research project the Researcher intends to carry out a phenomenological examination of qualified Nurses' perception meaning and experience of culture working in the Health Service Executive (HSE), West. The project will be socially and culturally situated.

The study objectives aim to;

1. Examine qualified nurses' perceptions, awareness and understanding of culture i.e. the meaning of culture to them. The Research seeks to discover the range of ideas and feelings that nurses have about culture in general, nursing culture and *'other'* cultures.

2. To understand and reveal the differences in perspectives between groups of nurses and to uncover the factors that influence these opinions, beliefs, attitudes and behaviour.
3. Reveal the factors that have the potential to facilitate cultural competence when working with or caring for diverse cultures.
4. Highlight the strategies to be put in place from an educational perspective that will assist nurses to develop cultural competence from the information rich data that will emerge from the focus group interviews.

A comprehensive literature review of the main study topic has been undertaken in order to explore the existing body of cultural academic knowledge. This is comprised of two chapters.

The first of these, Chapter Two will attempt to offer the reader a textual definition of culture and what it is? The various dimensions of culture will be offered by the Researcher in the analysis, with an account of Irish culture established. It becomes clear from the analysis that Ireland has struggled with its own cultural identity. Therefore given the undercurrent of multicultural diversity will Ireland freeze with *"... anxiety and fear over the demands placed on them by migration and diversity?"* (Keil & Hubner, 2005, p 641). The legislative and policy responses are offered by the Researcher as central to the response by government to a culturally diverse society.

In chapter three the Researcher presents an historical analysis of nursing culture. It is important that the reader becomes aware that nurses are cultural dwellers this provides each individual nurse with a source of meaning for social constructions (Paley, 2002). Therefore it seems likely that nurses will suffer from varying degrees of ethnocentrism – *"... the view of things in which ones own group is the centre of everything, and all others are scaled and rated with reference to it"* (Burnard, 2005, p 178). This is important as the *'other'* becomes identified though the recognition of difference as opposed to similarities (Winkelmann-Gleed & Seeley, 2005).

This recognition of difference permeates the nursing literature with the essentialist scientific perspective of *"check the box"* (Gray & Thomas, 2006, p 77) inherent in the nursing assessment of the patient with the use of such terms as race, ethnicity, religion and nationality. However, culture is more than conforming to certain characteristics and if nursing is to reflect the art of caring in order to deliver the highest standard of care possible in a diverse society then, they must endeavour to become culturally competent (Taylor, 2005; Papadopoulos et al, 2004; Boyle, 2000). The chapter then focuses on what cultural competence is and Madeline Leininger's Transcultural Nursing Model (1978/1995) is offered as a nursing solution. The Researcher espouses Education as the conduit to convey greater cultural awareness among nursing staff (O'Shea, 2008) with Papadopoulus, Tilki & Taylor's Model (2004) facilitating this learning process.

The methodological chapter 4 will set out the research philosophy of phenomenology, the design, rationale, data collection tool and analytical framework for this research project. This was achieved by the use of a purposive sample of eighteen nurses who met the required generic and specific participant selection characteristics. The data was gathered via four focus group interviews comprising of the eighteen participants. The rationale in choosing the focus group interview as the method of choice is that it provides the Researcher with in-depth descriptions and collective interactions of the experiences of the participants in an informal natural setting (Krueger & Casey, 2000). An audiotape was used for the duration of the interview to ensure that all information was captured. The interview transcripts were then verbatim typed and analysed using Colaizzi's (1978) seven step procedure. Ethical approval was sought from the Research Education Committee in Sligo General Hospital with issues of rigour thread concurrently throughout the project.

Finally the findings and discussion therein are articulated in chapter 5 with recommendations formulated that best suit from the Researcher's perspective in dealing with the social issue of cultural diversity this will bring the research paper to a conclusion.

1.3 Background to the Study

The interest and motivation in examining cultural perspectives among nurses has stemmed from the Researcher's background in Nursing and Sociology

and the relevance of the study of social science as a discipline to health care professionals. The Researcher's viewpoint on culture is that it is a means in place in society which helps the individual to interpret and understand the social world around them. However, for many nurses social knowledge, awareness and understanding is tacit as Schutz (1953) stated in Smith (1998) we are the person on the street, at home in a particular place and getting by without the need for much great reflection. Like Schutz the Researcher hopes that this scientific research will move the reader to the vantage point of the stranger, thereby, enabling the reader to live the experience by communicating the complexities surrounding the study of culture. Nurses require more than tacit knowledge given the diversity of today's cultural setting couple this with the fact that the nurse as a human being brings to the healthcare setting *"... not only his or her own values, beliefs and customs, but also those of the nursing profession"* (McGee, 1994, p 3).

The record growth in population in Ireland enumerated on the census night of April 23rd 2006 was 4,234,925 persons. This represented an increase of 317,722 when compared with 3,917,203 persons in April 2002 (CSO, 2006). In fact the 2006 population *"... was last exceeded in the census of 1861 when the recorded population was 4.4 million"* (CSO, 2006, p 9). However, to situate within an historical context and demonstrate why these figures are significant, that is, while the natural increases have been positive for the period under review, net migration has been more volatile (CSO, 2006). In fact the *"... the number of non-nationals enumerated as part of the 2002 census was 222,000, representing 5.8 percent of the population. While the*

corresponding figure for 2006 which has been *derived flow data on migration that the stock of non-nationals is likely to be about 400,000"* (CSO, 2006, p 9).

Essentially this demonstrates that one person in every ten or 10% of the population in Ireland are from different minority cultural groups (Phelan, 2006; Nurse, 2006), *"... this statistic has been challenged by some commentators who say that many migrant workers stay here for a short period of time before returning to their native countries"* (Phelan, 2006, p 7). The Researcher would like to stress that cultural diversity is not a new phenomena to Ireland as evidenced in chapter 2 of the research (NCCRI & IHSMI, 2002).

Travellers are a minority community indigenous to Ireland (Brenner, 2003; Boyle, 2000). As Boyle, 2000, p 14 articulates *"... outside of this, one could have almost been excused for considering as an absolute that the population of Ireland was culturally the same".*

Regardless of who, how many and why, cultural diversity has arisen in Ireland in the last decade (NCCRI & IHSMI, 2002). It is not something that we can hope will go away if ignored and it is only a matter of time before ethnic minority groups need to access institutions either as employees or service users and the health service is one such organisation (Boyle, 2000). The HSE has endeavoured to develop a range of services, to respond to the demographic changes by working in collaboration with a number of statutory and non governmental agencies (Nurse, 2006). These service initiatives are underpinned by a number of national policies and frameworks including

Quality and Fairness: A Health Strategy for All, (2001), The National Action Plan Against Racism, (2005), The National Anti Poverty Strategy, (1997) The European Intercultural Workplace (EIW) Project, (2007) and The National Intercultural Strategy (2007).

The latter of these i.e. the National Intercultural Strategy, published by the HSE in March 2007, aims to provide a framework embracing the health care and support needs of culturally diverse individuals (Nurse, 2006). In referring to the HSE, one must ask the question which is the focus of this research project and that is, what is the perception, meaning and experience of qualified nursing staff working in the HSE, West of the phenomenon culture? To a certain extent The European Intercultural Workplace Healthcare Report (2007) does establish an overview of sector specific work practices across Europe based on national situational analysis. The perspective of employees in this report is of particular interest to the researcher and will inform the research findings and discussion chapter.

Primarily the aim within the HSE is to strive towards cultural competence (Brenner, 2003). Competence can only be achieved if there are an awareness and understanding of others (Boyle, 2000). In order to achieve this professional education is one of the key factors that enable a competent understanding of others (Cortis & Law, 2005; Graham, 2005; Alleyne et al, 1994; McGee, 1994).

1.4 Definition of Key Terms

Qualitative research as an inductive method places an emphasis on the interpretation of meanings (Payne & Payne, 2004). In this approach there is no prior social order as what counts as social is rigorously developed (Payne & Payne, 2004; Bryman, 1988). Therefore, qualitative research does not subscribe to the notion of operational definitions of key terms or concepts, as these will emerge during the course of the study. However, the Researcher will provide an outline glossary of key terms referred to in this research project. The rationale presented in defining the terms is based on the premise that in the first instant a mixed method has been utilised in that the Researcher invoked a questionnaire and secondly the key focus of this study is to create understanding which can only be ensured by defining key terms. In offering the glossary of terms (Appendix I) in the project, the Researcher would like to acknowledge and endorse the sentiments of Smith (1998, p 339) who posits that *"... all these key words are matters of dispute and contestation that is, what they mean depends on the approach in which they are placed".*

Chapter 2

The Sociological Context of Culture

Literature Review

CHAPTER TWO

2. Literature Review

2.1 Introduction

It is the Researcher's intention in this literature review chapter to examine the key concept under question, that is, the perception and meaning of culture from a sociological perspective. This will be accomplished by focusing on the question of what culture is, how it is defined sociological and in particular what it means to be Irish. Helman (1994, p. 2) states both concepts complement each other that is Irishness and culture as *"... the ways that human groups organise themselves, and the ways that they view the world that they inhabit ... is necessary to study both their society and their culture".* Bhikhu Parekh (2000, p 146) reiterates this inseparable nature of culture and society *"... in the sense that there is neither a society without a culture nor a culture which is not associated with some society".*

Culture will remain the main overall concept under examination with multiculturalism and interculturalism forwarded as two of the many theoretical perspectives utilised to deal with culturally diverse societies. The focus will be generalised, however the Researcher recognises that nursing as a profession has its own distinct culture, with this in mind *"... awareness and understanding of cultural nuances and potential implications are essential throughout the practice of nursing"* (HSE, South, 2006, p 24). In chapter 3 the Researcher

intends to construct the meaning of culture in nursing and forward a nursing response to embracing the multicultural nature of society.

A dichotomy exists for all nurses, as they have a prevailing viewpoint about culture from a societal perspective as well as one from a professional perspective, in essence most nurses have been socialised twice , furthermore *"... the concept of 'culture' itself has been misunderstood, or even misused"* (Helman, 1994, p 4). Holland & Hogg (2001, p 2) concur with Helman as *"... the terms culture, race and ethnicity are often confused in their interpretation by healthcare professionals and the public in general"*.

Nurses do not differ from all other health care workers in that they have a prevailing viewpoint of culture, this is not always easily discernable. However, it profoundly influences the way individuals, families and communities are viewed (Gray & Thomas, 2006). This view point is predominately influenced by the positivist/essentialist philosophy in which culture is easily discernable from a nursing perspective and assumes that one's culture can be revealed through a set of questions *'the nursing assessment'* (Gray & Thomas, 2006). This limited essentialist view has the potential to create negative implications for nursing practice and education.

There is more to culture than simply asking questions such as *'What religion are you? What nationality are you?'* as the creation of a list of features can be viewed with confidence as being real. However, the list skilfully conceals the fact that the identified features are based on scientific knowledge which in turn

has been generated by human beings and is therefore a product of the social activity of interaction (Gray & Thomas, 2006).

The essentialist philosophy sets out to distinguish one group of people from another on the basis that they share recognisable sets of beliefs and values (Gray & Thomas, 2006). This assumption simplifies culture as a narrow, homogenous concept signified by the yardsticks of race, religion, age, gender and ethnic origin (Yearwood, 2006). This results in little reflection on understanding the broad and multifaceted concept that culture is given the three prevailing viewpoints that exist anthropologically, philosophically and intellectually (Gray & Thomas, 2006; Yearwood, 2006; Tovey & Share, 2003; Parekh, 2000; Helman, 1994).

2.2 What is Culture?

The word *'culture'* is derived from the Latin word *'cultura'* and the French word *'culture'* at the root of these words is the "... *tiling of land, the improvement of crops and crop production"* (O'Hagan, 2001, p 31). This original meaning centred on the notion of a symbolically powerful and nurturing earth. O'Hagan (2001, p 31) postulates that the association with land *"... remains a core component in the subjective meaning many of us are likely to provide for the world today".* This is evident in references to the land of our birth or nationality (O'Hagan, 2001). This inadequacy of the definition of culture can lead to misunderstanding as culture must be defined in order to avoid confusion and ambiguity for healthcare professionals (O'Hagan, 2001).

The concept of culture itself still remains difficult to define as Tovey & Share (2003, p 325 & 329) postulate *"... the term 'culture' is one of the two or three most complicated words in the English language"* with *"... 'Culture' one of the most complex terms in the lexicon of the social sciences".*

Culture is a contested, dynamic concept therefore many theories and explanations have been forwarded since anthropologists first began to theorise it in the 18th century (Gannon, 2004; Holland & Hogg, 2001). Indeed anthropologists were among the first to define culture this is evident from E. B. Tylor's 1871 definition cited in Helman (1994, p 2),

> *"Culture or civilisation is that complex whole which includes knowledge, beliefs, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society".*

Tylor's definition is one of the most enduring as it is equated with civilisation thereby suggesting that there is a difference between the human and animal world and refinement is key (O'Hagan, 2001). O'Hagan (2001, p 32) rationalises the enduring all embracing aspect of the definition which from his perspective is clarified by the use of the statement *"... and any other capabilities and habits required; these include language"* (O'Hagan, 2001, p 32). Civilisation vis a vis language is only one of several levels that culture is articulated at – this is at the most basic level as all societies share a common language (Parekh, 2000).

Given the three levels that exist of culture,

Cultural anthropology - civilised and cultivated

Cultural philosophy – ideas, values belief systems

Cultural intelligence and artistic activity – high culture that is fine art and literature and in more recent years has incorporated pop music (Gray & Thomas, 2006; Yearwood, 2006; Tovey & Share, 2003; Parekh, 2000; Helman, 1994). Much of what sociologists have to say about culture comes from anthropological studies (Bradshaw et al, 2001). Sociologists conform to the notion that culture can be defined by categorisation just as anthropologists did into non-material and material concepts (Macionis & Plummer, 1998; Helman, 1994). Culture is therefore a set of guidelines or a framework (Henley & Schott, 2004; Boyle, 2000; Helman, 1994) by which the human individual organises, legitimises and underpins the functioning of his society by implementing this culturally categorised set of rules (Helman, 1994). Macionis & Plummer (1998, p 98) refer to these categories as *"... the thoughts and things".*

Tovey & Share (2003, p 325) state that *"... at its broadest, culture embraces the customary ways that people behave towards each other".* Given that 90% of culture is invisible it is remarkable that with only 10% of all the many aspects of culture are immediately obvious, such as what we eat and drink and religious rituals that the organisation of society is achievable (Parekh, 2000). The intangible worlds of ideas created by the members of a given society are difficult to measure as they are invisible (Macionis & Plummer, 1998). On the other hand material culture is the tangible creation of artefacts

that are visible, easily quantifiable, constituting and symbolising the way of life of a people (Macionis & Plummer, 1998). This material aspect of culture is very much espousing the dominant philosophy of essentialism which put forward the view that every functioning thing has a defining essence this includes the non-material aspects such as values, beliefs and behaviour (Helman, 1994). Parekh (2000) in his book **Rehinking Multiculturalism: Cultural Diversity and Political Theory** outlines how Western traditional philosophies from Plato onwards have limited resources to cope with the diversity of the non-material aspects of culture.

As the Researcher will demonstrate the many definitions forwarded by sociologists embody these non-material and material aspects of culture (Goodman, 1992).

> *"... culture refers primarily to the way of life of a people, social group or historical period. It includes two main elements : ideas, for example, from philosophical systems, values and rules for behaviour through to concepts and perceptions in everyday use; and material artefacts such as tools, works of art, furniture or food".*
>
> (Tovey & Share, 2003, p 325).

Macionis & Plummer (1998, p 98) define culture as,

> *"... the values, beliefs, behaviour and material objects that constitute a people's way of life. Culture includes what we think, how we act and what we own".*

The sociological definitions forwarded often overlook the operating differences of the visible versus the invisible with the consequence that many of the solutions to societal issues *"... do not work or cannot be implemented ... because differences in thinking among the partners have been ignored"* (Hofstede & Hofstede, 2004 p 2). Tovey & Share (2003, p 350) allude to this complex nature of culture as it is inherent not only *"... to a set of practices that take place in the 'public' world, but also to the texture of everyday life within households, families and workplaces".* Given that every culture develops over time, with no co-ordinating authority *"... it remains a complex and unsystematised whole"* (Parekh, 2000, p 144).

In Western society culture has become the catchword for all of society's non-material and material patterns (Hofstede & Hofstede, 2004). It demonstrates how culture is central to all life, as it shapes thinking, imagining and behaviour (UNESCO, 1995). However, the human as an individual possesses differing patterns of thinking and feeling as he or she acts as a *"... operating system"* (Hofstede & Hofstede, 2004, p 4).

Hofstede & Hofstede (2004, p 3) customarily refer to the term culture as the *"... software of the mind"* thereby recognising diversity, as no two minds think alike. In forwarding this analogy they are not suggesting that the human individual is programmed in the same way as a computer but that the human individual as a rational or irrational being has the basic ability to deviate or make informed choices that are sometimes *"... new, creative, destructive or unexpected"* (Hofstede & Hofstede, 2004, p 3).

"None of us, therefore, is simply a package of culture...we all have culture, but our culture does not define us"

(Henley & Schott, 2004, p 3).

The family is a universal concept of all cultures (Bond & Bond, 1994) where the enculturation i.e. the gradual acquisition of *"... the cultural 'lens' of that society"* occurs (Helman, 1994, p 3). Our view of these cultural experiences encountered from within the family unit show us that *"... if we behave in ways that do not fit in with the culture ... they make their disapproval clear"* (Henley & Schott, 2004, p 13). Therefore cultural background with its *"automatic"* learned behaviour (Boas, 1928 cited in Gannon, 2004, p 3) *"... has an important influence on the many aspects pf people's lives including their: beliefs, behaviours, perceptions, emotions, language, religion, rituals, family structure, diet, dress, body image, concepts of space and of time, and attitudes to illness, pain and other forms of misfortune"* (Helman, 1994, p 4).

Conversely,

"... as we learn what is acceptable within our own culture and/or religion the foundations are laid for regarding difference with suspicion. If we are taught that what we do and how we view things are 'correct' and 'right', we can be forgiven for assuming, however unconsciously , that people who do and view things differently are wrong and less deserving of our respect"

(Henley & Schott, 2004, p 13-14).

Those individuals who view and do things differently are identified as the *'other'* (Gray & Thomas, 2006, p 78) and it is this notion of the *'other'* that is embodied in the essentialist philosophical position, in which white western ideals are viewed as superior i.e. ethnocentricism de facto racial superiority. Boas (1928) cited in Gannon, (2004 p 3) highlighted the dangers of ethnocentricism, in his studies on brain characteristics in which he refuted the notion of racial superiority by demonstrating that *"... the differences between races are so small that they lie within the limits of which all forms may function equally well".* Once groups are identified based on difference higher values can be ascribed to certain characteristics and typically the dominant group attaches the highest value to those attributes associated with itself (Gray & Thomas, 2006). Ethnocentric views and practices within the clinical setting can lead to, as Yearwood (2006, p 161) suggests *"... misdiagnosis, conflict and ultimately poor treatment choices".*

Culturally homogenous perceptions of society fail to recognise diversity thereby ignoring the contribution that different cultural groups can make both socially and economically (INC, ECF, 2006). The UNESCO, World Commission on Culture and Development (1995) uproots the traditionally held view that culture is not a part of economic development and forwards the opposing argument that development divorced from its human or cultural context is growth without a soul.

The Researcher's rationale in forwarding these views is to historically situate the many definitions put forward on culture and the associated influences and trends at the time *"... as socially constructed artefacts that arise within a specific historical context ... that reflects the values and assumptions of the society in which that process occurs"* (Gray & Thomas, 2006, p. 77-78). This serves to remind us that the scholars and academic writers were and continue to be influenced by the dominant theories of their era.

The *macro* perspectives analyse the way society as a whole fits together. Therefore that philosophy portrays things or essences as fixed and static in time and stable over time and furthermore independent of what an individual perceives them to be i.e. culture the *"straitjacket"* (Gray & Thomas, 2006; Henley & Schott, 2004). This perspective purports that concepts such as culture, race or identity are clearly defined objective, measurable terms that set out unambiguous differences among people (Gray & Thomas, 2006). Culture is therefore *"... an objective, empirically verifiable entity"* (Gray & Thomas, 2006, p 77).

Smith (1998, p 89) illustrates this when he refers to *"... 'Parkinsons' Scholar's Guide, a Racial classification system"*. This was a booklet designed for schoolchildren post the Crimea War in Britain by a Burnley Chemist, the contents of which were designed in *"... a factual way alongside a guide to arithmetic, imperial to metric conversion tables, basic geometry, corrections of grammar and spelling, and notes on etiquette"* (Smith, 1998, p 89). Placing the Racial classification system alongside scientific contents yielded the status

of truth (Smith, 1998). O'Hagan (2001, p 125) reminds us that race is a social construct originating in the perceptions of conquering Europeans who were keen to produce a classification system *"... conducive to social, political and economic domination".*

This *"check the box"* stereotyping model (Gray & Thomas, 2006, p 77) inherent in this macro school of thought is simple, as it ignores similarity and identifies difference i.e. Female/male, Irish/polish, white/black, Roman Catholic/Muslim, married/divorced etc.

The conceptualising of the word culture in nursing literature conforms to the essentialist perspective with the use of such terms as race, ethnicity, religion and nationality seen as existing and stable over time which in turn have become a series of boxes to check (Gannon, 2004; Gray & Thomas, 2006). This narrows the view of what counts as culture as the entities that create and recreate culture on a continuous basis are made invisible (Rosemblum & Travis, 2000). This view of culture is not consistent with the profession of nursings' philosophical commitments striving to promote holistic care and the active respect for the diversity and uniqueness of the individual, families and communities. It would be true to say *"... that most nurses enter the profession out of a desire to help others; in other words to 'care'"* (Allen, 1995, p 538).

This view of measuring culture via racial features was important as it supported western ethnocentric and racists standpoints which have survived

to present day. Ethnocentricism may lead to stereotyping, *"... or the universal tendency to assign simplistic explanations to complex phenomena and to generalise those explanations to an entire category in such a way that individual differences are rejected"* (Racher & Annis, 2007, p 260). Like prejudices, stereotypes are not supported by available evidence (Racher & Annis, 2007) and are *"... negative, belittling and even hostile"* (Henley & Schott, 2004, p 14). Stereotypical assumptions are utilised to justify discrimination against those who are perceived as different to our own *'not one of us'* (Henley & Schott, 2004). This is Racism and is defined by the NCCRI (2007, p 33) as,

> *"... a specific form of discrimination and exclusion faced by minority ethnic groups in Ireland. It is based on the false belief that some 'races' are inherently superior to others because of different skin colour, nationality, ethnic or cultural background".*

Since culture is concerned with the meaning and significance of human activities and relations, belonging to a cultural community *"... admits of much variation and is not homogenous in nature"* (Parekh, 2000, p 148). Core belief systems and value systems are held more strongly when there is a loss of control over aspects of life due to illness, with the behaviour and subsequent responses to ill health such as fear, pain and anxiety culturally determined (Chang & Kelly, 2007). Caring is at the heart of nursing requiring *"respect and appreciation for all human beings"* (Gray & Thomas, 2006, p 78).

In studying culture utilising quantifiable methods it is difficult to capture the true meaning of essences that by their very nature are varied and messy (Gannon, 2004; Tovey & Share, 2003). The essentialist philosophy does serve to keep the messy micro perspectives at bay as it on the other hand offers an alternative view of culture *"... that makes visible the processes by which concepts are created, developed and maintained"* (Gray & Thomas, 2006, p 77). However "*... as a consequence, the sociology of culture has been seen as less than scientific, its findings less able to be generalised"* (Tovey & Share, 2003, p 326).

The micro philosophies of Symbolic Interactionism and Phenomenology differ from the macro theories as they reject the notion of a unified homogenous cultural system (Haralambos & Holborn, 1995). Culture includes *"... the 'maps of meanings' which make things intelligible to its members"* (Hall & Jefferson (1996, cited in O'Hagan, 2001, p 35). Therefore the locus of identity is constantly undergoing change and does not form a coherent whole (Parekh, 2000). In symbolic interactionism symbols are seen as defining objects in a particular way (Haralambos & Holborn, 1995). George Herbert Mead (1934) cited in Haralambos & Holborn (1995, p 893) takes this a step further and maintains that even though cultural constructs such as symbols and meanings shape human behaviour there is an element of choice as to how individuals behave.

Mead cited in (Haralambos & Holborn, 1995) forwards a number of reasons as to why this is so:

1. *"Many cultural expectations are not specific. Society may, for example, demand that people wear clothes, but there is usually considerable freedom as to which cloth to wear.*
2. *Individuals have considerable choice as to which roles they enter, for example they have an element of choice in what job they do.*
3. *Society does not have an all-embracing culture. Subcultures exist and people can choose which of them to join.*
4. *Many cultural meanings indicate possibilities rather than requirements. Thus the symbol 'chair' the possibility that people can sit on the object, but they are not compelled to do so."*

Symbols are interpreted by individuals, who actively create their social environment and in turn are shaped by it. Irish culture utilises symbols such as the Gaelic language and religious rituals and the freedom of choice to practice same. A national emblem such as the Irish Flag has evoked a mix of behavioural responses with individuals willing to die in order to preserve its meaning. As humans, unlike animals we are not programmed to react automatically to particular stimuli such as the flag, spoken word or religious festivals in an instinctual fashion. The human being is unpredictable e.g. the Irish athlete Sonia O'Sullivan was rediculed by the media in the aftermath of the 1995 World Athletics Championships where upon having won the race she declined the offer to carry the Irish flag from her Father, she was viewed as being unpatriotic! The practice of making use and classifying these stimuli, is rooted in Phenomenology in which understanding and knowing is the key as opposed to explaining (Smith, 1998; Haralambos & Holborn, 1995).

According to the phenomenologist Edmund Husserl, cited in Haralambos & Holborn, (1995, p 898) he *"... did not believe that this process (of understanding and classifying) was in any sense objective; the classification of phenomena was entirely a product of the human mind, and could not be evaluated in terms of whether it was true or false".* What this means for social researchers are that the essences or distinguishing features of phenomena or things such as a gun is bullets or a society is culture thereby placing what is external into a category i.e. bracketing. This aspect of Phenomenology will be discussed more fully by the Researcher in Chapter Four.

The definitions of culture forwarded constitute the two sides of the same coin that is macro on one side and micro on the other (Giddens, 2006). Culture is now recognised as an important issue in the perception diagnosis and treatment of illness (Helman, 1994). Helman (1994, p 11) says that,

> *"... medical personnel must strive to understand before treating ... and need to take account of the specific needs and circumstances of different communities, their social, cultural and economic backgrounds, and what the people living in them actually believe about their own ill-health, and how it should be treated".*

Nursing professionals in particular need to merge the two sides of the coin in order to, critically examine ways in which culture is constructed and *"... the consequences of those constructions for both individuals (self and others) and society at large – health care in particular"* (Gray & Thomas, 2006, p 81).

This might disturb the neat and tidy package that has been created in defining culture from an essentialist perspective. However, nurses need to become focused on attitudes, skills, increased awareness, understanding as well as having knowledge of their own culture and that of their profession in order to encourage open and equal relationships to flourish between people of all cultural backgrounds (Gray & Thomas, 2006; Papadopoulos et al, 2004; Gannon, 2001; McGee, 1994).

As Parekh (2000, p 144) posits *"... culture is concerned with structuring and ordering human life and is articulated in the rules and norms that govern basic activities and social relationships".* These very rules and norms are the less obvious areas of culture with the difficulty lying in becoming aware of these deeper aspects referred to as the remaining 90% of the iceberg. The thoughts, feelings, emotions and attitudes of culture remain concealed leaving the interpretation of these aspects multidimensional and complex (Gannon, 2001).

There is however no uniform definition of culture and as Cortis (2003, p 33) suggests *"... it is more useful to consider culture as a tool that defines reality for its members".* Therefore, given the complexities that surround the definition of culture, what are the views forwarded by the social scientists? (Tovey & Share, 2003). For social scientists two toolkits exist with two distinct functions i.e. Culture as a Way of Life and Culture as a Contested Space (Giddens, 2006; Cortis 2003; O'Hagan, 2001).

2.3 Culture as a Way of Life versus Culture as a Contested Space

Sociologists are interested in understanding culture as it seems to be different wherever we look and as a result have been fascinated by the concept not just as an idle academic pursuit (Giddens, 2006). To try to restrict the meaning of culture by projecting a single philosophical view is placing limits on what counts as culture therefore in order to make sense of the complex nature of culture sociologists' focus on two ways of understanding culture i.e. culture as a way of life and culture as a contested space (Smith, 1998).

2.3.1 Culture a Way of life

Some textual sources refer to culture *"... as a way of life ... a structure of feeling or design for living"* (Smith, 1998, p 264). This notion of culture has emerged in part from the discipline of anthropology, in which the lived experience of other cultures is examined and in so doing *"... we can identify what is distinctive about our own culture"* (Smith, 1998, p 264). Giddens (2006, p 32) believes that culture should be studied in terms of its own meanings and values and concludes that;

> *"... no societies could exist without culture. Without culture, we would not be human at all, in the sense in which we usually understand that term. We would have no language ... no sense of self- consciousness, and our ability to think or reason would be severely limited".*

Tovey & Share (2003, p 351) explain this notion of culture as *"... a process of intellectual, spiritual and aesthetic development".* Culture in this context is synomous with the anthropological definition of civilisation and the establishment of truth (Henley & Schott 2004; Tovey & Share, 2003; Parekh, 2000; Smith, 1998). Therefore civilisation came to be defined in terms of western European societies, the point being that by providing an explanation of cultural practices in Europe this yardstick of measurement could be used to explain similar processes in *'other'* places (Smith, 1998). In this view of culture one's own culture might be contrasted with those less developed. Such ideas of having received a good upbringing and an education, good table manners and knowledgeable with regard to the ways of the world is *"... the highly normative concept of culture"* (Tovey & Share, 2003 p 351).

As with any other society a multicultural society needs a broadly shared common culture to sustain it (Parekh, 2000). Sharing a cultural way of life can only come about through interaction and respect for diversity (Parekh, 2000). Parekh (2000, p 219) contends that culture as a way of life can be demonstrated by *"... something as mundane as cuisine",* Chinese cuisine was originally an exotic import to the West, however over time it has become an integral part of Western dietary culture. This demonstrates how Human beings have the capacity to share needs in common, however different cultures define, develop and structure these practices differently resulting in new ones (Parekh, 2000). According to Raymond Williams cited in (Smith, 1998, p 268) this type of analysis goes much further than *"... simply*

documenting the lives of ordinary people, for it also considers how it is possible to evaluate as well as reconstruct culture".

2.3.2 Culture as a Contested Space

> *"Every culture seems normal to the people within it, though they may not like every aspect of it"*
>
> (Henley & Schott, 2004, p 10)

The articulation of culture as a contested space originates from Marxist Theory, however in this perspective Marx's view of cultural change was as a result of economic interests (Smith, 1998). Hall (1981) cited in Smith (1998, p 267) sees cultural representation as more than class and economic struggle and interest, indeed he regarded communication and its cultural interpretation via language as giving rise to the meaning of culture. However, as Smith (1998, p 268) states *"... culture involves constant struggle ... but they are never complete for there is no closure of meaning".*

Cultural is therefore synomous with identity and this is constructed within a culture to which cultural identity can be attached (O'Hagan, 2001; Hall & Du Gay, 1996). Hall & Du Gay (1996, p. 18) contest that *"... identity continues to be the problem as it was throughout modernity ... indeed the modern problem with identity is how to construct an identity and keep it solid and stable"* while at the same time *"... avoiding fixation and keeping the options open".* The very essence of culture is that it includes different strands of thought as every

tradition can be read in different ways the diverse and contested nature that it occupies in space and time (Parekh, 2000).

Smith, (1998, p 269) further explores this notion of culture *"... located in a shifting organisation of space and time"*. This conceptualises culture as contested as we consider the dynamics at play that have an impact on how human beings organise and reorganise themselves as well as find meaning in what they do (Smith, 1998). Parekh (2000, p 337) cautions that *"... a culture's relation to itself shapes and is in turn shaped by its relation to others ... a culture cannot appreciate the value of others unless it appreciates the plurality within it"*.

2.4 Irish Culture and being Irish

Like any other political community Ireland and Irish people need to develop some sense of identity *"... the kind of community it is, what it stands for, how it differs from others, how it has come to be what it is ... in short a view of its collective and national identity"* (Parekh, 2000, p 230). For many of us being Irish is a taken for granted way of life *"... like the air we breathe, our culture is all around us from the day of our birth"* (Henley & Schott, 2004, p 2), until our first encounter with either *'other'* territories or individuals from *'other'* countries. Primarily the idea of difference is reinforced with the identification of similarities taking time (Gannon, 2001). Unfortunately often difference is perceived negatively, as it is viewed as a threat to the familiar ways of doing things.

From the Researcher's perspective Irish culture is indeed a contested entity with the diversity of cultures becoming an increasingly visible aspect of Irish society (NCCRI & IHSMI, 2002). Boyle (2000, p 14) posits that,

> *"... until relatively recently Irish society was largely mono-cultural with regard to its ethnic and cultural make up ... apart from established minority ethnic groups such as the Travelling community ... Outside of this, one could have almost been excused for considering as an absolute that the population of Ireland was culturally the same".*

However, this is in the broad sense of a cultural understanding. *"The belief that Irish culture is united around a single shared culture"* (Tovey & Share, 2003, p 327) fails to take cognisance of the fact that cultural and ethnic diversity within Irish society are not a new phenomena (Brenner, 2003; NCCRI & IHSMI, 2002).

According to Brenner, (2003, p 22) *"... the Traveller community is estimated at 22,000, and there are long established Jewish, Islamic, Asian, and Chinese communities here."* Travellers have a long history in Ireland as an indigenous minority group (Brenner, 2003; NCCRI & IHSMI, 2002; Boyle, 2000). The mono-cultural analysis may have been applied to Ireland in the past *"... although the 'purity' of any cultural group, however remote, could still be seen as questionable"* (Gannon, 2004 p 10).

In Ireland we tend to forget that we have also experienced a multicultural history for centuries as an Island we have never been isolated from international intercourse with encounters with different ethnic origins (Rolston, 2004). As we *"... discover that apparently unique Irish experiences have universal dimensions"* (Tovey & Share, 2003, p 327). However, it can be noted that even as a result of these foreign encounters *"... an acknowledgement of the existence of racism in Ireland has been slow to develop"* (Rolston, 2004, p 355).

From the arrival of St Patrick to our shores in 432, through to the Norman invasions in 1169, the subsequent Plantation of Ulster in 1609 and the Good Friday Agreement of 1998, culminating in the St Andrew's Agreement of 2007 in total over 1,500 years of interfaith and intercultural tolerance (O'Rourke, 2002; Mac Annaidh, 2006). Our political and historical landscape has been marked by Sectarianism with multicultural rights and values subjugated and denigrated, as we have a tendency to only accept those who have assimilated e.g. more Irish than the Irish themselves with regard to how we have historically viewed the Norman invasion (Gannon, 2001; Mac Annaidh, 2006).

Therefore, dealing with the issue of diverse cultures is not new to the Irish context; however it has been fraught with difficulties. Colonisation in particular has ensured that Ireland has been incorporated into a global empire what this has meant is that the Irish have been *"... racialised and involved in the racialisation of others"* (Rolston, 2004, p 357). Therefore, our experience is

distinct and will "... *require both appropriate policies and their effective implementation"* (INC, ECF, 2006, p 9).

For many of us what it means to be Irish is constructed along the lines of the essentialist perspective, at a superficial narrow cultural level, the *'check the box'* model of racial characteristic inherent i.e. fair skinned, freckles, red hair, blue or green eyes, being able to speak Irish, Irish dancing etc (Gray & Thomas, 2006).

The Irish language is also synonymous with Ireland *'Cead Mile Failte'* the Ireland of a hundred thousand welcomes (Rolston, 2004). Language is the key to the world of culture and all cultures have language as a communication system in the format of a set off symbols which allows the members of a society to communicate with each other (Macionis & Plummer, 1998). O'Hagan (2001) concurs with this and forwards language as both the vehicle by means of which culture is transmitted from one generation to the next and also as an integral part of all aspects of culture".

In Ireland the 1937 Irish Constitution set out the Irish language or Gaelic as the officially recognised communication system in Ireland and still is. The ideal being that all the Irish States' citizens learn the language well enough to speak it (Saris, 2000). The Irish down through the centuries have utilised their native language to perceive their world *The Sapir-Whorf Hypothesis* (Macionis & Plummer, 1998).

This contests that each language has its own words or expressions of which there are no precise counterparts in other tongues (Macionis & Plummer, 1998). Linguistic relativism was lost from within Irish culture as a result of colonisation, this can be noted from the direct English translations of many Irish place names e.g. one such place name lost in translation is Dun na nGael, translated to Donegal in English but actually means the Fort of the Foreigners. This serves to demonstrate that the meaning inherent in a language is much more than mere words (O'Hagan, 2001). From the Researcher's perspective the conclusion can be drawn that language is not only central but is pivotal to the communication process as misunderstanding can lead to drastic consequences therefore the value of language cannot be misjudged. For many migrant nurses English is a second or third language and can cause cross cultural communication problems (Winklemann-Gleed & Seeley, 2005)

Bradshaw et al (2001) pose the question do the Irish value their language? As English had greater cultural capital and was seen as a universally acceptable language in the late 19th and early 20th centuries with the emigrant population who left Irish shores to seek employment in America and the UK. To meet this challenge, Irish politicians cultivated a deliberate and peculiar style of oratory, by beginning speeches in Gaelic, and then swiftly switching to English a format which has survived to this day (Saris, 2000). On the other hand Bradshaw et al (2001, p 118) argued that these *"... variations in their own right are interesting and may even increase our ability to survive"* i.e. the Irish language.

Indeed language the world over is recognised as a powerful source of ethnic identity (Parekh, 2000). Many minority ethnic groups often react to inequality or perceptions of inferiority by maintaining artificially their cultural or religious traditions (Parekh, 2000). Parekh (2000) refers to this as *'defensive ethnocentricism'*.

> *"As populations shift and their status changes, people turn to the cultural distinctions embodied in their traditions to resist what is perceived as a threat to the integrity, prosperity or survival of their community, to the continuity of its culture or the transmission of its values"*
>
> (UNESCO, 1995, p 2).

This sense of threatened identity is articulated in its more extreme form of '*offensive ethnocentricism'* by many Northern Irish Catholics and Protestants alike e.g. Sinn Fein, Local Assembly members introducing themselves in Irish at the start of business in Stormont and the Garvagy Road Marches during the loyalist season whose Ulster Scotch dialect is not lost on observers. In Ireland as is true of any society all social groups draw upon the past to legitimate and validate both their present attitudes and their future aspirations (Graham, 1997). The Irish are often also described from a broader perspective as both Catholic and Gaelic speaking, these were two major cultural markers that gave us our identity (Gannon, 2001; Tovey & Share, 2003). It is also worth noting that the Irish person's sense of,

"... Irishness is also influenced by parameters such as urban or rural upbringing, parents' occupation and income level, religion, educational level, family political allegiance, family values and interests, friends and environment as well as a host of other factors"

(Gannon, 2004, p 12)

Regardless of whether the cultural construction of the Irish identity is narrow or broad the content outlining "... *'who we are' and 'who we are not' provides a means whereby the dominant group can be fictitiously maintained as a homogenous, unaflicted and normal group of people"* (Gray & Thomas, 2006, p 79).

We might well ask the question then of *"... what constitutes a real Irish person?"* (Tovey & Share, 2003, p 330). The idea of identity is complex as it encompasses the personal attributes of gender, sexual orientation, occupation, class group and age (Gannon, 2004). If true Irishness is equated to being Roman Catholic and Nationalist – defacto Anti – English, in fact most of the twentieth century being Irish, was the opposite to being English, for many of us difference meant inferiority therefore are we racist by default? (Gannon, 2001). Dr Ronit Lentin (2008, p. 3) posits that in the wake of the Second World War and the Holocaust an alternative explanation has been provided "... *for human difference by supplanting culture and ethnocentrism*

... to become the code words for race and racism". Lentin's (2008, p 2) contention is that Ireland is indeed racist as we utilise the euphemisms of, *"... interculturalism, transculturalism, integration and cultural diversity ... for something that one does not want to hear mentioned".*

A significant feature of being Irish is the portable cultural attributes, with many referred to as Irish even though they are second or third generation John Fitzgerald Kennedy, Grace Kelly and Ronald Reagan only some of the prominent examples (Tovey & Share, 2003). This white depiction of Irishness still refuses to recognise many *"... Black Irish or Irish people of colour"* (Gannon, 2004, p 17) *"... there were no people of colour in Ireland"* (Rolston, 2004, p 356). Indeed many long standing Irish immigrants have a question mark over their identity as unlike America dual terms such as, African Americans, Irish Americans, Italian Americans are not used in Ireland to describe people from other heritages *"... either you are Irish or you are foreign"* (Gannon, 2004, p 14). In denying race *"... culture has become the badge of difference"* (Lentin, 2008, p. 4).

2.4.1 Cultural Diversity from an Irish perspective

Cultural diversity is fast becoming the norm for most areas of life in Europe with Ireland being no exception (EIW, 2007). Cultural diversity is defined by Parekh (2000, p. 165) as *"... the presence of a variety of cultures and cultural perspectives within a society".* O'Hagan (2001, p. 243) views diversity as *"... contrasting perspective on knowledge".* Depending on how cultural diversity

is approached there is a potential for two outcomes that is it *"... can erect barriers between people but can also provide bridges"* (Kreitler, 2005, p 95).

2.4.2 Cultural Diversity

Even though from a global perspective we are all members of a single biological species i.e. Homo sapiens, there are differences the world over, this is indeed an expression of our cultural identity (Macionis & Plummer, 1998). Marxist Theory which perceives difference as a concept that acts as a major catalyst for cultural evolution (Goodman, 1992). He offers a radical alternative i.e. the contested nature of culture in comparison to the Functionalist Talcott Parsons, stressing that the shared values of stability and co-operation are the key; this again reiterates the notion that by belonging to a specific cultural group we share the same values i.e. culture a way of life (Goodman 1992). Therefore, by sharing the same culture we agree on the interpretations of reality (Bradshaw et al, 2001). In essence for Parsons each cultural institution such as the family, education and political systems form a structure that is made up of interconnected roles or interrelated norms that operate in nearly all cultural institutions e.g. in the case of the family husband/father, wife/mother, son/daughter. Cultures are reflected in the way in which the human individual expresses him or herself – cultural identity (INC, ECF, 2006).

2.4.3 The Changing Irish Identity

The rising tide of globalisation via the economy, the mass media and the political processes accelerates and facilitates cultural change (INC, ECF, 2006; Gannon, 2004). In the last six decades Irish society has undergone a radical change i.e. *'modernisation'* since the much publicised speech given by DeValera on the radio to the nation on March 17th 1943 in which he depicted the Irish as a frugal peoples, whose land would be bright with cosy homesteads and the fields and villages joyous with the sounds of industry and *"... the laughter of comely maidens, dancing at the crossroads"* (Saris, 2000; Coogan, 1993). This speech as Saris (2000, p 14) quite rightly points out set up the *"... vista of Ireland which can still be glimpsed in some Bord Failte brochures"* as a particular sort of a community i.e. rural, respectable, spiritual and harmonious. Indeed this speech had far reaching consequences as it set in place the distinguishing features of Ireland as a nation (Saris, 2000). Arenberg and Kimball two Harvard trained anthropologists carried out studies in County Clare, *Family and Community in Ireland* (1940) probably one of the better known, these studies reiterated and strengthened the vision of Ireland as portrayed in DeValera's speech.

The speech had a binary twist in that it was delivered by *"... an Irishman of Spanish-Cuban extraction, a devout catholic who was quite possible born illegitimate"* (Saris, 2000, p 15) therefore, ipso facto a foreign leader was our most native. This undertone of diverseness epitomises the Irish throughout the 19th, 20th and 21st centuries, setting themselves apart as different from

England yet imitating them, being European yet peripheral in nature and mimicking America socially whilst stressing no huge affiliation towards it (Saris, 2000).

"For generations the Irish have been emigrants" (INC, ECF, 2006, p 7) an that emigrant experience can be tracked back for three or four centuries, this however does not mean that this emigrant experience of the stranger in a foreign country has permeated into the psyche of those currently resident or working in Ireland (INC, ECF, 2006). It is only when we ourselves experience difference and non familiarity i.e. cultural shock like Schutz that we begin to reflect on our own cultural identity and for the first time encounter difference negatively rather than the similarities that unite (Gannon, 2001, Smith, 1998). This revelation in the literature prompted the formation of the Researcher's hunch that the experience of nurses who had worked abroad and encountered different cultures increases tolerance towards diversity.

Irish cultural circumstances have changed and with this the dominant images that have been forged in a particular era for a particular purpose were inevitably challenged or contested (Graham, 1997). Since the 1990's four catalysts have changed the nature of Irish society, the Celtic Tiger Economy, has *"... resulted in a growing migrant workforce"* (Radford, 2007, p 17) the decline of the hegemonic position of the Catholic Church, the return of the Irish Diaspora and the economic downturn (Keenan, 2008).

(See Table 2.1- Estimated immigration classified by Nationality, 2003 – 2008)

Table 2.1 Estimated immigration classified by Nationality, 2003 - 2008

Nationality	Immigrants					
	2003	2004	2005	2006	2007[1]	2008[1]
Irish	17.6	16.7	18.5	18.9	20.0	16.2
UK	9.1	7.4	8.9	9.9	5.9	7.0
Rest of EU 15	8.8	13.3	9.3	12.7	10.4	8.6
EU 12	-	-	34.1	49.9	52.7	33.7
USA	2.1	2.3	2.1	1.7	2.8	2.0
Rest of World	22.4	18.8	11.6	14.7	17.8	16.3
Total	**60.0**	**58.5**	**84.6**	**107.8**	**109.5**	**83.8**

[1] **Preliminary**

Source: (CSO, April, 2008) **Press Release**

Non-Irish Nationals Living in Ireland

Given the growing immigrant numbers some *"... 420,000 from 188 different countries"* (CS0, 2008, p 1) this composition and the knock on transformation in demographics in turn posses *"... opportunities and challenges in relation to an increase in pressure on health service provision, infrastructure and human resources"* (Radford, 2007, p 16).

The Health Research Boards Report (Radford, 2007) entitled *'Health, Faith and Equality'* (p 17) outlines the magnitude of the problem in the following paragraph,

"In relation to the rapidity and size of this growth, a brief cross border comparison is of relevance. From May 2004 to Sept 2005, while

293,000 workers moved to the UK, (14,395 of whom applied for the Workers Registration Scheme in Northern Ireland)...in the Republic, 133,258 individuals obtained PPSN (personal public service numbers). In the period Jan 2005 to Nov 11th 2005, a further 128,702 PPSN numbers were issued in respect of former EU accession countries. While it is vital to acknowledge these figures do not record the number of those who have returned home, to put them into perspective, Ireland has a population 15 times smaller than that of the UK yet it has attracted more migrant workers per capita in the period 2003-2005 than the US and the UK have had to in the past 30 years".

At the outset of this section the Researcher quoted Henley & Schott (2004) that Irishness is taken for granted most especially by those who are members of the majority culture,

"... grow up unaware that they have a specific culture. They may not realise that what they perceive as normal, universal values and ways of behaving are in fact cultural; and 'normal' only to their group or social class"

(Narayanasamy & White, 2005, p 102).

With global world economics at play globalisation is seen to pervade nationhood and cultural identities – the erosion of the nation's culture and with this the perception of threat (Narayanasamy & White, 2005; Gannon 2004; Rolston, 2004). Conversely, becoming aware of our own culture as distinctive

is not possible if there is no contact with others, as encounters are all important for the cultural development of a modern society and nursing (Gray & Thomas, 2006; Tovey & Share 2003; Gannon, 2001; Leininger, 1995). It is this awareness of self and others via encounters two key concepts in Transcultural Nursing Theory and education that the provision of holistic Nursing Care depends (Leininger, 1995; McGee, 1994).

2.5 Multiculturalism & Interculturalism – Responses to Cultural Diversity

An National / International perspective

If we think about how much Irish society has changed over the last three decades even with regard to the essential aspects of everyday life, such as gender roles, family structure, religious practices, work practices, economic structures, health systems etc it is easy to see how natural the phenomenon of cultural change was over a gradual period of time globalisation in the current context has accelerated this change (Bradshaw et al, 2001). Cultural diversity has developed exponentially with one in ten of the population born outside Ireland, with the projections for 2030 estimating that approximately 1 million foreign born individuals will reside here (HSE (a) 2008; CSO, 2006; DJELR, 2005; Nurse, 2006). Multiculturalism and Interculturalism are only two of the very many internationally recognised educational responses to Cultural Diversity (Tovey & Share, 2003).

2.5.1What is Multiculturalism?

Multiculturalism is directly related to the philosophical debate dealing with cultural divides in so doing it examines what is necessary for cultural diversity (Negrier, 1997). Multiculturalism has a deeply ethical agenda as it "... *promotes social goods including mutual understanding, mutual affirmation, cooperation, inclusion, equity, and social justice"* (Fowers & Davidov, 2006, p. 584).

Multiculturalism as an approach is at best described as superficial and can be broadly described as education about other cultures and as with the essentialist perspective focuses on obvious superficial elements of minority cultures the *"... saris, samosas and steel band syndrome"* (Cortis, 2003, p. 34) e.g. food, ceremonies, celebrations, music or dance.

Globally it has been cynically described as tokenistic by failing to address the core issues of inequality (Gannon, 2001). A number of criticisms also exist,

1. It concentrates on teaching about minority cultures this gives the impression that only minority cultures have a culture.
2. As mentioned previously it emphasises the superficial aspects of culture – thereby reinforcing stereotypes.
3. It over emphasises difference and excludes the inclusion of similarity.
4. It is characterised by ethnocentricism – framed by the dominant ethos.

5. Is not required as an approach where skin colour is white (Gannon, 2004, pp 52-56).

It is based on the premise that cultural pluralism is the model of choice for society given this condition cultural diversity will flourish while cohesion of society is maintained (Lappin, 2007; Graham, 2005;). Multiculturalism is often seen as top-down government support for the cultural and religious institutions of minority communities and is characterised as government policy support of cultural diversity for its own sake (Lappin, 2007). Multiculturalism espouses cultural equality; this in turn provides minority groups with an enormous weapon forcing the majority to give into their demands. The main consequence of this approach is moral inversion which holds that since the minority are weak they must always be the victim, so even when the minority behave badly it must always be the majorities fault (Lappin, 2007). It is therefore a hostile and discriminatory approach to *'foreigners'* unless white and wealthy which stems from the fear that *"... this will dilute Irish cultural distinctiveness"* (Tovey & Share, 2003 p 156).

2.5.2 What is Interculturalism?

Conversely, an intercultural approach draws more on real exchanges from the bottom-up i.e. interaction, understanding, respect and integration between different cultures and ethnic groups. Interculturalism *"... suggests the acceptance not only of principles of equality of rights, values and abilities, but also the development of policies to promote interaction, collaboration and*

exchange with people of different cultures, ethnicity or religion" (HSE (a), 2008, p 27). The basic premise being that cultural diversity is positive and is a strength that can enrich society (NCCRI, 2007).

Interculturalism is strong multiculturalism and is now replacing assimilation and multicultural approaches. By embracing this approach recognition is given to the fact that one size does not fit all as this approach promotes interaction, understanding and integration between and among other groups (Department of Justice, Equality & Law Reform, 2005; Tovey & Share, 2003). Underpinning this approach is Intercultural competence and communication and the recognition of Human Rights (Gannon, 2001). New comers are more oftener than not reacted to negatively with individual reaction based on the notion that they will threaten our way of doing things around here, what we have to remember is that our way of doing things is constantly undergoing change (Gannon, 2001). With *"... 'Our ways' based on the assumption that it is the norm to be Irish, settled, catholic/Christian, white, heterosexual and English or Irish Speaking, thus effectively marginalising anyone who differs from these norms"* (Gannon, 2007, p 1).

While new comers want to and need to adapt on a behavioural level to social norms there is also the strong commitment to maintain their own norms and values as these assert identity and ameliorates the pain of separation from their own culture (Papadopoulos, Tilki & Taylor, 1998).

The diverse nature of norms required to operate in the social context presents Ireland with a unique opportunity to build a society by utilising an intercultural approach that is based on the principles of competence, communication, equality and the recognition of human dignity thereby allowing open and equal relationships to flourish between people of all cultural backgrounds (NCCRI & IHSMI (2002). A vital set in this process is the development and framing of *"... inclusive legislation, policy and social structures to ensure equal participation in Irish society of all its members"* (Gannon, 2001, p 5).

2.6 The Legislative and Policy Responses

It is outside of the scope of this research study to provide a comprehensive analysis on the approaches and developments worldwide. However this chapter will examine the key European and National Legislative and Policy contexts as outlined by the Researcher in the Introduction and these are Employment Equality Legislation (1998) and (2004) and the Equal Status Acts (2000) and (2004), Quality and Fairness: A Health Strategy for All, (2001), Cultural Diversity in the Irish Health Care Sector, (2002), The National Action Plan Against Racism, (2005), The European Intercultural Workplace Project (EIW), (2007) and The National Intercultural Health Strategy, 2007 – 2012. (2008).

The Researcher intends to give a summary overview of each of the policy and legislative developments. Inherent in the documents is the inclusion of a

population health approach to planning and implementing health service provision.

2.6.1 Equality Legislation (1998-2004)

Nowadays it is recognised that tackling health inequalities is a major challenge for the HSE as it is acknowledged that whilst services typically meet the needs of the majority they do not always respond adequately to those on the margin (Equality Authority, 2004). Equality refers to making services equitable by choice of the individual (Berman & Paradies, 2010). Equality legislation in Ireland is framed to cover discrimination and equality in relation to both employment and the provision of services such as the health service. The legislation covers nine grounds including:

1. Gender
2. Marital Status
3. Family Status
4. Sexual Orientation
5. Religious Belief
6. Age
7. Disability
8. Race
9. Membership of the Traveller community.

(Equality Authority, 2004)

Equality does not mean treating everyone the same *'one size fits all'* but rather that an equality competent health service should therefore ensure that services are responsive to all parts of the community recognising that a range of factors including marginalisation, discrimination, and alternative cultures and practices impact on the equitable provision of that service in terms of Access, equality of treatment, participation and resultant outcomes (Equality Authority, 2004). Berman & Paradies, (2010) examine the broader relationship between inequality and racism and caution that failure to delineate these relationships will result in the failure of public policy. They have noted that there is a *"... government reluctance to create controversy by explicitly naming racism"* (Berman & Paradies, 2010, p 215).

2.6.2 Quality and Fairness: A Health Strategy for All, (2001)

The vision of the Health Strategy is underpinned by the key tenets of the Equality legislation as reflected in the principles of Equity, People-Centredness, Quality and Accountability. The vision clearly articulates these principles:

> *"A health system that supports and empowers you, your family and community to achieve your full health potential*
>
> *A health system that is there when you need it, that is fair and that you can trust*
>
> *A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account"*

(DoH&C, 2001, p 8)

The strategy is the guiding blueprint that will operationalise policy and give direction to service provision in achieving the vision of a responsive health system moving forward. The strategy acknowledges the need for targeted approaches to address disadvantage with an overall emphasis on primary care provision. The Primary Care Task Force as set out in the strategy (DoH&C, 2001, p 26) are charged with prioritising disadvantaged areas by introducing health impact assessments via a coordinated, integrated, collaborative approach. Commitments such as these are centrally important to groups who have poorer health status, including minority ethnic groups such as the traveller community (NCCRI & IHSMI, 2002).

2.6.3 Cultural Diversity in the Irish Health Care Sector, (2002)

Demographic changes over the last five years such as the overall population growth and increased immigration (CSO, 2006) have lead to an increasing demand for health services given the multicultural populations accessing health care (HSE (b), 2008). It is the inclusion of these minority ethnic and culturally diverse groups as an increasingly important entity within the Irish health care sector that lead to the development of this guideline document (NCCRI & IHSMI, 2002) *"... this was a debate prompted by the significant increase in people of other cultures coming to live and seek out a living in Ireland"* (Boyle, 2000, p 14).

The document itself points to the increasing visibility of cultural diversity which brings with it opportunities and challenges for all concerned (NCCRI & IHSMI, 2002). Ethnic and cultural diversity are not new phenomena in Ireland – the traveller community as previously referred to by the Researcher is one such example (Mac Annaidh, 2006; Brenner, 2003; NCCRI & IHSMI, 2002; O'Rourke, 2002; Boyle, 2000). The document points to the valuable lessons that can be learned from how issues were addressed when dealing with this indigenous minority group (NCCRI & IHSMI, 2002).

The key concepts of Cultural awareness, knowledge, sensitivity and encounter are emphasised as the necessary elements to ensure cultural flexibility in service provision,

> *"... awareness and sensitivity training for staff is a key requirement for adapting to a culturally diverse population. The purpose of this training should be the development of the knowledge and skills to provide services sensitive to cultural diversity. Such training can often be most effectively delivered in partnership with members of the minority groups themselves"*
>
> (NCCRI & IHSMI, 2002, p 5)

Nursing is best positioned as nurses and midwives comprise the largest professional group (HSE (b), 2008) to offer a response by utilising evidence based models as forwarded by Papadopoulos, Tilki and Taylor (2004) and nurse educators can be responsive to this need, with the Centres for Nurse

Education (CNE's) seen as pivotal with regard to the provision of important skills development and training (HSE (b), 2008; O'Shea, 2008).

2.6.4 The National Action Plan against Racism (NPAR), (2005)

This is one of the first government plans which offers a reasonable and common sense approach to accommodate cultural diversity in Ireland (DJELR, 2005). *"... the overall aim of the plan to provide strategic direction to combat racism and to develop a more inclusive, intercultural society in Ireland ... based on policies that promote interaction, equality of opportunity, understanding and respect"* (DJELR, 2005, p 27). An Intercultural theoretical framework is utilised to underpin the plan and acknowledges the five objectives of:

1. Protection
2. Inclusion
3. Provision
4. Recognition
5. Participation.

(DJELR, 2005, p 27)

The Plan's link with Equality is evident as it *"... seeks to be inclusive of the multiple forms of diversity and discrimination, with reference to the nine grounds identified in the equality legislation"* (DJELR, 2005, p 28).

The context of the Plan is timely given the increase in cultural diversity over the last decade in Ireland as evident from CSO figures (2006) (Table 2.1) and is primarily the result of labour migration and a significant increase in the numbers of refugees and asylum seekers coming to Ireland. European Union expansion to 27 member states will continue to ensure that intercultural policy development in Ireland will continue to keep pace with demographic developments. It is the Researcher's opinion that the overall trends within the macro society are mirrored within the microcosm of society, nursing being one such element. Therefore, it is timely and relevant that nurses given such culturally diverse encounters should be aware, knowledgeable and sensitive to the needs of those who access the health service either as service users or employees and are culturally different as *"... research in many countries confirms that cultural and ethnic minorities can experience higher illness and mortality rates compared to the general population"* (DJELR, 2005, p 115).

The Plan is strengthened by the provision of rationale other than equality and human rights to include:

- The business case
- The social cohesion case
- The reputation case

(DJELR, 2005, p 41)

Cultural diversity is a multifaceted issue which will continue to present a challenge to all sectors within Irish society. The role of research studies such

as this is critical to pinpointing the needs of employees in dealing with diversity (DJELR, 2005). Regardless of whether those from diverse cultures are employees of the health service they will be clients of our health service *"... and consequently we need to be flexible in order to accommodate different cultural needs"* (NCCRI &IHSMI, 2002, p 7). An interculturally aware workforce can only come about when employees are aware and in turn are empowered to develop more effectively the process of integration (EIW, 2007).

2.6. 5 The European Intercultural Workplace Project (EIW), (2007)

This report is European in context and traces how workplaces throughout Europe are experiencing major transformation. Its aim is to focus on the similarity of challenges and opportunities *"... of the intercultural workplace in different sectors and in different member states"* (EIW, 2007, iv) with the core outcome of establishing an overview of sector specific work practices in Europe (EIW, 2007). A sample of ten member states was utilised to produce three trans-national comparative reports. The main focus of the Researcher's enquiry is the report pertaining to the Health care sector which helps identify the intercultural training needs and evidence based practice within the European context that will *"... inform the production of effective intercultural training materials to a common European standard"* (EIW, 2007, iv). The report acknowledges that cultural diversity is not new but recognises *"... that ethnicity can still be a key factor in health inequalities, and the 'inverse care law' – communities in greatest need are least likely to receive the health*

services that they require – still applies to many parts of Europe" (EIW, 2007, p 1).

The ten European countries that formed the object of analysis were the UK, Germany, Bulgaria, Greece, Finland, Poland, Norway, Sweden, Italy and Ireland. The report identified that Ireland and Norway had the most homogenous populations whilst Ireland compared with Finland with regard to a *"... sharp increase in immigration over a short, and recent, period"* (EIW, 2007, p 2). Immigration *"... raises the issue of providing culturally competent healthcare to patients of different cultural backgrounds"* (EIW, 2007, p 4). The report highlights the difficulties associated with this given that in Ireland general statistics are not available on the numbers of culturally diverse staff employed by the health services (EIW, 2007). St James teaching hospital in Dublin is taken as an example;

Total number of staff employed	= 4000
SRN's	= 1200
Outside EU	= 518
Within EU	= 45

(EIW, 2007, p 3).

This highlights the need for a training programme *"... to create a culture in health care* settings *that supports the delivery of care in a culturally appropriate manner"* (EIW, 2007, p 3).

The report references the challenges identified in the workplace as posing greatest stress i.e.

- Language – proficiency, speaking the mother tongue, use of interpreters, dialects, accents and slang, medical jargon.
- Communication – directness/indirectness, small talk and humour.
- Cultural Values and practices – Religious clothing and food, the role of family, concept of face, concept of time, power distance/hierarchy, gender roles, the spirit of initiative, attitude to health.
- Racism – discrimination, prejudices, host conformity pressure

(EIW, 2007, pp 9-20).

The report is of interest form the Researcher's perspective in that it offers *"... pragmatic solutions adopted by practitioners themselves"* (EIW, 2007, p, 9). These are outlined as;

Languages	-	Interpretative services – UK and Ireland
		Roma Health Mediators – Bulgaria
		Primary Health Care Traveller Project – Ireland
Communication	-	Mentoring employees
		Induction
Cultural Values	-	Intercultural Strategy (Ireland)
Racism	-	Cultural Diversity Officer (CDO) (Ireland)

(EIW, 2007, pp 21-25).

The report stresses that cultural difference should not be ignored and recommends *"... that intercultural training be made an integral part of initial and further training of health care professionals"* (EIW, 2007, p 28).

2.6.6 The National Intercultural Health Strategy, 2007 – 2012. (2008)

This strategy builds on the initial recommendations set out in the Eastern Regional Health Authority Strategy launched in 2004 in developing that work in Ireland it dovetails in with the National Health Strategy (2001), the National Action Plan against Racism (2005) and the European Intercultural Workforce Plan, (2007) these confirm the need to develop and enhance service provision (HSE (a), 2008). The strategy is a comprehensive framework in Ireland within which care and support needs may be effectively addressed and is underpinned by equality legislation (HSE, (a), 2008).

A central vision of the HSE Transformation Programme (2007-2010) is reiterated in the strategy (HSE (a), 2008, p 6) that *"... everyone has easy access to high quality care and services that they have confidence in and staff are proud to provide"*. Health service developments in conjunction with best practice with a focus on measures to prevent social exclusion are two core objectives reflected in the Intercultural Strategy, this is by no means suggesting that good practices do not exist but rather tend to be fragmented around the country *"... with access to service often dependent on geographical location, rather than need"* (HSE (a), 2008, p 29).

This needs to be operationalised given the changing demographics of the country (see Table 2.2 Produced from CSO statistics, 2006) and the resultant multicultural nature of Irish society.

Table 2.2 – Population Changes

	April 2002	April 2006	% Increase
Population Figures	3,917,203	4,234,925	8.1%
Family Structure Irish & Non-Irish Nationals	70,721	95,636	26%
Family Structure Non-Irish Nationals only	20,185	50,655	60%

Whilst the National Health Strategy (2001) contained the overriding principles of equity, accessibility, quality and accountability the strategy has additional values acknowledged (HSE (a), 2008, pp 8-9) these are:

- Intersectoral Collaboration – *"... a cross cutting ... joined-up co-ordinated approach"* to ensure relevant agency involvement.
- Equality and Targeting – this lies at the heart of the strategy with the objective of achieving full equality for all service users.
- Intercultural and Anti-racism – underpinned by NPAR (2005) and gives recognition to the negative effects of racism on physical and mental wellbeing supported by the key tenets of Interaction, Understanding, Respect and Integration.
- Community Participation around Health – the empowerment of all service users and endorses an active Community Development Approach.

- Partnership Working – A model of partnership creating the involvement of all stakeholders.
- Learning and Support for Staff – the creation of culturally competent health services given the appropriate intercultural training and support.

The Researcher hopes that with the development of this research project, elements from the *"Model of Implementation"* (HSE (a), 2008, p 116) will be realised i.e. the growth of necessary skills and competencies by building a training programme that will support staff to deliver services that are appropriate to need.

2.7 Conclusion

In this chapter the Researcher has presented many of the diverse sociological definitions of culture. The definitions posited offer the reader with two perspectives essentialism and constructivism, the multidimensional material and non-material aspects of culture.

The Researcher demonstrated that the ability to define culture is further complicated by its vernacular use in every day life, with as a result culture in its broader sense coming into play as values, beliefs, convictions, habits, pastimes, music, art or behaviours and these very human characteristics can either serve as barriers or bridges between people (Kreitler, 2005). Sociologists have an established view of culture i.e. culture as a way of life versus culture the contested space.

The Researcher offers an overview of Irish culture which has undergone dynamic change in that we are no longer culturally homogenous (Gannon, 2004; Brenner, 2003; Boyle, 2000). Cultural change of any dimension can be a powerful force and it can be difficult for individuals to cope with in an environment *"... where little is familiar and almost everything is done differently"* (Henley & Schott, 2004 p 6) as culture is part of our identity. To quote Immanuel Kant (1724-1804) cited in Henley & Schott (2004, p 19),

"We do not see things as they are, but as we are"

However, becoming aware of our own culture as distinctive is not possible if there is no contact with others, as encounters are all important for the cultural development of a modern society (Gray & Thomas, 2006; Tovey & Share 2003; Gannon, 2001).

The Researcher has endeavoured to demonstrate how change has been accelerated in the Irish cultural setting amid a globalisation context both at a European and World wide level (Bradshaw et al, 2001). In Ireland cultural diversity has developed exponentially with one in ten of the population born outside Ireland the projections for 2030 estimating that approximately 18% just fewer than 1 million foreign born individuals will reside here (HSE (a) 2008; CSO, 2006; Nurse, 2006; DJELR, 2005).

This indeed challenges our own understanding of Irish culture which has been fraught with difficulty and for those seeking refuge on our shores from other

EU or non EU States the complexity lies therein Martin Luther King cited in O'Rourke (2002) encapsulates the realities of cultural diversity from the perspective of those who are culturally distinct,

"I cannot be what I ought to be until

you are what you ought to be"

The realisation of this dream can only become possible by both legislative and societal changes embracing the following concepts of awareness, encounter, interaction, knowledge, understanding, sensitivity, competence, respect and Integration as espoused in e.g. the National Intercultural Health Strategy (2007-2012) and Madeleine Leininger's (1976) Transcultural Nursing Theory. Taking cognisance of the difficulty in defining culture from a sociological perspective the Researcher will endeavour in chapter three to present an overview for the reader of the origins and nature of Nursing Culture.

Chapter 3

The Nursing Context of Culture

Literature Review

CHAPTER THREE

3. Literature Review

3.1 Nursing Culture

Culture is a prevailing component of all professions including nursing (Paley, 2002). In this chapter the Researcher will unveil the journey of culture as a concept in nursing. This will be accomplished by focusing on nursing's origins as a humanistic pragmatic art and its resultant professional scientific credence as an outcome of European influences. It will also be demonstrated that the messy female sentimental behaviours of nurses have had an overarching influence on nursing culture as a culture of care and nurturing behaviours (Allen, 1995). Nurses are social agents as they are cultural dwellers (Paley, 2002; Lea, 1994). Therefore care cannot be divorced from the beliefs, values and ideals inherent in nursing practice and theory and therein lies the dichotomy the essentialist/positivist nature versus the humanistic/constructivist nature i.e. the art and science of nursing.

The Researcher will also present a portrait of nursing in Ireland with the predominant influences of the religious orders from the nineteenth century to present day and their impact on nursing culture (Condell, 1998; Scanlan, 1991). As a profession Irish nursing has been shaped and reshaped from an International, European and National perspective (O'Shea, 2008). Therefore it has not escaped the diverse nature of society and as a response nursing theorists have presented models and philosophies of care in order to meet

diverse societal changes. The work of American Anthropologist Madeline Leininger (1976) and from a UK perspective Irene Papadopoulos et al (2004) gives recognition and includes the diversity of culture in nursing and the significance of cultural competence in healthcare.

3.1.1 The Cultural Journey

Clearly within each profession there is a transmission process which Paley (2002, p 567) describes as the *"... getting through mechanism ... It is called 'culture'"*. The culture of nursing consists of a variety of professional ideals, values and beliefs which are in turn communicated to the student or new nurse via the dual processes of socialisation and education (Gray & Thomas, 2006). This in turn profoundly shapes the way the nurse-patient interaction is carried out as viewing the patient as a thing or an object dehumanises the care process (Basford & Slevin, 2003; McGee, 1994).

As a student nurse the journey is at the beginning of the search *"... for explanations and understandings of the world and the essence of nursing and all its dimensions"* (Basford & Slevin, 2003, p 3). This journey from its outset focuses on the knowledge and value systems of contemporary practice (Basford & Slevin, 2003; Robinson & Vaughan, 1992). The key universal concept at the heart of this nursing journey is *'caring'* (Basford & Slevin, 2003; Allen, 1995). The Researcher is by no means suggesting that nurses have the monopoly on caring as this would serve to ignore the many lay caregivers that exist in society (Allen, 1995).

The Greeks use the word *'paraclete'* to describe nursing and it translates as *"... one who draws alongside"* (Shannon, 1991, p 27). The nurse is the person who is there who knows what disturbances in health have occurred for the individual, this presence requires knowledge and the ability to interpret what has happened and what is likely to happen (Shannon, 1991). The skill required is of a humanistic practical nature the *'art'* and the knowledge is theoretical/empirical in nature the *'science'* resulting in the act of caring (Basford & Slevin, 2003; Allen, 1995; Robinson & Vaughan, 1992; Shannon, 1991). This has given rise to a growing recognition that *'art'* and *'science'* combine in a unique way in nursing as nursing *'science'* is different from traditional science as it is caring in origin (Basford & Slevin, 2003). Never the less caring is a value laden concept as it is central to our interactions and relationships with each other therefore will differ over time and space (Basford & Slevin, 2003; McGee, 1994). Caring has been viewed as a messy and even sloppy humanistic concept *"... and as long as nurses retained ... sentimental views of their role, they would never be seriously respected as a profession"* (Allen, 1995, p 538).

It is the nurse who is charged with the caring responsibility (ABA, 2000; McGee, 1994) *"... by ensuring that privacy, dignity and religious and cultural beliefs are respected"* (Perminder & Gurdev, 1995, p 2). Socialised concepts of race, culture and ethnicity are characterised by behaviour attitudes and beliefs and can have an impact on the equality of the care given (Papadopoulos, Tilki & Taylor, 1998; McGee, 1994).

Felicity Stockwell (1972) demonstrated this in her study entitled '*The Unpopular Patient*' in which she focused on the interpersonal relationships between nurses and patients in general hospital wards in the UK discovered that a patient's popularity could influence the quality of nursing care. This study also demonstrated observable differences in interaction between the most and least popular patients. With nurses spending more time caring for patients who communicated readily with them and co-operated in being helped to get well. In contrast nurses' less popular patients were those who complained and implied that they were suffering more than was believed by the nurses. The element of interest to the Researcher is that patients with different cultural and religious backgrounds were also significantly more unpopular than others. Traits such as language barriers, cultural differences in pain response and sick role behaviour were identified as having contributed to *'foreign'* patients being least popular among nurses.

What the study demonstrated is that nurses as individuals are *'cultural dwellers'* with their own personal and professional culture providing each individual nurse with a source of meaning culminating in inscribed ethnocentric assumptions it is because of this that the difficulty lies (Paley, 2002). Nursing does not exist in a social vacuum, but rather the discipline of nursing is shaped by the values of the time (Paley, 2002; Allen, 1995). It is essential that nurses make sense of and understand their past in order to develop and plan for the future (Basford & Slevin, 2003).

The very base or fundamentals of Nursing is that it is both an *'Art'* and a *'Science'* *"... nursing as a discipline requires both a scientific and a humanistic base for practice"* (Allen, 1995, p 538). The upsurge in theory development raised many questions about the nature of nursing as an *'art'* and 'science' (Savage, 1998). Culture as a concept defined sociologically by the Researcher in chapter two dwells in the dual philosophies of essentialism i.e. culture the outcome a purely empirical scientific perspective and constructivism i.e. culture the process interpreted from the humanistic environment in which it occurs.

Historising the culture of nursing, puts into perspective the origins of the cultural values, beliefs, ideals and attitudes that permeate nursing theory and practice (Allen, 2006). The Researcher in tracing nursing from its origins to present day is advancing the ideal that it is only then, *"... we begin to understand the confusion and the profusion"* of nursing in the twenty first century (Baly, 1980, p ix).

Nursing as a profession has developed *"... as a response to changing social need"* (Baly, 1980, p 1). Therefore the *'art'* and *'science'* of nursing,

> *"... has a dynamic relationship with the evolution of man, with cultural and social diversities, and with environmental, epidemiological and scientific discoveries. From this position the history of care should not be seen in isolation from the present, but regarded as a seamless*

interface that can inform the present through data, experience and collective wisdom"

(Basford & Slevin, 2003, p 3).

How this historical story was recorded reflects the prevailing cultural influences of the time and as feminists would suggest is recorded in such a manner as to emphasise the dominant male position (Basford & Slevin, 2003; Kelly, 1999). This dominance of the male perspective on the recording of nursings' historical events is especially salient when considering the position of women within the context of healing and caring i.e. the female gender bias (Basford & Slevin, 2003; Kelly, 1999; Wilkinson & Miers, 1999; Walsh & Ford, 1994). Indeed gender is an indispensable concept when examining the structures of nursing (Wilkinson & Miers, 1999).

Gender as a descriptive concept has a bearing on how we relate to each other first as boys and girls and secondly as men and women (Giddens, 2006; Wilkinson & Miers, 1999). Gender is not just a distinction of sex *"... but is also a social and cultural construction"* (Hugman, 1991, p 174). From an occupational perspective sex and gender issues have a bearing as they,
"... form a basis for distinction in all aspects of work, including employment patterns, career opportunities and earning levels" (Hugman, 1991, p 174). The distribution of women and men in the caring profession displays these distinctions with male assumptions concerning women's career choices echoed by female nurses themselves (Wilkinson & Miers, 1999; Hugman, 1991).

In nursing the proportion of women as a whole in the profession over the last two decades has been measured at between 90 and 97 per cent with men at between 3 and 10 per cent (Hugman, 1991). Nursing is equated with women's work *"... these are the areas of emotionality, reproduction and child care, and service modelled on the domestic world, through which the position of women in the home or domestic service is replicated in health and welfare work"* (Hugman, 1991, p 181).

The cultural history of nursing as a female domain stretches from antiquity to present day (Basford & Slevin, 2003; Baly, 1980). Reference to the word *'nurse'* appears quite late in the history of cultural development of nursing with *no reference " ... to either the nurse or nursing care"* (Basford & Slevin, 2003, p 11). The fragmentary records that are available of ancient medicine seem to indicate that medical practitioners of remote past cultures notably ancient Greece and Rome gave no thought to the kind of therapeutic attention and care that modern nursing provides (Kelly, 1999). The notion of nursing as a vocation emanated in Roman times with the Roman noblewomen perceiving *"... nursing to be a vocation and a high status occupation usually provided nursing care"* (Basford & Slevin, 2003, p 12).

The early Christian influences on the culture of care and nursing saw care provided to the sick and needy by both monks and deaconesses alike (Basford & Slevin, 2003; Baly, 1980). The monks became the custodians of much medical writing although this period was devoid of scientific advancements (Baly, 1980). Many lay women had great knowledge of herbs

and healing skills; however much of Europe was suffering from the ravages of war, diseases, poverty and the lack of social stability (Baly, 1980). This period would give rise to the witch hunts for the next four centuries which were fuelled by the Church suggesting *"... that women particularly those who had healing skills, were in collusion with supernatural powers and should be opposed and feared"* (Basford & Slevin, 2003, p 15).

Unfortunately with the resultant deaths of these women burned at the stake for their supposed demonic acts much of the healing knowledge that would have been passed from mother to daughter was lost (Basford & Slevin, 2003; Baly, 1980). The literature also suggests that the condemning action of the church at this time undermined women's position in society thus excluding them from the emerging medical schools (Basford & Slevin, 2003; Smith, 1998; Baly, 1980). The end result was the production of a culture of healing that was two tiered with the male doctors at the top and the women healers at the bottom, and with this came the rise of the culture of subservience (Basford & Slevin, 2003; Kelly, 1999; Baly, 1980). As Smith (1998, p 54) expresses this taken for granted prejudice,

> *"... the emergence of science was a very masculine affair ... assumptions of the period relegated women's concerns as closer to nature than to culture and science ... women were portrayed as corrupting influences on virtuous men undermining their rationality".*

From the sixteenth to the nineteenth centuries the culture of healthcare in Europe was derived from the influence of the religious orders (Savage, 1998). This period saw a proliferation of both Catholic and Protestant religious orders in Europe in the aftermath of the schism (Basford & Slevin, 2003). The ethos of both religions permeated nursing culture with,

> *"... the Catholic Church advocating a benevolent position suggestion that the art and science of nursing was a vocation, a calling from God ... while the Protestant Church espoused the notion that each individual had a clear responsibility to the community and the family unit"*
>
> (Basford & Slevin, 2003, p 16)

The diversity of disease and human dysfunction was examined in microscopic detail by the medical profession who asserted their dominant position in health care (Basford & Slevin, 2003; Baly, 1980). Health care in the 18th Century was now offered within the framework of the institutional setting and it was at this time in Ireland when the voluntary hospital system was founded (Condell, 1998; Scanlan, 1991). Nursing care within this context was akin to the functions and duties of domestics and attendants and as such did not merit any degree of intelligence or nursing (Basford & Slevin, 2003; Condell, 1998; Scanlan, 1991).

With the culture of nursing care depicted as menial work this in turn portrays the status of the nurse at the time but this description also serves to highlight

the relationship that nurses had with others within the hospital (Kelly, 1999). The public image of the nurse was not good as nurses were *"... recruited from the lower classes or they were patients themselves"* (Basford & Slevin, 2003, p 17). This portrayal was not enhanced when eminent writers such as Charles Dickens created the character of *'Nurse Sarah Gamp'* in his book **Martin Chuzzlewit** as a slovenly drunkard of questionable morals and with whom an education and training was notably absent.

Reform was to come with the first influences from France and Germany (Basford & Slevin, 2003). In particular the German model of nursing was to have a profound impact on two English women Elizabeth Fry and Florence Nightingale (Basford & Selevin, 2003, Baly, 1980). Both women had an immense influence on the education and training of nursing in England this was to eventually form the framework of contemporary practice (Baly, 1980). Nightingale *"... the founder of modern nursing"* (Savage, 1998, p 1) gave nursing an element of respectability as she was a member of the British middle class. Training schools were established in the UK this was paralleled in Ireland when the religious orders commenced training in 1891 in the Mater Misericordiae Hospital, Dublin (Scanlan, 1991). It is significant to note that the lay involvement in nursing in the UK differed from that in Ireland; indeed religious involvement was not prevalent in Europe (Kelly, 1999). Whilst there were undoubted benefits from the involvement of religious orders in nursing the culture of Irish nursing was indelibly marked by their involvement, nuns were female they were willing to work for limited remuneration as they had taken vows of obedience and operated within a hierarchical disciplined

structure (Condell, 1998; Scanlan, 1991). This disciplined compliant structure served to stifle creativity and led to ritualise nursing cultural behaviour, orders were to be obeyed not questioned with the good nurse doing what she was told (Walsh & Ford, 1994).

This historical account from the Researcher's perspective is important as "... *history influences attitudes and belief systems*" (Cortis, 2003, p 35). The resultant values of obedience and subservience led to a lack of assertiveness among nurses (Baly, 1980). Therefore the historical analysis offered portrays a patriarchal system as the dominant ethos, this it can be said was culturally distinctive in Ireland's case as the Catholic Church's philosophy legitimised the professionally subordinate role of women (Kelly, 1999). This mirrored the predominant philosophies of this epoch of asceticism and romanticism with the former defined as a way of life based on self denial and the latter as that of a visionary viewpoint (Robinson & Vaughan, 1992).

Asceticism originated in the religious orders in that higher spirituality could be achieved through obedience and denial with Nightingale adapting the social expectation stance of romanticism i.e. loyalty to men this in fact meant being loyal to doctors and administrators (Kelly 1999). In Ireland this was achieved by an authoritarian management and training system and a hierarchical structure in which the majority of matrons were from higher social classes or from religious orders (Scanlan, 1991). This system has served to influence nurse's behaviour and value systems even as professional groups today. Values are the infrastructure the very principles which underlie and direct

nursing behaviour (Shannon, 1991). In this regard Irish nurses do not differ from other nurses practicising in Europe, Australia and America in that they are all *'cultural dwellers'* (Paley, 2002) and as such *"... the discipline of nursing is shaped by the values at the time"* (Allen, 1995) with culture being the ultimate source of the meaning derived from those value and belief systems (Paley, 2002).

Many of nursing's value and belief systems were incorporated into nursing philosophies as to have a *"... philosophy of nursing means clarifying and being articulate about those values which we are prepared to uphold, both as individual human beings and as nurse practitioners"* (Shannon, 1991, p 26).

Nursing in Ireland has also been infused with these values and belief systems via the wealth of nursing literature (Condell, 1998). This was accelerated by the advances made by eminent international nurse theorists such as Hildegard Peplau, (1952), Virgina Henderson, (1961), Dorthea Orem, (1980) Imogene King, (1981) and Nancy Roper, Winifred Logan & Alison Tierney, (1985), (Condell, 1998, p 3).

The Researcher would like to note that theoretical models in themselves do not enact changes in the way that the professional practice of nursing is performed but rather that it is how the models are used in action that determines change of a sustained nature (Basford & Slevin, 2003).

Whilst Nightingale provided a foundation to describe nursing, the nursing theorists have shifted the emphasis from control of the environment to interaction with the individual (O'Shea, 2008).

The models constructed *"... translate the essence of nursing into frameworks for theory and practice. They also serve to distinguish clearly the nursing model of care from the medical model"* (O'Shea, 2008, p 10). Nursing is not just a science it also involves art and the end product of care which culminates in the intertwining of the dual elements of nature and nurture. Amidst these current times of change in Irish society it is crucial that Irish nursing maintains it cornerstone of cultural care *"... that ensures that core values and ideals are not lost in the maelstrom of evolution and change"* (O'Shea, 2008, p 11).

3. 2 Nursing in Ireland - Cultural Diversity

As has been demonstrated at the heart of nursing is the culture of caring which requires respect and appreciation for all human beings (Gray & Thomas, 2006). With cultural diversity now parked firmly on the Irish healthcare system's doorstep *"... the population of Ireland will continue to become more ethnically and culturally diverse"* (O'Shea, 2008, p 142). It is therefore *"... vital for healthcare practitioners to have an understanding of the range of cultures ... the challenge is to elicit these health beliefs from their patients and plan care that works for them"* (Graham, 2005, p 79). In order for this to materialise *"... adequate education and continuing education are*

critical" (O'Shea, 2008, p 82). O'Shea (2008, p 209) proceeds to inform us with regard to what this,

> *"... continuing professional development should include education and training on cultural issues in the delivery of services, including an appreciation of the multi-ethnic nature of Irish society and the importance of sensitivity and understanding of cultural differences".*

As nurses we also need to reflect on the issue of cultural diversity and whether we pay enough attention to it? And is the acknowledgement personal and silent with regard to the impact on aspects of our practice?

Wilkins (1993, p 603) writes that nurses, in an ever-changing multicultural society have to be responsive and the *"... nursing care should be as congruent as possible with the client's cultural orientation".* Nurses need to learn as much as possible about cultural beliefs especially those beliefs and practices of individuals in their care (Chang & Kelly, 2007). Even the founding mother of nursing Florence Nightingale who was deeply embedded in essentialism recognised the need for cultural care,

> *"... the women who teach in India must know the languages, the religions, the superstitions and customs of the women to be taught"*
>
> (Cited in Wilkins, 1993, p 602)

Culturally appropriate care can be challenging as virtually all societies are no longer homogenous i.e. more than one culture within their borders (Boyle, 2000; Wilkins, 1993). However in order to be effective care givers, nurses have a duty to link culture to care (ABA, 2000; Wilkins, 1993). Culture is central to the individual this is reinforced in the Code of Professional Conduct for each Nurse and Midwife (ABA, 2000) as the patient is central to the care procedure. The Code is a solid framework upon which nurses can deliver, *"... the highest standard of care possible to patients"* (ABA, 2000, p, 2). The notion of competence is the focus of the Irish Nursing Board's regulatory framework *"... competence is the ability of the registered nurse or registered midwife to practice safely and effectively"* (ABA, 2000, p, 3). *"Since Ireland is becoming an increasingly multicultural society, we need to constantly assess how competent we and the general public are at informing ourselves about issues relating to people of other cultures"* (Boyle, 2000, p 14)

3. 3 The Concept of Cultural Competence – cultural flexibility

The changing demographics of Ireland as reflected in the 2006 Census clearly demonstrates the increase in cultural diversity (CSO, 2007). The development of cultural competence among nurses and other healthcare workers is pivotal if they are to meet the needs of the diverse populations they serve (Taylor 2005; Papadopoulos et al, 2004; Boyle, 2000). Demonstrating that cultural competence is an essential knowledge component in nursing and the wider healthcare professions as care and culture are inextricably linked (Wilkins, 1993).

The nurse-anthropologist Madeleine Leininger (1995, p 40) takes the credit for *'giving birth'* to the term *"... cuiturally competent nursing"* (Gray & Thomas, 2006; Narayanasamy & White, 2005; Leininger, 1995). The literature would suggest that there is limited consensus around an exact definition of what constitutes cultural competence (Taylor 2005; Papadopoulos et al, 2004).

Papadopoulos et al (2004, p 109) defines cultural competence as;

> *"... the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs...cultural competence is the synthesis of a lot of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding"*

Campinha-Bacote, cited in (Taylor, 2005, p 137) puts forward a more compact definition in that she views cultural competence as;

> *"... an ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client".*

Within nurse education cultural competence is the term used *"... to address the skill and content needed to provide care with consideration for various cultural facts associated with a given individual"* (Gray & Thomas, 2006, p 79).

To become a culturally competent practitioner the nurse needs to acquire a set of academic and interpersonal skills (Gray & Thomas, 2006). Campinha-Bacote (2002) cited in (Taylor, 2005 p 137) outlines the necessary constructs that culminate in achieving cultural competence of *"... cultural awareness, cultural desire, cultural knowledge, cultural skill and cultural encounters"*. There is however consensus in the literature that cultural competence requires the nurse practitioner not only to be aware of the diverse values and belief systems of patients but to also be tuned into or *'culturally sensitive'* to their own beliefs and value systems (Gray & Thomas, 2006; Leishman, 2004). Boyle (2000, p 15) articulates and further simplifies the requirements necessary in order to become culturally competent;

Seven Steps to Cultural Competence
▪ Know yourself
▪ Keep and open mind
▪ Respect differences
▪ Be willing to learn
▪ Learn to communicate effectively
▪ Be non-judgemental
▪ Be resourceful and creative

Cultural competence is therefore a process of integration of all of the requirements (Taylor, 2005; Papadopoulos et al, 2004; Boyle, 2000). Boyle (2000) stresses that being culturally competent is not about knowing all that there is to know about different cultures as this may derive in part from an overall reliance on the essentialist viewpoints of culture and related concepts and has the tendency to simplify the complexity of culture into neat compartments (Gray & Thomas, 2006).

Boyle (2000) posits that the central primary feature of cultural competence is to demonstrate an openness and motivation to acquire new ways of practising care. This motivational disposition is complex as our tendency to behave in a certain way has been shaped by four diverse forces (Kreitler, 2005, p 97). These forces are represented in the discipline of psychology by beliefs of four types;

1. *Beliefs about self e.g. I am happy most of the time*
2. *Beliefs about rules and norms e.g. One should respect cultural difference*
3. *Beliefs about goals e.g. I want people to respect me*
4. *General beliefs e.g. people differ in their cultural background.*

Before the practitioner can begin to understand other cultures there is a need to understand and reflect on the meaning of ones own beliefs about culture. Therefore from the Irish nurse's perspective this is his/her understanding of Irish culture and nursing culture (Glazner, 2006; Leishman, 2004). As nurses this is crucial because the very nature of our cultural conditioning is culturally bound *'like the air we breathe'* (Henley & Schott, 2004, p 2) this means that we are not always consciously aware of innate values and beliefs (Taylor, 2005; Boyle, 2000). Within the health care setting there are cultural dynamics at play between the patient and the nurse and as a result assumptions are sometimes wrongly made with the outcome that the nurse imposes their predominately western professional and personal practices on the patient (Boyle, 2000). Leininger (1995, p 12) refers to this as *"... cultural imposition ... one of the most serious problems in nursing".*

3.4 Transcultural Nursing Care – An established nursing solution to cultural diversity

In an effort to make cultural care the dominant and central focus of nursing (Leininger, 1995, p 11) established *"... the theory of Culture Care Diversity and Universality"* as a solution to the problem of cultural imposition. Leininger's rationale was simple, globalisation,

> *"Our world continues to change and is bringing people close together in one world with many diverse cultural values, beliefs and lifeways. With these global cultural changes have come new expectations and challenges in nursing to prepare nurses through transcultural nursing education to become competent, sensitive and responsible to care for people of diverse cultures in the world"*
>
> (Leininger, 1995, p 3)

This statement by Leininger (1995, p 3) clearly places transcultural nursing as an imperative *"... arching framework"* for all areas of nursing practice in a globalised world. Globalisation can have two overreaching affects in that firstly it is tolerated if the ethnic and cultural influences give rise to increased economic flows i.e. consumerism, employment and wealth however secondly and of greater concern is that globalisation *"... is seen to pervade nationhood and cultural identities"* (Narayanasamy & White, 2005, p 105). This from an Irish perspective is timely as given the inward migratory flows over the last few years approximately 160 different nationalities now live in Ireland with as a

result cultural implications and challenges presenting in the existing health service structure that have never before been experienced in the day to day life of Irish nurses (Brenner, 2003). From within the globalisd world other factors influence the utilisation of transcultural nursing models.

Leininger (1995, p 13) outlines these factors as:

- Migration
- Multicultural identities
- Technological advances
- Cultural conflict
- An increase in travel
- Increase in Legal cases
- A rise in Feminism and gender issues
- Demand for cultural based health care

As previously described by the Researcher every individual and that includes the nurse *"... perceives the world through the lens of their cultural background"* the cultural dweller (Lea, 1994, p 308). Leininger (1995) sees the nurse's role as multicultural (Wilkins, 1993). Therefore *"... knowledge about the patient's cultural values beliefs and practices are integral to providing holistic nursing care"* (Lea, 1994, p 208).

Felicity Stockwell in her (1972) study referred to earlier by the Researcher gives an understanding of how culture affects nurse-patient relationships

which is vital if a transcultural nursing approach is to be proposed (Lea, 1994). It is suggested that a transcultural world view of nursing assists the nurse to see all patients in his/her care as empowered human beings (Wilkins, 1993).

In order to do this *"... all nurses will need to be prepared in transcultural nursing with substantive knowledge and skills to function in an intense multicultural world"* (Leininger, 1995, p 4). The vehicle for the acquisition of this transcultural nursing knowledge is nurse education however the Researcher will first outline transcultural health care practice from some of the existing body of literature.

3.5 Definition, Nature, Rationale and Importance of Transcultural Nursing.

Much of the literature about transcultural health care is written in the context of North America Camphina-Bacote (2002) and Leininger (1995). There are also some emerging perspectives from the UK, Papadopoulos (2006), Narayanasamy & White (2005), Papadopoulos et al (2004), Cortis (2003), McGee (1992) and from an Irish perspective Brenner (2003) and Boyle (2000).

Madeleine Leininger is recognised as the founding mother of transcultural nursing theory and defines it as;

"... a formal area of study and practice in nursing focused upon comparative holistic cultural care, health, and illness patterns of individuals and groups with respect to differences and similarities in cultural values, beliefs and practices with the goal to provide culturally congruent, sensitive and competent nursing care to people of diverse cultures"

(Leininger, 1995, p 4)

In this definition Leininger (1995, pp 4-11) in her textbook entitled **Transcultural Nursing, Concepts, Theories, Research and Practices** includes several important ideals;

1. Transcultural nursing is a legitimate and important societal need – the argument here is that the legitimacy for transcultural nursing stems from the fact that patients as human individuals have rights and expectations to have their values, beliefs and needs meet by nurses as caregivers.
2. Transcultural nursing as a formal area of study – given that the early history of modern nursing – essentialism did not recognise cultural care dimensions - humanism. What the theory now offers is the need for educational preparation as the concepts of culture and care are complex phenomena. Within the context of nursing today this educational process commences with the nursing student formalising cultural care knowledge. Nurses operate from an evidence base and no longer rely on common sense, prejudices or being kind to assure

competence in caring for those who are culturally different. As Leininger (1995, p 6) indicates that *"... transcultural nursing education and concomitant practices generally provide a deep appreciation of human cultures, their histories and how cultural values and beliefs can be so powerful and meaningful to people"*. Leininger (1995, p 6) emphasises that the importance of this formalised education is that "... *being prepared in transcultural nursing means not only learning about diverse cultures ... but also studying one's own cultural values, beliefs and needs"*. Cultural secrets are unveiled about one's own culture and that of others.

3. The focus on comparative differences and similarities – transcultural nursing utilised a comparative focus to study patterns, expressions, values, beliefs within and among cultures. This *why* focus is essential and central to transcultural nursing theory. What Leininger (1995, p 8) refers to as *"the all alike syndrome"* moves to become understanding variation and from this it becomes obvious that *"one size does not fit all"* an inherent assumption in assimilation models (INC, ECF, 2006, p 18). Culture is firmly a contested space (Smith, 1998). It is from this ideal that cultural specific care stems this is *"... tailor-making the client's specific needs to be congruent with daily lifeways"* (Leininger, 1995, p 9).
4. Culture is central to know, understand and serve people – within this ideal Leininger (1995) reiterates the powerful influence that culture has on the way we execute our everyday activities – culture a way of life.

Leininger (1995, p 9) defines culture as;

"... the learned and shared beliefs, values and lifeways of a designated or particular group which are generally transmitted intergenerationally and influence one's thinking and action modes"

Leininger views the diffuse nature of culture as a learned way of living as difficult to understand. Cultural communication is an integral aspect of becoming astute in nursing care practices.

5. The focus upon human care and expressions – human care is an integral part of culture. In this ideal Leininger (1995, p 10) draws on the many definitions of culture to define care ;

"... the learned and transmitted cultural ways of assisting, supporting, enabling and helping people whether ill, well or dying, with compassion and respect in order to improve a human condition or help an individual face death or disability ... caring is the heart and soul of nursing, caring is power, caring is healing, and caring is the distinctive feature which makes nursing what it is or should be as a profession and discipline"

It was with the care focus as a way of life in mind that Leininger (1995) established the theory of *Cultural Care Diversity and Universality*. Leininger (1995) holds the view that care is powerful, as without it there can be no cure – the analogy is thereby drawn as without culture there can be no society.

Leininger's (1995, p 417) ultimate aspiration is that *"... someday all people in the world will be served by professional nurses prepared in transcultural nursing and using research findings generated from Cultural Care Theory".*

As the Researcher has demonstrated the practice of nurses caring for people of diverse or similar cultures is now even more relevant in a highly multicultural society. The UK literature that exists, Narayanasamy & White, (2005), Papadopoulos, et al, (2004), Cortis, (2003) and McGee, (1994) sets out the requirements that are desirable for the implementation of transcultural nursing care.

These are;

1. Educational forums to allow the transmission of knowledge – some 100 cultural specific studies by Leininger
2. Information technology with a Data Base of culturally determined aspects of health, illness and care
3. Caring systems in place
4. Effective Communication processes
5. Self awareness development – with regard to one's own culture
6. Guidance on practical implementation – incorporating resourcefulness and creativity
7. Address the issues of Racism and Prejudice as Leininger (1995) fails to address this.

Other limitations are identified in the literature even though transcultural nursing purports *"... to provide a holistic approach to culturally sensitive care"* (Narayanasamy & White, 2005, p 107). The criticisms include;

- An oversimplification of cultures – the clarifying and packaging of culture even though it is a complex phenomenon to define as the Researcher has shown.
- The theory has the potential to produce stereotypical images of certain cultures – this has the danger of creating predetermined assumptions about individuals before an encounter – the essentialist perspective reinforcing the problem of paternalism and ethnocentric care which it seeks to address (Wilkins, 1993).
- A narrow focus – special attention given to individuals who belong to a specific culture with as a result the individual left feeling patronised.
- The creation of the Expert nurse – some observers view this as a positive feature, however this has the potential that all aspects relating to cultural care will be left to them. This in turn removes as Boyle (2000, p 15) suggests the willingness or motivation to learn from the nurse. It also fails to acknowledge the fact that given the volume of existing cultures worldwide *"... more than 3000 and untold numbers of cultural variations and interpretations"* together with the non static nature of cultural knowledge expertise would be difficult to obtain if not near impossible to maintain (Narayanasamy & White, 2005, p 107).

- The need to consider racial prejudice and attitudes – that have the perception *"... that blame culture as the problem and cause of ill health"* (Narayanasamy & White, 2005, p 107). Papadopoulos et al (1998) reiterate this and concur that it is not enough to focus on culture "... factors that influence culture such as poverty and racism must be considered". This view is also echoed by Alleyne et al (1994).

Nevertheless despite these criticisms transcultural nursing is a beneficial tool in bridging the gap across cultures and the "... widespread ignorance among health professionals at all levels about the culture and customs of the ethnic patients they encounter" Papadopoulos et al (1998, p 5) as;

1. Care and culture are placed centrally in the theory – Culture as Cortis (2003, p 35) suggests *"... is fundamental to the realisation of holistic and individualised care"*. Whilst McGee (1994, p 6) alludes to the unique feature of Leininger's work includes *"... a focus on the concept of care as the distinguishing feature of nursing setting it apart from other professions"*.
2. Leininger discerns the nurse as having a multicultural role.
3. Leininger addresses the needs of student and trained nurses from diverse cultures.
4. The development of Clinical Nurse Specialist in Culture who have *"... studied selected cultures in depth"* whilst also providing a formal

programme that teaches all nurses to care for individuals from different cultural backgrounds (Wilkins, 1993, p 603).

5. The importance of involving the extended family.
6. The promotion of respect and tolerance as nurses have to take on board value systems which are diverse to their own thus transcending *"... their own cultural orientation and view the patient through the patient's cultural lens"* (Lea, 1994, p 209).

3.5.1 The Irish Response

As outlined by the Researcher in chapter 2, has been influenced from a European policy framework perspective. This has culminated in the development of legislative, planning and guidance documents, with the overarching objective of safeguarding individual rights whilst informing the health care worker of what needs to be done, as opposed to how this can be done e.g. The National Action Plan on Racism (NPAR) 2005 and The National Intercultural Health Strategy (2007 – 2012) (HSE, 2008).

The most recent health driven document is essentialist in construction entitled The Health Services Intercultural Guide (HSE, 2009). The guide is informative in content and offers a *"check list"* of care needs to culturally and religious diverse groups. Whilst the guide offers much needed invaluable and timely information to health care workers it cautions against the dangers of stereotyping *"... we cannot assume or imply that each individual member of a particular group will definitely conform to a particular pattern"* (HSE, 2009, p

18). Even though the Researcher contends that the guide is selective and restricted to information that is directly relevant to religious philosophical beliefs it is never the less an invaluable tool with the communication of same to health care workers dependent on the correct conduit i.e. education.

3.6 Nurse Education

Wilkin's (1993, p 604) statement *"... the need to incorporate transcultural concepts into nurse education is evident"* and places nurse education as the pivotal vehicle in the transmission of culturally competent knowledge. As nurse educators help shape nursing attitudes by;

> *"... fostering positive attitudes towards patients irrespective of ethnicity can introduce programmes to sensitise them to the problems inherent in stereotyping, prejudice and discriminatory practice".*

(Narayanasamy & White, 2005, p 107)

This coupled with the fact that HSE Policy emphasises that the patient and communities should be central to the provision of service (HSE, 2006, Transformation Programme, 2007-2010) and sets nurse education at the forefront of the provision of educational programmes (Government of Ireland, 1998). With the Centres for Nurse Education (CNE's) *"... seen as being of great importance in the provision of important skills development and training"* (O'Shea, 2008, p 217).

Given that the vehicle has been identified within an Irish nursing context the mode of transmission of that knowledge also needs to be focused upon. The report commissioned by the Irish National Committee, European Cultural Foundation (2006, p 53) indicated;

> *"... that a model of good practice to improve intercultural education in Ireland should include both practical skills and theoretical understanding. Training should be integrated across entire training programmes and should from part of both pre-qualification and continuing professional development training"*

To provide this theoretical knowledge and skill with structure and to facilitate learning the following four stages are forwarded by the Researcher. The stages can be modified to suit the type and level of learner (Gray & Thomas, 2006, pp 79-81 and Papadopoulos et al, 2004, pp 109-110).

This notion of good practice in Person Centred Intercultural Care is reiterated in the Health Services Intercultural Guide (2009) and reinforces the need for the *"... principles of patient safety, quality care and value ... guide all interaction with people using health services"* (HSE, 2009, p 18). The success of these interactions is dependent on the following 4 Stages as outlined in Papadopoulos, Tilki and Taylor Model (2004) (See Figure 3.1).

Stage 1: *Cultural Awareness* – This begins with the examination of one's own personal values and belief systems. This stage is based on the premise that cultural background is a major factor in shaping one's values and belief systems and in turn health beliefs and practices. This in turn makes the individual aware of their prejudices and enables them to eliminate, manage or deny them. It also assists in the removal of the guilt of prejudices *"... as they are viewed as something that innocent people are likely to acquire as a result of living in a particular culture"* (Gray & Thomas, 2006, p 80).

Stage 2: *Cultural Knowledge* – This is the active process of searching for and obtaining a base line worldview of other cultures. The knowledge can be acquired in a number of ways via contact *'cultural encounters'* (Gray & Thomas, 2006, p 80) with different cultural groups or seeking information from other disciplines other than nursing e.g. social science in particular anthropology, psychology, biology and pathology. Cultural encounters can be difficult as the mutual learning opportunity is absent in the current essentialist approach as groups are defined in opposition to each other them and us. Therefore *"... knowledge is required in order to understand the similarities and differences in cultural groups as well as inequalities in health within and between groups"* (Papadopoulos et al, 2004, p 109). The knowledge is not purely based on an essentialist factual approach but is formed by incorporating a dynamic constructivist view as over reliance on essentialism perpetuates *"... the notion that the body of information about culture is stable and fixed and promotes an unspoken idea that once understanding is achieved, no further knowledge is needed"* (Gray & Thomas, 2006, p 80).

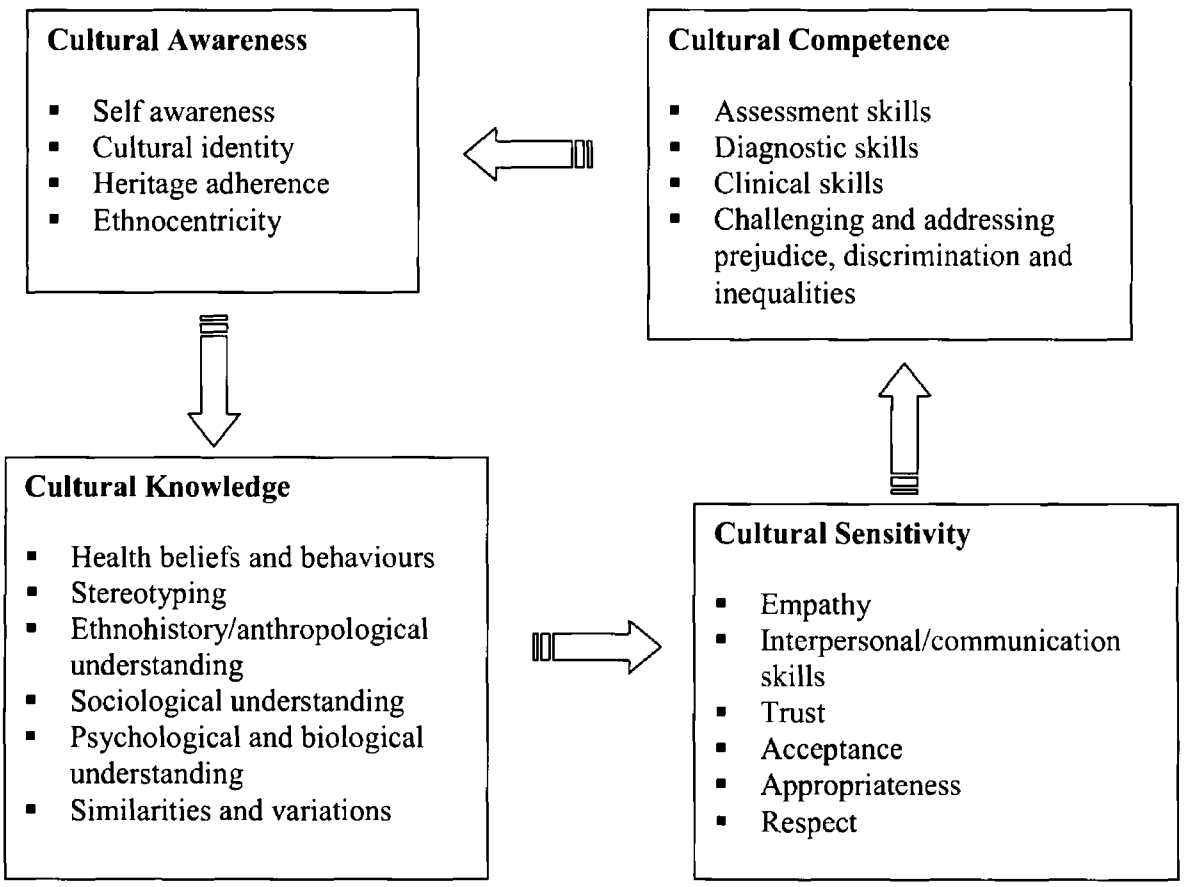
This stage clarifies that knowledge of cultural groups is not a taken for granted set of facts.

Stage 3: *Cultural Sensitivity* – This is how nurses as professionals view individuals in their care as considering individuals as partners is the key to truly sensitive care (Papadopoulos et al, 2004). By purely focusing on the culture of *'other'* limits the attention given to shared similarities and in turn limits the ability of the nurse to meaningfully respect an individual who is different (Gray & Thomas, 2006). Cultural communication is a key component of this stage however it is a fact of life that when individuals meet the idea of difference is reinforced with the identification and appreciation of similarities taking time (Gannon, 2001). The Researcher would also like the additional elements of *'Cultural desire'* and *'Cultural Skill'* considered (Campinha-Bacote, 1999, cited in Gray & Thomas, 2006, p 79). A desire to learn is an essential element in any learning event i.e. actively seeking to understand the culture of another, with the skill component the practical ability of the nurse to synthesise his/her knowledge gained in a culturally sensitive way if this is achieved then **Stage 4** *'Cultural Competence'* is acquired.

Cultural competence as a concept has already been discussed by the Researcher in this chapter. From a nursing perspective the importance of providing *"... culturally acceptable healthcare services cannot be overestimated"* (McGee, 1994, p 7). Nurse educators should be teaching all of the stages as outlined above thereby equipping nurses with the necessary skills that will empower them as caregivers to *"... make a clear and*

appropriate assessment of the needs of each individual" (Wilkins, 1993, p 609).

Figure 3.1 – Papadopoulos, Tilki and Taylor Model (2004)



Source; Papadopoulos et al, (2004) *"Promoting cultural competence in healthcare through a research-based intervention in the UK"* Diversity in Health and Social Care, 1 p 110.

3.7 Conclusion

In this chapter the Researcher has demonstrated that Nursing as with all other professions has culture as a prevailing viewpoint (Paley, 2002). Ideals, values

and beliefs permeate nursing and as a result has a profound impact on the nurse patient interaction (Basford & Slevin, 2003). The enculturation journey for many nurses begins when they are student nurses at the heart of which lies the universal concept of caring. The Researcher did caution that this is not to suggest that nurses have the monopoly on caring (Allen, 1995).

Culture is a value laden concept in nursing as it is central to our interactions with each other, therefore nursing culture as with the societal concept of culture is multifaceted and difficult to define (Tovey & Share, 2003). Nursing culture comprises of the dual elements of art and science, the constructivist positivist debate i.e. the humanistic and scientific base of practice (Allen, 1995). Indeed it is the adherence to this sentimental caring view which leaves nursing not being seriously respected as a profession (Allen, 1995). Stockwell's (1972) Study on the *"Unpopular Patient"* sets the scene in demonstrating how the patient's popularity impacts on the care relationship and highlighted how different cultural and religious backgrounds are significant influences. Nurses are cultural dwellers with their own ethnocentric viewpoints (Paley, 2002).

An historical overview of nursing is offered by the Researcher. The historical annals represented, depict nursing as a female domain with the predominate influence of woman both venerated and criticised as science is a very masculine affair (Condell, 1998). Nursing came to be portrayed as menial work which was marshalled by European influences and in Ireland's case the religious orders (Paley, 2002; Lea, 1994).

Many of the beliefs and values came to be incorporated into the philosophies and theories. Their overall function was to translate the essence of nursing into theoretical frameworks for practice. The Researcher seeks to unveil if any of the theories are congruent with the ever changing cultural diversity of Irish society (O'Shea, 2008). Cultural competence is pivotal in meeting the needs of diverse populations. The American nurse Anthropologist, Madeleine Leininger (1995) is credited with this concept which contains the constructs of awareness, desire, knowledge, skill and encounter (Gray & Thomas, 2006; Taylor, 2005). This offers the nurse a transcultural world view (Wilkins, 1993) which purports to bridge the gap across cultures (Narayanasamy & White, 2005). For this to occur education is the required vehicle with the theoretical knowledge imparted in a staged manner (Papadopoulos et al, 2004). Perhaps this solution to the cultural issue will encourage nurses to explore, examine and talk about aspects of multiple worldviews and assist them to realise that cultural factors do impact on practice as;

"In the end, all our contrivances have but one object: the continued growth of human personalities and the cultivation of the best life possible"

Lewis Mumford (1944)***"The Condition of Man"***

Chapter 4

Methodology

CHAPTER FOUR

4. Methodology

4.1 Introduction

The aim of this study is to examine qualified nurses' perception, meaning and experience of culture working in the HSE, West. In this chapter the Researcher will discuss the methodology selected i.e. phenomenology to fulfil this aim. The selection will be accomplished following an exploration of existing methodological approaches in the literature. The alternative approaches of positivism, grounded theory and ethnography will be presented. The methodology of Phenomenology chosen to underpin the study will be discussed in some detail in order to inform this theoretical decision *"... as reality does not exist within a vacuum"* (Crossan, 2003, p 52), *"... everything has a background. Everything has a context. In an expansive sense, everything is part of a greater whole"* (Schutz & Cobb-Stevens, 2004, p 218). Therefore it is the Researcher's intention to demonstrate that the composition of culture is influenced by the context in which it takes place "... *that among the various factors that influence reality construction culture, gender and cultural beliefs are the most significant"* Crossan (2003, p 52).

The steps of the research process will be informed by the pilot study process to explore the use of the data collection tool i.e. the focus group interview. The study proper will then be conducted.

4.1.1 Quantitative versus Qualitative Debate in Nursing

Traditionally nursing research has been dominated by quantitative approaches (Fealy, 1994). Quantitative research is based on the methodological principles of positivism which is the oldest theory in the social sciences (Sarantakos, 1993). This approach is formal, controlled, objective non-biased and generates rigorous numerical data (Field & Morse, 1985). In utilising quantitative research a researcher seeks to look for facts and causes and to examine relationships between variables as *"... understanding is gleaned through the interpretation of statistics"* (Fealy, 1994). The researcher is separate form the research process and participants are viewed as subjects of study with the generation of meaningful data the main focus (Field & Morse, 1985).

Conversely, qualitative approaches provide rich in-depth subjective non numerical data and are therefore more suitable for the complex social world of nursing research as it aims to explore social reality (Leininger, 1995; Sarantakos, 1993; Bryman, 1988). The qualitative approach of which Sarantakos (1993) suggests is a type of research that refers to a number of methodological approaches made its appearance in nursing in the 1960s (Morse, 1991). This was despite the scientific aura accredited to positivism and quantitative approaches as they are concerned with order, control and prediction *"... establishing ... the natural science model as real research"* (Playle, 1995, p 980).

The strength of qualitative research lies in the fact that it has a holistic focus, which allows for flexibility and the attainment of a deeper more valid understanding of the phenomenon, than can be achieved through a more rigid positivist approach (Cormack, 2000). This allows for the acknowledgement of personal meaning and subjective understanding which is vital to nursing practice and can be argued as unique to the art of nursing i.e. the human interaction, caring and nurturing (Playle, 1995).

As Fealy (1994, p 15) claims qualitative research *"... yields information which is rich and which is of quality"* and *"... reaches the parts other methods cannot reach"* (Pope & Mays, 1995, p 42). The overall goal of this study is to establish an understanding of culture in the natural setting of nursing thus *"... giving due emphasis to the meanings, experiences and views of all the participants"* (Pope & Mays, 1995, p 43).

However, as no one research method is without bias (Bowling, 2002). The Researcher will ensure that the primary tool of choice i.e. the Focus Group Interview (FGI) will be tested for rigour and validity in the Pilot process. The FGI will be semi structured and will serve to obtain the descriptive data from an *"... emic perspective"* via a purposive sample of qualified nurses working in the HSE, West i.e. *"... the native's point of view"* (Field & Morse, 1985, p 11).

A secondary tool i.e. the Participant Reply Form (Appendix IV) will serve to elicit an exploration relating to working outside of ones own cultural setting. Open ended short answer questions will serve to explore if there is a link

between the variable of working aboard and tolerance towards others (Field & Morse, 1985). This mixed method approach has been adopted to investigate different aspects of the same phenomenon (Bryman, 1988). In so doing the Researcher is giving recognition to the potential benefits of some form of measurement (Silverman, 1998). In addition this research study has the potential to inform the strategic planning process of the HSE, West.

Pope & Mays, (1995, p 42) contend that *"... some of the most important questions in health services concern the organisation and culture of those who provide health care".* Culture the descriptive concept in this study is operationalised by the metaphysical variables of perception and meaning which Crossan (2003, p 53) posits *"... are beyond the scope of science".* The Researcher does not intend to measure these variables as with quantitative deductive theory *"... building as it does on previous knowledge"* (Field & Morse, 1985, p 4) when the purpose of the study is to inductively gain insight and understanding and *"... bring knowledge"* about culture *"... into view"* (Field & Morse, 1985, p 5). The knowledge produced as with any professional discipline may serve to improve the practice in that profession (Field & Morse, 1985). In order to ensure a clear rationalisation of the philosophy chosen the potential utilisation of other philosophical traditions such as positivism, grounded theory and ethnography will be briefly examined. The Researcher would like to clarify her own position as not being entrenched in any one philosophy but one that is open to a range of philosophical discourses.

4.2 Methodological Approaches in Nursing Research

What is Phenomenology?

The later part of the 19th and early 20th centuries saw many thinkers, philosophers and social scientists particularly from the micro/interpretative schools of thought; question the appropriateness of the scientific method as a way of explaining phenomena and events within the social world (Fealy, 1994). As the social world is a real lived experience and as such does not lend itself towards measurement, predictability, order, control or quantification (Field & Morse, 1985).

Phenomenology can *"... refer to a research method, a philosophy and an approach"* (Dowling, 2004, p 31). As a distinct qualitative research method phenomenology has been applied to the study of sociology and nursing in the 1970s (Morse, 1991). This approach attempts to understand the meaning of observed phenomenon and human experience *"... it stresses that only those who have experienced phenomena can communicate them to the outside world"* (Mapp, 2008, p 308). It therefore seeks to answer questions of meaning by understanding an experience from the perspective of those who have experienced it (Mapp, 2008). The phenomenological term *"... lived experience is synonymous with this research approach"* (Mapp, 2008, p 308). The philosophical movement itself is still in the process of being clarified (Dinkel, 2005). As a result *"... one can find multiple interpretations and modifications of phenomenological philosophy"* (Morse, 1991, p 25).

Moustakas (1994, p 41 & 33) views phenomenology as *"... the first method of knowledge because it begins with things themselves"* in which;

> *"... everyday understandings, judgements and knowings are set aside and phenomena are revisited, freshly, naively, in a wide open sense, from the vantage point of a pure or transcendental ego"*

The Researcher will now present a brief background to the origins of phenomenological research by outlining the three main schools of thought whilst clarifying its aim and how it differs from positivism, grounded theory and ethnography.

4.2.1 Phenomenological origins

The phenomenological movement has a long history and developed along three phases:

1. The Preparatory Phase,
2. The German Phase
3. The French Phase

(Dinkel, 2005).

The difficulty in defining phenomenology is that there are interpretation and philosophical differences among the phases (Mapp, 2008; Dinkel, 2005; Moustakas, 1994).

The key concern of this research is The German Phase. Both Edmund Husserl and Martin Heidegger dominated theory development in this phase with the primary focus seeking the nature and origin of all knowledge (Dinkel, 2005; Moustakas, 1994; McNeill, 1989).

Husserl identified three key components, they are

- essences or ideal types,
- intuiting or logical insight
- phenomenological reduction or bracketing.

His drive was derived from the belief that experimental scientific research could not be used to study all human phenomena (Mapp, 2008; Dinkel, 2005). Thus as opposed to quantifying everyday experiences in the style of the natural sciences, this approach attends to our actual living in the *'life-world'* as it is experienced.

The *'life-world'* is a concept defined by Husserl. That is the world as we find it from the Researcher's perspective, as we actively create social reality, through social interaction (McNeill, 1989). His key assumption was,

"... knowledge of social reality is best gained by observing and describing phenomena within the natural setting of the phenomenon and from the subjective perspective of the 'native' within his/her natural setting" (Fealy, 1994, p 16). Husserl's contention was that the subjective perspective of the researcher could be transcended if we bracketed our personal biases (Mapp, 2008; Dinkel, 2005; Dowling, 2004; Paley, 2002;).

Conversely Heidegger's hermeneutic school of thought worked on the premise *"... that researchers interpret the data coliected in terms of their own experience and knowledge"* (Mapp, 2008, p 308). Heidegger's assumption was that there is more than just being as it involves a presence in the world, people and being are interdependent.

It is to the two German schools of thought in phenomenological approaches that the Researcher will focus descriptive phenomenology as espoused by Husserl and interpretive phenomenology as presented by Heidegger (Hermeneutics) (Polit & Beck, 2004). The goal of descriptive phenomenology is the description of meaning of an experience from the perspective of those having that experience at a particular time in their lives (Mapp, 2008). On the other hand interpretative phenomenology simply means that the researcher brings his or her own expert understanding and experiences to the research process and reinterprets every day experiences (Dinkel, 2005).

The Researcher's rationale in choosing a descriptive phenomenological framework, is based on the premise that the research examines qualified nurses perception, meaning and experience of culture working in the HSE, West. This framework allows narrative information to help towards an analysis of the participant's descriptions and experiences of social world phenomena and happenings (Fealy, 1994). This is in contrast, to the Heideggerian phenomenological perspective which would require the Researcher to reinterpret the phenomena (Mapp, 2008).

Other frameworks such as Positivism, Grounded Theory and Ethnography were explored briefly for the purpose of this study, however they were deemed unsuitable these are now forwarded by the Researcher.

4.2.2 Positivism

Husserl (1965) cited in Moustakas (1994, p 46) observed that *"... naturalism recognises the need for a scientific philosophy, but it is the greatest obstacle because it recognises as real only the physical".* Therefore when Positivism is applied to the study of human experience – in this study that is culture, which is diverse, complex, multifaceted, difficult to define with intangible qualities this is less successful as there is inconsistency with the order and regularity of the natural world. Positivism takes the view that the only valid form of knowledge is scientific knowledge (Fealy, 1994). Knowledge is objective truth and is accumulated via empirical observation *"... uncontaminated by notions of judgement, interpretation and other subjective operations"* (Fealy, 1994, p 14). Nursing is not quantifiable and its research is not about a search for truths.

Phenomenology as a constructivist perspective is unlike the positivist philosophy which is realist and views culture as being *"... under the control of human reason"* therefore predictable (Tovey & Share, 2003 p 7). Positivism is the high moral tradition in which culture, race and diversity are objective entities with listed difference easily identifiable; *"the check box"* (Gray & Thomas, 2006).

In this research study the meaning of culture will be developed by active subjects i.e. nurses who are cultural dwellers in a pre-interpreted world and as such the Researcher can dismiss Positivism as a research philosophy as it is incongruent with the research of culture *"... and widely dismissed as incompatible with nursing research"* (Clark, 1998, p 1244). The Researcher would like to acknowledge that she is not proposing a radical argument against positivism given that it is vulnerable to straight forward criticism and it is unlikely to add great weight to the proposed alternative of phenomenology as *"... few if any philosophers these days subscribe to..."* positivism (Clark, 1998, p 1246).

4.2.3 Grounded Theory

Many nurse researchers have moved to more practice based studies using methods derived from more humanistic philosophies, the aim being to tap into the natural aspect of nursing practice knowledge (Ramprogus, 2002). Grounded Theory could be considered for this particular study as it is concerned with the generation of new theory or the discovery of theory in areas where there is a dearth of research (Polit & Beck, 2004; Wimpenny & Gass, 2000). This is the case from an Irish perspective as there is a paucity of research on cultural and intercultural awareness particularly amongst nurses in Ireland (Brenner, 2003; Boyle 2000). All this coming to the fore when Intercultural awareness is becoming a topic of immense interest in the health services given the multicultural nature of Irish society (HSE, 2006).

Grounded theory has been described not so much as a method, but more as a style of doing qualitative research given that the position adopted is not to begin with theory and test it but rather to begin with an area of inquiry and allow whatever is theoretically relevant to emerge (Wimpenny & Gass, 2000). The researcher is lead by the research data gleaned from the interviewing process with the literature review of the research topic conducted when the study has concluded (Roberts, 2008). Grounded theory is similar to Husserlian phenomenology as both traditions identify the essential requirement of bracketing or reduction which is undertaken to suspend belief so that preconceptions and presuppositions are put aside this is viewed as a necessary requirement in order to become immersed in the participant's world (Mapp, 2008; Dinkel, 2005; Jacelon & O'Dell, 2005; Wimpenny & Gass, 2000). Bracketing therefore prevents the data analysis from becoming a reflection of the Researcher's preconceived values and ideas (Jacelon & O'Dell, 2005).

The Researcher dispensed with this approach as it was not the spark of a new theory which was sought but to reveal the phenomenon of culture to which meaning is being attached (Wimpenny & Gass, 2000).

4.2.4 Ethnography

Similarly ethnography was not an option for this study, as its essence centres around grasping the *"... natives point of view"* (Morse & Field, 1996 p 2). Ethnography has a great deal to offer the social sciences originating from its

origins in Anthropology. Morse (1991, p 41) defines it as *"... a way of collecting, describing and analysing the ways in which human beings categorise the meaning of their world"* and *"... involves extensive fieldwork"* (Moustakas, 1994). At first glance this approach seems appropriate as the knowledge generated is a social achievement (Morse, 1991). However this approach necessitates the researcher to become totally immersed in the lives of the participants *"... it is, however, a description ... that can emerge only from a lengthy period of intimate study and residence in a given social setting"* (Moustakas, 1994, p 2). Given that the method of choice for ethnography is participant observation this would involve the Researcher entering into and becoming involved in the chosen social setting i.e. the clinical area (Payne & Payne, 2004). This presented the Researcher with the following difficulties that culminated in the decision not to choose this method and they were:

1. The Researcher comes from a nursing background herself and is employed by the HSE therefore perceptions of her real intentions could pose an ethical issue in that the participants may have been sceptical of the independent nature of the research and the influence of the employer.
2. Ethnological practices involve *"... prolonged, systematic, first hand and direct encounter with the people concerned"* (Payne & Payne, 2004, p 73) this was unlikely from the perspective of the Researcher, to be seconded for a period of time from her own work to carry out the research.
3. Ethnological observation and participation involves an eclectic approach (Sarantakos, 1997) which means employing the use of

different data collection techniques such as asking questions, long interviews and background documentary methods in the Researcher's opinion this would place further demand in the clinical area workloads that more often than not deal with crisis situations.

4. Finally, there is often over confidence about the extent to which the Researcher has actually been accepted by social groups the Researcher's nurse teaching background might have given rise to the potential of the Hawthorne effect (Payne & Payne, Polit & Beck, 2004; Bowling, 2002).

In summary given the limitations of Positivism, Grounded Theory and Ethnography as outlined by the Researcher the descriptive Husserlian phenomenological approach was chosen as the most suitable research method as it aims to focus on the nature of the lived experience and will be elicited by utilising a purposive sample of qualified nurses working in the HSE, West with the main data collection tool facilitating this process i.e. the focus group interview *"... social reality is not out there, waiting to be experienced by social actors ... instead, we actively create social reality through social interaction"* (McNeill, 1989, p 120).

The Focus Group method was chosen by the Researcher as opposed to the following alternative methods:

1. The 1:1 interview (Face to Face) method as it was felt by the Researcher that the participants may have felt the need to respond to the Researcher in a particular way (Bowling, 2002). Secondly, it was

felt that the involvement of other participants in the focus group interview had the potential to increase participants' responses as many respondents add greater in-depth information to the data collection process having been triggered by the responses of other participants (Krueger & Casey, 2000). Finally, the Focus Group method was utilised instead of the 1: 1 interview because of time constraints in that this method could be completed across four events instead of 18 individual face to face interviews.

2. The Oral History method which aims to allow the participant to talk about past events these can carry much memory bias with the danger of the respondent reinterpreting events and therefore requires cross checking with other sources of information (Bowling, 2002). Whilst this method and methods similar to it such as the Life History method allow for more complex and sensitive issues to be probed the main disadvantage is that they are time consuming, difficult to collect and analyse and as a consequence there is a greater opportunity for interviewer bias to intervene(Bowling, 2002).

The Researcher recognises that whilst there is inevitable potential for interviewer bias in Focus Group Interviews the greater involvement and participation prompted by the interaction of all involved only then will the respondents reveal their true inner feelings, attitudes and behaviours (Bowling, 2002). Kitzinger (1994) posits that the Focus Group method is a useful technique for exploring cultural values and beliefs about in particular health related issues.

4.3 The Pilot Study

Prior to embarking on the main research study the Researcher carried out a Pilot Study on November 30th 2009. A pilot study refers to a small scale version or *"... dummy run"* (Robson, 1993 p 301) undertaken in preparation for the main study.

The aim of the pilot study is to identify potential practical problems during the research process. Identifying and rectifying any anomalies at this stage of the research process will add to the credibility of the study. As the Researcher in this study is a novice, the pilot study will give her an opportunity to gain confidence in planning and conducting guided focus group interviews for the main study.

The site chosen for the pilot study was a nurse educational setting with eight participants spanning a two hour time frame. The Researcher took on the role of primary moderator by encouraging group conversation and asking the primary questions (see Table 4.1). The role of Assistant Moderator was to act as the field note taker and technical operator (see Table 4.2).

Table 4.1 – Facilitator/Moderator Guidelines

Introduce self, position and the organisation supporting the research
Introduce the participants to each other
Briefly describe the aims, nature and purpose of the study
Discuss what will be done with the data collected
Ask if anyone has any questions relating to the study
Ask if anyone wishes to withdraw
Mention that the discussion will be audio taped and notes taken throughout by the interviewer
Discuss the role of the moderator i.e. to keep the discussion focused on the topic
Inform participants that they are free to speak whenever they have something to say, and encourage the participants to be open and honest and say what they really mean and feel, emphasising that the moderator has no vested interest in the nature of the responses
Set ground rules in relation to one participant speaking at a time, this can create difficulties during subsequent transcription
Suggest that participants should talk to each other rather than the interviewer or the moderator
Allow the participants to wind down at the end of the interview

Source: Adapted from:

Ramprogus, V. (1995)

The Deconstruction of Nursing Developments in nursing care 7 Aldershot: Avebury.

Table 4.2 – Assistant Moderator's Role

Selection Criteria:

A Nursing Background
An Educational Background
A fellow Research Student – committed
A work colleague with previous research experience

Responsibilities:

Listen / Observe / Analyse

- Room set up assist the Researcher
- Ensure equipment supplies Tape recorder
  Blank tapes
  Microphone working
  Spare Batteries
  Markers, pens paper etc
  Name labels/tags (if required)
  Refreshments
  Handouts
  Ventilation
- Welcome the Participants – along with the Researcher
- Sit away from the main group – opposite the Researcher so that your attention can be obtained quickly. Also if a participant arrives late you can greet them.
- Take Notes – Well said quotes
  Non Verbals, head nods, hand movement, physical excitement
  Sketch the seating arrangements
  Any Question you would like to ask at the end
- Do not participate in the discussion – talk if invited
- Oral summing up at the end (No longer than 2 minutes) allowing the participants to add, correct, rephrase etc.
- Ensure Incentives such as lunch are arranged
- Debrief with the Researcher and record same – this should include feedback on Researcher interview skills and any adjustments required.

Source: Adapted from;
Krueger, R & Casey, MA (2000) **Focus Groups. A Practical Guide for Applied Research,** 3rd edn. London: SAGE

4.3.1 Pilot Sample

In total eight participants who are all registered nurses (homogenous characteristic) were purposely selected from an educational and practice development/clinical background. They were invited to attend the Pilot Focus Group interview via email. The eventual number participating was four. The participants had been chosen as they met the Characteristic Selection Criteria (See – Table 4.3).

Table 4.3 – Participant Selection Characteristics

CHARACTERISTICS	
Generic	**Specific**
Adults – Male/Female	Nurses (Homogenous) – Irish Ancestry and Foreign Nationals who have either trained in Ireland or abroad
Own life experiences	Registered – with ABA
Currently employed	Employed by the HSE, West
Living in the Ireland	

4.3.2 Pilot Ethical Issues

The Researcher's conduct and behaviour as a registered nurse is guided by the Irish Nursing Board's Code of Professional Conduct (ABA, 2000). In conducting this study the Researcher will support the principles inherent in the Code (ABA, 2000) by the American Nurses Association (ANA) Ethical Guidelines (Appendix V) as these specifically underpin field work (Polit & Beck, 2004). Prior to the commencement of the Pilot permission had been sought from the educational facility Director (Appendix II Letter of Permission).

Ethical approval had also been sought from the Hospital Ethics Committee with the application submitted by the Researcher in September 2009 and approval granted on November 17th 2009. In order to corroborate the approval the participants were shown the copy of the Research Ethics Approval letter received by the Researcher. The participants had also received the Research Information form (Appendix III) prior to the pilot date. Consent was obtained (Appendix VI) and the participants were informed of their right to withdraw at any time. The use of the Participant Reply Form (Appendix IV) which included the questionnaire was also explained.

4.3.3 Pilot Data collection and analysis (Making sense of the situation)

The Researcher has utilised Gibbs Reflective Cycle (1988) in order to analyse the practicalities of conducting a focus group interview as the data collection method of choice (See – Table 4.4). Colazzi's Framework (1978) will be utilised

Table 4.4 – Gibbs Reflective Cycle

Description of the Event	What happened?
Feelings	What I was feeling and thinking?
Evaluation	What was good and not so good about the experience?
Analysis	What sense can I make of the situation? – re-evaluating the experience
Conclusion	What else could I have done? What knowledge did or could have informed me?
Action Plan	If the situation arose again, what else could I do or do differently?

Source: Adapted from; Gibbs, G. (1988) **Learning by doing, A guide to teaching and learning methods** Oxford: Further Education Unit Oxford Polytechnic

4.3.3 (I) What happened?

Planning for the pilot focus group interview began many months in advance of the physical preparation of the environment *"... to field a focus group requires that the researcher give careful time and attention to how they will prepare for the session"* (Redmond & Curtis, 2009, p 60). Green & Browne (2005, p 68) discuss the need for the Researcher to *"... adapt the methods used to the particular setting that you are working in"*. The amount of time spent planning can be deceptive and appear simple yet Redmond & Curtis (2009, p 60) caution that it *"... can be the most complicated stage of the focus group process"* and subsequently frames all decisions the Researcher will make about the research study (See – Appendix X Research Timeframe).

A quiet room was prepared by the Researcher and Assistant Moderator which contained a central conference style table and chairs. A *"do not disturb"* sign was placed on the door (Clarke, 1999). The initial plan was to disperse the participants around the table so that they were visible to each other with the Assistant Moderator sitting close to the door in order to usher in any late comers. The tape recorder was placed at the edge of the table in proximity to the Assistant Moderator who was responsible for operating the device.

Four of the participants arrived, two others had sent a message that they would be late, in light of this two chair spaces were left near the door and two did not respond. This left those in attendance sitting on one side of the table this will be discussed by the Researcher in the evaluation. To begin with the

Researcher welcomed everyone, introduced herself and the Assistant Moderator the Facilitator/Moderator Guidelines (Table 4.1) was adhered to (Ramprogus, 1995). Appendix III – Participant Information was recapped upon as the participants had been sent this via email prior to the interview any questions raised would be answered at this point. The study aim was also outlined and clarified (O'Connor & Murphy, 2009; Clarke, 1999).

The participants were assured that confidentiality and anonymity would be maintained.

The participants were allowed time to complete Appendix IV – The Reply Form and Appendix VI – The Consent Form; these were coded and signed by the Researcher. The participants were informed that upon completion of the interview process a light lunch would be provided.

The Pilot Focus Group Interview Guide (Appendix VII) was designed by the Researcher *"... to collect data that is relevant to the topic under investigation"* (Redmond & Curtis, 2009, p 60).

These were;

1. Examine qualified nurses' perceptions, awareness and understanding of culture i.e. the meaning of culture to them. The Research seeks to discover the range of ideas and feelings that nurses have about culture in general, nursing culture and *'other'* cultures.

2. To understand and reveal the differences in perspectives between groups of nurses and to uncover the factors that influence these opinions, beliefs, attitudes and behaviour.
3. Reveal the factors that have the potential to facilitate cultural competence when working with or caring for diverse cultures.
4. Highlight the strategies to be put in place from an educational perspective that will assist nurses to develop cultural competence from the information rich data that will emerge from the focus group interviews.

The questioning format adhered to the Hawaiian Principle – this is the *"... funnelling concept"* with the discussion moving from the broad to the narrow i.e. general to the specific (Krueger & Casey, 2000, p 62). Each of the participants introduced themselves and outlined their current role as health care workers. Lively conversation and discussion followed which Lasted 90 minutes, about their personal and professional cultural awareness, understanding, experiences and feelings.

4.3.3 (II) The Researcher's thoughts and feelings

The thoughts and feelings of the Researcher were recorded prior to, during and following the Pilot focus group interview.

Prior to the interview – this was the first time that the Researcher conducted a focus group interview, therefore as a novice fear of failure was the key feeling

encountered by the Researcher. The practicality of translating this was no one turning up. The following is a recounting of the many thoughts, and feelings which the Researcher experienced;

- Will the participants turn up? And if so how many? And will the numbers be enough given the literature's suggestion of a minimum of four? (Krueger & Casey, 2000; Clarke, 1999).
- Will the recording equipment work?
- Will the equipment record the material when turned on?
- Will they understand the questions?
- Will the participants feel relaxed enough to answer the questions?
- Will they talk freely?
- What will I do if the participants wander off the topic?
- What if one participant takes over?
- How will I handle difficult comments or behaviour?
- Will I manage to cover all the salient areas in the timeframe available?
- Will I run over time?
- Will I run out of time?

The one reassuring concept was that the Researcher was not alone the Assistant Moderator had research experience this combined with the fact that the Researcher felt confident that her knowledge in the research study area was comprehensive and well prepared. Nevertheless doubts and an uneasy feeling, nagged the Researcher who had limited experience conducting a focus group interview in that she was accountable to the participants in her

ability to *"... accurately represent their perceptions about this issue"* (O'Connor & Murphy, 2009, p 144).

During the interview – The topic certainly captured the interest of the participants who engaged vigorously in the process. Husserl's Transendental Phenomenology espouses the contention that the subjective perspective of the researcher can be transcended if we bracket our personal biases (Mapp, 2008; Dinkel, 2005; Dowling, 2004; Paley, 2002). The ability to bracket presuppositions and recognise when self could be utilised proved difficult to the Researcher who found she was analysing what was being said by the participants (Morse, 1991).

There was also a fear of deviation from the script i.e. The Pilot Focus Group Interview Guide. The Researcher also engaged in note taking as there was a feeling of loss of control to the Assistant Moderator. The Researcher in persisting with the note taking role lost eye contact with the participants missing in the process many valuable cues and gestures. The Assistant Moderator did request the Researcher to refrain from the activity of note taking and when this transpired rapport improved between the Researcher and the participants. There were also too many questions articulated in the guide and an overwhelming sense of needing to get responses to each one of them was experienced by the Researcher with the result that the participants were not encouraged to elaborate on strong feelings expressed.

Following the interview – The main feelings were those of relief that the interview was over and that the Researcher had survived the ordeal. The Researcher was also happy and satisfied that all of the participants had contributed and this was enhanced by comments such as *"... culture is a very interesting topic"* (PFGI 1 – Participant 1). There was also consensus among the participants with regard to how quickly the interview had passed this was not expressed as relief but rather as enjoyment.

The Researcher was proud of the flow of the interview in that she had achieved what she set out to do i.e. data gathering regarding nurses' perception, meaning and experience of culture working in the HSE West. Kitzinger (1994, p 106) cautions the researcher that *"... it would be naïve, however, to assume that group data is by definition 'natural' in the sense that it would have occurred without the group having been convened for this purpose ... focus groups are artificially set up situations".*

4.3.3 (III) Evaluating (what was good and not so good)

What was good – The Researcher felt that from what was available in the literature with regard to the format for conducting focus groups that there was a high level of adherence (Green & Browne, 2005; Krueger & Casey, 2000; Kitzinger, 1994; Morse, 1991).

This assumption was based on the following:

- *"The Key to successful focus groups is careful preparation"* (Green & Browne, 2005, p 69) this was achieved by the Researcher's planning and thinking about the appropriate methods, venue, group, resources required and the Pilot Focus Group Interview Guide (Appendix VII).
- The choice of the purposive sample was selected on the basis of best match with characteristics (Table 4.3).
- The venue chosen was also the natural setting for the participants i.e. where they work. Thereby insuring a relaxed non threatening environment was achieved.
- Consideration had been given to local management structures in that written permission was sought from the Director of the facility Letter of Permission (Appendix II).
- Ethical written assurances of confidentiality and written consent i.e. prior to the pilot date the Researcher had forwarded the Research Information Form (Appendix III) and Consent (Appendix VI) was obtained on the day of the pilot.
- Pilot Focus Group Interview Guide (Appendix VII) allowed for the flow of the interview. The introduction was brief summarising the aim, briefly outlining what would happen to the data collected and assuring participants with regard to confidentiality (Green & Brown, 2006). The ice breaker start ensured group interaction and that everyone got an opportunity to speak (Green & Browne, 2005; Kitzinger, 1994;). The use of the funnelling concept (Green & Browne, 2005; Krueger & Casey, 2000) this moved the questions from the general to the specific. The very first question was focused in construction in that the

participants where ask to think about how they are identified by others as identity is a key feature of culture (Green & Browne, 2005). *'Why'* questions were not asked as these are ambiguous and can often sound interrogative (Green & Browne, 2005). This will be further discussed in the Main Study by the Researcher.

- The use of the Assistant Moderator ensured the smooth execution of the interview and left the Researcher free to devote attention to the interview as the Assistant Moderator was clear with regard to her role and responsibilities Table 4.2 – Assistant Moderator's Role.
- The Researcher's/Facilitator's personality, social identity and interpersonal skills were key fundamental to influencing the process of interaction. She also managed to generate interest about the topic of culture however the Researcher did find the role at times uncomfortable and unclear as a delicate balance needed *"... to be struck in terms of prominence and involvement"* (Sim, 1998, p 347).

What was not so good – The Researcher's inexperience and flaws in conducting the interview discussion was the key problem identified, hence the importance of conducting the pilot in order to identify such weaknesses (Krueger & Casey, 2000). The Researcher felt a need to control the process and at the commencement of the interview did not trust the Assistant Moderator to act as field note taker. This meant that by engaging in the activity of note taking cues were not being picked up and the timely use of interjecting probing comments and transitional questions were missed

(O'Connor & Murphy, 2009). The Assistant Moderator indicated this with the following written comment

> *"... you're not picking up cues because you're not looking at your participants enough. Hand over more to your participants. You're dealing here with a very articulate group who know each other; know you, other groups may need more of a sense of interaction".*

As a result one key comment missed was *"... feel proud to be Irish"* (PFGI 1 – Participant 4) the Researcher should have picked up on this very powerful emotion by probing about what they meant by pride in the context of culture. The use of the United Nations (UN) Racism definition in question 19 of the Pilot Focus Group Interview Guide (Appendix VII) created confusion.

> *"I'd like to share with you a summary definition of racism by the UN- I will circulate it to you on the page here; please take a minute to read it, I will read it aloud"*

The Assistant Moderator recognised this in her written comments *"... Racism not sure about this as the definition comes at the end of a long intense interview? Ask the question or put in the Participant questionnaire".*

The Researcher also felt that stating the participant's name each time they spoke interfered with the flow of discussion and sometimes disrupted the flow of the participants perception of experiences, *"... what was I saying"* (PFGI 1 –

Participant 1). The Researcher felt this needed to be done in order to assist with clarity for the verbatim typing.

The Pilot Focus Group Interview Guide framed with 23 Questions directly relating to the topic of culture and as a consequence the Researcher felt that she had to ask all the questions. This resulted in the Researcher reading out each question leaving the interview less conversational and spontaneous as the Assistant Moderator comments *"... need to connect with the speaker encourage ... need to be more open less bureaucratic".* Redmond & Curtis (2009, p 68) refer to this as *"... an important misconception in that the moderator has to get through ail the questions"* they go on to reiterate that, *"... what is important is that the main topic area is covered and that everyone has at least been encouraged to discuss it".*

A further cause of distress to the Researcher was the realisation that the participants sampled from an educational and practice development background lacked recent clinical experience as a result this meant that the responses were dependent *"... on the specific context and circumstances of the individuals taking part"* (Barbour, 2007, p 92). This particularly related to the questions which covered *"... caring for and working with diverse cultures".* This was sensed by the Assistant Moderator as she noted in the summary remarks, when she penned the following comment in the field notes *"you need to avoid the summary sounding like you didn't get what you were looking for".*

The planning as stated earlier by the Researcher can be deceptive this as Redmond & Curtis (2009, p 61) suggest *"... should promote interaction"* because of the room seating arrangements at the outset of the interview the four participants were positioned in a linear fashion this did not lend itself towards group interaction as contact between some participants was obscured by others. Seating would be arranged in a more open fashion for future focus groups.

4.3.3 (IV) Analysing (making sense of the interview)

Analysis that involves creating meaning and understanding from a process such as the focus group interview is a key constituent of Gibbs Reflective Cycle (O'Connor & Murphy, 2009). Preparation is pivotal to the success of the interview process (Green & Browne, 2005) as the process seeks to provide and elicit qualitative data by capitalising on the interaction that occurs within the group setting (Sim, 1998). The homogenous purposive nature of the participants selected by the Researcher supports group interaction and dynamics as opposed to a group of strangers (O'Connor & Murphy, 2009; Redmond & Curtis, 2009). Kitzinger (1994, p 113) cautions *"... that regardless of how ... selected, the research participants in any one group are never entirely homogenous"* as differences exist between individuals and within the group one such difference in the PFGI was gender as one participant was male. This lends to the validity of the responses as *"... diversity within a group ensures that people are forced to explain the reasoning behind their thinking"* (Kitzinger, 1994, p 113)

With the primary topic of investigation Culture and in particular Nurses' perception, meaning and experience within the caring domain, Sims (1998) reiterates the suitability of the focus group as a method of choice when investigating such issues in nursing. From the Researcher's perspective it was reassuring to read in the literature that no individual sample selection process is ideal but that the Researcher should make an informed knowledgeable choice when selecting a data collection method (Redmond & Curtis, 2009).

The interview guide was comprehensively developed and contained 23 specific questions with the objective to collect data that was relevant to the topic under investigation i.e. culture (Redmond & Curtis 2009). The guide also served as a useful map that plotted the focus group interview from start to finish and kept the focus (O'Connor & Murphy, 2009; Redmond & Curtis, 2009).

Barbour (2007) suggests that little is known about why people agree to take part in focus groups as there is little in the way of return on investment for the participant one reason forwarded in the literature is that they can be cathartic. For this reason the Researcher gave the group the reassurance that a copy of the Research study would be forwarded to them upon completion by making this gesture there was a sense of giving something back (O'Connor & Murphy, 2009). The Researcher did not want to give the participants the impression that the organisation was listening when the fact is that this study is a

personal academic exercise therefore the participants were reassured that this was the case (O'Connor & Murphy, 2009.

The participants were also informed with regard to ethical considerations as the Researcher feels that *"... ethical issues are not just something that needs to be taken into account in completing application forms for ethics committees"* (Barbour, 2007). Therefore consideration of ethical issues was a feature at each stage of the interview process with careful consideration given to how data gathered would be stored and dealt with, Study Information, Consent and Confidentiality (Barbour, 2007). The Researcher also explained the aim of the Study to the participants and clarified their right to withdraw at any stage of the process (Krueger & Casey, 2000). Moderating of the interview was achieved by the presence of an Assistant Moderator as *"... data needs to be collected not only on what the participants say, but also on how they interact with each other"* (Sim, 1998, p 347). This person can stand back from the group and pick up undue prompting (Sim, 1998).

Another important consideration in the data collection process recommends that written notes should be taken even when a tape-recorder is employed as this provides a means whereby the non-verbal interaction can be observed and linked to the verbal accounts recorded (Krueger & Casey, 2000; Sim, 1998). Sim (1998, p 347) also recommends that *"... written notes are better taken by a co-researcher than by the moderator" this* advise was employed by the Researcher.

Group dynamics which take place in a focus group are central to its success (Sim, 1998). Interpersonal processes can cause problems in that censoring of views held by some participants may emerge, conversely the emergence of dissonant views which Kitzinger (1994, p 113) calls *"... Argumentative interactions"* often contributes to the richness of focus group data (Sim, 1998). This was not encountered by the Researcher in the pilot however she remained mindful of its occurrence. The homogenous composition of the pilot focus group imbued confidence amongst the group when expressing individual views influencing in turn the conformity of opinion (Sim, 1998; Redmond & Curtis, 2009). For this reason the Researcher made the choice not to select a heterogeneous group of migrant nurses and Irish nurses for the main study as minority viewpoints may give way to majority stances (Redmond & Curtis, 2009; Sim, 1998).

Finally in reflecting upon the execution of the pilot focus group interview the Researcher will adhere to the recommendation in the literature that more than one focus group interview be conducted (Krueger & Casey, 2000; Sim, 1998).

4.4 Conclusion

In concluding this section of the methodology chapter the Researcher has discussed the strengths and weaknesses of both qualitative and quantitative research. Qualitative research was enlisted as the framework of choice. The subsequent rationale for placing this study within the Husserlian descriptive phenomenological framework of which the Researcher gave an historical

account. Husserl's perspective was deemed to be best suited to the examination of culture and its meaning from the subjective perspective of the social dweller i.e. the nurse. The framework allows for the generation of narrative information which assists in the analysis of nurses' descriptions and experiences of culture (Fealy, 1994).

The Researcher explored other frameworks namely positivism, grounded theory and ethnography for possible suitability in conducting the study. These however were subsequently deemed unsuitable. Positivism on the basis that nursing is not about a search for truths (Clark, 1998). Grounded theory was rejected as new theory was not being sought but to reveal the meaning of the phenomenon of culture for nurses (Wimpenny & Gass, 2000). Finally ethnography was dispensed with as this involves total immersion in the lives of the nurses (Moustakas, 1994) and it was unlikely from the perspective of the Researcher to be seconded for a period of time to carry out the research.

A Pilot was then conducted by the Researcher as a *"... dummy run"* (Robson, 1993, p 301) and the Researcher utilised Gibbs Reflective Cycle to analysis and gain deep insights into the planning, preparation and conducting phase by using the chosen data collection tool i.e. the focus group interview. By so doing the Researcher has learned the specific issues to be addressed with regard to carrying out further focus groups (O'Connor & Murphy, 2009). The success of which is dependent on a structured format (O'Connor & Murphy, 2009). It is the Researcher's contention that focus group interviews are a

useful method for generating data about in particular how social knowledge about culture is constructed (Green, 2006).

The next section of the chapter will reinforce the methodological choices made by the Researcher in relation to the main study.

4.5 The Main Study

4.5.1 Gaining Entry and Access

Access involves *"... gaining permission to do research in a particular social setting or institution"* (Fareed, 1996, p 273). The access for this study was initially achieved by approaching the Director of the Centre of Nurse Education *"... the gatekeeper"* (Fareed, 1996, p 273) to obtain preliminary approval and with whom the research was discussed. A letter of permission (Appendix II) seeking approval to undertake the study was given and this was accompanied by the Participant Information Sheet (Appendix III). Morse & Field (1996) stress, that these initial approaches are crucial, in gaining successful entry to the field of study. With approval for the study granted at both an educational and clinical level i.e. qualified nursing staff attending continuing education courses in the education centre and ethical approval to interview nursing staff in the clinical settings.

The Researcher also needed to include the potential that the population could comprise of qualified nursing staff working in the counties of Donegal, Sligo, Leitrim, Cavan and Mayo attending courses in the education centre hence the inclusion of the HSE West in the study title. The Researcher was cognisant of the fact that the entire population frame of qualified nursing staff working in the HSE North West comprised of a population of over 2000 nurses approximately therefore interviewing the entire population was not feasible. Given the geographic spread of the participants this would involve

interviewing and accessing nurses in the Acute Service Sector and other continuing care service areas. Therefore in order to incorporate this contingency approval was also sought from the Hospital Ethics Committee in September 2009 with written authorisation for the study granted on November 17th 2009.

Having secured access in an ethical manner the Researcher proceeded to schedule interview dates and times in conjunction with the education centre timetable along with personal telephone calls and emails to institutional and department heads to negotiate access. Four interviews dates were secured and scheduled and these would take place in both educational and institutional settings. The Researcher also made the decision that each potential participant and in the case of phenomenology *"... anyone who has lived the experience of the phenomenon under investigation is qualified to act as a source of data"* (Fareed, 1996, p 273). The participants were therefore given the following to be read prior to the focus group interview as this allows participants to give some consideration to their own views prior to attending the interview thus deterring *'group think'* (Kitzinger, 1994):

Appendix III - the Participant Information Sheet detailing the study.

Appendix IV - the Reply Form which would obtain the demographic details of the participants.

Appendix VI – the Consent Form which would obtain the participant's willingness to become involved in the study and would be signed on the scheduled dates of the interviews.

4.6 Sampling Strategies

Sample size is typically small in phenomenology (Mapp, 2008; Fareed, 1996). A purposeful sample of nurses was selected. The rationale utilised in selecting a purposive sampling by the Researcher stems from the fact that a participant is selected *"... according to the needs of the study"* (Morse, 1991, p 129) and *"... who will have knowledge of the phenomena concerned"* (Mapp, 2008, p 309). In essence the number of participants was determined by the quality of the data which emerged (Mapp, 2008; Fareed, 1996).

The needs of this study are as indicated in Table 4.3 – Participant selection characteristics, are typified by a nursing qualification, registered with ABA and living and working in the North West of Ireland. Polit & Beck (2004) outline the importance of considering common characteristics of participants whose experience is considered as typical. However as the study progresses atypical characteristics need to be sought as Morse (1991, p 129) suggests *"... so that the entire range of experiences and the breath of the concept or phenomena may be understood"*. In this study the atypical characteristic was being a migrant nurse whose knowledge of the research topic culture will present the range in the experiences.

The Researcher will now outline the factors which were considered with regard to the sampling strategy such as choosing the sample, ethical issues, data collection, data analysis, rigour, validity and generalisability.

4.6.1 Choosing the Sample

Cormack (2000, p 210) suggests that *"...an essential part of sampling is to determine precisely who is to be included in the study".* To ensure that the sample is representative of the target population the Researcher will familiarise herself with the variables e.g. age, gender, nationality, qualifications, employment status etc. (See Table 4.5 – Demographic Profile). This strategy will ensure that the participants chosen can provide the necessary information and are typical of the population in question (Morse & Field, 1996).

The purposive sample chosen reflected the Gender balance in Nursing from a national perspective. Gender has particular significance in nursing with 95-97% of the nursing profession female; this needed to be reflected in the purposive sample which it was, as of the 18 nurses interviewed originated from general nursing backgrounds across four focus groups two were male representing 11.1% or in other words just fewer than 90% of those interviewed were female. Furthermore, if the Researcher had purposively sampled nurses from a predominately mental health background this would have skewed the percentage of males involved and would not have been reflective of the national gender percentages.

Table 4.5 – Demographic Profile

Criteria	Category	No Participants
Demographic Area	Donegal Sligo Leitrim	2 8 8
Nationality	Irish British Indian Filipino	8 1 1 8
Age	< 30yrs 30-40 40-50 50+	2 9 5 2
Gender	Male Female	2 16
Professional Qualifications (Initial Qualification)	RGN RPN RNT RNMH RSCN RM Other (RNID)	15 1 2
Academic Qualifications	1 2 3>	17 7 2
Length of Experience	< 10 10-30 >30	2 14 2
Cultural Training	Received Not Received	2 16
Worked Abroad	Abroad Ireland (Only)	17 1

Note: Only 2 of the Irish Participants had a single Professional qualification (Certificate level)

All 9 of the overseas nurses had a single Professional qualification (Degree Level)

As the study is employing focus group interviews, the literature varies with regards to suggestions on an optimal group size. Polit & Beck (2004, p 342) suggest between *"... 6 to 12 people"* whereas both Krueger & Casey (2000) and Kitzinger (1994) recommend that each group comprise of between four and eight people.

The Researcher adhered to the proposed FGI Plan which had envisaged the carrying out of 3 – 4 Focus Groups comprising of no less than 4 and no more than 12 participants (Redmond & Curtis, 2009; Krueger & Casey, 2000).

The Researcher carried out four interviews in total (Table 4.6 – Focus Group Interview Schedule)

Table 4.6 – Focus Group Interview Schedule

WHEN?	No. of FGI	No. Interviewed	WHO?	Where?
Nov Wk 4 2009	FGI 1	4	Irish Nurses Working in variety of Service areas – Care of the Elderly, General and Intellectual Disability	CNME
Dec Wk 2 2009	FGI 2	5	Irish Nurses Working in variety of Service areas – Care of the Elderly, General and Intellectual Disability	CNME
Dec Wk 2009	FGI 3	4	Non - Irish Nurses Working in Community Care Service Areas – Care of the Elderly	CA
Jan Wk 4 2010	FGI 4	5	Non - Irish Nurses Working in Community Care Service Areas – Care of the Elderly	CA

The guided focus group interview allows participant's views and feelings to emerge, whilst at the same time allowing the interviewer some control by utilising Appendix VIII - the FGI Guide this was achieved (Robson, 1993).

4.6.2 Ethical Issues

"Ethical practice is not an add on, to social research but lies at its very heart" (Payne & Payne, 2004 p 66). Polit & Beck (2004) state that there are three main ethical considerations in research:

1. Beneficence
2. Respect of human dignity
3. Justice.

Inherent in beneficence is that all research must deliver a beneficial outcome *"... knowledge for the common good and that it will not harm the participants"* (Polgar & Thomas, 2008, p 259). In this research autonomy was ensured as the Researcher reiterated to the participants that they had the right to withhold information and withdraw at any time (Fareed, 1996). Participation was voluntary and the FGI's were conducted in such a way so as to encourage the participants to speak openly about their cultural experiences and emotions, revealing for many privileged information which had remained private or invisible.

In ensuring that respect for human dignity was kept in mind ethical clearance from the relevant research ethics committee was sought for this study, in September 2009 as it was crucial to protect the anonymity and confidentiality of the participants in this research (Polgar & Thomas, 2008). In keeping with this ethical approval ethical codes have also been developed to guide the efforts of researchers (Polit & Beck, 2004). In studying people and in particular asking them questions about their beliefs about a specific topic such a culture *"... not only do the values of the researcher but the researcher's responsibilities to those studied have to be faced"* (Silverman, 1998, p 200).

Justice therefore must prevail and one way of overcoming this is by consulting the ethical guidelines of one's professional association (Silverman, 1998). Therefore for the purpose of this study the Researcher was guided by the ethical guidelines of the American Nurses Association (ANA) (Appendix V) as outlined in Polit & Beck (2004 p 144). All such guidelines stress the importance of *'informed consent'* in particular where the researcher is making a recording of the interviews (Silverman, 1998).

Inherent in this is the researcher – participant relationship which is a key concern in ensuring sound ethical standards (Sarantakos, 1997). The Researcher achieved the by:

Proper Identification – at the outset of all four FGI the Researcher identified herself to the participants and the Assistant Moderator was also identified.

Clear outset – Fundamental to research is honesty in practice (Payne & Payne, 2004). The personal nature of the research study was outlined i.e. fulfilment of a Research Master's programme. The research aims and objectives were also clearly articulated to the participants. Rice & Ezzy (1999, p 39) caution that *"... while participants can typically be informed about the goals and general nature of most research projects, qualitative research is often exploratory, with a concomitant lack of clarity about the consequences of the studies' findings."*

Participant welfare – "... the researcher should always be concerned with the welfare of the respondent" (Sarantakos, 1997, p 23). Therefore in the interest of physical safety the rooms utilised were prepared in advance, with adequate ventilation and hydration ensured. The incentive of Lunch was also provided by the Researcher for the participants. As welfare is more than physical the emotional needs of the participants were also cared for i.e. *'why'* questions would be avoided as these are interrogative in nature and suggest that *"...when asked why, respondents feel like they should have a rational answer appropriate to the situation"* (Krueger & Casey, p 59). Participants were also encouraged to say exactly how they felt and that they were not to take into consideration the sensitivities of either the Researcher or the Assistant Moderator.

Informed consent – Freedom to participate was conveyed to the participants. The Researcher endeavoured to protect all participants' rights through the voluntary nature of participation and the freedom to withdraw from the interview at any time was also verbally communicated. Completion of the consent form (Appendix VI) assured participants' anonymity and confidentiality.

The right to privacy – When the FGI were being conducted in the assigned venues a *'do not disturb'* sign was placed on the door this ensured privacy for those participating in the interviews. Not all questions were answered by the participants in turn the Researcher did not pursue responses thereby acknowledging the participant's wish not to impart the information required.

The right to anonymity – The researcher ensured that the data gathered did not relate to specific names and would be identified in transcript as e.g. FGI 1 Participant 1 and only parts of authentic statements were included in the findings for this reason.

The right to confidentiality - verbal assurance regarding the storage and destruction of the interview tapes and questionnaires and the write up of the findings was given to the participants. How the findings would be disseminated was also discussed at the outset of the FGI. However the Researcher must caution that while she endeavoured to ensure confidentiality of each group member it can be difficult to ensure that individual participant's or those engaged in the verbatim typing of the interviews maintain confidentiality (MaClean et al, 2004; Kitzinger, 1994).

4.6.3 Data Collection

For the purpose of this study the Researcher has engaged the Focus Group Interview as the method of choice. This method *"... is useful in that it provides a description of experiences using information obtained in the participants' own words and not with the researcher's views imposed on them"* (Fareed, 1996, p 273). The primary rationale in choosing this method was that the qualitative framework engaged in this study Phenomenology required the generation of in depth information as *"... the concern is with individuals and their views ... as what is studied is the 'noesis' the appearance of things as opposed to 'noumena', the things themselves"* (Cohen, 1987, p 31).

The individual must therefore be studied in their natural context *"... the 'Lebenswelt' (Life-world)... the world of everyday lived experience"* (Cohen, 1987, p 31). The field notes generated were recorder by means of an audiotape and summary notes were taken of the FGI by the Assistant Moderator as *"... written notes are better taken by a co-researcher"* (Sim, 1998, p 347).

(i)Focus Group Interviews

The Researcher chose the focus group interview which is defined as *"... an interview with a group of individuals assembled to answer questions on a given topic"* (Polit & Beck, 2004 p 719) *"... including a moderator or a facilitator"* (Polgar & Thomas, 2008, p 111). The hallmark of focus groups interviews is their explicit use of collective interaction to produce data and insights that would be less accessible without this interaction *"... the researcher is outnumbered and the participants may interact with each other, modify each other's responses and ask questions of each other"* (Polgar & Thomas, 2008, p 111). This was the intention of the Researcher to observe the interactions of selected groups of nurses discussing the topic of Culture from their lived experiences. It is for this reason that in recent years the FGI has become popular in nursing research particular with the examination of complex cultural issues such as racism in the classroom, care and caring cultures and the experiences of nurses working in different care environments and transcultural nursing (Markey & Tilki, 2008; Rytterstrom et al, 2008; Tilki et al, 2006; Bai, 2000).

The FGI is not new with its popularity increasing in the field of social science research post the Second World War (Rice & Ezzy, 1999; Kitzinger, 1994). Robert Merton (1946) cited in (Rice & Ezzy, 1999, p 73) *"... employed this method to examine people's reaction to wartime propaganda"*. The FGI has also gained popularity in Market research as a key method of examining trends and are *"... particularly useful when a researcher wishes to explore people's knowledge and experiences"* (Rice & Ezzy, 1999, p 74). These uses of the FGI further copper fastened the Researcher decision in invoking this tool as the data collection method of choice given that the central concern of this study was to elicit Qualified Nurses Perceptions, meanings and experiences of culture working in the HSE West hence the appropriateness of the method.

The FGI and the experiment also belong to the same group of research methods the similarity between the two methods extends to the aspect of environment control as the interview settings were maintained constant and this served to enhance the study rigour from the Researcher's perspective (Payne & Payne, 2004, Sarantakos, 1997).

The optimal group size suggested in the literature varies from as few as three to as many as eighteen however most of the authors caution that the amount of information contributed by individual participants will determine group size (Redmond & Curtis 2009; Polit & Beck, 2004; Bowling, 2002; Krueger & Casey, 2000; Rice & Ezzy, 1999; Sim, 1998; Sarantakos, 1997). Krueger & Casey (2000) suggest that serious consideration should be given to the use of

smaller groups as in a smaller group participants have a greater opportunity to talk. It is the dynamic group interaction that distinguishes the focus group from large group interviews or individual interviews as this dynamic interaction stimulates the thoughts of participants and reminds them of their own experiences and feelings about the research topic giving courage to participants to mention sensitive issues (Kitzinger, 1994). In this study the numbers participating in each of the FGI varied between four and five (Table 6).

A semi-structured guide (Appendix VIII) devised by the Researcher was utilised as a trigger while conducting the focus group interviews. The Researcher/Interviewer made a conscious decision not to use *"why"* questions as these present problems i.e. the participants feel that they are being interrogated. Krueger & Casey (2000, p 59) refer to this and suggest that *"... when asked why, respondents feel like they should have a rational answer appropriate to the situation".* The answer is therefore intellectualised and comes from the brain and not from the deeper forces which underlie behaviour. For this reason many researchers are fearful that true feelings and attitudes will not be elicited which is the essence of Phenomenology enquiry. Therefore Krueger & Casey (2000) caution, that if it is necessary to include *"why"* questions then they should be specific.

The use of an audiotape was supported by using a Moderator *"... who plays a critical role in the success of focus group interviews"* (Polit & Beck, 2004 p 343) as they supplement notes and keep the discussion focused on the topic.

The Researcher remained conscious of the fact that *"... reactive effects"* (Bowling, 2002, p 219) or Payne & Payne (2004, p 108) refer to this as *"... a form of experimenter effect"* or *"reactivity"* in which participants say what they think the researcher wants to hear. These reactions are often referred to in shorthand phrase as the *"... Hawthorne Effect"* (Payne & Payne, 2004; Polit & Beck, 2004; Bowling, 2002). This is when individuals know that they are being studied, they change the way that they behave, and the researcher's difficulty is to know how things have changed. The Researcher sought to address this likelihood by selecting an homogenous sample (Table 3), maintaining the interview conditions constant and conducting four FGI's in an effort to maximise internal validity (Polit & Beck, 2004; Sim, 1998). The composition of a group can influence opinion as *"... generally speaking, the more homogenous the membership of a group, in terms of social background, level of education, knowledge and experience, the more confident group members are likely to be in voicing their views"* (Sim, 1998, p 348). This may to a certain extent compromise external validity, however it can be argued that if findings are not internally valid, they cannot possibly be externally valid (Payne & Payne, 2004; Polit & Beck, 2004).

The venues were maintained as a constant. Two of the four FGI conducted in a classroom in the education centre and two in a visitor's room in the clinical setting. The rooms were spacious enough to accommodate the group comfortably but not to large to intimidate the groups. Privacy and noise were key concerns of the Researcher therefore a *'Do not disturb'* sign was placed on the door for the duration of each interview (Clarke, 1999).

The comfort needs of the participants were also considered with ventilation, hydration and nutrition the responsibility of the Assistant Moderator. The participants were reminded of the Participant Information (Appendix III) and allowed time to complete the Biographical Reply Form (Appendix IV) and the Consent Form (Appendix VI). Moustakas (1994) suggests that the interview begins with Informal social banter aimed at creating a relaxed and trusting atmosphere and puts the participants at ease this enables the researcher to identify and clarify formal cues regarding the research topic.

The length of a FGI is guided by the process of saturation i.e. when the narratives become repetitive and no new data is revealed (Mapp, 2008). The length of each FGI varied from 1.5 to 2 hours *"... the duration of the interviews will not exceed 90 minutes"* (HSE, 2006, p 109).

4.6.4 Qualitative Analysis

"It follows that, if we want to explain social actions, we have first to understand them in the way that the participants do" (McNeill, 1989, p 120). This is what the analysis of qualitative data is concerned with i.e. describing the actions and interactions of participants and understanding what lies behind these actions (Cormack, 2000). It's therefore a labour intensive activity that requires *"... creativity, conceptual sensitivity and sheer hard work"* (Polit & Beck, 2004, p 570).

Qualitative data analysis is a challenge for three reasons. Firstly, there are no universal rules to be followed, secondly there is an enormous amount of work required and finally the challenge is to reduce the data gathered for reporting purposes (Polit & Beck, 2004). The latter of these presents the social researcher with the problem of balancing the need to be concise with the need to maintain richness.

The Phenomenological Husserlian approach chosen for this study presents a further challenge in that the researcher must unravel and reveal the structures, logic and interrelationships obtained from the phenomena under inspection i.e. culture. This is fraught with difficulty as the Researcher will aim to 'bracket' her beliefs to describe the experience the participants have had (Mapp, 2008). This proved to be frustrating as it involved dissecting a series of narratives that were powerful and competing in their own right in order to identify themes when at times the text of the narrative seemed inseparable.

Data management is therefore reductionist in nature, as it involves converting large masses of data into more manageable segments (Polit & Beck, 2004). Phenomenological schools have developed different approaches to data analysis. Three such approaches that are frequently utilised are Van Kaam (1966), Colaizzi (1978) and Giorgi, (1985) all of whom are based on Husserlian philosophy with each writer providing useful insights to phenomenological research. All three focus on description of meaning, the manipulation of data with the eventual identification and extraction of essential themes which are in turn organised into categories (Paley, 1997). For the

purpose of this research the Researcher has chosen Colaizzi (1978), as the final step in this approach seeks validation of results via return to the participants. *"Valid or true analyses, therefore, are achieved through the involvement of the participants in the process of analysis and, furthermore, it is the participants who actually confer validity on the researchers' analyses"* (Walters, 1995, p 795). Therefore in Colaizzi's version *"... an essential structure of the phenomenon' is formulated in the final phase"* (Paley, 1997, p 190). This analysis procedure was utilised by Leishman (2004) in which she explored the views of one group of healthcare professionals on the importance of cultural awareness in health care practice a study not dissimilar to this study.

In phenomenological research, analysis of the data begins as soon as the first set of data is received. The Researcher listened to all four taped interviews. These were then transcribed verbatim by a transcriptionist. Confidentiality was also discussed and written guarantees were sought. The article by MacLean et al (2004) was given to the transcriptionist to read in order to ensure the correct transformation of content from speech to the written word. The interview transcripts were typed up in a manner that left a significant margin on the right hand column of the page for coding purposes.

The following seven procedural steps have been put forward by Colaizzi (1978) (Appendix IX) and were adhered to by the Researcher in the conducting of this study.

Step 1 – This involved reading and re-reading each transcript in conjunction with listening to the tape recording of the actual interview. In order to obtain a complete picture of the material.

Step 2 – Having read and re-read the data a series of 'significant statements' were then extracted from the data. this was facilitated by the use of different coloured highlighter pens.

Step 3 – The 'significant statements' were then transformed into the words of the Researcher i.e. 'formulated meanings' whilst using as far as was possible the participants' own words e.g. one such 'significant statement' highlighted in FGI 1 by P 3;

"Culture is everything from our language to the weather to how people dress to the food we eat, em, the beliefs, values, traditions and customs that we have so for me culture is everything".

Within the right hand column the Researcher attributed the 'formulated meaning' to this 'significant statement' as that of;

"The nurse's understanding of the meaning of culture".

In formulating meaning the Researcher was making a leap from the original protocol of the participant and in so doing endeavoured not to sever connections from this unique statement. As Colaizzi writes cited in Valle (1998, p 53),

"... his formulations must discover and illuminate those meanings hidden in the various contexts and horizons ... in the original protocols".

The next three steps are complimentary to each other.

Step 4 – involves clustering the formulated meanings into themes that are common.

Step 5 – The Researcher made use of what Valle (1998, p 53) refers to as the *"... zigzag procedure"* in which the Researcher moved back and forth between each of the clustered themes in each of the four interviews and wrote them down on a single sheet of paper.

Step 6 – A $_3$ sheets were then utilised by the Researcher they were labelled with each category or theme from Step 5 and had the 'significant statements' assigned to them by physically cutting and pasting.

Step 7 – In this final step of Colaizzi's procedure this involved the Researcher returning to the research participants (Valle, 1998). In its strictest sense Colaizzi was not adapted by the Researcher in this instance as not all of the participants were given the themes identified to consider the reason for this decision was based on the following:

1. Researcher's timeframes (Appendix XI) - therefore getting the responses/comments back was a consideration that might prolong the completion of the study. Given that 18 participants were involved which was a large volume to await return. Instead the Researcher forwarded the identified cluster themes (Appendix X) to three reliable participants who were asked *"How do my descriptive results compare with your experiences?"* and *"have any aspect of your experience been omitted?"* (Valle, 1998, p 53). Any relevant new data that emerged was worked into a revised final description (Valle, 1998).
2. The control of confidential information – The Researcher felt that she could not guarantee the confidentiality of some of the sensitive

information in the transcripts this fear has been realised over the recent weeks given the discovery of HSE files in public areas.

The Researcher was aware that this decision had the potential to limit the findings to some extent however she had to work within the confines of this decision.

The Researcher did consider the use of a computer for basic content analysis as this facilitates the handling of large volumes of data (Silverman, 1998). However this has the potential of distancing the researcher from the field work and gives the false hope that the programme such as Computer Assisted Qualitative Data Analysis Software (QAQDAS) will write up the findings. The large volumes of data generated in phenomenological research in the case of this study four FGI Transcripts containing on average 14,000 words each compounds computerised coding (Rice & Ezzy, 1999). More importantly computer content analysis was not chosen because of its over emphasis on coding and retrieval schemes the richness of the meaning would be lost which is central to phenomenology.

4.6.5 Rigour

Rice & Ezzy (1999, p 36) suggest *that "... qualitative research reports should provide an explicit account of how the research was conducted by the researcher".* This is referred to as methodological or procedural rigour (Rice & Ezzy, 1999). The Researcher maintained and reported on the methodological

and analytical decisions that were taken throughout the study. The account presented accurately represents the understandings of events and actions within a Qualitative Phenomenological Husserlian framework and the worldview of participants engaged in this account i.e. nurses. In applying rigour to qualitative research studies qualitative researchers have traditionally used terms such as establishing"*...'truth value', 'applicability', 'consistency' and 'neutrality'...*" (Appleton, 1995, p 995).

From the Researcher's perspective a crisis of confidence about the validity of her own interpretations was encountered as unlike quantitative research which purports that the world can be measured and explained in terms of universal laws and objective truths (Bryman, 1988). Qualitative research in contrast views social reality as having a *"... specific meaning and relevance structure for the beings living, acting, and thinking within it"* (Bryman, 1988, p 51). In qualitative research data collection and analysis should not be driven by positivistic principles such as validity and reliability as there exists a notion of multiple realities and in order to understand the meaning of a person's actions the researcher must see things from their point of view (Polgar & Thomas, 2008).

Qualitative research is carried out in a natural setting in the case of this study that is the clinical and educational environment with no attempt made by the researcher to control extraneous influences (Polgar & Thomas, 2008). The extraneous influences that transpired when conducting this study were reflected in the accounts of the many culturally experiences forwarded from a

personal perspective by the participants. The use of the Assistant Moderator and in particular their role (Table 4.2) of observing copper fastened the neutral role of the Researcher in anticipating interference with the participants' responses (Krueger & Casey, 2000). This was further enhanced by the use of Researcher Bracketing and ensured that individual experiences' of the Researcher were set aside (Dinkle, 2005; Jacelon & O'Dell, 2005). Therefore the questions raised regarding validity and reliability of a descriptive study such as this may be different to those addressed in a quantitative study because of subject selection, data collection and data analysis which are conducted in different ways and for different purposes (Field & Morse, 1985).

Validity is defined by Payne & Payne (2004, p 233) as *"... the capacity of research techniques to encapsulate the characteristics of the concepts being studied, and so properly to measure what the methods were intended to measure"*. The literature review presented the characteristics of the concept being studied i.e. culture from a sociological and nursing perspective. In so doing a complex multidimensional perspective was presented by the Researcher. Participant Selection Characteristics (Table 4.3) were also outlined with homogeneity identified as a key trait (Kitzinger, 1994). In other words the research design should set out what it sets out to test (Walters, 1995). This is based on the notion of objective truths and letting the facts speak for themselves is congruent within this perspective (Walters, 1995). From the Researcher's perspective valid analysis was achieved via the involvement of participants in Step seven of Colaizzi's Procedural Analysis (1978).

Reliability is defined by Payne & Payne (2004, p 195) as *"... that property of a measuring device for social phenomena ... which yields consistent measurement when the phenomena are stable, regardless of who uses it, provided the basic conditions remain the same"*. In ensuring reliability the Researcher presented a clear and systematic account of the research process as recommended by, Polgar & Thomas, 2008; Payne & Payne, 2004: Rice & Ezzy, 1999; Bryman, 1988 and Field & Morse, 1985. This is particularly apparent in relation to the data collection process i.e. the conducting of the focus group interviews and the data analysis framework i.e. Colaizzi (1978). The use of the topic guide in the focus groups served to maintain focus and ensured that all the participants were afforded the opportunity to address the same issues; this also went some way in guaranteeing consistency between interviews. The cluster themes formulated from the significant statements during the data analysis procedure were presented to three of the participants who had taken part in the study. The Researcher approached the participants on a one-to-one basis and asked them to read the themes generated and to comment if the themes were a reflective of their experiences. The use of direct quotes in the findings further substantiated the themes generated.

Bracketing which is a key concept of phenomenological inquiry was utilised as recommended throughout the focus group interview process. This is as was already addressed in the study a means of temporarily setting aside the Researcher's own individual experience in so doing *"... making a conscious effort to suspend all presuppositions, criticisms, evaluations and opinion, the researcher begins to know about the phenomenon as described by*

participants and becomes the instrument for data collection" (Dinkel, 2005, p 9). For Husserl this reduction was necessary if a rigorous foundation for the natural and human sciences was to be established (Paley, 1997).

The Researcher dealt with bracketing by presenting her biases in the introductory chapter and these were reiterated throughout the research process as for example the Researcher clearly indicated to the participants during the data collection method i.e. FGI that there were no vested interest in conducting this study thereby guaranteeing the study's neutrality. In the presentation of findings the Researcher kept the essence of the data by including the significant statements as opposed to those formulated by her. This action by the Researcher set aside her natural attitude and the incidental experiences of life that dominate her consciousness and of which she is unaware of thereby maintaining validity (Sarantakos, 1997). The inclusion of a glossary of terms (Appendix 1) presented a difficulty for the Researcher as definitions of concepts emerge in phenomenological research, whilst on the other hand formulation of a glossary ensures clarity and accuracy and makes repeatability possible which is a key determinant of rigour (Appleton, 1995).

4.6.6 Generalisability

A qualitative study whose findings fit outside contexts of the current research study can be described as having translatability (Field & Morse, 1985). Qualitative studies, even by providing a careful description of the participants and setting cannot be replicated exactly (Field & Morse, 1985). Therefore,

generalisability must be treated with care in qualitative research as this is not its purpose which is to *"... elicit meaning in a given situation and to develop reality-based theory"* (Field & Morse, 1985, p 122).

The Researcher would like to further acknowledge in this study that there are two perspectives from which the issue of generalisability from utilising focus groups may be problematic (Sim, 1998).

Firstly, the focus group is a sample of the target population which has been gathered through the process of purposive sampling. In this study the Researcher targeted those who best fit the task at hand. There is a danger that *"... more self confident and articulate individuals to be more willing to agree to take part"* (Sim, 1998, p 349). Coupled with this, the nature of the interviews take a lot of time and effort to conduct, transcribe and analyse and as a result the researcher is able to gain data on far fewer subjects, than the quantitative researcher, this potential limitation has significant effects on validity (Cormack, 2000).

Secondly, external validity is challenged as focus groups produce situated accounts tied to a specific social situation (Sim, 1998). Kitzinger (1994) also refers to this limitation when she suggests that it cannot be assumed that what a person says in a focus group may be a predictor of what s/he would say in some other social context as focus groups by their nature are artificially constructed.

Within this study it is acknowledged by the Researcher that the role of the data collection tool is essentially idiographic as it provides in depth insights into social interaction occurring in a particular context (Sim, 1998). However, theoretical generalisability may be an alternative as phenomenological studies teach us much about how we ourselves interpret and make sense of the world. Thereby, allowing sufficient generalisability to other situations in this case other nursing research studies.

4.7 Conclusion

In this section of the methodology chapter the research process as applied within the present study was outlined. Data was gathered using focus group interviews and guided for consistency utilising the topic interview guide. The issues of confidentiality and ethics were dealt with. The audio taped interviews were then *verbatim* typed and analysed *utilising* Colaizzi's (1978) Seven Step Procedural Framework.

Finally, the issues of rigour, validity and reliability were defined and discussed from a qualitative phenomenological Husserlian perspective. In concluding the chapter generalisability was also dealt with in which theoretical generalisability from data gathered via focus group interviews is not impossible, but it was noted is very different to that displayed from quantitative approaches to research (Sim, 1998).

A presentation and discussion of the findings is forwarded by the Researcher in the next chapter.

Chapter 5

Presentation of Findings & Discussion

CHAPTER 5

5. Findings & Discussion

5.1 Introduction

This chapter will set out the findings and the discussion therein of the study a Phenomenological examination of qualified nurses' perception, meaning and experience of culture working in the HSE West. As discussed in the previous chapter the data gathered in this study was analysed using Colazzi's (1978) data analysis framework. The data analysis yielded the extraction of 502 significant statements from the four Interview transcripts that directly pertained to the experience. The significant statements were further reduced in the words of the researcher to 408 formulated statements *"... to discover and illuminate those meanings hidden in the various contexts and horizons"* (Valle, 1998, p53).

This resulted in the formulation of three overall themes under which 54 general theme clusters were formed into 21 sub themes.

The three emergent themes were:

1. Rediscovering Culture & Irishness
2. Nursing culture - Workplace Practices & Issues
3. The Cultural Competence Model - Is it appropriate or useful?

The researcher would like to state that whilst the cluster themes appear to belong to one emergent theme elements can be relevant to other themes this served to highlight the complex nature of culture. An example of this is the

cluster theme of beliefs and values which are encountered in all three of the overall emergent themes. The Meaning of culture cannot be defined without reference to the concepts of beliefs and values. Values and beliefs are also central to nursing and caring and are the building blocks of nursing philosophies, models and theories and underpin practice in the clinical setting. Indeed values and belief systems are the underpinning tenets when perceiving difference in others as assumptions of others stem from these norms.

The transcripts' significant statements were coded by the researcher to facilitate the reader's appreciation of the context. The coded system ensured the annonyminity of the participants as indicated by the use of the following,

Code

FGI = Focus Group Interview

1 = Number of the Interview

The nurses participating are identified according to nationality hence,

IrlN = Irish Nurse

BN = British Nurse

FN = Filipino Nurses

InN = Indian Nurse

e.g. FGI 4, InN, P4, PG1.

This refers to focus group interview, number four, Indian Nurse, Participant 4, page one.

5.2 The Analysis and discussion of the Findings

Prior to the exploration of the emergent themes the researcher will offer an analysis and discussion of **Appendix 4 - The Reply Form.**

5.2.1 The Reply Form – significant questions

This contained nine questions and was utilised by the researcher to demonstrate credibility to the value of the findings (Field & Morse, 1985). All eighteen participants consented to and completed the reply forms. Whether the Researcher recognised it or not at the time the formulation of a hunch was inevitable in this qualitative research study (McNeill, 1989). Even though the Researcher did not formally express this hypothesis which was,

"That working abroad broadened the value and belief systems of nurses and increased tolerance to diversity".

The hunch was framed in questions one and nine. The completed questionnaire reply form also sought in question three to reflect the gender divide in nursing. The strong female gender divide was indeed reaffirmed with only two of the eighteen participants' male.

The reply form commenced with demographic information and demonstrated that N=18, of the participants are currently residing (a generic selection characteristic) and working in the HSE, West (a specific selection characteristic) therefore fulfilling the study selection criteria.

Diversity and cultural origins were reflected in question one which sought the nationality of each of the participants and found the following:

Eight Participants were Irish

Eight Participants were Filipino

One Participant was Indian

One Participant was British

This question strengthened question one and two in the FGI Guide (Appendix VIII) as there was a clear reference to national cultural identity this is important as many of the participants will have unconsciously adhered to their own culture and in turn have adapted to Irish culture by varying degrees and will have had conscious experiences of migration and settlement from an Irish cultural perspective (Papadopoulos, Tilki & Taylor, 1998). Nationality also determines citizenship and with this is endowed a certain kind of exclusivity as if someone is a citizen he/she has certain protection and entitlements that do not apply to the outsider (Papadopoulos, Tilki & Taylor, 1998). The feelings around being accepted in the country that you have chosen to live and work in are vitally important in determining beliefs and attitudes. Indeed the Irish *"... experience may be felt differently by different newcomers. it may be bleak or warm"* (ECF, INC, 2006, p 8).

Educational qualifications and experience underpinned questions four, five and six. The attainment of major awards would have exposed the participants to higher level learning and as a result the attainment of knowledge with

regard to cultural care models. Not to mention, the nursing classroom is a microcosm of the clinical environment where people of diverse cultures bring different experiences, knowledge, skills and attitudes working together to achieve particular learning outcomes and goals (Tilki et al, 2006). Length of clinical experience and where that clinical experience occurred increases the exposure to *"others"*. Cultural knowledge attained in the clinical setting is cited in the literature *"... as the important element in developing cultural understanding and the ability to deliver appropriate care"* (Papadopoulos, Tilki & Taylor, 1998, p 178). None of the participants had less than five years clinical experience therefore the richness of the responses would benefit from this depth of exposure to the clinical environment.

Information regarding cultural education and the introduction and awareness with regard to cultural care models was framed in questions seven and eight. Half of the group had received cultural training this included the British Nurse, all eight Filipino Nurses and the Indian Nurse. However, only one of the Irish Nurses indicated an awareness of cultural care models with the overwhelming majority stating that they had no knowledge of cultural care models. This is despite the literature suggesting the need to ensure that health care practitioners are suitably prepared (Papadopoulos, 2006; Holland & Hogg, 2001; Boyle, 2000; Papadopoulos, Tilki & Taylor, 1998; Leininger, 1995; McGee, 1994).

The Researcher's hunch framed question nine as information was sought regarding having worked abroad or outside of the Irish Healthcare setting.

Seventeen of the participants had worked either abroad or in different cultural settings. Significantly only one participant had never worked outside of the Irish Healthcare system. From the context of the study the Researcher wanted to examine the experience of working abroad and ascertain whether or not this made a difference when dealing with *"others"* and did that experience bring with it openness or the skills to deal with diversity?

In this Research Study the FGI Guide (Appendix VIII) framed the interview process this will also serve as a guiding tool to structure the format of this findings and discussion chapter.

5.2.2 My Identity – who am I?

Questions one and two of the FGI Guide (Appendix VIII) sought the perceptions of the participants with regard to their identity. In utilising these questions the Researcher had a dual purpose firstly as an Icebreaker and secondly to create awareness amongst the participants with regard to the constant struggle involved with identity no more than with culture without any real closure of meaning (Smith, 1998).

"I am going to think on this ... you see there are always two perceptions there is the way you see yourself and the way others see you so often times the two don't meet"

(FGI 1, IrIN, P1, PG1)

Both culture and identity are synonymous with the construction of the individual's cultural identity so that attachment can be achieved. Cultural identity is mistakenly regarded as consensual they represent community struggles and the right to represent it to others (Allen, 2006).

" ... I guess I belong to the third batch that came here of Filipino Nurses"

(FGI 4, FN, P2, PG2)

As is demonstrated from the Filipino and Indian nurses they identified themselves in accordance with nationality and profession and perceived this as a given and in so doing are keeping their identity solid and stable (Hall & Du Gay, 1996). This differs from the accounts forwarded by the Irish and British nurses, who forwarded a more pluralistic identity,

"... a normal human being living life to the full"

(FGI 1, IrIN, P2, PG2)

The Researcher would suggest that if the Irish and British nurses were abroad that they may also identify themselves along the lines of nationality and profession. This did not occur in this research study.

Strong associations with family and community were forwarded in the accounts these are both agents of socialisation and are key in the transmission of cultural values and beliefs from one generation to the next.

In the following account family is cultural location or cultural geography which asserts the interrelationship between human beings and their sense of space and physical environment which not only mould and shape individual identities but also the evolving nature of culture (O'Hagan, 2001).

"I would be identified, emh, as a daughter I suppose first and foremost, more recently as a wife ... I would be, I suppose, identified as my role because I live in the town and I am from the town my role as a nurse in the hospital ... that people would definitely identify me or otherwise as that, emh, but I suppose first and foremost I would be identified through my parents as in (parent's name) daughter".

(FGI 2, IrlN, P4, PG2)

The above account forwards the emotion of belonging to the land *"this land is me"* I was born and reared here. Margaret Mead explored the cultural bases of personality and identity and how culture was much more significant than either race or biology in personality development and she wrote about how the child rearing aspects of culture are instrumental in shaping the personality of the child.

These findings serve to demonstrate that identity is a complex, multifaceted and elusive concept which is really only known to self. It is also related to skin colour as colour is a marker of belonging, being of the same skin colour as the host community suggests being of the same nation and creates ethnic invisibility (Papadopoulos, Tilki & Taylor, 1998). In this study the Filipino and

Indian Nurses identify themselves as a minority ethnic group this a clear indication from the Researcher's perspective that uniformity is served as being a member of the nursing profession however, assimilation has not occurred as this would serve to mask any ethnic differences – distinct but yet a part of (Papadopoulos, Tilki & Taylor, 1998).

The three emergent themes will now be explored in more detail and supported with exemplars from the transcripts. The focus groups that excerpts are taken from are indicated in brackets following these statements.

5.3 Theme 1 – Rediscovering Culture & Irishness

This theme emerged from the findings revealed by questions three, four, five, six and seven of the FGI Guide (Appendix VIII).

> *"I think that it is very hard to describe culture at a fixed moment in time because as you said (the participant's name) I do think that it is forever changing".*
>
> (FGI 1, IrIN, P2, PG5)

This statement highlights the limited value of the tools utilised to define culture in the literature as culture is not static. Nurses require knowledge of culture as it is essential to know, understand and serve people (Leininger, 1995). The Researcher in discussing this finding will present the findings from the perspective of the participants understanding of the diffuse term culture and then move the discussion to the perceptions of Irish culture. Irish culture is presented stereotypically in the interviews as the Irish person is presented by the participants as conforming to this image. The stereotype of *"... the drunken, stupid Paddy or the terrorist is not an attractive image to aspire to"* (Papadopoulos, Tilki & Taylor, 1998, p 125). This fixed notion of Irishness in turn is contested as the dynamic of Irish society is considered by the participants and reveals culture as the contested space referred to in the literature review (Parekh, 2000; Smith 1998).

5.3.1 Rediscovering Culture

Defining culture or more to the point rediscovering what culture means to the nurse working in the HSE West was the motivating factor for the inclusion of this question. To define culture purely from an essentialist perspective would as Parekh (2000) suggests not bestow any clarity to the concept. Culture is a diffusely used Global concept which is subject to powerful influences and multiples of interpretation. O'Hagan's (2001, p22) warns that to leave individuals to attempt to define culture, something that we are not overtly aware of until we encounter *others "... has the potential for developing a limited, imbalanced, even negative perception of culture".* The term embraces everything that can be seen and felt hence the emergence of culture as a *'Global'* yet *'core'* word.

5.3.2 *A "Global" yet "Core" word*

Globally the abuses of the concept are tenfold because of its attractiveness and strength of meaning (O'Hagan's, 2001).

"... for me culture is everything"

(FGI 1, IrIN, P2, PG3)

To define the term in this way highlights its regularity of use as to describe a concept as core to everything there is the emphasis on that particular element being essential to the existence of that entity. In defining culture the participants highlight the core nature of the concept and hence the difficulty with an overall definition. Hofstede & Hofstede (2003) echo this sentiment

and have forwarded culture as the catchword for all of society's patterns and this is articulated by the participants in the following excerpts.

"Its hard to actually describe it. The the the powerful force it is ... this is the bedrock really of any society this culture. It is like the foundation of a house. This is what anchors a society, this culture everything stems from that"

(FGI 1, IrlN, P1, PG4)

"I feel like it's very wide, like I can't say one thing that what I feel like ... it's different for everyone"

(FGI 4, InN, P4, PG4)

These accounts serve to confirm the complex, multifaceted, dynamic and non static nature of the word and the difficulty in distinguishing what is a reflection of its true meaning. Culture was articulated at several levels by the participants this reflected what the sociologists have to say about culture.

5.3.3 *The three levels of culture*

The findings then moved to eliciting a definition of culture which reinforced the three existing reference points as cited in the literature (Tovey & Share, 2003; Parekh, 2000) where culture is viewed anthropologically as civilised and cultivated, philosophically as values and belief systems and high culture associated with fine art and literature. These three sociological descriptions are articulated in the following excerpts from the interview transcripts,

"The way people live, how people adapt, you know, environment"

(FGI 4, FN, P1, PG4)

"Your culture guides your behaviour, your values and beliefs are all influenced by your culture"

(FGI 1, IrlN, P3, PG3)

The high cultural concept associated with culture was indicated by the participants' acknowledgement of traditions, customs, language, food and in particular festivals and celebrations such as Christmas and the New Year.

"Christmas time would be a big thing at home and the New Year as well"

(FGI 4, InN, P1, PG10)

"Culture is everything from our language to the weather to how we dress to the food we eat, em, the beliefs, values, traditions and customs that we have so for me culture is everything"

(FGI 1, IrlN, P2, PG3)

Food as referred to by the participant in the above excerpt is not as clear cut as might be suggested there are some food stuffs that are associated with certain cultures e.g. rice with Asian cultures, fish and chips with the British and burgers with the Americans. However given the diverse nature of cultures in the 21st Century we are now hearing reference to the British Curry or the Irish Burger reflecting a move away from the traditionally associated food stuffs.

In common with the literature the findings revealed the following;

- Culture the set of rules – the blueprint of society
- Culture as learned and shared
- Culture's tangible and intangible nature

Henley & Schott (2004) view culture as a set of guidelines or a framework that legitimises the functioning of society. The participant accounts reproduce this aspect of culture.

"Culture it's the whole life the whole thinking the whole running of a society … it permeates every single facet of life … to me culture is the whole basis of any society"

(FGI 1, IrlN, P1, PG4)

The influence exerted by culture is necessary as Parekh (2000) suggests that culture is the force that orders human life, it is the rules of the game that governs human activity and behaviour and we play by the rules in order to survive. What is rediscovered within this is the dichotomy of its existence that even though the participants view culture as a stable, guiding framework articulated in the rules and norms of everyday life culture is a far from stable concept. The fact that something so chaotic can achieve stability creates the difficulty – culture the life blood, the workings of a society.

Key to the survival of culture is learning and sharing in forwarding this perception of culture the participants are identifying the key role that the primary agents of socialisation play.

This is reflected in the following participant account,

"When you look at culture from an individual perspective I suppose a lot of things that I personally would have in what I feel is my own personal culture would come from my parents. A lot of it would be stuff that I learned from them and that I aspire to that I saw in the way that they engaged with the world and I aspire to bring these attributes with me and probably em hopefully to pass them on to my kids through time"

(FGI 1, IrIN, P1, PG6)

This highlights that cultural processes are learned and shared and many cultural experiences encountered within the family unit are often lasting.
This echoes Hofstede & Hofstede (2003) affirmation that human individuals are programmed to make informed choices. Family units e.g. show a particular view of a cultural experience which is automatically learned and in turn influences the individual's behaviours, beliefs and attitudes etc. Tovey & Share (2003) refer to this complex aspect of culture in that it is not only a set of practices that take place in the public arena but that it is comprised of the essences of everyday life within families and institutions.

The family is not the only unit of socialisation with this affect professional organisations such as nursing also imbue in it members specific behaviours, values, beliefs and attitudes. This ensures the transfer of the culture of an organisation from one generation to the next in the case of nursing many of its historical shackles still exist today despite the Nursing literature advocating empowerment within the profession (Papadopoulos, Tilki & Taylor, 1998). Gibson (1991) in her concept analysis of empowerment views it as positive as it addresses the individual's strengths, rights and abilities. Papadopoulos, Tilki & Taylor (1998, p 215) caution that there is a *"... powerful legacy of professional socialisation that may foster barriers to empowerment".* These legacies will be visited in themes two and three respectfully i.e. Nursing Culture and Work place practices and issues

The tangible and the intangible nature of culture was discussed by the participants and was expressed mirroring the Iceberg concept as the visible versus the invisible aspects of culture in that we cannot feel, touch or measure many of these concepts i.e. the thoughts and the things (Macionis & Plummer, 1998). The iceberg concept of culture was clearly identifiable in the participants' accounts.

"Culture is something that is expressed and felt ... and there are many different cultures within our lives, cultural organisations and em peoples' nationalities and so forth"

(FGI 2, IrlN, P4, PG3)

This would suggest that the participants were more likely to describe the 90% of culture that is invisible i.e. the deep aspects of culture as opposed to the material aspects which are visible. The following are exemplars of many of the immaterial terms referred to in this research:

"Tradition

Behaviour and influence in particular

Beliefs and values

Practices – Religious

Customs

How People express themselves

Conduct yourself at work

A sense of neighbourhood"

On the whole the findings suggest that there is awareness and consensus with regard to understanding culture the ambiguity exists with regard to defining it and this was identified by the participants. The multifaceted and dynamic nature of culture cannot be viewed in isolation from the time, the place and the person. The participants had difficulty in agreeing on a definitive of culture which is reflective of the literature the honesty of this is encapsulated in the following statement,

"... to actually put words on culture is very difficult".

(FGI 1, IrIN, P3, PG6)

This would suggest that culture should be studied in terms of its own meanings and values (Gidden, 2006). The findings indicated that without the conduit of culture which none of the participants contended did not exist humanity would be severely restricted. The findings also revealed that defining culture is an ongoing task that requires guidance with much more ground to cover in order to limit the confusion which results from its multiple uses and abuses.

5.3.4 Irishness – the meaning therein

If *"... identity is the action unit of culture"* (Fitzgerald (1993) cited in O'Hagan (2001, p 30) then Irish identity conforms to the multifaceted and dynamic nature of culture. For many of the participants they had never really stopped to think about their own culture,

"I never really thought about my culture when I was here in Ireland and even when I was in England there was no real great striking difference between cultures there is some but nothing that would really make you stand back until I spent a year in Africa, now that really was where I saw culture ... you know I remember saying to myself one day ... this is SOME culture this country you know."

(FGI 1, IrIN, P1, PG4)

The account brings to the fore the impact of cultural encounter and how awareness of '*the other*' reinforces the idea of difference. On the other hand

the need to have encountered others was also identified in the accounts as without this there was a recognition that for many their culture experiences is a taken for granted way of life (Henley & Schott, 2004).

The findings generated an experience of Irishness as being essentialised and racialised. The findings that emerged were on the one hand essentialist with frank accounts forwarded by the participants of the *'tick-the-box'* of physical traits and characteristics associated with being Irish the objective and measurable terms (Gray & Thomas, 2006).

"Yes, red hair and blue eyes, they couldn't believe that someone like me was blonde coming from Ireland".

(FGI 2, IrlN, P2, PG4)

The constructivist view of Irishness was less tangible and measurable as the discussions lead into the more emotive and deep ethnocentric/eurocentric views and life experiences of the participants from their cultural perspective.

"When your in Ireland and you think of culture you think of everyone else's culture but when you are away travelling you think an awful lot about your own culture about what it is to be Irish and when people find out that your Irish how they perceive you"

(FGI 2, IrlN, P4, PG3)

For most of us our orientating view point about culture is essentialist in other words every functioning thing has some defining essence (Gray & Thomas, 2006). The interview yielded and listed an authentic and functional list of distinguishing features and characteristics associated with being Irish. Qualitative research is messy work particularly when minority groups are involved and with the focus of this research to elicit meaning a very real fear of the researcher is that this would not occur given the social position racially and professionally of the researcher. The physical traits will now be forwarded by the Researcher with the findings for this theme concluded from a constructive perspective.

5.3.5 The Physical and Personal attributes

Race is not a scientific category but is a political and social construct (Gunaratnam, 2003). The biological marker such as skin colour is given a privileged position and being Irish is seen as being white and having other physical associated traits such as red hair and green eyes. This refers to being Irish at its broadest sense and forwards identity and race as clearly defined objective measurable terms as Gray and Thomas (2006) forward these concepts as essentialist scientific truths dovetailing neatly into a tick the box stereotypical model which is socially constructed and historically originated in the perceptions of colonising Europe.

From the accounts the specific traits provided were from the perspective of what others supposed perceptions of the Irish were,

"I have come from nursing in Germany and I would have done my training in Germany so the Irish were thought, were seen to be very friendly (laughing) love the parties and the all thought the Irish were red haired and blue eyed (some Laughter)

(FGI 2, IrIN, P2, PG4)

Because of the incredulous element of laughter expressed by some of the participants the reference to physical attributes was reinforced by the particular participant in order to emphasise the view held by others of what the Irish appear like physically.

"Yes, red hair and blue eyes, they couldn't believe that someone like me was blonde coming from Ireland".

(FGI 2, IrIN, P2, PG4)

For some of the participants this gave rise to feelings of the romantic image of the Irish as portrayed in the movies, the media, and literature with direct reference made to such movies as *"The Quiet Man"* and *"Ryan's Daughter".*

"Do you know sometimes I think that Irishness is like something that is nearly mythical? Like what we see in the movies I can just see Maureen O'Hara move across the screen with her Red hair flowing and her dazzling blue eyes (group laughter")"

(FGI 1, IrIN, P4, PG8)

This image of the *'cailin ailainn'* is still the vista of Ireland from a tourist perspective and is the symbolic construct of our cultural identity (Saris, 2000). This was reinforced in the accounts furnished by the Indian and Filipino nurses who had been shown a video prior to their emigration in order to become familiar with Irish culture,

"... before we came over we were shown a video of what Ireland is, like you know with Irish people ... emm the landscapes it was landscapes and the towns were shown and the people, lovely, happy, chatty"

(FGI 4, FN, P1, PG5)

The divergent nature of the labelling became apparent from the interviews. The positive versus the negative traits were highlighted by the participants. This move away from identifying with certain racial characteristics is what Parekh (2000) refers to as the locus of identity which is constantly undergoing change and does not form a coherent whole. The Irish were presented as always drinking and having the *'craic'*,

"I suppose there are a lot of what would you say labels that are attached to Irish culture like we will start off with the land of Saints and Scholars (laughs) I don't think so. Em, you know, Guinness, craic, lazy do you know all those symbols ... that we're all drunk and Roman Catholic ... all the generalisations that are made about Irishness".

(FGI 1,IrlN, P2, PG8)

This is in direct opposition to the image of the *'Hard working Irish';* in a sense the participants justify the behaviour on an account of the economic contribution that the Irish make all over the World. It is their right to let their hair down given that they work so hard.

"Irish people are accepted very much all over the World, they are accepted as you know dependable, decent and kind".

(FGI 1, IrlN, P4, PG8)

Humour was also presented as a pervading feature,

"I think there is amazing humour here that is one thing that I (laughs) enjoy about the Irish people is their humour ... that bit of wit, the humour the turn of phrase I think is great".

(FGI 1, Irl, P1, PG10)

The Filipino nurses viewpoints whilst they initially viewed Irishness negatively in referring to the drink culture and demonstrated that they found this social practice to be incomprehensible and unacceptable behaviour this was balanced by other more positive traits some of which were powerful and emotive.

"One more thing I have noticed about your culture is you like to drink ... as if there is no other thing to do but drink, you know they keep on drinking, the sun is out yet all of them are inside in the pub drinking".

(FGI 4, FN, P2, PG6)

The participant disproved of this behaviour and the Researcher found that during the interview process this aspect of the interview caused a ripple effect as the area of public display of affection was also perceived as being unacceptable moral and social behaviour.

"Shocking it's like between a boy and a girl, I was in (city name) there was a boy and a girl just kissing you know in the street like, Ooooh I don't like … displays of affection".

(FGI 4, FN, P3, PG6)

A recurrent image recounted by the Filipino nurses' accounts is the perception of the troubles and Irish Nationalism with reference made to the IRA,

"It was shown on video what Ireland was like you know people … the towns were shown because our perception when we came here and when we say Ireland were pertaining to war between you know, clashes between religions. That's what we perceive at home, the IRA, that kind when we say Ireland that's what people perceive at home. Like when I was interviewed and I got the job my Dad would say 'is it safe out there?'"

(FGI 4, FN, P1, PG5)

"I think like the Northern Ireland like thing as well as having really shaped our culture in Ireland and probably will continue to shape it over the next centuries

as well. Particularly as not all the conflict is resolved … you know very tough times … and you know shaped the culture of generations in a positive way rather than a negative way".

(FGI 1,IrlN, P4, PG9)

Whilst the above account of the Troubles saw the positive effects this was not the prevailing sentiment.

"Northern Ireland … you know that perception certainly … it painted a bad picture for the world … in the States or in England the perception was that we were all fighting with one another".

(FGI 1,IrlN, P1, PG11)

Despite the above participants best endeavours when working abroad to explain the conflict there was an inability by those removed from the geographical landscape to understand. This image of conflict still remains despite the Good Friday Agreement (1998) which was credited with the impetus for resolution,

"The Northern Ireland Agreement has certainly done a lot to change that".

(FGI 1, IrlN, P1, PG11)

The British participant had come to Ireland at the age of seven and her experience was one of fear as the darker side was revealed in stark terms on the roads,

"I came to Ireland when I was 7 and it was the time when the IRA were very ... active and I would remember as a 7 year old you would see on the roads 'BRITS OUT' and it used to scare the living daylights out of me and at school you would go in and they would say you English B and i find my son now who is 18 he is still being called the same things at school. The culture hasn't changed you just learn to live with it".*

(FGI 3, BN, P1, PG7)

Ireland is inseparable from the concept of Nationalism which is laid bear in the accounts above. Nationalism which is embedded deep in the psychic of individuals has in turn influenced the outlooks of many. Territory is the basic unit of construction of a nation and legitimises the identity and the sanctioning of a society (Graham, 1997).

The Indian and Filipino nurses also presented this conflict image of Ireland,

"Our perception when we came here Ireland was pertaining to war between, you know, clashes between religions. That's what we perceive at home the IRA".

(FGI 4, FN, P1, PG5)

Having lived and experienced the reality of cultural life in Ireland this image had been transformed,

"But the Irish culture so far, it's the same ... there would be a major role for religion here and in the Philippines".

(FGI 3, FN, P1, PG5)

Even though O'Hagan (2001) would describe this as a problematic component for the Filipino nurses the identification of such a topic as sectarianism by the participant is a beginning step towards cultural competence which cannot be achieved if negative and hostile perceptions of a central concept are never acknowledged, explored or challenged within small group environments.

This account demonstrates that core beliefs and value systems are held more strongly when individuals lose control over aspects of their lives such as non familiarity with their environment and as a result their response to observed behaviour becomes culturally determined – culture the toolkit (Chang & Kelly, 2007). Alternatively, these findings demonstrate that the Indian and Filipino nurse participants were realistic and generous in their perceptions and expectations of Irish culture and verified a healthy attitude and approach towards Irish culture however this has taken time on average between two and nine years for many of these participants,

"... to adjust to the people, to the environment"

(FGI 4, InN, P2, PG6)

This was possible as the participants found that the,

"Irish people are very friendly people. I was surprised actually when I first came here, you know even though you don't know someone you should greet each other, especially you know with the older generation".

(FGI 4, FN, P2, PG6)

The Researcher noted that there was an acknowledgement by the participant of this positive experience of Irish culture and the changes taking place in that friendliness is accredited to the older generation. The findings are revealing in that it is the area of difference greeting others as opposed to similarity that is discussed by the participants. Kreitlier (2005) discusses the role that human characteristics play and how culture may turn these traits into barriers or bridges between people.

The talkative nature of the Irish was frowned upon but not perceived negatively especially within the work setting. Working and talking were seen as two realms that should not mix the statement below outlines this attitude in an non derogatory sense,

"Very chatty, even at work. So, personally, I am not like that, you know, I don't talk a lot when I am working. But the Irish people usually chat at work. It's like its part of your culture".

(FGI 4, FN, P2, PG6)

Getting the work done did not involve conversation but was equated with quiet efficiency. The participant was very cautious in quantifying this observation as

the follow on statement suggests that the conversations were all above board as she recounted,

"...I very seldom hear gossip now. It's general talk. They never really talk about someone"

(FGI 4, FN, P2, PG6)

Friendliness a personal attribute identified previously and a sense of humour is demonstrated and echoes the clichéd depiction of Ireland as the land of a hundred thousand welcomes in the following accounts (Rolston, 2004).

"We certainly are a friendly nation and I certainly will say that without any shadow of a doubt, we are the most friendly people. You can strike up a conversation I won't say with everybody hah! But with lots of people no matter where you go in the country eh you cannot do that as readily in other countries"

(FGI 1, IrIN, P1, PG10)

It was felt by this participant that conversation is not the done thing in other cultures and that the reason for this is,

"... they kind of look at you kind of suspiciously if you start to engage with people in a kind of a lengthy conversation in other English speaking countries"

(FGI 1, IrIN, P1, PG10)

However, regardless of this suspicion one of the participants remarked that,

"... and another thing, whenever your away to if you say your Irish, it seems to be like everyone is Irish, oh! I'm Irish too, my great, great, great Granny is Irish (Group Laughter) like I'm Irish too you always hear that when your abroad".

(FGI 2, IrIN, P4, PG5)

All of the participants agreed with this statement, this was conveyed in the paralinguistic *"emhs"* of consensus. This echoed what Tovey & Share (2003) refer to as the portable cultural attributes of the Irish which are highly sought after.

The accounts also presented the Researcher with latent ethnocentric views attributed to others in which the participants express a belief that their own cultural groups' beliefs and values are the best. The Researcher would like to caution that all cultures suffer from ethnocentric viewpoints to varying degrees and this is not just specific to Irish culture (Burnard, 2005). The literature would suggest that ethnocentricism is a powerful insidious force which we are often times blind to acknowledging that it exists. The Researcher writing this paper has been raised and socialised from a Western world view perspective the Indian and Filipino nurse participants in this study stem from an Eastern background and these in their own right originate from divergent philosophical world views. Boi, (2000) contends that ethnocentricism stems from a lack of

knowledge about other cultures which indeed seem to be the case from the findings of this research.

The following statements were of interest to the Researcher as reflective of ethnocentric stances,

"I do feel that Irish people are accepted very much all over the world they are accepted as you know being dependable, decent and kind".

(FGI 1, IrlN, P4, PG8)

"We certainly are a friendly nation and I certainly will say that without any shadow of a doubt, we are the most friendly people"

(FGI 1, IrlN, P1, PG10)

This participant goes on to portray the Irish as intelligent with a determined strength of conviction with the participant basing the evidence on the charismatic white political leader of the free world John. F. Kennedy,

"I think we are and I say this without being boastful here that I think we are a highly intelligent race of people, I do because we have proven around the world in lots of countries because the Irish have risen to the top in lots of countries they have gone to the top in their professions. Emh we had John F. Kennedy who came from Irish ancestors, you know very intelligent, very, very intelligent people you know".

(FGI 1, IrlN, P1, PG11)

This is reflective of the concern that white people have with meritocracy and represents the connection between progress and the West and points to the rest as being backward and lagging behind (Cortis & Law, 2005).

The following are an exemplar of the meritocratic views forwarded by the Irish nurses;

Generous of wealth and spirit,

Friendly,

Good *'Craic'* or having a sense of humour,

Hard Working,

Dependable,

Decent and Kind.

"How you were brought up your culture, your roots, your beliefs, your religion, how you treat other people, if you are Irish it's our culture to be generous, you reform especially if you go abroad you do try, people look at you in a certain way then you try to be that way".

(FGI 2, IrlN, P1, PG3)

O'Hagan (2001) claims that ethnic identities often originate in a struggle for meaning which has a cohesive effect making them feel part of a manageable community of sentiment and cultural heritage that eventually triumphed through the assertiveness and the collective power of an identity this is indicative of many Irish communities.

Whilst all of the participants in the study made reference to the Troubles in the North, a darker side of Ireland was revealed in the British and Irish nurse interviews in which they spoke openly about the Clerical Abuse Scandal. For many years the perception of Ireland was the land of Saints and Scholars (Saris, 2000). Ireland is the Motherland of many diaspora abroad and the image of a mother is that of one who protects and nurtures. This has surely been shattered in more recent times by the revelation of the sustained concentrated assault upon a nation's children by the state, church, educational and welfare systems combined (O'Hagan, 2001). For many children their past is a door to be closed unlike many of us who treasure the rich stream of cultural memories which have shaped our identity (O'Hagan, 2001).

It was the destruction of innocence and the abuse of power by the church oligarchy which gave rise to the following accounts from participants,

"We see it at the top ... the church ... the dishonesty that went on the cover up the lying, the cheating and the obstruction to get the truth".

(FGI 1, IrIN, P1, PG10)

The difficulty for many of the participants was the fact that Ireland's missionary image lies in binary opposition to the monster revealed in the Murphy Report,

"...sending their own people out to work in different areas in the missions and then this ... I mean the thing about religion going through a very bad phase at

the moment I have no doubt that all that is being revealed at the moment will influence and shape our culture".

(FGI 2, IrIN, P2, PG6)

Many of the comments forwarded by the participants coincided with those in the public domain and were identified as overwhelming anger, sadness, remorse and in many instances disbelief and shame as to how this could have happened was palpable. The universality of these responses is collectively echoed in the interview notes and was recorded as nodding and attentive silence during the various participant narratives. These statements were identified by the Researcher as situationally influence, as the FGI's had taken place after the release of the Murphy Clerical Abuse Report (2009).

5.3.6 The religious rituals and practices

There is a growing awareness among policy makers of the interrelations between religious and ethnic identification (Ganaratnam, 2003). It has been widely acknowledged that in the aftermath of Sept 11th 2001 religious identification for Muslims in particular lead to an increase in Islamaphobia (Ganaratnam, 2003). This is juxtaposed to the perceptions of an increasingly secular and irreligious Western World (O'Hagan, 2001). Religious identification can be an important yet changing part of the lived experience of different groups as traditions, practices and beliefs can vary between individuals making generalisations difficult for those in the caring profession (Ganaratnam, 2003). In Ireland historically religious beliefs formed the foundation stone of family life with many cultural practices developing and

growing from this (O'Hagan, 2001). Ireland has a long history of religious persecution and troubles. Roman Catholicism is the largest religion in Ireland with just over 3.68 million followers (CSO, 2006).

This was reflected in the following statement as a key cultural institution identifiable with being Irish,

"... We're all Roman Catholics"

(FGI 1, IrIN, P2, PG8)

Religion was identified as a cultural similarity as opposed to difference by the Filipino nurses,

"... but the Irish culture so far, religious wise, it's the same Catholicism there would be a major role for religion here and in the Philippines"

(FGI 4, FN, P1, PG5)

There was an importance attached to religion in that this was perceived as a welcoming cultural trait in that it made the Filipino nurses feel at home this is indicated in the statement by the use of the phrase *'religious wise, it's the same'*. Haralambos & Holborn (1995) refer to this as choice within culture in that society does not have an all embracing culture but that rather elements exist and people can choose which of them to join.

"... Very religious beliefs, very catholic and very you know strict".

(FGI 3, FN, P1, PG5)

The religious aspect of Irish culture was also emphasised by the Irish nurses,

"People when they knew you're Irish they're like, oh! you must be catholic; I've got that a lot of that".

(FGI 2, IrlN, P4, PG5)

There was a co relationship between religion and family forwarded from the accounts of all the participants,

"I suppose that family and friends are very important to Irish people where you come from a sense of belonging".

(FGI 2, BN, P3, PG5)

"I like here. What I like in here would be Christmas time, the family gather around, you know, in one house it would be the same at home you know. They stick together for Christmas and the New Year. They have dinner together and in a kind of a way it reminds me of home because that's what we do at home as well".

(FGI 4, InN, P1, PG10)

In the above account there was an acknowledgement by the non Christian nurse that the fundamental values of the different world religions are similar in

that all religions have there own festivals and histories and times for celebration (Henley & Schoot, 2004). The Researcher would like to caution that whilst the influence that religion has on individual lives varies prediction is not possible as it does not adhere to the essentialist school of thought that of established truths (Henley & Schoot, 2004; Smith 1998).

5.3.7 Ireland and Change

The roar of the Celtic Tiger in the late 1990s in Ireland saw the emergence of an associated multicultural status prompted by the significant increase of people from other cultures coming to live and seek out a living in Ireland (Boyle, 2000). Media reports were alarmist and sensational and this tended to be the way the public was informed (Boyle 2000). Indeed the media reports only served to heighten the anxiety and fear of the perceived demands being placed on society by migration and diversity (Keil & Hubner, 2005). The Researcher in conducting this research wanted to gain an insight into the perceptions of the participants to difference amid the backdrop of cultural diversity, given that the aim of the nursing profession is to strive towards cultural competence enabling nurses to work effectively in cross cultural situations (Brenner, 2003).

The nurses participating in the focus group interviews captured the richness of the diverse mix reflective of Irish society. Perceptions of diversity reflected a blending within society. The participants went on to recount how they perceived themselves as more noticed when they came to Ireland at first however, as time has passed they have become blended as diversity is the

recognised norm. This perception articulates the values of multiculturalism which is seen as the norm.

One of the Filipino nurses who has lived in Ireland for over nine years encapsulated this,

"When we came at first it was kind of a different culture, they would look around at you … something new for them you see but now, it's different. Its just usual for Irish people to see foreign nationals actually including Polish, Chinese, Koreans even and Africans."

(FGI 4, FN, P2, PG12)

It became obvious from the accounts that the welcome extended to the Indian and Filipino nurses lacked cultural sensitivity as there was no awareness or utilisation of knowledge by the public with regard to ethnicity or race.

"They're friendly but kinda giving you the strange eye … sometimes when you meet them on the streets, they'd say 'where are you from?' and I would be about to say … 'ah China' they would say, cause its always Chinese people that are here".

(FGI 4, FN, P1, PG11)

This form of cultural insensitivity gave rise to the emotion of annoyance and a feeling of awkwardness this was dealt with by the participants stating that they simply ignored it,

"... a bit awkward but I just don't pass any heed".

(FGI 4, FN, P1, PG12)

The British and Irish Nurses perceptions were contradictory to those forwarded by the Indian and Filipino nurses as agreement with the Multicultural status of Irish Society was guarded and viewed with scepticism as being cosmetic,

"I think that cosmetically it is but I'm not quite sure that it really is but it is perceived to be. I think that we want to believe that we are but I'm not quite sure if we really are".

(FGI 1, IrIN, P1, PG12)

The recent status of multiculturalism in Ireland was acknowledged and the novice nature of this was recognised,

"I think that we are very new at taking up cultures in this country ... it takes a long time for different cultures to be established within a culture ... we won't really be able to say that Ireland is multicultural until along time down the line".

(FGI 1, IrIN, P3, PG12)

The participant goes on to present why Ireland is not yet truly multicultural,

"I mean you wouldn't be saying that your neighbours in London are non-nationals they would all be seen as from England and that would be it".

(FGI 1, IrlN, P3, PG13)

Parekh (2000) would see this as a healthy recognition of difference, however he refers to the tendency of searching for the single best structure, which can be problematic as one size does not fit all. Parekh's (2000, p 220) vision of multiculturalism recognises the dynamics that emerges from the ways that,

> *"... cultures constantly encounter one another both formally and informally and in private and public spaces. Guided by curiosity, incomprehension or admiration they interrogate each other, challenge each other's assumptions, consciously or unconsciously borrow from each other, widen their horizons and undergo small and large changes"*

Therefore Parekh's understanding of multiculturalism is not about everyone becoming one with the dominant culture – mainstreaming, but more about each culture incorporating elements of the others and imaginatively giving these elements a multicultural dimension.

The notion of taking on board elements of other cultures was encapsulated in the following participant account,

"I worked with so many nationalities in England ... nurses, doctors, lots of nationalities so you know I just blended in with them or they blended in with us (Laughter)".

(FGI 1, IrIN, P1, PG15)

One participant blamed the system for the sustained lack of understanding of other cultures which is perpetuated by wider institutions and systems such as the Education System and drew the following analogy,

"I wouldn't think that we would feel that Ireland is multicultural ... even if we go back to Secondary school if you weren't a catholic you didn't have to take the religion class ... the only foreigners would be doctors children and that practice did nothing to assist then to appreciate our religion or indeed us with theirs for that matter".

(FGI 2, IrIN, P4, PG8)

Diversity and multiculturalism is about creating a culture that seeks, respects, harnesses and values difference, thereby making each individual unique, it is not supposed to be exclusive in the way we relate to others. However, this has been lost track of in the race to meet statutory requirements with the virtues of multiculturalism exaggerated in order to gloss over the persistence of racism (Keil & Hubner, 2005).

Overt racism and cultural supremacy do exist and were demonstrated in the following participant account,

"I don't know whether it was a little bit racist of me but I looked at the school mix in one particular school (school name omitted) and it was just only non nationals, my (child's gender omitted) would have been the only Irish in the class so I looked, and I now travel 20 minutes, there are 3 schools in (Town name omitted) I have gone outside the Town"

(FGI 2, IrIN, P2, PG9)

For the participant this was clearly a sensitive issue as on the one hand there was recognition of how this account conveyed the everyday nature of racism against the expressed choice of a desire to have ones child socialised amongst his/her own cultural group as preference was given to the white Irish,

"I don't know whether it's a good thing or a bad thing even though I mixed with all different cultures growing up ... basically I wanted (child's gender omitted) to have a few Irish friends as opposed to just all non-nationals".

(FGI 2, IrIN, P2, PG9)

As Cortis & Law (2005) contend that if one accepts that structures are reproduced through socialisation which is also the contention of the Researcher, then the question of the intentionality of this participant becomes more important and complex as even non-racist individuals can help to perpetuate racist practices. The preference of white Irishness is underpinned by attitudes, beliefs, values and feelings which are routed and expressed in the discourse of everyday life (Alasuutari, 1995). McGee (1994) on the other

hand would see this as a necessary requirement and argues that in order to be competent in the delivery of transcultural nursing care nurses need to be able to express and examine their own cultural biases and behaviours and not just those of the client.

Eckhardt et al, (2006, p 19) contend that,

> *"Multiculturalism encourages social cohesion and implies tolerance of differences, mutual respect between people of various backgrounds and equal access to all rights, opportunities and privileges by all".*

That said the Irish nurses continued to highlight the vagrancies of some policy decisions in the following account,

> *"... for instance ((child's gender omitted) was at a Halleluiah Concert and they usually sing Christmas Carols but they didn't this year and when we asked 'Why' it's because of the whole multicultural thing".*
>
> (FGI 2, IrlN, P3, PG9)

Policy makers need to be cognisant of the cultural practices, values and beliefs of the indigenous peoples and be careful not to throw out the baby with the bath water as this can prove divisive and cause cultural tensions. This can result in perceived inequality with policy development being viewed as favouring minority groups. This was voiced in the following account,

"I feel very strong about holding our own values ... I don't think a Hospital should have to take down a crib because of multiculturalism ... we are Irish we should have our own values and hold onto them, because if I went to Egypt I wouldn't condemn the Mosque, I wouldn't tell them to take down the Globe".

(FGI 2, IrIN, P2, PG10)

The above account embodies what Parekh (2000) refers to this as *'defensive ethnocentricism'* where the indigenous peoples turn to cultural distinctions underpinning their traditions to resist perceived threats to the transmission of their cultural way of life. Tovey & Share (2003) refer to this as the dilution of Irish cultural distinctiveness and is perceived as alienating the Irish people and the meaning of Irishness.

For many of the participants *'fitting in'* or adapting is important,

"I think you should respect you know the culture of whatever country you are in at the time ... "

(FGI 2, IrIN, P1, PG10)

These accounts by the participants with regard to their perceptions of how Ireland has changed culturally gives a sense of a larger Irish family rather than a nation, as the idea of a nation state gives rise to boundaries which are politically and culturally defined. From many of the accounts the perceptions

and understanding of Ireland and societal change came from their emigration experiences and encounters with others which have not always been constructive. The Researcher's proposition at the outset of the research study identified a relationship between the experience of working abroad and openness to different cultures as having increased tolerance towards diversity. The research findings were rejecting this null hypothesis as even though 'X' had occurred i.e. nurses had experience of working abroad 'Y' i.e. greater tolerance of difference was not following (Cormack, 2000). Therefore the Researcher could conclude that having worked abroad had no significant impact on dealing with *'others'*. The significance of this with regard to the nursing dyad will be discussed in the following emergent theme – Nursing culture workplace practices and issues.

5.4 Theme 2 – Nursing Culture workplace practices and issues

The findings from this emergent theme identified from the focus group interview was guided by questions eight to twelve of the FGI Guide (Appendix VIII) and sought to ascertain the understanding the participants have of Nursing Culture, their feelings of working with and caring for diverse cultures and the existence of or having encountered racial attitudes.

The cultural experience of the nurse takes place in the phenomenal field a term which encapsulates how all nurses have been influenced by the totality of their human experiences, as after all, nurses are cultural dwellers (Paley, 2002; Mendyka, 2000). The Researcher would like to caution that the phenomenal field of any one individual in the case of this research study the nurse can never entirely be known by another person although the values, beliefs and attitudes observed and recorded in the focus group interviews give an insight into the individual nurses' reality.

The changes within Nursing in Ireland have echoed societal change at a macro level in two ways developmentally and demographically. Developments legislatively have allowed for the expansion and extension of the role of the nurse in the modern healthcare environment. This has been coupled with educational changes the introduction of nursing as a third level qualification thereby enabling and empowering Irish nurses to respond consistently with sound evidence based knowledge as the cornerstone of their professional competence (O'Shea, 2008).

Historically and sociologically there is some sort of transmission process as with culture that enables the nurse to learn the rules of the culture of nursing (Paley, 2002). The nurse dwells in culture from training to qualification and beyond and in a particular lifeworld that enables the cultural meanings to be inscribed on him or her (Paley, 2002) This cultural learning creates a unity on two fronts firstly belonging to a group and secondly sharing a coherence of meaning (Benner, 2000). This belonging to a group gives particular meanings to experiences inheriting then as a package (Paley, 2002). It is with this in mind that the fundamentals of nursing theory and practice are shaped (Allen, 1995). The Researcher would like to caution that this phenomenological research study is not about the prediction of meaning as we cannot predict the meaning someone ascribes to something on the basis of what culture he or she belongs to (Paley, 2002).

The literature review in this study shows that the culture of nursing in Ireland lacked dominance amongst the professions in general and as a result was indelibly marked by the values of obedience, subservience and denial (Condell, 1998). This disciplined, compliant, hierarchical structure stifled development and lead to ritualised cultural behaviour, as orders were to be obeyed not questioned and the good nurse did what she was told (Walsh & Ford, 1994). That said these cultural origins had a profound influence on the attitudes, belief systems and values within nursing (Cortis, 2003).

This was reflected in the accounts forwarded by the British and Irish Nurses,

"... the Irish nursing system is just rooted in rituals"

(FGI 2, BN, P4, PG 20)

"... when I started nursing first and the subculture that was in nursing, that you always appear busy, your always running, you don't argue with authority, you keep your head down, you work very hard, you don't question authority ... as a junior ... the student nurses in fact (laughing) were lower than anyone else ... student nurses took the stairs and the other people took the lift ... so you know that went on lots"

(FGI 1, IrlN, P3, PG15&16)

The socialisation effects of nursing the secondary agent were powerful and had a lasting damaging impact this was indicated in the following account by the same participant,

"I suppose an negative impact on me as an individual as a young nurse at that time, was you know if you saw something wrong you just put your head down and said nothing ... you were severely punished if you did speak out ... My God if you questioned you were in very big trouble"

(FGI 1, IrlN, P3, PG16)

This is how nursing was identified in the seventies, eighties and nineties as this is when the participants would have trained. There was an indication of change within nursing however there also was a recognition that a lot of this behaviour still existed,

"I think that a lot of that's still within nursing today ... a lot of fear, a lot of control, a lot of the keep quiet don't raise your head you know".

(FGI 1, IrIN, P4, PG17)

This account suggested that these practices are known amongst the nursing profession *'you know'* and are an immense challenge to the culture of nursing in Ireland. A comparison was drawn by the participant with the nursing profession in Northern Ireland and highlighted the stark differences of the socialisation effects with that of nursing in Southern Ireland,

"... a most definite different culture coming from Northern Ireland to Southern Ireland ... it was a completely different culture which was more and more controlling"

(FGI 1, IrIN, P4, PG18)

This in the Researcher's opinion is a clear indication of the legacy the female religious influences had advocated, hierarchical structures, obedience, subservience, autocracy, quiet efficiency, disciplined and task centred clinical environments (Scanlan, 1991). It was not clear from the interviews if nursing had moved away from many of these practices today in the Irish healthcare setting. It is the Researcher's contention that the religious influences and value systems require further study which the context of this research does not allow for.

Nursing is a predominately female domain and the role that gender plays has a bearing on how individuals relate to each other within the male/female context (Hugman, 1991). This serves to highlight the predominance of the female as nurse and carer. This concurs with the literature in that female involvement in nursing is measured at between 90 and 97 percent (Hugman, 1991). Nursing is equated with women's work and nurturing neither of which is viewed as male characteristics (Bashford & Slevin, 2003). Furthermore the prevailing definitions of masculinity act as a barrier to men's entry to nursing with those who do enter finding themselves conforming to the stereotype of the dominant male and causes many to move away from the caring role into managerial positions (Winkelmann-Gleed, & Seeley, 2005).

There was a grieving for this loss of the male influence in the care setting identified in the accounts forwarded,

"I always thought if there were more men in nursing that it would be a bit different. I know that doesn't say a lot for women in nursing, but I think too many women in the one room is unhealthy ... a male perspective is very different from a female perspective ... by nature ... nursing would be different"

(FGI 2, IrIN, P3, PG19 & 20)

This created much discussion amongst the group and the Researcher sought the participant to elaborate on the statement, the response yielded feelings of dismay and disillusionment,

"I just think that women can be bitchy ... they create situations ... that don't need to happen and there's a lot of back biting in nursing a lot of you know unnecessary nastiness and its still out there and I don't think it will ever change".

(FGI 2, IrIN, P3, PG 20)

The language used *'bitchy'* refers to the female of the animal world and is derogatory and was highlighted in both the British and Irish nurses focus group interviews and was rationalised as the result of,

"... I think they all had a terrible time, and I think they feel others deserve to be treated the same ... there were just some despicable characters in nursing ... they were treated very very badly it was very much based on status, you didn't sit with such a one at a table ... I know going back 10 years listening to girls who were training in their midder in Dublin and they couldn't sit beside Ward Sisters at their tea break and stuff like that".

(FGI 2, IrIN, P4, PG 21)

Wilkinson & Miers, (1999, p 67) would concur with this sentiment stating, "*... that there is substantial evidence to suggest that nurses themselves experience working in organisational structures – nursing hierarchies – negatively".* This has been noted as causing separation among groups of staff at different grades as opposed to creating a team that will work as a cohesive unit together (Wilkinson & Miers, 1999).

It is the Researchers contention that this requires further study in order to understand the relationships within the Nursing profession in light of in particular the move to third level qualifications. The Researcher has made this statement on the findings of the research as it was highlighted in the findings that many of the feelings were generated as a result of the following participant statements,

"... some nurses thrived on that sort of status ... in the day that the nurses and the guards were superior, they were seen as good steady jobs, but the longer you were in the job the more authority you had and the more respect ... they themselves feel that they have lost it to a point ... student nurses come in now and they are on the ball and they're very assertive very efficient and very good at what they are at ... I think there is a lot of intimidation ... this is a change as I think years ago the student nurse knew you didn't speak until you were spoken to"

(FGI 2, IrIN, P4, PG 21)

The Researcher noted that the interviews portrayed negative attitudes towards the value of qualifications in general and in particular the training of *'other'* groups of nurses which reflected generated and perpetuated racial discourse. The Researcher would like to stress that the negative attitudes towards qualifications were identified on three levels,

1. Foreign National Nurses
2. Nurses who trained in England
3. Between nurses trained in various institutions in Ireland.

1. Foreign National Nurses

Aspects of basic human caring were questioned particularly effective demonstration of interpersonal skills i.e. the affective domain of caring which includes the ability to express authenticity, congruence, empathy, genuineness and nonpossessive warmth (Mendyka, 2000). This is revealed in the following account,

"... they don't seem to they are not as caring about the patient, like if a patient is in pain, you know, the pain is obviously, you have a reason to have to deal with it ... the (nursing group omitted) nurses weren't more empathetic towards patients".

(FGI 2, IrlN, P4, PG20)

This account reveals that it is imperative for nurses to be able to recognise and respect the importance that culture and meanings of the illness experience pose for those of whom they provide care (Mendyka, 2000). The perception was revealed that migrant nurses do not have this skill. Resulting in the perspective that the unique phenomenal field was lost and therefore how could holistic care be practiced.

The Indian and Filipino nurses felt hurt and undervalued by these perceptions which were very real to them in that their educational attainment was openly questioned ignored and undermined in that certain skills that they had obtained throughout their training they were no longer allowed to practice. This in turn they felt limited their practice and raised issues with regard to their

ability to maintain their clinical competence. The account that follows demonstrates this,

"... when you're a registered nurse at home, you do the whole lot medically, male catheterisation, IV infusion, the whole lot. When I came here first there was a particular patient and his catheter was blocked. I said I will change it; I have no problem with it. So I did and the nurse said are you qualified to do it? At home did you take the course in the area? ... when you say you're a registered nurse at home, you're competent to do the whole lot, but here you have to do courses in order for you to be competent ... I was offended it was kind of offensive".

(FGI 4, FN, P1, PG27)

Therefore their skills were devalued unless they trained here,

"... you know you're well able to perform such a procedure, they won't allow you unless you have trained here".

(FGI 4, FN, P2, PG27)

The Indian and Filipino nurses participating in this research had access to their qualifications, for many migrant nurses it is unimaginable the difficulties they encounter in accessing and proving their qualifications (Winkelmann-Gleed & Seeley, 2005). A further point of reference by the Researcher is that these nurses are referred to and socially constructed as the *"other"* throughout

the interview transcripts rather than as part of the nursing team this highlights an insidious exclusionary culture that exists within the Irish Nursing System.

2. Nurses who trained in England

This exclusionary culture extends to those nurses trained in the UK, even if their background is Irish as the feelings expressed were similar to those articulated by the Indian and Filipino nurses. The feelings ranged from being demoralised at having to repeat academic programmes which they had already completed to being considered as not having the same status as those nurses trained within the Irish system. The following accounts encapsulate these feelings,

"... I feel like my whole 20 years in England is just down the drain as here I could start again because even doing my degree recently, I repeated at least four modules that I had done before ... but I had to do them because they were a couple of years out of date. What a waste of time ..."

(FGI 2, BN, P1, PG18)

This was rationalised on two bases firstly that from a legal perspective there is a necessity to meet requirements and secondly that the governing bodies of the nursing profession in both England and Ireland are not willing to take responsibility for training provided within either jurisdiction,

"... law is a completely different ballgame over here ... we're governed by An Bord Altranais and the NMC over in England I think its just ... that one isn't

prepared to fully and solely take on the training that the other has provided. So I suppose it's their way of being sure of the skills across the board from an Irish perspective".

(FGI 2, IrlN, P4, PG19)

Therefore the findings highlight the perception of superior academic rigour and status attached to nursing qualifications obtained in Ireland; however this notion of status varies even within the Irish training system.

3. Between nurses trained in various institutions in Ireland.

The Irish nurses spoke of the subculture of nursing that exists in Ireland i.e. those nurses who trained in Dublin were perceived as having obtained a more superior training,

"... those who trained in Dublin you are constantly reminded of that fact ... not for all of them mind you but for some hospitals in particular ... they saw themselves as the elite".

(FGI 2, IrlN, P4, PG21)

The accounts forwarded indicated damage to self esteem as the participants were made to feel inferior and under additional pressure to prove themselves in the status stakes,

"... they were seen as a different status in society, they were better"

(FGI 2, IrlN, P4, PG21)

The status reference was further elaborated on as being linked with years of experience and the prestige that nursing as a profession was afforded from the wider Irish society. This is indicated in the following statement,

"... the older you were, the longer you were at it, obviously the better you were"

(FGI 2, IrlN, P3, PG21)

5.4.1 Racist never!

These findings demonstrated that whilst migrant nurses encountered academic prejudice it was not limited to their group as both British and Irish nurses also encountered similar experiences. The statements presented in this section illustrate the perception that Irish nurses working in the HSE West have of migrant nurses and migrant nurses' integration. The Researcher in doing so highlights that of the eight Irish nurses participating seven had worked abroad or outside of the Irish healthcare system yet despite the expressions of the ethnoracial experiences which they had encountered. There was a worrying trend of resentment displayed towards the migrant nurses working here. This trend is a perturbing feature for Irish nursing in striving to achieve a harmonious professional culture devoid of racism. The interviews also revealed that this trend has been accelerated by the recent economic downturn,

" ... I would have the height of sympathy for them ... because when I worked in Australia and I know its English speaking I remember the problems I had

there with the ways of doing things … not to mention being met with ye bloody Irish you're everywhere".

(FGI 2, IrIN, P4, PG25)

In the above statement there was a resigned acceptance to this being the norm with regard to how migrant nurses are perceived by other cultures but in the encounter which the participant recalls, identity was central *'ye bloody Irish'* as classification was not on the basis of the individual being a man or a woman it was social (Winkelmann-Gleed & Seeley, 2005). People classify themselves into social categories that are based on observable and hidden commonalities the migrant nurses in this research did this,

"… my name is (name omitted) I am a Filipino nurse"

(FGI3, FN, P2, PG2)

How you view yourself influences your identity as a migrant, an example that clarifies this is, if the Researcher was to introduce herself as an Arab who is Muslim perceptions of this social identity would not be positive. *"At worst the recognition of difference can lead to exclusion and expressions of unfairness and intolerance by the majority as the stranger may be perceived as a threat and accused of taking 'our' jobs"* (Winkelmann-Gleed & Seeley, 2005, p 960).

"… accepting them into our jobs … not to mention you know jobs that our own can't get"

(FGI 2, IrIN, P4, PG26)

These harboured feelings of resentment have implications as they can give rise to feelings of anger and fear,

"... I think that's going to become more difficult (giving them jobs) when you have a lot of staff nurses, young staff nurses, being let go. I've heard several people recently within the HSE giving out about, 'it's a disgrace that they are still here' and all that. I think its only going to get worse in that sense. People are going to be less accepting of them in the next while"

(FGI 2, IrIN, P3, PG26)

This participant did not directly refer to racism but the view expressed in the above statement manifests this very concept. Xenophobic attitudes were expressed as part of the general public discourse,

"... my God you know that it's terrible, they're permanent now and if you went to Saudi or somewhere you would never get a permanent contract so the way they look at it so they should never have been made permanent they should be kept on temporary contracts ... and now they should be put out"

(FGI 2, IrIN, P3, PG27)

The migrant nurses were viewed as getting preferential treatment by management,

"... well because if they are going home they obviously need longer, ya know breaks to go home and I know, em, there are staff complaining saying well if they can take six weeks during the summer why are we not allowed"

(FGI 2, IrIN, P3, PG29)

This blame culture was attached to the Indian and Filipino nurses who were perceived as having contributed to these attitudes towards themselves as a result of not mixing or demonstrating a reluctance to integrate and they were also accused of not listening.

"... they are not mixing with each other and they are not mixing with others"

(FGI 2, IrIN, P3, PG24)

There was reluctance on the part of the Irish nurses to acknowledge the ghettoisation that had occurred of Irish nurses themselves when they had worked abroad this had been mentioned in the earlier part of the focus group interviews,

"... as a group the Irish tended to stick together ... we would have socialised with and worked with each other"

(FGI 2, IrIN, P5, PG6)

Papadopoulos, Tilki, & Taylor, (1998) affirm the positive aspects of being with ones own cultural background and suggest that not only does it help the individual keep in touch with their heritage and culture it asserts identity and

ameliorates the pain of never seeing home again,

"I would say Ireland would be racist towards other cultures, em, I know from being working in England I would have more knowledge of other cultures than I would from any experience I have in Ireland ... you know like you might see a black person and I suppose they would say it out where I might see it but I wouldn't".

(FGI 2, BN, P1, PG5)

The concept of racism was referred to by the participant, the account would suggest that there is a need for nurses to understand and study racism. The underlying perception revealed by the statement is that race is an invisible trait and that we should not notice each other's racial group membership Characteristic – the colour blind approach (Cortis, 2003). This approach considers racial and ethnic group membership irrelevant and that social life is based on interpersonal behaviour. This reference to racism by the participant provoked a defensive response from the other participants in that focus group in that two did not agree with the Irish being given a racist tag and stated that there was a lack of encountered experience in dealing with multicultural issues.

5.4.2 We're new at this game

"I'd say it's really because were still a very new multicultural country"

(FGI 2, IrIN, P3, PG5)

The Researcher was troubled by the use of the term *'new multicultural country'* as a possible excuse for the continued use of racialised language by the participants. By utilising the term multiculturalism in this way suggests that a bunch of so called *'others'* need to be taken into the mainstream which is white therefore whiteness assumes the central role and remains dominant with English seen as the official language (Allen, 2006). The statement was a clear indication of how Ireland's multicultural status is currently viewed by nurses living and working in the HSE West and that is *"... as a description of the demographic make-up of modern states"* (Berman & Paradies, 2010, p 220) but not what lies within it.

England is credited with having more experience in dealing with the exotic for a longer period of time therefore Ireland needs to be given time to adjust to the cultural mix,

"England do you know would have years, of so many different cultures, I think Ireland, its all still very new to us".

(FGI 2, IrIN, P4, PG5)

The increase in cultural diversity over the past decade is primarily the result of labour migration to Ireland. The April 2008 figures (CSO, p1) estimate the numbers at approximately *"420,000 comprised of 188 different countries".* In total some 10% of the general population are foreign nationals with their own distinct cultural practices, beliefs and value systems. Nursing has also experienced in recent years a significant increase in overseas recruitment

these changes within the *"Whiteness"* of the nursing profession in particular in Ireland have made cultural diversity an important issue (NCCRI & IHSMI, 2002).

It is the Researcher's contention that no more than with cultural practices 'like *the air that we breathe'* (Henley & Schott, 2004) our white skin colour is an important dimension of racial privilege which remains unconscious (Allen, 2006). In order for these cultural differences to be engaged with positively within the workforce careful attention must be paid *"... to how history, theory and power operate within any language we employ"* (Allen, 2006, p 65). If someone is described as non white or the *'other'* social histories are being mobilised as certain social characteristic and qualities are being linked with the individual and this only serves to reproduce the privileged white norm. Therefore dealing with diversity issues is not as simple as *"... add colour and stir"* (Allen, 2006, p 66).

"... they blended in with us (Laughter)".

(FGI 1, IrIN, P1, PG15)

This account demonstrates the relationship of dominance within which cultural difference is constructed. The Researcher own language for example using the word difference suggests classification and classification involves power (Allen, 2006). Constant comparison becomes a feature which for many, is demonstrated unconsciously and is evident in the use of the words *'they'* and *'us'* in the significant statement above.

The *'they'* pertains to the minority them and *'us'* to the majority which is regarded as the norm. As a result minority needs are perceived as receiving preferential treatment this is raised in the following statement,

"... for example I was up at the Swine Flu Vaccination Clinic and the Doctor was going off it seemed like every time, like every minute I looked he was going off into a room praying, its like how many prayers does he have to keep praying"

(FGI 2, IrIN, P2, PG21)

The open practice of religious beliefs was being frowned upon by the participant who expressed verbally the feelings of resentment towards the behaviour. This was viewed as a form of escape from workload commitments as part of the team and lacked fairness,

"... I would have had that experience as well where the nurse would go off ... and they were lovely an all but you know it felt like all this to do ..."

(FGI 2, IrIN, P1, PG22)

There was no attempt made with regard to discussing the practice with the doctor in question. This apparent non communication was raised by the researcher and there was an interesting statement forwarded,

"... like you feel you can't say to them you can't do that ... its more like fear of God if anything, that you would be pulled for racism or something like that"

(FGI 2, IrIN, P4, PG24)

The Rosanna Davison versus Ryan Aer (2011) is a case example of this very issue and the realisation of the participants' worst fears. Therefore the statements made by the participants were from their perspective justified. Communication difficulties were a key factor inherent in the statement which interfered with the Nurse Doctor dyad and resulted in the expression of intolerant by the nurse (Eckhardt, Mott & Andrew, 2006).

All communications theory discusses the importance of verbal and non verbal communication. In the literature review chapter the reader was introduced to language in particular and how this can give rise to cross cultural communication problems (Winkelmann-Gleed & Seeley, 2005). With language in the mix which is the key element of communication these difficulties can give rise firstly to problems in the nurse patient dyad and secondly to the temptation to exoticise. Problems with the nurse-patient dyad was demonstrated in the research study carried out by Felicity Stockwell (1972) referred to in the literature review which clearly indicated that the individual's ability to communicate is linked to the *"label"* of unpopular patient. A key finding identified in Stockwell's research identified English speaking patients as being more popular. In research carried out by Eckhardt, Mott & Andrew, (2006, p 24) they concur with this finding *"... one participant felt the staff saw her as a trouble-maker because she didn't eat what she was given".*

Exoticising on the other hand is seen as the singular criteria for comparison and eliminates similarities from consideration (Gunaratnam, 2003).

"Their English hasn't got a lot better ... they speak their own language"

(FGI 2, IrlN, P3, PG25)

In this research study language and the ability to communicate effectively is an expressed concern by both Irish and migrant Nurses. The migrant nurses felt unsupported by their nursing colleagues particularly when faced with relatives who often ignored them despite having been successful in English exams and strict selection criteria. This is clearly indicated in the following statement,

"... you get the sense sometimes when you would be sitting there working, when a relative comes in. You know they don't really look at you straight, they are looking for you know, an Irish nurse to talk to, even though you are right there"

(FGI 4, FN, P2, PG19)

The Irish nurses in their accounts acknowledged this practice,

"... sometimes they answer phone calls or queries from relatives and we ultimately say oh I'll take that or can I help because it's just easier to take the call or whatever than to sort out the complication that it causes"

(FGI 2, BN, P1, PG25)

Paley (2002, p 567) points to this as the identification of meaning as being culturally grounded and *"... for an individual, background meaning is provided by the culture, subculture, and family to which the person belongs".* The participant was not in any way dismissing the migrant nurse but was given recognition to linguistic meaning and that interpretation of background meaning and what counts as real is what culture gives a person from birth. Benner (2000) identifies the importance of the system of attaching meaning in linguistic exchanges and stresses that this transpires if the condition of belonging to or membership of a culture is present.

This practice by the British and Irish nurses was interpreted by the migrant Indian and Filipino nurses as non support of fellow nursing colleagues and this sentiment is palpable in the next statement,

"Yes, if you are in charge of the client they should just say, he's in charge of the client you might as well talk to him, but they don't"

(FGI 4, FN, P1, PG19)

This finding was also reflected in similar research carried out in the UK by Alexis & Vydelingum (2004) in which support was portrayed as the most important attribute that is necessary when working as a nurse. The study revealed that the anxieties experienced by the migrant nurses were *"... compounded by the lack of support that they received from their white British counterparts"* (Alexis & Vydelingum, 2004, p 16). The effect that this can have

on the nurse's confidence as feelings of failure or being rejected was reiterated in that research with similar reflected in this research,

"... you feel upset sometimes ... because you know you are well able to explain the condition of the patient and you're well able to answer questions that they are going to ask""

(FGI 4, FN, P2, PG20)

The coping strategies utilized is a feeling of resignation and that perhaps things will improve over time,

"All you have to do is just ignore it ... and just be professional when approached. You go nowhere"

(FGI 4, FN, P1, PG20)

Becoming familiar with the relatives over a period of time is seen as the outcome – time the healer and the eventual reward seen as acceptance,

"... but once you get to know them they are fine"

(FGI 4, FN, P1, PG20)

This description of the time required to build good relationships is also echoed in research by Murphy & MacLeod Clark (1993) who found that spending time with the relatives and involving them in care *"... was described as the key*

component in building a good relationship with them" (Murphy & MacLeod Clark, 1993, p 445).

Acceptance of the essential nature of belonging to the Irish and nursing culture club *'when in Rome do as the Romans do'* is recognised by the migrant nurse in the following statement,

"... whatever things you know ... this is the way they do it here, because you can't change the system ... you know you have to its like as if you're starting from scratch but you have to adapt"

(FGI 3, FN, P1, PG26)

Recognition is given that there are more ways of belonging than being born into it (Paley, 2002). Whilst being born into a culture club is pivotal an individual can also convert, learn about it over time, pick it up at work or be exposed to it through the media (Paley, 2002).

"... you know you just have to learn this is the way they do it here"

(FGI 4, FN, P2, PG28)

Inherent in all of this is the encounter with others, of different ways of life or doing things. Encounter with others must be motivated by a desire to become culturally competent if nurses are not being facilitated to critically reflect on their own culture then the consequences of this impacts professional and personal development (Boyle, 2000).

5.5 Theme 3 - The Cultural Competence Model - Is it appropriate or useful?

5.5.1 Cultural competence - 'what's that?'

The findings from this emergent theme identified from the focus group interview was guided by questions thirteen to seventeen of the FGI Guide (Appendix VIII) and sought to ascertain the knowledge nurses have in the HSE West with regard to cultural care models, the level of support available and initiatives or strategies in place that enable cultural flexibility.

The interviews highlighted that very little is known about cultural competence,

"... cultural awareness yea, competence not"

(FGI 2, BN, P1, PG38)

Cultural competence is defined *"... as the ability to understand and work effectively with patients whose beliefs, values and histories differ from one's own"* (Capell, Dean & Veenstra, 2008, p 121). There is a continuum of cultural competence which is identified in the four different levels of culturally competent practice, from incompetence, to awareness, to safety and eventually competency (Papadopoulos, 2006). Paula McGee (1994) alludes to a poverty of culture knowledge and awareness amongst nurses. Knowledge is not just about sanctioned empirical information it is also about how to be a professional and how to speak and act in a particular setting

(Allen, 2066). However, from the accounts the participants' forwarded cultural competence from an Irish perspective has no clear yard stick against which to compare good practice (McGee, 1994). The findings revealed that the participants demonstrated little or no knowledge of Cultural Care Models and those who did express awareness were reluctant to engage with the use of same in the care setting. This was demonstrated in the following significant statement,

"I would question whether you would even need a cultural care model ... because we have all said here that our beliefs are apparent in nursing and it does not matter what person you put in front of you, what culture they're from ... you still treat them ... the same"

(FGI 1, IrIN, P3, PG24)

This lack of enthusiasm with regard to the utilisation of cultural care models in the clinical setting is significant given that all of the participants in the research study felt inadequately prepared from their training and education. The danger as Boyle (2000) posits is that as a result the individual imposes their own personal behaviour on the patient or work colleague without critically reflecting on the cultural dynamic of the practice. This is the practice of cultural imposition (Leininger, 1995) which emphasises the model of western culture as superior to all others. This sentiment is evident in the following account,

"I was working on the labour ward and I noticed that there were all these older men you know who were nearly on their fourth wife coming in with these teenagers and it just horrified me you know and then they didn't even bother to come to say hello or congratulations or anything else unless it was a boy. I remember thinking how lucky I was not to be part of that culture and started feeling sorry for the women".

(FGI 1, IrlN, P2, PG26)

The binary nature of the cultural characteristics was indelibly marked on the psyche of the participant coupled with the perceived disrespect for women and female children. This account emphasised for many of the participants just,

"... how powerful culture was"

(FGI 1, IrlN, P1, PG26)

Other accounts revealed similar sentiments and one account in particular forwarded by a participant who had worked in Africa related to Koagies Blood (White Person's Blood) and was recounted, as suggested by Berman & Paradies (2010) by the participant with the emotions of passion, anger, disbelief towards the perceived incredulous barbaric practices with regard to the lives of women,

"I asked the interpreter what's happening here and what had happened is that a mother had given birth and lost a lot of blood, she needed blood and was

going to die if she didn't get it. So I immediately reacted and said well look I will give her blood you know if my blood is compatible with hers … another Irish person who was working as well that day walked over to the Doctor's office … the first thing that the doctor said was that we do not take blood from women … my colleague said if you don't mind me saying so this is a most insulting society I have ever worked within so he just laughed … So I said I'll give blood so he said yes okay"

(FGI 1, IrIN, P1, PG27)

Tolerance of diversity from this participant's perspective was not evident in Sudan nor indeed was there any attempt by the authorities to recognise the disadvantage faced by females in Sudanese society to ameliorate the experiences of women. The overt nature of this practice was the element that impacted on the value and belief system of the participant – with the challenge to their ethnocentric views. This stance epitomises what Berman & Paradies (2010, p 217) refer to as *"internalised dominance and is the incorporation of attitudes, beliefs or ideologies about the inferiority of other social groups and/or the superiority of one's own social group".*

The interviews also suggested that cultures with beliefs and value systems different to our own are less law abiding a stereotypical belief demonstrated in the following account,

"… this particular girl she was African in origin emh! She was very unhappy with the care a particular person was giving in the place where she was

working ... this other person was another nurse ... she spoke to her on several occasions about her care and their was no change. So she decided she needed to sort this out herself so she came in early before the shift started and broke yer woman's nose ... on the way to work"

(FGI 1, IrIN, P3, PG25)

This account was met with disbelief and laughter during the recording of the interview at the possibility of this occurring the participant recalled that they had been informed by the nurse that,

" ... you know she was explaining to me that in her culture that is how you sort the problem out yourself"

(FGI 1, IrIN, P3, PG25)

The significance of this account from a research perspective is that even though nurses may work in close association with each other there is very little exchange of knowledge about one another or that which is exchanged is at a superficial meaningless level this is the poverty of cultural awareness that Cortis (2003) and McGee (1994) allude to of the saris, samosas and steel band syndrome. This piece meal recognition of culture only serves to trivialise and devalue deep held cultural beliefs at a material level for those who are perceived as different.

This is clearly evident in the following account,

"... they ask things like what do you eat at home? Is this what you eat at home? Is this what you do in your spare time at home?"

(FGI 4, FN, P3, PG15)

Despite the superficial nature of the knowledge sought by nursing colleagues it was welcomed and viewed as *'intimate'*. All of the migrant nurses interviewed talked about the reciprocation of the cultural knowledge however there was a recognition that it did not go far enough as there were gaps,

"... It just correlates one after the other, you know, so they learn from us, and we learn from them ... there's reciprocation. So that's why we are still here for the last nine years"

(FGI 4, FN, P3, PG15)

This is the aim of multicultural models which *"... should promote an awareness of one's own culture, thus reinforcing a sense of identity and pride in oneself"* (McGee, 1994, p 14) which in turn enhances the concept of acculturation.

The migrant nurses drew attention to the fact that there was very little information with regard to the indigenous Irish culture in many of the pamphlets and literature available in the clinical environment this is summed up in the following statement,

"... I saw handouts here about different cultures ... I think it would be more appropriate if they were available in their own culture, because we get more Irish people here as patients ... there should be handouts regarding that, more than with other cultures and religions"

(FGI 4, InN, P3, PG24)

This statement was made amid a trend expressed by all of he participants in this research towards a colour blind care approach,

"... like what my colleagues said regarding the care. It's the same everywhere, wherever you go in India, or here or the Philippines"

(FGI 4, InN, P3, PG22)

Colour blind care assumes that everyone is equal and therefore that everyone should be treated the same way, irrespective of culture, race or ethnicity (Holland & Hogg, 2001).

5.5.2 The Colour Blind Approach - The One size fits all

Professionals adopt the colour blind approach because they see it as neutral the safe option and one that no one can challenge them for using (Henley & Schoot, 2004). Although this colour blind approach is often well meant in reality it is also discriminatory and maintains the status quo with the provision of care *"... based on the cultural preferences and historical needs of the white majority population – and neglects or marginalises the needs of black and minority ethnic communities"* (Henley & Schoot, 2004, p 50).

The approach assumes that everyone should adapt to the dominant culture (Holland & Hogg, 2001). The requirement for different cultures to become more like us is a predominant sentiment of these research findings,

" ... you could do it first that we would get educated and then they could get educated with our culture and then bring the groups together and let them have a talk in an informal non threatening environment"

(FGI 2, IrIN, P1, PG29)

Cultural Care models it can be argued ensure respect for diversity and different cultures and values (Papadopoulos, 2006). Therefore the therapeutic relationship is equality based (Holland & Hogg, 2001). There can be no doubt that care is influenced by the surrounding culture (Rytterstrom et al, 2008) and if this culture is negative towards difference creating a care scenario where practice is no longer ethical,

"I think that there are some reservations there, if you were to look after two patients with a similar complaint from two different cultures say the Irish Catholic culture and the Muslim culture then I would much prefer looking after the Irish person ... a culture that I am familiar with"

(FGI 2, IrIN, P1, PG27)

A fear of the unknown and not being competent in cultural care contributes to this aversion (Rytterstrom et al, 2008) as is evidenced in the follow on statement in the above account.

Leishman (2004) illustrated the cultural awareness of ten nurses working in Scotland. The study highlighted the lack of knowledge and understanding of the diverse cultural that made up the population of Scotland and emphasised a gap in the provision of Education and Training. The study also showed that if nurses felt uncomfortable about his or her knowledge of a patient's cultural or religious belief then there was an avoidance demonstrated towards working with that patient or interacting with them this was reflected in this research study. Yet despite the shortfalls there was a clear willingness demonstrated by the Scottish nurses to redress the balance by forwarding innovative and balanced suggestions.

The Researcher contends that cultural flexibility is a key competency requirement of all nurses and can be achieved by the use of Cultural Care Models (Flowers, 2009). This rational for this requirement is that being treated in a culturally competent manner is a reasonable expectation for all in the 21st century as it is no longer tenable to treat everyone ion the same manner (Papadopoulos, 2006)

5.6 Study Benefits

This research whilst benefiting the personal and professional development of the Researcher will form the basis of an educational programme from a work perspective, which will address the cultural educational needs of the qualified nursing staff employed in the HSE, West. Cultural training of service providers needs to take place with follow on evaluation to ensure its effectiveness. This research has also drawn attention to the problems faced by nurses in caring for and working with individuals from different cultural backgrounds and the findings reveal that the experience of working abroad does not equip the nurse with the necessary toolkit when faced with diversity. It is the Researcher's aspiration that this research will give rise to the opportunity to begin to develop core cultural competencies for health care professionals such as nurses, who are at the front line of service delivery. It is also hoped that with the completion and subsequent dissemination of this research that it will inform the ongoing work of Ms Caoimhe Gleeson, Equality Officer, HSE, West.

5.7 Study Limitations

This research whilst examining the phenomenon of culture will not claim to reveal the richness of the phenomenon as this research is limited to one geographical area and the sample i.e. n = 18 is too small to generalise empirical findings (Alexis & Vydelingum, 2004). Morse & Field (1996) suggest that one requires at least twenty five participants for saturation to occur. The

purpose of qualitative research is to elicit rich data not to generalise (Alexis & Vydelingum, 2004). The validity of the findings would require further sampling to include a more representative section of nurses given that the population of Nurses employed in the HSE North West Area is approx 3000. In addition to this, none of the nurses in the sample were from a mental health background which reflects a different gender ratio, nurse socialisation processes and did not have the same religious influences as other disciplines within an Irish nursing context.

The choice of the research methodology of phenomenology could also be perceived as a drawback as it does not claim to be representative of the lived experience of social and historical situatedness which has an influence on research methods. Anthropological approaches are more suited to cultural studies such as this however, these could not be invoked as an option for this research by the Researcher as anthropological approaches necessitate the researcher to become totally immersed in the lives of the participants whilst utilising the method of participant observation. This is at variance with the methods chosen by the Researcher i.e. focus group interviews and questionnaires.

The Researcher as a Nurse Educator who is involved in participant continuing education programmes this role may interfere with the results of the study in terms of the participants providing information for the research which the researcher would perceive as *'right'* information. This was previously dealt with in Chapter 4 in the pilot study with the Researcher endeavouring to utilise

Researcher bias positively. The use of the Assistant Moderator also countered this bias and the choice of Phenomenology which utilises the concept of *'Bracketing'* ensures objectivity.

Focus group interviews generate large volumes of data are labourious and time consuming to analyse. Whilst participant inhibitions can be overcome in focus group interviews, the down side can be that some participants on the other hand can have a dominant influence on the interview process and those who are less articulate may be inhibited from expressing alternate viewpoints (Bowling, 2004). This was overcome by utilising purposive sampling and keeping the numbers of participants in each FGI at a min (Krueger & Casey, 2000). The Researcher would like to contend that although one is conscious of bias and guards against it it is impossible to judge with certainty how this particular limitation affected the research.

The lack of skill of the Researcher with regard to the execution and control of focus group interviews was also a concern in that there was a very real fear that a relaxed atmosphere would not be achieved leaving the participants uncomfortable and passive. Researcher confidence was strengthened by the Pilot Focus Group Interview 'dummy run' and the utilisation of a reflection in the evaluation process (O'Connor & Murphy, 2009).

The Researcher was hesitant about the use of the Participant Reply Form (Appendix IV) which sought information regarding having worked abroad from the participants. The utilisation of this particular question only became clear

when the findings were presented as it revealed that working abroad did not equip the participants with the openness or skills to deal with diversity. This was from the Researcher's perspective an integral part of the process of operationalisation in which the abstract becomes specific (Sarantakos, 1997). As questionnaire content is crucial as this will lead to the type of information sought in this research, therefore questionnaire content must be organised according to the following criteria:

- Composition
- Relevance
- Symmetry
- Clarity and Simplicity
- Language
- Attitude
- Presuming (not permitted)
- Avoidance of suggestive questions

(Sarantakos, S. 1997, p 237)

The main limitation in this research is that the caring dyad was not dealt with this would have required a change of title to in how cultural care is provided. The Researcher is cognisant of the paucity of investigation in this area from an Irish perspective however, whilst this research serves to uncover the initial layers of the meaning and experience of culture among qualified nursing staff working in the HSE, West, a need for further studies is proposed to inform the existing body of knowledge.

5.8 Recommendations

The findings of this research reveal that nurses have a difficulty with cultural knowledge because of its multifaceted nature and that cultural experiences do not serve to create a greater level of tolerance or openness towards *'others'*. Holland & Hogg (2001) make reference to this confusion amongst Healthcare Professionals which for many nurses exists on two fronts by;

1. The intermingled use of the terms culture, race and ethnicity.
2. By what De Santis (1994) cited in Holland & Hogg (2001, p 4) "... *believes that when patients and nurses meet one another, there is in fact a meeting of three cultures,*
    - *i. the nurse's own professional culture...*
    - *ii. the patient culture...*
    - *iii. the culture of the setting".*

The Researcher would add another cultural dimension to this salad bowl which is the nurse's own personal cultural identity to the mix. Against this backdrop the nursing literature advises nurses that the needs of many different cultural groups are not being met and that there is a need to ensure that Healthcare practitioners are culturally competent in order to fulfil this need (Flowers, 2004)

The following recommendations are forwarded by the Researcher and are in line with the main themes explored in the study.

Theme 1: Rediscovering Culture and Irishness

Culture is one of the most difficult terms to define in the lexicon of the English language and with this in mind the Researcher would like to forward 4 ways to address this issue:

1. Creating a welcoming friendly environment which recognises that cultural difference exists and matters
2. Listening is a key skill in caring and to those from other cultures also means having an awareness of communication differences in the use of e.g smiling; the concept of time; eye contact; status; and privacy are only a few. Accurate interpretation of communication processes is essential in order to prevent negative violations.
3. Sensitivity to cultural needs and understanding the concept of *"face"*. For many the nurse is seen in a 'senior' or raised position.
4. Encounter with other cultures enhances the first hand knowledge of the individual observer we are not going to understand the meaning of a particular culture unless we experience it e.g. learning the language of a different country as language is inherent in learning about cultures and is the primary vehicle for transmitting cultural traditions. Creating a cohort of nurses who can communicate in languages other than English will help alleviate health care costs and promote better access to healthcare services a notion prescribed to in the HSE Transformation Programme.

Awareness of personal culture, values, beliefs, attitudes and behaviours – the process of professional development and competence in cross cultural

encounters begins as self awareness sometimes referred to as self exploration (Calvillo et al, 2009). Before addressing multicultural backgrounds nurses must first address their own personal and professional knowledge, values beliefs, ethics, attitudes and life experiences to maximise the cultural assessment of their patients as cultural self awareness and communication modes impact on the caring dynamic

Theme 2: Nursing Culture – Workplace practices and issues

The establishment by the Irish Nursing Board (An Bord Altranais) of nationally recognised cultural competencies this will give credence to and highlight the importance and applicability of cultural competence in the care setting. It also provides nurses with the knowledge, attitudes and skills required to meet the standard of care the public expects of professional nurses.

In order to nurse and care effectively for people of *'other'* cultures cognisance must be given to attitudes which are just as important as knowledge and understanding in fact if they are not dealt with they have an impact on the way knowledge is interpreted. Self awareness training is the first step towards practising culturally competent care as we must know ourselves before we know other (Boyle, 2000). The use of Diversity Trainers who subscribe to the process of self examination or awareness is an important step in developing Cultural Competence.

The development of an Organisation wide Cultural Care Policy in line with the new national PPPG Framework which will act as a reference source in guiding staff from a corporate level with regard to cultural needs as nurses are required to know the proper policies, procedures, protocols and guidelines to follow if patient's or colleague's rights are violated.

'Gatekeeping' (Holland & Hogg, p 173) within the nursing profession needs to be established to ensure that cultural issues are dealt with at the recruitment stage with interview teams trained appropriately to ensure that bias and prejudice are kept to a minimum.

Nursing Documentation – needs to make use of Cultural Care Models and in so doing cultural knowledge is embedded in the clinical areas as this ensures immersion with every day use and the development of culturally skilled practitioners.

Open discussion regarding the immigration issue should be encouraged by Nursing Leaders who must strive to make the detoxification of immigration issues possible.

Theme 3: The Cultural Competence Model – Is it appropriate or useful?

Education was identified as a key change catalyst. Therefore comprehensive frameworks of continuing educational forums need to be established and lead out by Practice Development and the CNME's nationally. This would facilitate the educational needs of clinical staff that care for and work with different cultures.

Cultural competence can only come about by nurses learning as much as possible about the specific cultures of patients to whom they provide care and building up a shared information base as a resource. The information needs to be general and specific as this helps to reduce gender, ethnic and racial disparities. With the identification of Champions, that is nurses who are competent in caring for distinct cultural group/s this can be achieved.

The use of focus groups before and after intercultural encounters provides nurses with affirmation and disconfirmation of highly subjective and personal assumptions and provides for a reflexive pathway.

The establishment of Nursing Leadership support and a sustained commitment to cultural competence is a key ingredient in the provision of culturally congruent care and must be directed by the ONSD. Leaders are instrumental in fostering an organisational climate supportive of diversity and who clearly articulate the vision required in order to strive towards cultural competence. In order to ensure this nurse leaders need to allocate resources, establish diversity policies, set realistic goals, promote communication and evaluate outcomes in order to gauge success.

A variety of challenges, opportunities and strategies were identified by the participants. From the findings the responses were considered under the following distinct sub areas.

Education

Cultural Motivation - Distance learning packages/e learning programmes – given the staffing resources and the work patterns of nurses.

The provision of IT Supports in all care facilities in order to ensure the use of up to date evidence to underpin practice.

Cultural Encounter - Face to face Workshops with culturally distinct groups enhancing awareness, understanding and knowledge.

Cultural Skills - Language classes informing staff of the basic rudiments of both indigenous and foreign languages.

Religious Practices were referred to throughout this Research – The provision of the Health Services Intercultural Guide (2009) responding specifically to religious needs is an initial starting point for HCWs serving as a relatively inexpensive clinical resource.

Resources

Cultural Provision - Multilingual Handbooks – containing basic linguistic Information.

Budgetary allocation – that this be acknowledged to allow effective training for all grades of HCWs.

Cultural Teams – comprising of the employer, the employee and the service user be established in

order to support and audit cultural practices in the Healthcare environment.

Cultural Competence – That cultural training become a mandatory requirement for all HCWs in light of the impact that cultural beliefs and practices have on health.

5. 9 Conclusion

Within this chapter the Researcher made the decision to present the Findings and Discussion together as to have separated both would have lead to the replication of information presented. The discussion was presented in relation to the relevant literature, participant experiences and researcher analysis.

Three themes were elicited from the findings:

1. Rediscovering culture and Irishness,
2. Nursing Culture workplace practices and issues
3. Cultural competence models are they appropriate or useful?

Within theme one the findings from this and other studies revealed that nurses had a difficulty defining culture with as a result multiples of interpretation. O'Hagan (2001) warns that to leave individuals to attempt to define culture, something that we are not overtly aware of until we encounter '*others*' has the potential to lead to 'a limited, imbalanced, ethnocentric perceptions of culture.

Within theme two the findings revealed that nurses are cultural dwellers with their own personal and professional culture which in turn provides each nurse with a meaning filled experience that in turn ascribes to ethnocentric assumptions. The research revealed that the British and Irish nurse participants who had worked abroad only served to reinforce negative value and belief systems and controversially revealed that the experiences gained abroad left many of the participants more racist than as if they had never left. The statements indicated feelings of resentment, and intolerance with has not been helped by the current economic crisis. This theme also revealed that whilst nurses advocate holistic care which is underpinned by the tenet of individual care there was a distinct preference advocated by all of the participants towards a cultural blind approach which assumes that everyone is equal and everyone should be treated the same (Holland & Hogg, 2001).

Finally, in theme three given the current demographic changes in Ireland diversity is firmly parked on our doorstep. Multicultural Irish society is viewed as a demographic concept. The participants highlighted the need for post registration education to address the multi ethnic mix in Irish society. The findings clearly demonstrated a dearth of knowledge with regard to cultural care models and the need for continuing education which will equip the nurse with the essential knowledge, skills and attitudes to care for and work with different ethno cultural groups. The predominate attitude to difference identified was that of *'them and us'* fitting in and treating everyone the same – the one size fits all model as opposed to cultural care models. These cultural care models are transformationist in that they allow the individual to examine

their own attitudes, beliefs, values and feelings (Holland & Hogg, 2001). This is not suggesting that the use of these models are the solution to diversity issues and that nurses will have expert knowledge about culturally diverse groups as a result but that instead they will ensure greater cultural flexibility.

Chapter 6

Conclusion

CHAPTER SIX

6. Conclusion

This research provided a rich description of the lived experiences of qualified nurses' perception meaning and experience of culture working in the HSE West.

Irish society over the last decade has grown and become more culturally diverse (Boyle, 2000). As a result the need for nursing care that embraces cultural competence becomes increasingly more important (Leishman, 2004). This research study has demonstrated that whilst there is evidence of understanding of culture as a concept there is no unified definition from a nursing perspective. Nursing is immersed in culture with its practices, theories and models woven by values and belief systems. Nursing subscribes to holism however an essentialist tick-the-box solution is sought to deal with diversity and this is at variance with the constructivist ideal of holism (Gray & Thomas, 2006).

This small scale study encountered nurses who demonstrated an awareness of the impact and power of culture and what this can create within the caring dyad. Irishness was viewed negatively and positively with ethnocentric views transgressing the research findings. Racism was referred to and discussed in the guise that we are new at the game of dealing with diversity. The migrant nurses had demonstrated insight with regard to the nuances of Irish culture adapting to their new cultural environments.

Whilst *'fitting in'* is the accepted norm the migrant nurses felt unsupported by their Irish nursing colleagues when communicating with relatives in the care domain and as a result felt rejected from the group which Benner (2000) refers to as a unifying aspect of belonging to a culture. The findings of the study suggested that the commonality of the suggested philosophy of care *"one size fits all"* was remarkable given the diverse cultures of the nurses themselves with little or no regard demonstrated towards cultural care models. This originates from the belief that they see the colour blind approach as a neutral and safe option and one that no one can challenge them for using (Henley & Schoot, 2004).

Whilst Leininger (1995) promotes the expert cultural care models on the other hand advocate the four main concepts of cultural awareness, knowledge, sensitivity and competence they do not expect that every nurse will become an expert in understanding all ethnocultural groups but that each nurse is culturally flexible (Boi, 2000).

This research has highlighted the importance of the skills and knowledge development required in order to work competently in a diverse care setting and that it is only through education and training that this can be achieved (Boi, 2000).

The research area identified by the Researcher as requiring further exploration and examination is that of nursing relationships Wilkinson & Miers, (1999, p 67) would concur with this sentiment stating, *"... that there is*

substantial evidence to suggest that nurses themselves experience working in organisational structures – nursing hierarchies – negatively". This has been noted as causing separation among groups of staff at different grades as opposed to creating a team that will work as a cohesive unit together (Wilkinson & Miers, 1999). It is the Researcher's contention that this requires further study in order to understand the relationships within the Nursing profession in light of in particular growing diversity within the nursing profession.

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Appendices

Appendix I

Glossary of Terms

Acculturation	-	Modification of one's culture as a result of contact with another culture
Attitude	-	A mental perspective/standpoint about a particular phenomenon
Bias	-	Deviation in one direction of the observed value from the true value of the construct being measured
Competence	-	The demonsration of required knowledge, skills and attitude in the practice of nursing
Deduction	-	A theoretical or mental process of reasoning by which the investigator commences with an idea and develops a theory from it
Demographics	-	The profile of a given population
Diversity	-	The perceived difference between different social groups
Empirical	-	Based on observation
Enculturation	-	The immersion in one's own cultural practices
Ethnicity	-	Defining groups in terms of their cultural characteristics Rather than supposed biological difference
Ethnocentric	-	The tendency to view one's culture as morally surperior to others and as a result to judge others by one's own cultural standards

Ethnography	-	The study of people in their natural settings
Focus Groups	-	A research method of interviewing people while they are interacting in small groups
Functionalism	-	a macro theory based on interrelationships within the Social system
Globalisation	-	The global power that exists outside nation states, global forces are said to weaken the power of the nation state
Grounded Theory	-	The researcher develops a conceptual theory from the data and then makes new observations to develop these theories
Historically Situated	-	Where research is situated, influences its practice in terms of a particular tradition of thought
Independent Variable	-	The variable that explains
Indigenous	-	Native, from within a particular nation state
Induction	-	Begin with the observation and measurement of a phenomenon and then develop theories or ideas
Interculturalism	-	An approach that promotes interaction, understanding, respect and integration between different cultures and ethnic groups on the basis that cultural diversity is a strength that can enrich society
Interpretive	-	A micro level theory in which social scientists must include the meaning that social actors give to events and behaviour
Interview	-	A research method that involves a trained interviewer

		asking questions and recording respondents replies
Minority	-	Lesser numbers from within a distinctive group
Multicultural	-	The belief that ethnic and cultural groups can co-exist in a society showing respect for one another's culture
Naturalistic Research	-	Descriptive research in the natural unmanipulated setting
Observation	-	The researcher systematically watches, listens to and records the phenomenon of interest
Operationalise	-	The development of approximate measures which enable the phenomenon to be measured scientifically
Perspective	-	A way of interpreting phenomenon
Phenomenology	-	Based on the premise that unlike innate objects humans have a conscience. Therefore they interpret the world around them gain meaning and as an outcome construct an individual social setting/reality
Purposive Sample	-	A non-probability sampling method by which the researcher selects participants based on judgement about which ones will be most representative or informative
Qualitative Research	-	Social research carried out in the field, with a non statistical form of analysis giving meaning to the phenomenon under investigation
Quantitative Research	-	Social research which is statistical as it measures and analyses phenomenon in a numerical way
Racism	-	A specific form of discrimination and exclusion faced

		by minority ethnic groups
Reliability	-	The extent to which the measurement is consistent and repeatable
Research Design	-	Refers to the research strategy invoked and how sampling methods, data gathering, data analysis and findings are to be conducted and presented
Research Method	-	This is the data collection tool of choice e.g. focus group interviews
Rigour	-	The validity and reliability of the research method i.e. how thorough is the researcher
Sample	-	A subset of the population/universe under investigation
Sampling	-	Techniques used to obtain the population subset
Social Situatedness	-	Where research is situated influences its practice, this is in terms of a particular culture with its own distinctive values and debates
Symbolic Interactionism		A micro theory of social science which is concerned with how meanings are produced in social exchanges and in particular deals with the use of symbols
Tacit Knowledge	-	The knowing how about things without reflecting on theory and rules underpinning the knowledge
Theory	-	A set of logically related propositions about a phenomenon and their implications
Validity	-	The extent to which researcher findings can be generalised to the wider population

Source : Adapted from:

Bowling, A. (2004) Research Methods in Health

Investigating Health and Health Services

Second Edition, p 430-438

London: Open University Press

Haralambos, M. (1995) & Holborn, M. Sociology Themes and Perspectives

Fourth Edition

Bath: Collins Educational

Appendix II

Letter of Permission

To the Director of the Centre of Nurse Education

26 Glenview Park
New Grange
Grange
Co. Sligo
(071) 916-3989
17 June 2009

Dear Dr Hodson,

I am currently undertaking a Masters in Humanities at Sligo Institute of Technology. The area that I have chosen to study will examine the cultural awareness and attitudes of qualified nursing staff working in the HSE, West. In order to progress this research I have conducted an extensive literature review of the research topic Culture Oct 2008 - Dec2009. It is also my intention to collect data via Focus Group Interviews in relation to this research phenomenon so as to acquire a deeper more meaningful understanding of the qualified nurses' awareness and attitudes to Culture.

I am therefore proposing to initially undertake one Pilot Focus Group Interview with the Nurse Education Staff in the Centre in early November 2009. This will allow design issues to be developed/changed before the Focus Group Interviews are conducted. It is my intention to carryout 3-4 focus group interviews comprising of eighteen to twenty four qualified Nurses in a number of purposively selected settings one being your educational facility. Upon approval from you, these interviews are planned to take place over a two month timeframe from November to December 2009. Nurses who volunteer to participate in the research project will be fully appraised of the details of the study and will be assured of confidentiality and the freedom to withdraw from the research at any time.

I would be grateful if you would consider my request and I welcome an opportunity to discuss this research with you at your convenience. My Research Proposal was completed in June 2007. If you have any further queries please do not hesitate to contact me at the above number.

Thanking you in anticipation of considering my request.

Yours sincerely

_____

Martina Harkin-Kelly

Appendix III
INFORMATION SHEET FOR PARTICIPANTS

Title of Research Study:

"A Phenomenological examination of qualified nurses' perception, meaning and experience of culture working in the HSE, West."

Dear Participant,

You are invited to take part in the above research study with the aim of examining *"qualified nurses' perception, meaning and experience of culture working in the HSE, West"*. I would like to interview you as part of a Focus Group to ask you about your thoughts and feelings about how Nurses perceive, understand and value culture. This research is part of a Masters in Humanities which is being undertaken in Sligo Institute of Technology by the Researcher, Martina Harkin-Kelly and as part of this academic programme is required to carry out a research project.

Before you decide whether to take part in the research it is important that you understand what it is for and what you will be asked to do. Please take time to read the following information and discuss it with others if you wish. It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep. You will also be asked to sign a consent form. You can change your mind at any time and withdraw from the research without giving a reason. There will be no implications for you whether or not you decide to participate in this study. You are welcome to phone me if you would like any further information. My contact details are outlined below.

The purpose of the research study is to examine nurses' perceptions, understanding meaning and experience of culture. I would like to ask questions about what it is like for you to experience culture from a personal or professional perspective, your thoughts, your feelings as well as situations, events, places and people connected with your experience.

You have been chosen because you meet the specific characteristics of the research study i.e. you are a qualified nurse with either Irish or foreign ancestry who has trained in Ireland or abroad, and is registered with An Bord Altranais and currently employed by the HSE West. The study will involve no less than 18 and no more than 24 participants, who will all be interviewed in 3 - 4 groups comprising of no less than 6 and no greater than 10 participants. The interview will take approximately $1^{1}/_{2}$ – 2hrs. If you choose to take part I will organise a location for the interview convenient to you with refreshments provided.

The information gained from this research will be used to make recommendations for best practice and will offer insights into the cultural issues in the North West of Ireland. The Researcher will also be publishing an abstract and excerpts of the Project in various professional journals and libraries. The results of the study may also lead to further studies into Cultural Issues.

Talking about culture may be upsetting for you. You are free to stop the interview at any time if you do not wish it to continue. If the interview upsets you and you feel you would like/need some additional help after the interview I will be able to advise you who to contact, for example GP, Community Nurse, Counsellor or another key worker.

The interview will be recorded on audio tape and then transcribed onto a computer. The audio tapes will be stored in a locked secure place at all times and the computer data will also be protected from intrusion. The audio tapes will be destroyed at the end of the study. Your response will be treated with full confidentiality and anyone who takes part in the research will be identified only as code numbers or false names. You can request a copy of the interview transcript if you wish. The interviews will be analysed by using Colazzis' Procedural Steps (1978) by the Researcher, Martina Harkin-Kelly. At the end of the research I will write a report and the results may be published in peer reviewed journals and conference presentations. No research participant will be identifiable from any publications. This study has been reviewed and approved by the Research Ethics Committee at Sligo General Hospital.

Please do not hesitate to contact me if you need further information

Martina Harkin-Kelly

Specialist Co-Ordinator

Centre of Nursing and Midwifery Education, Sligo/Leitrim

HSE West

Cregg House Campus

Rosses Point Rd

Co. Sligo

Email martinah.kelly@hse.ie

Work Number: (071) 917-7743
Personal mobile: (087) 7774799

Thanking you in anticipation,

Yours sincerely,

_____

Martina Harkin-Kelly

Appendix IV

Participant Reply Form

Martina Harkin-Kelly
CNME, Sligo/Leitrim
Cregg
Rosses Point Rd
Co. Sligo

Phone: (071) 917-7743
Mobile: (087) 7774799
Email: martinah.kelly@hse.ie

Dear Martina,

On reading your proposed research project information flyer, I am interested in participating in the focus group interviews scheduled between Nov 2009 and Feb 2010. I will be attending a CPD Course on _____ or available in the designated clinical area on _____

Researcher use only

Code:_____

Name: _____

Contact Address (Home) (Work)

_____ _____

_____ _____

_____ _____

Contact Details (Home) _____ (Work) _____

(Mobile) _____

Please record your responses to the questions by ticking the appropriate box or space as requested.

1. Nationality: Irish ☐ Other ☐

Other (please specify) _____

2. Age: Less than 30 yrs ☐ 30 – 35 yrs ☐

36 - 40 yrs ☐ 41 – 45 yrs ☐

46 – 50 yrs ☐ 50+ ☐

3. Gender: Male ☐ Female ☐

4. Professional Qualifications

RGN ☐ RNMH ☐

RPN ☐ RSCN ☐

RNT ☐ RM ☐

Other (please specify) _____

5. Academic Qualifications

Certificate ☐ Diploma ☐

Degree ☐ Higher Dip ☐

Masters ☐ Doctorate ☐

6. How long have you worked in the clinical area

< 5 yrs ☐ 5 - 10 yrs ☐

11 – 15 yrs ☐ 16 – 20 yrs ☐

21 – 25 yrs ☐ 26 – 30 yrs ☐

30 + ☐

7. Have you received training on cultural issues?

Yes ☐ No ☐

If Yes (please specify)

_____

_____

_____

8. Would you be aware of any Cultural Care Models in Nursing?

Yes ☐ No ☐

If Yes (please specify)

_____

_____

_____

_____

9. Have you ever worked outside of Ireland?

Yes ☐ No ☐

If Yes (please specify)

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire. Your assistance in providing this information is very much appreciated.

Martina

Appendix V

American Nurse Association

Ethical Guidelines

- Respects autonomous research participants' capacity to consent to participate in the research and to determine the degree of that participation without negative consequence
- Provides all necessary information to enable the participants to execute the decision to participate or not
- Prevents/minimises harm and/or promotes good to all research participants
- Protects the privacy of research participants to the maximum degree possible
- Ensures the ethical integrity of the research process by the use of appropriate checks and balances throughout the conduct, dissemination and implementation of the research
- Reports suspected, alleged or known incidents of scientific misconduct
- Maintains competency in the subject matter and methodologies of his/her research field

Source: Adapted from

Polit, D. F. & Beck, C. T. (2004) Nursing Research Principles & Methods p 144 Philadelphia: Lippincott

Appendix VI

Consent Form

Thank you for your willingness to participate in this research project entitled *"A Phenomenological Examination of Qualified Nurse perception, meaning and experience of culture working in the HSE, West"*. Before we commence this interview I would like to reassure you that as a participant you have very definite rights.

Your participation in this Focus Group Interview is entirely voluntary and you are free to withdraw from the interview at any time.

Excerpts of this focus group may form part of the final research study and as such a transcript may be included as an appendix, however under no circumstance will your name or identifying characteristics be revealed. Confidentiality will be maintained at all times.

I would be grateful if you would sign this form as consent to your participation in this focus group.

Researcher: _____ Date: _____

Participant: _____ Date: _____

Appendix VII

Pilot FGI Guide

Key thought; How will the Researcher/Interviewer ensure that the questions achieve the goal of the Research Project?

The Key Goal; Gain insight into how nurses perceive, understand and experience culture.

The Researcher/Interviewer will be guided by the Facilitator Guidelines adapted from Vince Ramporgus (1995) **The Deconstruction of Nursing.** (See Table 1 – Methodology Chapter).

The following questioning format adheres to the Hawaiian Principle – this is the *"...funnelling concept"* with the discussion moving from the broad to the narrow i.e. general to the specific (Krueger & Casey, 2000, p 62).

The Researcher/Interviewer has made a conscious decision not to use *"why"* questions as these present problems i.e. the participants feel that they are being interrogated. Krueger & Casey (2000, p 59) refer to this and suggest that *"...when asked why, respondents feel like they should have a rational answer appropriate to the situation"*. The answer is therefore intellectualised and comes from the brain and not from the deeper forces which underlie behaviour. The Researcher/Interviewer is fearful that true feelings and attitudes will not be elicited which is the essence of Phenomenology enquiry. As Krueger & Casey (2000) caution that if *"why"* questions are to be utilised they should be specific

FGI [ ] **Date; [/ /]** **Venue;**

Ice Breaker Q's	**Interviewer Notes**
1. I'd like everyone to introduce yourselves and say what your current role is?	
2. How do you **identify** yourself?	
Key Q's (Culture)	
3. What is your understanding of the term **culture** / what comes to mind when you hear the term culture?	Culture essential to know understand and serve people Leininger (1995).
4. How would you describe your **own culture**?	*Respondents are likely to talk about being Irish from their own experiences*
5. Do you remember when you first became aware of **your culture**?	*Here I may expect to hear about being Irish, and perhaps traditional identifiers of Irishness, or perhaps participants may talk about being abroad and what they felt Irishness was in comparison to other cultures*
6. What is your understanding of **Irish Culture**?	*Expecting a more general discussion on what being Irish means*
7. Do you think Ireland is a **multicultural society**?	*The response here is likely to say yes, it has become more multicultural*
8. What **personal issues/experiences** have arisen for you as part of a multicultural society?	*Here I should hear about the physical, psychological, social and spiritual differences e.g. food, prayer, dying, gender differences, communication, language…*
9. What **professional issues/experiences** does living in a multicultural society raise for you?	*Similar to above but should focus on working with other cultures need to ensure that there is a **clear separation between Q above and this Q.***

Key Q's (Nursing Culture)	
10. Is there a **culture in Nursing**?	
12. What is really important to you **as** a nurse – **beliefs** are **core to being a nurse** are **these of** any **benefit when caring for** individuals with **different cultural needs**?	
13. Are you aware of any **Cultural Care Models** in Nursing?	May or may not demonstrate awareness this would give weight to the need for education some models are outlined below (Papadopoulos et al, 2004; Camphina-Bacote, 2002; Leininger, 1995)
14. Have you had **clinical experience of caring for or working with other cultures**?	
15. How did you **feel caring for or working with different cultures**?	
16. What issues have arisen for you in **working with professionals** from different cultures?	
17. Have you been **supported by the HSE** in dealing with **cultural diversity** in your work?	*I should hear about initiatives/strategies undertaken by the HSE to support people in culturally competent practice*
18. If you do not feel supported what has **hindered** you within the HSE?	

19. I'd like to share with you a summary definition of racism by the UN- I will circulate it to you on the page here; please take a minute to read it, I will read it aloud. Do you think that **distinctions, and exclusions or restrictions (Racism) on the basis of people's ethnicity, skin colour nationality, occur/exist in the HSE?**	*'The term "racial discrimination" shall mean* Any distinction, exclusion, restriction or preference based on 'race', colour, descent, national or ethnic origin which nullifies or impairs the recognition and exercise of peoples human rights and fundamental freedoms, in the political, economic, social, cultural or any other field of public life (e.g.: education / health services), on an equal footing with others. Summary: Definition used by the U.N International Convention on the Elimination of all Forms of Racial Discrimination
20. Do you adhere **to culturally sensitive practices** in your work? Can you give some examples?	
21. Are these **practices within** or **outside** of **your control**?	
22. Do you think your **skill in culturally competent practice** has developed over the years or not?	
23. Do you have any further **suggestions** on how better to **address cultural competence** among nurses?	

Closing Questions	
Allow the Assistant Moderator to Recap on what was said. Then ask the Participants if this reflects what was said.	
24. Is there anything you would like to add at this stage?	
The following questions are for the use in the Pilot only	
25. Anything I should have talked about but didn't?	
26. Any areas for improvements?	

The term "racial discrimination" shall mean;

Any distinction, exclusion, restriction or preference based on 'race', colour, descent, national or ethnic origin which nullifies or impairs the recognition and exercise of peoples human rights and fundamental freedoms, in the political, economic, social, cultural or any other field of public life (e.g.: education / health services), on an equal footing with others.

Summary: Definition used by the UN International Convention on the Elimination of all Forms of Racial Discrimination

Appendix VIII

FGI Guide

Key thought; How will the Researcher/Interviewer ensure that the questions achieve the goal of the Research Project?

The Key Goal; Gain insight into how nurses perceive, understand and experience culture.

The Researcher/Interviewer will be guided by the Facilitator Guidelines adapted from Vince Ramporgus (1995) **The Deconstruction of Nursing.** (See Table 1 – Methodology Chapter).

The following questioning format adheres to the Hawaiian Principle – this is the *"...funnelling concept"* with the discussion moving from the broad to the narrow i.e. general to the specific (Krueger & Casey, 2000, p 62).

The Researcher/Interviewer has made a conscious decision not to use *"why"* questions as these present problems i.e. the participants feel that they are being interrogated. Krueger & Casey (2000, p 59) refer to this and suggest that *"...when asked why, respondents feel like they should have a rational answer appropriate to the situation"*. The answer is therefore intellectualised and comes from the brain and not from the deeper forces which underlie behaviour. The Researcher/Interviewer is fearful that true feelings and attitudes will not be elicited which is the essence of Phenomenology enquiry. As Krueger & Casey (2000) caution that if *"why"* questions are to be utilised they should be specific

FGI [ ] Date; [/ /] Venue;

Ice Breaker Q's	**Interviewer Notes**
1. I'd like everyone to introduce yourselves and say what your current role is?	
2. Outside of the work setting how are you **identified** by yourself and others?	
Key Q's (Culture)	
3. What comes to mind when you hear the term **culture**?	Culture essential to know understand and serve people Leininger (1995).
4. What is your understanding of **Irish Culture**?	*Expecting a more general discussion on what being Irish means*
5. Do you remember when you first became aware of **your culture**?	*Here I may expect to hear about being Irish, and perhaps traditional identifiers of Irishness, or perhaps participants may talk about being abroad and what they felt Irishness was in comparison to other cultures*
6. Do you think Ireland is a **multicultural society**?	*The response here is likely to say yes, it has become more multicultural*
7. What **personal issues/experiences** have arisen for you as part of a multicultural society?	*Here I should hear about the physical, psychological, social and spiritual differences e.g. food, prayer, dying, gender differences, communication, language…*
	*Similar to above but should focus on working with other cultures need to ensure that there is a **clear separation between Q above and this Q.***

Key Q's (Nursing Culture)	
8. Tell me what is your understanding of **Nursing Culture**?	
9. Have you had **clinical experience of caring for or working with other diverse cultures**?	
10. How did you **feel caring for or working with different cultures**?	
11. What **professional issues/experiences** have arisen for you when **working with** individuals from different cultures?	
12. Do you feel that there are **racial attitudes** among colleagues in the workplace?	
13. Are you **supported by the HSE** in dealing with **cultural diversity** in your work?	*I should hear about initiatives/strategies undertaken by the HSE to support people in culturally competent practice*
14. If you do not feel supported what has **hindered** you within the HSE?	
15. Do you adhere **to culturally sensitive practices** in your work? Can you give some examples?	
16. Are these **practices within** or **outside** of **your control**?	
17. Do you think your **skill in culturally competent practice**	

has developed over the years or not?	
18. Do you have any further **suggestions** on how better to **address cultural competence** among nurses?	

Closing Questions	
Allow the Assistant Moderator to Recap on what was said. Then ask the Participants if this reflects what was said.	
19. Is there anything you would like to add at this stage?	

Appendix IX

Colaizzis' Procedural Steps (1978)

1. All interviews are transcribed verbatim, read and re read all protocols to get a feel for the data
2. Extract significant statements
3. Spell out the meaning of each significant statement
4. Organise significant statements into clusters of themes, and refer back to original protocols, do not ignore data that do not fit
5. Use the themes extracted to describe what is being studied i.e. the phenomenon
6. Formulate a description of the phenomenon under study
7. As a final validating step return the description to the participants and ask them about the findings thus far

Source: Adapted from

Polit, D. F. & Beck, C. T. (2004) Nursing Research Principles & Methods p 585 Philadelphia: Lippincott

Appendix X

Letter to Participants Validating Verbatim Transcripts

Title of Research Study:

"A Phenomenological examination of qualified nurses perception, meaning and experience of culture working in the HSE, West."

Validation of transcripts from data gathering

Date: _____

Dear _____

I have enclosed the Verbatim Transcript from your Focus Group Interview so that you can review it. When reading through the transcript please do not correct grammatical errors as it is the description of the experience the meaning and feelings inherent in your statements that is critical. The transcript is all about the telling of your story. In particular read the statements made by you and if you feel that information is unclear, omitted or has been misunderstood please feel free to add comments in the blank right hand column that will further elaborate your experience. If you are satisfied with the transcript this will be indicated by the fact that you have made no comments.

When you have completed the edit please place and seal the transcript in the envelope provided and I will contact you on June 30th 2010 in order to collect same. At this time I would like to thank you for participating and sharing your experiences so openly in the Focus Groups without which this research study would not be possible. If you have any further questions about the study do not hesitate to contact me my contact details are outlined below.

Kind Regards

Martina Harkin-Kelly; Mobile: (087 7774799); email: martinah.kelly@hse.ie

APPENDIX XI

Research Title:

A Phenomenological Examination of Qualified Nurses perception, meaning and experience of culture working in the HSE West.

SIX STAGE APPROACH - RESEARCH TIMEFRAME

Legend:

- Stage 1
- Stage 2 A: Preparing the Proposal
- Stage 2 B: Awaiting Approval
- Proposal Submission
- Doing: Registration
- Stage 3: Extensive Literature Review/Methodology/Questionnaire Dev/Pilot
- Stage 4: Writing the Research Paper*
- Stage 5: Revising, reviewing and submission to the Internal Examiner
- Stage 6

Note

* The Researcher intends to take leave for this period

Source: Adapted from

APPENDIX XII

Research Study - Resource Plan

Human Resource Requirements		
		Totals
Researcher unpaid Leave x 2 months	€10,300	
Administrative Support (Grade III) x 4 weeks	€1,800	
Participant Incentives	€300	
		€12,400
Material Resource Requirements		
College Fees	€6,500	
Personal Computer	€2,000	
A4 Paper x 5 Reams	€75	
Postits x 5 Pack	€10.00	
Photocopying	€120	
Ink Cartlidges x 4 Colour	€80	
Highlighter Pens x 15	€15	
Flash Drive/Disco x 1	€56	
Audio Cassette Recorder x 1	€90	
Audio Tapes x 6	€25.00	
Phone usage	€150	
Verbatim Typing	€1,000	
Storage (Transfer Files) x 10 Pack	€57	
Printing & Binding of Thesis(Approx)	€500	
		€10,678
		€23,078
Annual Inflation Rate of 5%		**€1,155**
Overall approx cost		€24,233

Note:	This is an estimated resource plan for the 2 Year Academic Project The Author also intends to make use of the Endnote referencing management system The source of the prices outlined above is Sligo Supply Centre (2006) Office Supplies Catalogues, Buyers Guide