UNIVERSITY OF CALGARY

Lived Experience of Cross-Cultural Nurses: A Phenomenological Study

by

Sonya Joy Grypma

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

CALGARY, ALBERTA

JANUARY, 2001

ABSTRACT

The purpose of this thesis is to explore the phenomenon of caring as experienced by cross-cultural nurses, using van Manen's (1997) approach to phenomenology. The goal of this study is not to define cross-cultural caring, but rather, to describe the lived experience of cross-cultural nurses while simultaneously considering the question, "How might *this* be caring?"

Data was primarily collected via in-depth interviews with six cross-cultural nurses, and also included: participant observation for 2 weeks in Guyana; a review of over 50 published first-person narratives; and non-linguistic data in the form of photos and artwork. Data was analyzed according to van Manen's interpretive approach.

Three forms of caring emerged from the study: Caring as Connection ("touching of souls"; confronting barriers such as racism), Caring as Competence ([non]risk taking; finding a way despite being unprepared and unguided), and Caring as Fostering a Relationship with God (promoting Shalom).

ACKNOWLEDGEMENTS

I wish to express my gratitude to the Research and Scholarly Development Committee of the Faculty of Nursing at the University of Calgary for providing me with a Master's Student Thesis Grant to assist me with this study.

I wish to acknowledge the support and encouragement offered by my colleagues at the University of Lethbridge along the way. In particular I wish to thank Dr. Judith Kulig who has generously shared her transcultural knowledge, experience... and library!

Thank you to Dr. Marjorie McIntyre and Dr. Geertje Boschma for asking difficult questions and then providing me with freedom and resources to continue exploring.

Most of all, I would like to thank my supervisor, Dr. Beverly Anderson for her confidence in my work, her uncanny ability to point me to just the right resources, and her living example of both competent and compassionate nursing practice.

DEDICATION

To my husband Martin: For seeing the doors and then holding them open.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

CHAPTER ONE:

BEGINNINGS

If a man will begin with certainties, he shall end in doubts;
but if he is content to begin with doubts, he shall end with certainties.

Francis Bacon, (1561 – 1626) Oxford Dictionary of Quotations

NANCY - (in Guatemala)

From our bus window we see
the six year old and her parents
walking home on this deserted dirt road.

And I remember this morning
when she arrived at our clinic
screaming from the pain of her burns
after a 2 day journey from their village
carried in her father's arms.

And it dawns on me:
We advised them
to return daily for her dressing change.

PURPOSE OF STUDY

What is it like to nurse in a cross-cultural setting where one does not intuitively understand local social norms or nursing practice norms? What is it like to step out of one's cultural comfort zone to attend to the perceived suffering of others? That is, *What is the lived experience of caring in cross-cultural nursing?*

The purpose of this thesis is to explore the phenomenon of caring as experienced by cross-cultural nurses, using Van Manen's (1997) approach to phenomenological inquiry. My preliminary understanding of "caring" is related to the gothic root "Kara", meaning to lament with or feel another's pain (Blockley, 1997). This initial understanding of "caring" is based on the premise that nursing as a profession exists with and for suffering (to prevent, alleviate or help find meaning in human suffering). Thus, to "care" may be to connect with patients in a deeply meaningful way (Chinn, 1994). It is expected that new understandings of the phenomenon of caring as it relates to cross-cultural nursing practice will emerge during the study.

Other terms used in this study included "culture" and "cross-cultural nursing" "Culture" refers to the values, beliefs and customs shared by a group and passed from one generation to the next (Spector, 1996). "Cross-cultural nursing" occurs when a nurse identifying with one culture enters into a nursing relationship with a member of a foreign culture, most obviously by leaving his/her community of origin to practice nursing in an unfamiliar geographic setting.

The goal of this study has been neither to theorize about (van Manen, 1997) nor to consider causal accounts of the phenomenon (Munhall & Oiler Boyd, 1993). Rather, it is hoped that the revealed insights will extend current understanding of caring and cross-cultural nursing, and be useful for developing nursing theory and education.

AUTHOR'S CALL

My own experiences as a Caucasian outpost nurse on a remote First Nations reservation and as a short-term project nurse on two occasions in Uganda animate my own desire to better understand caring in cross-cultural nursing. As a nurse without undergraduate transcultural education working in cross-cultural settings, I feared I would unwittingly harm clients. This concern motivated me to seek knowledge regarding various cultural values and beliefs. My knowledge base was expanded in part by carefully listening to and observing the culturally diverse individuals around me. The community members responded to my genuine interest in them, and I experienced meaningful nursing interactions, ones that involved authentic interpersonal connection. I reflected on the inter-relatedness of caring and spirituality, where being in meaningful relation is understood both as a spiritual necessity and as the essence of nursing caring (Chinn, 1994;

Roach, 1997; Tournier, 1986). I wondered how important meaningful relationship is to the development of effective and satisfying cross-cultural nurse-client encounters. Drawing near to culturally different others has inspired and deeply satisfied me. I wonder whether "caring" as I have understood it is a significant aspect of other's practice.

SIGNIFICANCE OF STUDY

We live in an unprecedented period of human history where global interaction is more accessible than ever before because of advances in communication and transportation technology. Canadian nurses have opportunity to instantaneously correspond with nurses from practically anyplace in the world via the Internet. We are exposed to media images of life in other cultures. We have opportunities to fly to previously inaccessible regions of our own country and of the world. Canadians continue to welcome new immigrants into our own country. In short, nurses have increasing opportunity to interface with members of other cultures both at home and abroad. As a result, nurses and nurse educators are expected to be culturally competent in their prospective roles (Andrews, 1992, Canadian Nurses Association, 1997, Canadian Public Health Association, 1990; Princeton, 1993). Although there is a current thrust to internationalize higher education in Canada, very little is happening in nursing programs with regard to curriculum in international health (Ogilvie & Paul, 1999). By illuminating the practice wisdom of cross-cultural nurses, I hope to generate new and current knowledge appropriate for use in developing nursing curriculum and, ultimately, for preparing Canadian nurses for work among the culturally diverse.

SENSITIZING FRAMEWORK: Caring in Cross-Cultural Nursing

You may gain the finest effects in language by the skillful setting which makes a well-known word new.

Horace, 65 – 8 BC Oxford Dictionary of Quotations

At times I have regretted my choice of the word "caring" as a phenomenon to study. Some participants associate "caring" with "compassion" but seemed impatient with the term, as if to say, "yes - but that is not *all*!" I too have grown weary of the seeming ambiguity of the term "caring". I identify with Carla, a participant, who said:

"...I'm incredibly tired of people who throw the word [caring] around and you know, our electricians are caring, our plumbers are caring, doctors are caring and, you know, nurses are caring and we are a little bit more arrogant. We believe we've invented the word and that causes lots of problems. So, having said that, what really is caring?"

Indeed, *what really is caring*? Nurses are providers of nursing care, health care and physical care. We use the slogan "Nurses care" on buttons. Caring may be something we *are* (a quality), something we *feel* (an experience) and/or something we *do* (an action).

While we may have difficulty explaining what caring *is*, we recognize it's presence and it's absence. To *not care*, or to *care less* somehow means to be a less competent practitioner of nursing. More care suggests more competence. Quality-nursing practice is in part evaluated by the sheer existence of care and in part by the intensity of care. But this still does not define what caring *is* as a phenomenon of cross-cultural nursing practice.

My assumption is that caring not only *exists* in cross-cultural nursing practice but that it is somehow *essential* to it. I do not propose to deliver a definitive answer to the question "What is caring?" Rather, I aim to describe the lived experience of cross-cultural nurses while simultaneously asking the question "How might *this* be caring?" The purpose

of this study is to describe rather than to define the phenomenon of caring in cross-cultural nursing. By teasing out "caring" from the lived experience of cross-cultural nursing, I hope to open up new possibilities for understanding this "worn-out" concept.

I began this study with a number of assumptions. First I assumed that "to care" involves compassion and meaningful connection, and that effective cross-cultural nursing is born of a desire to connect meaningfully with others, regardless of differences of ethnicity, values, or social status. Second, I assumed that, along with preventing and alleviating suffering, nursing is concerned with patient's meaning-finding in suffering.. Thirdly, I assumed that nurses in cross-cultural settings are vulnerable in their exposure to environmental dangers and that this vulnerability increases their ability to care by diminishing barriers between themselves and patients.

Finally, and perhaps most significantly, I recognize that my Christian values, beliefs and assumptions influence my attraction to particular themes, my interpretation of the participant's experiences, and my decisions about what will be included in the final text. I struggle with whether it is necessary or appropriate to identify my allegiance to a particular religious worldview here. My hesitation stems from my fear that, by categorizing myself as "Christian", it may be presumed by the reader that I am involuntarily – or perhaps deliberately – choosing a predictable or even narrowly defined interpretation of human lived experience. There is a tension involved with desiring to reveal enough about myself to be helpful to the reader (to not leave lingering questions unresolved), yet not wishing to close down possibilities for conversations and new understandings of the phenomenon. Thus, as I attempt to overcome subjective feelings,

preferences, inclinations, or expectations that would prevent me from more fully understanding the phenomenon as experienced by others (van Manen, 1997), I trust the reader to do the same.

EPILOGUE

The opportunity for nurses to interact with members of diverse cultures around the globe is growing with advances in communication and travel. Nurses are increasingly expected to be culturally competent in their practice. Illuminating nursing wisdom imbedded in cross-cultural practice may bring us closer to a critical understanding of the place of caring in effective practice, and give a phenomenological baseline upon which to base further cross-cultural research and nursing education.

CHAPTER TWO:

EXISTING NURSING KNOWLEDGE

When we think we lead,
We are most led.

Lord Byron (1788 – 1824), Oxford Dictionary of Quotations

THEORETICAL CONTEXT FOR STUDY: Cultural Competence and Caring

An increase in the population of non-dominant cultural groups in North America over the past two decades has catalyzed unprecedented attention to transcultural issues in nursing (Andrews, 1992; Grossman, 1994; Outlaw, 1994; Rodriquez-Wargo, 1993; Talabere, 1996). Nurses are expected to be culturally competent in their practice and nurse educators are expected to provide culturally competent education (American Academy of Nurses [AAN]1992; Andrews, 1992; Canadian Nurses Association [CNA], 1997; Canadian Public Health Association [CPHA], 1990; Princeton, 1993). Yet, current nursing education is considered by both practicing nurses and policymakers to be inadequate for transcultural preparation (Murphy & Clark, 1993, Princeton, 1993, Reimer-Kirkham, 1998). The AAN Expert Panel on Culturally Competent Care identifies "[t]he development of knowledge and policies related to culturally sensitive and competent care [as] one of the vitally important areas, if not the most significant in the 1990's..."(1992, p. 278). There is a similar call to Canadian nurse academics to be culturally relevant in the new millennium (Ogilvie & Paul, 1999).

Ogilvie and Paul (1999) from the University of Alberta conducted a survey of university nursing programs to discern the degree of internationalization apparent in higher education in Canada. They discovered that, during the year of the survey (1996 – 1997), many faculties were engaged in international activities but that these were fragmented with little systematic planning or framing. They identified an "enormous potential for meaningful engagement of Canadian schools of nursing in internationalization initiatives" (p. 59). They highlight some key points about academic nursing in the United States as

noted by Keteflan and Redman (1997), urging Canadian academics to "take note" that, despite increasing cultural diversity and global awareness in the U.S., and despite the increase of internationalization in nursing activities (consultation, collaboration and exchanges), "nursing theory, research, education and practice has not changed appreciably to be globally relevant" (p. 60). Ogilvie and Paul conclude that Canadian nurse academics are obligated to make nursing programs relevant to the global community.

It is clear that nurses in the new millennium need to be culturally competent. However, present usage of the term "cultural competence" seems inconsistent (with differing emphases) and incomplete (i.e., "caring" is not identified as a relevant construct). Leininger originated the term cultural competence as part of her theory of Culture Care Diversity and Universality (Leininger, 1994). Nurse authors have since described cultural competence as an ideal characteristic of nurses, nursing agencies and nursing practice. Culturally competent *nurses* attain qualities such as a sensitive attitude, self-awareness, knowledge base of particular cultural groups, and an ability to complete a cultural assessment (AAN, 1992; Campinha-Bacote, 1998; DeSantis, 1994, Grossman, 1994). Culturally competent *nursing agencies* endorse policies that are sensitive to diverse cultural practices (Cross, Bazron, Dennis & Isaacs, 1989 in Campinha-Bacote, 1995). Culturally competent *nursing practice* is congruent with the clients's perceptions of their own needs (AAN, 1992; Cross, et al, 1989; Leininger, 1994; Talabere, 1996). But, do nurses with culturally competent qualities, who are working in culturally competent agencies that are providing culturally competent care, necessarily connect meaningfully with their patients? Where is *caring* in discussions of cultural competence?

There is little doubt that cultural competence as a concept lends direction to policymaking and curriculum development. In fact, nurse educators have used Campinha-Bacote's Culturally Competency Model of Care (1998) in planning and implementing transcultural courses (Grypma, 1999; Hadwiger & Hadwiger, 1998). In her model, Campinha-Bacote conceptualizes cultural competence as a *process* that involves the ongoing development of cultural knowledge (education foundation regarding various worldviews); cultural skill (ability to conduct a cultural assessment); cultural awareness (cultural sensitivity and self-awareness); and cultural encounters (direct cross-cultural interactions). As a framework for education strategies, Campinha-Bacote's model is attractive. Four questions arise in its implementation, however:

(1) Can cultural competence be reduced to distinct and consistent categories?

(2) Since it is possible for nurses to have developed cultural skills and cultural knowledge without having cultural awareness (as reported by Pope-Davis et al in their 1994 study of 120 undergraduate nursing students' self-reported cultural competency), is Camphina-Bacote's model "enough" for effective, fully engaged nursing practice?

(3) Are discussions of cultural competence in North American settings, where nurses tend to be from the dominant culture, transferable or even relevant to geographic and cultural settings where the nurse herself is the cultural outsider?

(4) Finally, and most significantly for this study, *How does the concept of cultural competency fit with an understanding of nursing as involving the prevention, alleviation, or meaning finding in suffering?* I believe that caring exists in cross-cultural practice and that studying practice as a lived experience can elucidate this elusive phenomenon.

While nursing researchers have tried to measure cultural competence and efficacy (Alpers & Zoucha, 1996; Bernal & Froman, 1987; Bernal & Froman, 1993; Hayes, Quine & Bush, 1994; Kulwicki & Bolinik, 1996; Pope-Davis, Eliason & Ottavi, 1994; Rooda, 1993), few have explored the lived experiences of nurses working with culturally different clients (Butrin, 1992; Murphy & Clark, 1993; Reimer-Kirkham, 1998; Smith, 1994). In Smith's (1994) phenomenological study of 10 white nurse practitioners caring for predominantly African American families in a rural setting, the nurses, rather than focusing on the client's characteristics, emphasized being with the client in a genuine way – in a way that *transcended* culture.

Similarly, Butrin's (1992) phenomenological study of 15 American nurse practitioner students and public health nurses found that the care in nurse-client dyads *transcended* culture. In both studies, nurses valued meaningful connection between themselves and culturally dissimilar clients.

All four studies of nurses' lived experience (Butrin, 1992; Murphy & Clark, 1993; Reimer-Kirkham, 1998; Smith, 1994) centered on nurses working in their home country. This indicates a need for research about the lived experience of caring in the practice of cross-cultural nurses. As nursing curriculum is being reviewed and revised to integrate transcultural nursing concepts, the need to study actual nursing practice to uncover the knowledge imbedded there seems critical.

CHAPTER THREE:

DESIGN AND METHODS

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And to know the place for the first time.

T.S. Eliot, The Four Quartets

PHILOSOPHICAL AND THEORETICAL PREMISES

Phenomenological research is the study of lived experience of the world as we immediately experience it rather than as we conceptualize, categorize or theorize about it (van Manen, 1984). Much research has been done in nursing over the past 25 years that did not originate within a nursing or patient context (Munhall & Oiler Boyd, 1993). Rather, research and subsequent theory development was largely influenced by non-nursing disciplines, and the positivistic philosophy and language congruent with these other disciplines were adopted into nursing (Munhall & Oiler Boyd, 1993). Presently, nursing researchers are valuing and incorporating qualitative methods of discovery through description and analysis of nursing phenomenon derived from nurses' and clients' lived experiences in client situations (Munhall & Oiler Boyd, 1993).

Phenomenology is a useful research methodology to study the meaning of elusive phenomena within the lived experience of cross-cultural nurses because phenomenology aims to come to a deeper understanding of our everyday experiences – to establish a renewed contact with original (pre-reflective) experience in order to illuminate and understand that which is normally hidden and intangible (van Manen, 1984)

METHODOLOGICAL STRATEGIES for data collection & analysis

The goal of phenomenology-as-method described by van Manen (1997) is to evoke understandings of phenomenon (lived experiences) through language. In keeping with the discovery orientation of phenomenology, I did not commence data collection with a precise and fixed methodology. Rather, I attempted to don a "phenomenological attitude" and attend to five methodological "themes" described by van Manen (1997).

Phenomenological Attitude

Human science research is the activity of explicating meaning. The human science researcher is "a sensitive observer of everyday life, and an avid reader of relevant texts in the human science tradition of the humanities, history, philosophy, anthropology and the social sciences as they pertain to his or her domain of interest" (van Manen, 1997, p. 29). Thus, I attempt to be a self-directed learner who lives phenomenologically – always open to learning, a keen reader and a curious observer.

Theme one: Turning to the nature of lived experience

As the researcher, it is appropriate that I am animated by a deep and personal desire to know or better understand the experience of cross-cultural nursing – as related to my first-hand experience with the phenomenon (van Manen, 1999) For this study, but also for myself, I ask, "What is cross-cultural nursing?" "What is it like to nurse cross-culturally?" "How is *this* caring in cross-cultural nursing?" While understanding caring in cross-cultural nursing has important implications for nursing praxis, a personal desire to understand draws me to this phenomenon.

Theme two: Investigating experience as we live it

During the data collection phase I traveled for two weeks to Guyana, South America, with one of my participants (Vicki) to act as a participant observer of her international nurse consulting practice. While my purpose was not specifically to collect data for this study, it was an opportunity to experience again what it is like to *be* a cross-cultural nurse. This experience gives me a significant contextual understanding of the lived experiences described by the participants.

My main strategy for data gathering was through open-ended interview of the participants, starting with the orienting request to "Tell me about an experience of nursing cross-culturally that stands out for you". Succeeding questions were developed based on the participant's answers, but always within the context of the question of what is the nature of the lived experience of cross-cultural nursing, and with an orientation to the question "What in this experience illuminates cross-cultural caring?" Second interviews re-visited themes emerging from the first interviews and were used to explore particular findings in more depth.

I paid close attention to the language used by the participants in the study. Terms and idiomatic phrases such as "calling" and "prompted by the Holy Spirit", "connection with a patient"; "risk-taker"; "heart-wrenching"; and "spiritual health" emerged from the data. I believe these have interpretive significance and so I reflected on them by myself, as well as with some of the participants.

I continue to encounter cross-cultural nursing phenomena - as I listen to a journalist describing his experience with relief workers in Bosnia, as I browse through bookstore paperback novels, and as I read letters from friends working overseas. I invite international students over for dinner and try to imagine what it is for *them* to be living cross-culturally. At one point during the study, I received a package from a participant working in Africa. She had trouble thinking of stories to share with me, so graciously sent a pile of first-person narratives from other nurses. I began to read, then saw a note written across the top of the pages saying: "human interest stories". I wondered if these anecdotes were written by the nurses to share with congregations and sponsoring

agencies. The stories are intriguing tales of extraordinary events. They are helpful "sound bytes" for an audience wishing to hear that their sponsorship is making a dramatic difference in the lives of the poor and oppressed. While that which is extraordinary is, well, interesting, I found that what attracts me more is that which is *between* the lines of nursing stories. 'Not just that the nurse brought a child to a hospital for successful treatment of a severe burns, but that she had to sit backwards on her knees during the 4 hour trip over dirt roads because the incessant bumping hurt her tailbone; that she had nothing to eat; that she found the child's persistent crying aggravating. That is, I am especially interested in the *ordinary* lived experience of cross-cultural nursing.

In pursuing a deeper understanding of cross-cultural work, I found myself struck at inconvenient times with nagging ideas: I wrote notes on MasterCard receipts, on my plane ticket, on my hand. I considered the effect of the Internet on cross-cultural work as I emailed participants in Africa, Guyana and the UK. I jotted down ideas as I fell asleep. I knew that I would not capture it all, but cast my net as wide and deep as I could.

Theme three: Reflecting on essential themes

The purpose of phenomenological reflection is to "try to grasp the essential meaning of something" (van Manen, 1997, p. 77). Because the meaning of a phenomenon is expected to be multidimensional (and difficult to explicate in a single definition), attempts to convey meaning are done textually – via organized narrative or prose. I reflectively analyzed the thematic aspects of the participant's (and my own) experiences. I read and re-read the interview transcripts and attempted to analyze them according to van Manen's "hermeneutic phenomenological reflection". Various themes were garnered from

the transcripts in an attempt to seek meaning, uncover thematic aspects, and isolate thematic statements. Narratives of some experiences were "linguistically transformed" into prose in an attempt to recover the evocative nature apparent in the "live" telling.

Artistic sources of data were also sought with the hope of gleaning thematic descriptions and to interpret meanings of these. I found six pieces of art where the artist was of another culture than the human subject(s). Photographs were also collected, and have been included with the epigraphs preceding each chapter.

First-person narratives of cross-cultural experiences by health care professionals (mostly nurses, some physicians) were collected and reviewed. Over fifty published narratives were accumulated and, while not as intensively analyzed as the interview data, were useful for comparative and illustrative purposes.

Once the themes were articulated, I determined the "essential themes" or meanings that are unique to cross-cultural nursing (without which the phenomenon could not be what it is). Identifying the essential themes lent direction to the creation of the final phenomenological text (research report) by providing a framework within which to discuss the most substantial findings (i.e. "Borders").

Theme four: Describing the phenomenon through the art of writing and rewriting

Phenomenological research is a form of writing. Creating a phenomenological text is the goal. Sensitivity to the undertone of language is important. The creativity of such writing may involve leaving some things unsaid to allow for a more reflective response. Anecdotes or stories are presented in the form of linguistic transformations (prose) in order to "compel; to lead us to reflect; to involve us personally; ...to transform...and to

measure one's interpretive sense [ability to make sense of meaning]...(van Manen, 1997, p. 121). Epigraphs preceding the chapters were chosen for their aptness in orientating the reader to the theme about to be explored.

Theme five: Maintaining a strong and oriented relation to the phenomenon

Maintaining a commitment to the study of the phenomenon is essential to phenomenology: van Manen warns that theoretical scholarship in [nursing] does not vouch for [transcultural] competence (1997). Abstracting and being removed from the "real world" of the lived experience of transcultural nursing risks losing the pre-reflective understanding of the phenomenon – the perceived value of which is the thrust of phenomenological inquiry. Thus, scholarliness is more likely ensured by ongoing concrete experiences with the phenomenon rather than theorizing about it. The opportunity to accompany Vicki to South America during the data collection phase was serendipitous in helping to maintain my commitment and orientation to cross-cultural nursing.

RESEARCH METHOD

Sample, setting and sources of data

Phenomenology-as-method must be considered to be tentative and flexible to allow for ongoing decision-making throughout interactions with research participants and through the discovery of the unforeseen (Munhall and Oiler Boyd, 1993). The aim of this study has been to explicate the pre-reflective experience of the phenomenon of caring in cross-cultural nursing practice. The goal has been to describe the lived experience of cross-cultural nurses with the hope that a clearer understanding of cross-cultural caring would emerge and add to the current understanding of these phenomena in nursing.

The primary source of data for this study was the transcripts of 10 interviews with 6 research participants. Participants were sought through a snowball strategy – by asking participants and nurse colleagues to identify other possible participants. I knew three of the participants prior to this study, colleagues identified two others, and I met the final participant at a conference where she introduced herself as a cross-cultural nurse.

Of the six cross-cultural nurses who participated in this study, one was a citizen of Japan, one of the United States, and four of Canada. The participants were not stationary and during the eight-month data collection phase many of them traveled, including to Africa (3 participants in 3 different countries), Guyana, Scotland and England. My priority was to conduct the interviews in person, so I traveled too. The 10 interviews took place in participants' (or their family member's) homes in two Albertan cities; in a hotel in Banff; in a university in Scotland; and on a garden terrace in Guyana. Field notes were written shortly after each interview.

The participants were chosen on the basis of inclusion criteria. 1) Participants must be nurses who have worked in communities ethnoculturally distinct from their own cultural heritage (i.e.: as "cultural outsiders"). 2) Participants must volunteer for the study. 3) Participants must be willing and able to articulate nursing experiences in these settings. 4) Participant's practice must be strongly oriented to cross-cultural nursing – they have recurring and ongoing cross-cultural experience. Efforts were made to recruit participant from more than one religious/philosophical perspective, and from more than one national perspective (i.e.. not just Western nurses). I found a number of potential participants in Guyana and Scotland, but only one met all of the criteria.

Four of the participants were interviewed twice. The American and Japanese participants were interviewed once because of logistical considerations (geographic distance). Follow-up for clarification was conducted mainly by email.

Complete demographic data was not collected on some of the participants, as not everyone was available for follow-up to clarify age and specific nursing experience. The ages were thus estimated or confirmed as: 20 - 29 (one); 40 – 49 (one); 50 – 59 (three); over 60 (one). The estimated or confirmed numbers of years in cross-cultural practice were: 3 years (one); 10 – 15 years (two); 25 – 30 years (three). The participants nursing roles in cross-cultural communities have included direct nursing care (five); teaching nursing or allied health students (three); administration (three) and consultation or collaboration (three): Some participants have experienced more than one role during their cross-cultural careers. Presently, the participants are: students (two: one post RN and one graduate student in public health); administrator (one); international nurse consultant (two); short-term project nurse (one)

Other data included over 50 published first-person narratives of nurses and physicians who have worked cross-culturally. These were obtained via CINAHL literature search (subject: transcultural nursing); via looking through archived copies of the Canadian Nurse journal, and by generally perusing newsletters I encountered in my personal mail and at nursing conferences.

Finally, I incorporated my own experiences as a participant observer in Guyana with Vicki. Data sources included my own daily journal and transcripts of one interview with Vicki.

Data Collection Procedures

Potential participants were contacted by email, telephone, or in person. The aim and methodology was explained verbally as well as on a written consent (see Appendix A). In general the first interview was arranged before the consent was signed, and the consent was explained in person immediately prior to the interview. In one case a consent form was not available at the interview, so *verbal* consent was obtained and tape-recorded. A consent form was subsequently mailed with the understanding that the first interview would be disregarded if items in the written consent were not congruent with the verbal consent requested. The signed consent was returned.

The purpose of the initial interview was to gather descriptive data around the phenomenon of cross-cultural nursing. The interviews were semi-structured and open-ended, with questions moving from the general to the particular (Munhall & Oiler Boyd, 1993). They were tape recorded and later transcribed by a professional transcriber. The researcher reviewed the transcripts for accuracy by reading them while listening to the tapes. Once corrections were made, the transcripts were deemed ready for analysis. A copy of the first interview transcripts was mailed or given directly to the participants in advance of the second interview in order to allow them to make corrections or clarify points, and to stimulate ideas for further discussion in the second interview. The researcher made every effort to review the first transcripts with the tapes prior to the second interview (i.e.: give the participants a corrected copy), but this was not always possible, in which case the participants reviewed an unedited draft of the transcripts.

Ethical Considerations

Ethical considerations were addressed based on the researcher's profound reverence for human beings and their experiences (Munhall & Oiler Boyd, 1993). Permission for the study was received from the participants, and ethical clearance was obtained from the University of Calgary Medical Bioethics Committee (Appendix B).

Freedom from harm was ensured by: 1) verbally explaining the study before obtaining signed consent; 2) seeking ongoing verbal consent for the study and continually reorienting the participant to the purposes of the interview and study process; 3) permitting withdrawal from the study at any point without repercussions; 4) ensuring confidentiality by using a code names on the transcripts and written data; 5) ensuring confidentiality by not naming specific communities when the participant preferred this; 6) not sharing the list of participants with others; 7) keeping the list of participants separate from the data generated in the study; 8) keeping all of the data in a locked cabinet accessible only to the researcher; 9) not using identifying factors in study reports or presentations; and 10) planning to destroy the data seven years after the study is completed. The second interviews provided a debriefing opportunity for the participants, and the researcher was accessible to the participants via email or phone for clarification throughout the study. Participants wishing to be more visible in the research process may take on a collaborative role in the study, possibly as co-presenters of the final research report at professional conferences.

It was recognized that in-depth exploration of highly personal areas might expose previously repressed fears and anxieties of the participants. This possibility heightened the

need for sensitivity on the part of the researcher. While a therapeutic relationship with the participants was not sought, the researcher recognized that the interpersonal nature of qualitative research may be perceived by the participants as beneficial – giving nurses an opportunity to share and reflect on their own stories, and to have their practice wisdom used in the development of cross-cultural nursing knowledge. Indeed, all six participants perceived a personal benefit from participating in the study because it gave them a rare opportunity to share their experiences in depth with someone genuinely interested and to reflect on their own practices and gain additional insight/ consider new ways to articulate their own work. The researcher offered to provide each participant with a copy of the final research report.

Data analysis

The goal of the analysis is to impose order on the raw data (Munhall & Oiler Boyd, 1993). The data generated was analyzed according to the five themes listed under Research Design above (van Manen, 1997). The textual data (transcripts, field notes) were subjected to a variety of strategies recommended by Munhall & Oiler Boyd to assist the researcher-as-instrument in sense-making of the data: The researcher 1) pondered the meaning of the data in parts and as a whole and on repeated occasions; 2) searched for repeated instances supporting interpretations; 3) reached for complex interpretations to account for variations; 4) related the findings to pre-existing knowledge. Non-textual data includes artwork created by artists from one culture depicting an aspect of life of a different culture. These were analyzed separately with the researcher interpreting and articulating themes represented there. Other non-textual data included photographs that

were deemed to be illustrative of the visual context rather than depicting particular themes that could be converted into the body of the research report. They are considered inspirational and are thus included in the final report without textual interpretation.

Provisions for Trustworthiness

Credibility (confidence in the truth of the data – Polit & Hungler, 1995) was addressed by viewing the participants as collaborators in the study. The participants were invited to review the transcripts of the first interview for accuracy and comment on developing themes for perceived approximation with their lived experiences. Also, some descriptions or preliminary data obtained from the participants was shared with other participants for them to reflect and comment on whether the descriptions resonated with their own experience (van Manen, 1997). In addition, themes encountered in the interview transcripts were compared with those found in participant observation, first-person narratives, and other textual data. Consistency of themes across various sources was considered as lending strength to the understanding of the phenomenon as a possible shared human experience (experienced by others as a recognizable phenomenon).

The "art of testing"(van Manen, 1997, p. 100) was utilized by sharing the first set of transcripts with a graduate hermeneutic phenomenology class at the University of Calgary Faculty of Nursing. Here the researcher discussed the preliminary data analysis and theme identification with other graduate nursing students and their professor to get a sense of whether the analysis was congruent with the transcripts. Serendipitously, new ideas were generated and new possibilities for understanding were stimulated through the discussion. In addition, the text was shared with the researcher's faculty advisor.

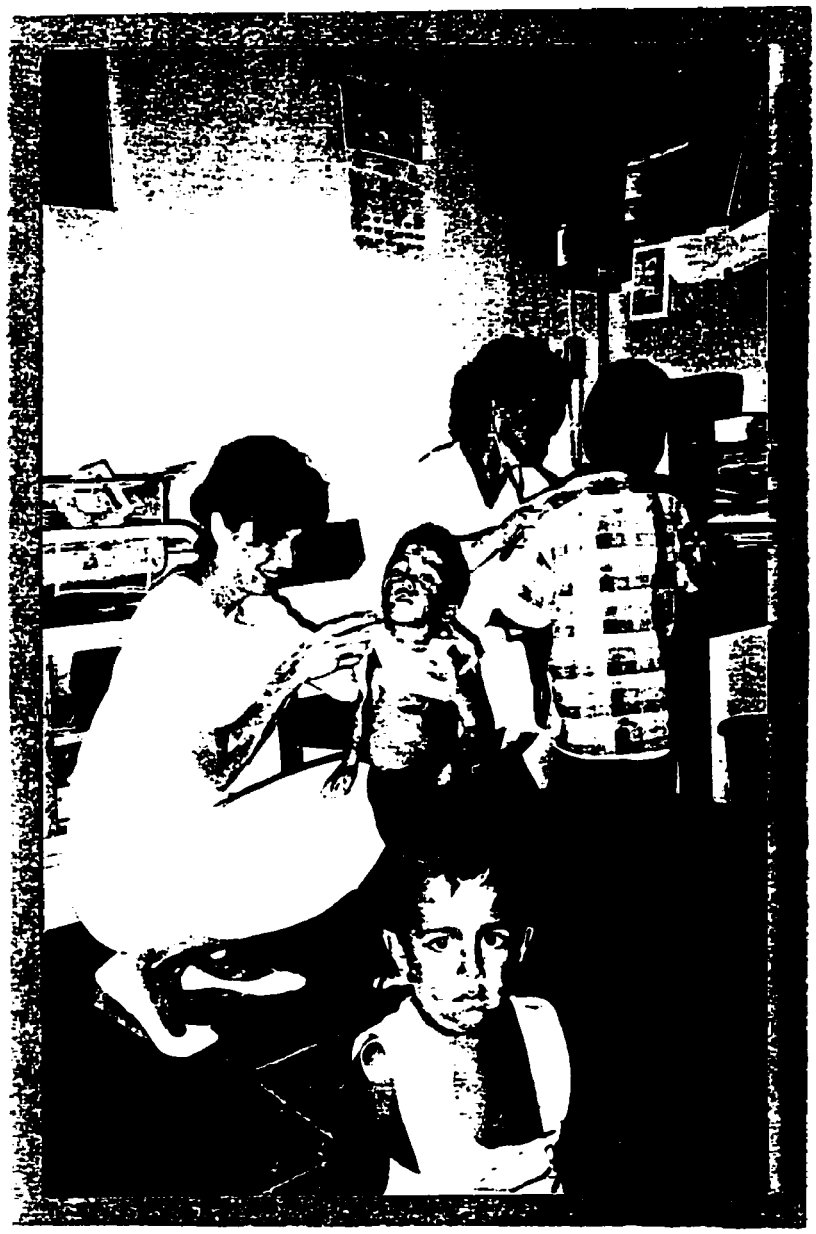
Transferability (the extent to which the findings can be transferred to other settings or groups – Polit & Hungler, 1995) is limited in a phenomenological study since the purpose is to explicate individual's lived experience at a particular point in time as remembered at a different particular point in time, and as interpreted by the researcher-as-instrument (van Manen, 1997). Phenomenological research is considered successful if the reader is evoked to a deeper understanding of the phenomenon by first of all identifying with it, that is, finding it to be recognizable (van Manen, 1997).

EPILOGUE

The field of transcultural nursing is gaining a lot of attention in recent nursing literature. The opportunity for nurses to interact with members of diverse cultures around the globe is increasing with advances in communications and travel. Caring in cross-cultural nursing is a poorly understood phenomenon. Illuminating nursing wisdom embedded in cross-cultural practice may bring us closer to a critical understanding of the place of caring in effective (culturally competent) practice, and give us new insights into the phenomenon of caring itself.

CHAPTER FOUR:

DISCOVERING BORDERS



Genius develops in quiet places,
Character in the full current of human life

Johann Wolfgang Von Goethe (1749 – 1832) The Oxford Dictionary of Quotations

SONYA: (in Guyana):

"I got into trouble
the last time I was here,"
Vicki tells me
as we stand in the customs and immigration line
at the Guyana airport,

"I was so eager
to see my Guyanese friends again
that I rushed to the border officer's desk
without waiting for my turn.
I was practically ready to jump over it".

NURSES WITHIN BORDERS

Cross-cultural nursing fundamentally involves borders. To be a cross-cultural nurse is to be-in-relation to particular geographic and ethnocultural borders. That is, cross-cultural nurses leave the physical and cultural parameters of their home community and enter into the confines of an unfamiliar community as a cultural outsider. To do so, they cross borders. Nursing practice that does not involve crossing ethnocultural borders is not cross-cultural nursing.

The political boundaries of specific countries or municipalities, that is, *geographic borders*, are the easiest to locate. Less clear are the *ethnocultural borders* surrounding a community with similar history/ memory, customs, values and beliefs. Ethnocultural communities have social norms and behavioral expectations not necessarily obvious to a cultural outsider. Locating and crossing these borders to enter more fully into a community is difficult. Tourists may cross geographic borders without actually entering into the "full current" of a community.

The six participants in this study are definitely not tourists.

Unlike the renowned humanitarian organization "Doctors-Without-Borders", the participants in this study could more accurately be named "Nurses-Within-Borders" These nurses situate themselves within the geographic borders of an unfamiliar community, and then work to locate and understand the cultural norms existing there. When they discover or discern cultural rules, such as acceptable dress, they adapt their own behavior to local behavior (when it does not conflict with their own value or belief system). As guests in various communities, the participants strive to work within the existing structures to influence change and to practice nursing.

In addition to being situated within geographic and ethnocultural borders, the cross-cultural nurses in this study display an ability to discern and work within both *personal and professional borders*. For all of the participants, locating particular personal and professional limitations has been painful, but the opportunities to expand their boundaries have been imbued with profound meaning.

The findings of this study are presented in five chapters:

CHAPTER FIVE - **At the Border**: Living on the Edge

CHAPTER SIX - **Straddling Borders**: Living Between Worlds

CHAPTER SEVEN - **Beyond Borders**: Living Beside a 4th Dimension

CHAPTER EIGHT – **Injured Borders**: Living Among Human Broken-ness

CHAPTER NINE - **Drawing Borders**: Reflecting on Cross-cultural Artwork

CHAPTER FIVE

AT THE BORDER: LIVING ON THE EDGE

We are not here to be "safe". We must have faith and take risks.
Life is not meant to be easy and humdrum.

Sir William Grenfell, Physician

SONYA (in Guyana):

I'll admit I feel scared
walking alone to the Georgetown public hospital.

I walk briskly,
my canvas bag tucked under my arm,
and wonder if I will be robbed
as the Canadian student was
five days ago.

Across the canal
I see again this plastic baby doll
nailed to a small wooden cross.
'A macabre crucifix.

Or is it a scarecrow?

All of the participants in some way experienced *Living on the Edge*. In choosing cross-cultural nursing as a career specialty, these nurses are exposed to risks not found in conventional nursing practice (*Risk-taking*). They have all felt unprepared for the professional and personal demands being in a foreign culture has entailed (*Trailblazing*). Yet each has found a way to practice within the existing constraints (*Finding a Way*).

RISK TAKING: Being Care-less or Care-full?

When I visited a hermeneutic phenomenology class to discuss my first interview with other graduate nursing students, I suggested that the participant (Lynn) displayed exceptional courage in taking a stand on behalf of her Dene maternity patient. One of the students remarked, "but cross-cultural nurses are risk-takers anyway, aren't they?" This comment remained with me throughout the study as I wondered - well, are they (we) risk takers? Does that explain why certain nurses are drawn to cross-cultural work and others are not? 'Because living in a foreign community carries presumed risks (like

contracting tropical diseases or being caught in the middle of a coup d'etat) and life on the edge appeals to those with a risk-taking disposition... doesn't it?

None of the six participants struck me as risk-takers. Indeed, those whom I directly asked if they would consider themselves to be risk takers seemed surprised at the question - as if to be a risk-taker meant to be frivolous, *care-less*. Instead, what impressed me was the *care-full-ness* associated with cross-cultural nursing practice.

Carla and I met after a mutual acquaintance heard that I was looking for cross-cultural nurses to participate in this study. She has worked for 10 years in Canada's Arctic (mostly in mental health); 4 months in Iraq (as a consultant in mental health); and 4 years in Sri Lanka (teaching in the first baccalaureate nursing program). We arranged to meet in Carla's home, where both interviews took place. It was during our second interview that Carla spoke most specifically about risk-taking in her practice:

CARLA:

> I used to tell people who were concerned about my living in Sri Lanka that, if something happens to me it is because I am in the wrong place at the wrong time...however, that could happen in Canada as well...[I do not participate in] just an irresponsible, not-thinking risk-taking...Like I wouldn't go skydiving because I would be scared out of my mind.

Carla refers to her decision-making as "pragmatism". She recognizes that there are risks in her cross-cultural practice, but decides "what degree of risk" she is willing to take according to an intuitive understanding of what is "sensible and responsible".

Like Carla, Vicki recognizes an element of risk involved in her international work. Vicki has over 30 years of cross-cultural experience and has worked in many countries including Bolivia (providing medical care from a floating clinic on the Amazon river with her husband, a physician); Zaire (teaching local nurses), India, Rwanda and Guyana. Vicki

and I met three years ago at a Nurses Christian Fellowship regional conference near Vancouver, British Columbia, where she lives. A year later we worked together as instructors for a transcultural clinical course. When seeking out a clinical placement for my own Master of Nursing studies, I asked Vicki if I could accompany her on a trip to Guyana, where she has worked as an international nurse consultant for the past five years She agreed, and for two weeks Vicki and I lived and worked together in Georgetown, Guyana. As a participant observer, I came alongside Vicki in her consulting and teaching, including becoming involved with teaching Canadian students (who joined us after one week) and Guyanese nurses enrolled in a pediatric specialty course.

I interviewed Vicki during this time in Guyana, and later in Scotland where we both participated in a Nurses Christian Fellowship International conference. The first interview took place on the garden terrace of our host's home in Georgetown. While in Guyana, we constantly discussed safety risks pertaining to the 10 Canadian students and us. One of the nursing students was robbed the day before our first interview.

SONYA – (in Guyana)

The thief took the student's backpack
from the sidewalk by her feet.
Passport, plane tickets, cash
all gone.

She realizes now that she was a target
Dressed as a foreigner, in shorts.
But she didn't think this could happen to her.

Vicki feels responsible.
Like a mother for her children.
She is questioning her judgment
in bringing the students to Guyana.

Vicki was shaken by the robbery of her Canadian student. After a few days of reflection and doubt and conversation, Vicki realized again that choosing to live "out of bounds" puts cross-cultural nurses at greater personal risk. While the students saw the rules regarding dress, for example, as confining, Vicki recognized that the function of safety "borders" is protection, not oppression. It is *care-less* to ignore known safety rules.

Like Carla and Vicki, Edith started her cross-cultural nursing career approximately 30 years ago. She, too, acknowledges that practicing cross-culturally places her at risk of personal harm. And she also believes that looking for and paying heed to local warnings (being *care-full* rather than *care-less)* can reduce risk.

Edith's name was given to me by a mutual acquaintance aware that I was looking for participants for this study. She has lived in the same African country for most of the last 30 years. Edith's nursing practice has included direct medical care, teaching of health assistants, and, for the past 16 years, administrating and overseeing the work of expatriate (foreign) nurses in six centers around the country. She was on a four-month furlough in Alberta when I interviewed her at the home of her sister and 99-year-old mother. Edith's ongoing position as a foreigner is, at times, tenuous. To ensure confidentiality and to prevent any possible repercussions for Edith, I will refer to the continent only. Edith describes risky situations that she has encountered in Africa.

EDITH:

> [When] the rebels came into the north...there were bombs...A lot of shooting going on, ammo dumps going off...One time there was an attempted coup... [Lately it is not safe to be] traveling after 4:00 pm because you're more liable for [road bandits]...[However, if] you...stayed within the rules and regulations it...wasn't dangerous... [unlike] Zimbabwe you know, where they went in after the white farmers and did a lot of plundering and killing.

Edith recognizes that danger is usually confined to specific times (government changes; after 4:00 pm) and places (the northern border; on dark roads). She does not "tempt fate" by being conspicuous (as white woman) at these times or places.

Ironically, Carla is headed to one area that Edith identified as a danger zone:

CARLA:

> Part of my decision-making about [going to] Zimbabwe was that I was going to be in Harare. I am not a farmer. I am not married to a farmer. And I'm not going to run around the country - which is a real shame 'cause I'm so curious and I've never been there before and I'm going to be stuck in the city... So, I don't think [being a cross-cultural nurse means being] a risk taker.... I don't consider myself to be a big risk taker.

It is interesting that Zimbabwe is deemed "too risky" by Edith, yet "worth the risk" by Carla. Perhaps, for Carla, the anticipated benefits outweigh the risks. Traveling to Zimbabwe to consult with the local Canadian International Development Agency (CIDA) regarding the potential to set up a pediatric nursing education program is appealing to her

Besides risks, there are other costs involved with going to Zimbabwe. During our second interview, Carla received a phone call from her travel agent who is organizing her flights to Harare. This interruption triggered a discussion about the other costs involved in cross-cultural work that Carla weighs out before making a final decision about whether to go on a particular cross-cultural assignment:

CARLA:

> The logistics alone is a lot of work; it's not like walking across the street here to the hospital, or to downtown. And you're balancing it with all kinds of things, like, I need to know because I have to pay my kid's university fees...I don't think we lead a charming life that we've just fallen into. If there has been interesting and charming and stimulating things about it - and there are - it's 'cause we made them happen.

It is not easy to make arrangements to do cross-cultural work: Plane flights, passports,

immunizations, obtaining role expectations, arranging for obligations at "home" to be met when one is away...there are *actual costs* involved with cross-cultural work that need to be considered before "signing up" to a particular project or with a particular sponsoring agency. In contrast, risks are *potential costs.* Whether working in Northern Canada or working overseas, participants spoke of being exposed to elements which could physically harm them: disease (particularly communicable), violence (war, crime) or injury (motor vehicle accidents). Determining the likelihood of being harmed by such factors may be assisted by reading relevant morbidity and mortality reports, risk assessment reports (pertaining to political stability) and travelers health & safety advisories.

A *care-full* practitioner, Carla deliberates and gathers as much information as possible before deciding on an international nurse consultant project. Ultimately, Carla must come to a decision about whether the actual and potential costs are worth the trip:

CARLA:

> You need to sit down and pick up the information and reflect on it, and once you do, you make your decision. And once you've made it, you go ahead and live with it. And you follow through...[Y]ou develop some kind of comfort level with your own judgment.

Carla tells me that, in the end, even after *care-full* consideration, going on an international project involves a leap of faith. In the case of Zimbabwe, Carla reads between the lines of the documents piled on her kitchen table sent by CIDA. She speculates that, given how difficult it would be for the CIDA staff in Zimbabwe to take responsibility for a foreigner if there was a threat to her safety, they would not be pursuing her services if it were too risky for her to come.

For Vicki, Edith and Carla, being comfortable with their own judgment may be an

advantage of having 30 years of cross-cultural experience: Experienced cross-cultural nurses may be able to distinguish *life on the edge* from *life on the ledge.* Knowing one's limitations in regards to the level of risk each is willing to take might have been developed over time, based in part on how fearful (or at-risk) they may have felt in a given situation or community. What about novice cross-cultural nurses?

Pam Nordstrom is a Canadian nurse working in Somalia. She was exposed to peril that she seems to have not anticipated:

> *The drive to our compound taught us our first lesson in survival - the person with the biggest gun wins. Masses of people yielded to our Land rover, I think less from courtesy than from fear of the AK-47 and M-16 guns protruding from the windows. What kind of a mission had I signed myself up for?*
>
> Canadian Nurse, January 1994, p. 49

Was Pam informed of the specific risk involved in traveling to Mogadishu during a war? Are novice cross-cultural nurses "blind" to inherent dangers? Or, perhaps different nurses have differing ideas of how much risk they are willing to take. Dorothy Scheffel speaks of the danger that she encountered in Uganda, but seems cavalier about it:

> *Some nights we could hear machine guns. There were rumors of scary things happening all around us. We didn't know if they were going to knock on our door that night, steal everything we owned, and kill us - because that's what they were doing right down the street...I got beat up in Nairobi, and it didn't kill me. It wasn't very nice, but I believed God intervened. God was faithful to take care of me then. It didn't destroy me.*
>
> Journal of Christian Nursing, 1993, 10 (4) p.12

I worked twice in Uganda around the same time as Dorothy. Like her, I know what is it like to lay awake at night listening to machineguns. I can recall having an AK-14 aimed at me by an adolescent boy in army fatigues at a roadblock. I know what it is like to

be scared. The American professor of orthopedics with whom my husband and I stayed while on a short term project in Uganda was murdered after we left – by a car thief outside of the clinic where we had worked. I was surprised and relieved to find that the participants in this study, like me, are not fear-less. They simply try to avoid situations that might make them fear-full:

CARLA:

> I don't ever recall in places like Inuvic of me being afraid. There were communities [in Northern Canada] that I would not wanted to have lived on my own. 'That were, where there was a history of violence and a history of very poor race relations, and one of the places was [a certain community] and you couldn't have enticed me to work there.

The ability to assess for risk and cost is an important aspect of Carla, Vicki and Edith's practice. What they are willing to "pay" in terms of risk and cost seems closely tied with their motivation for going (benefit), and will be further discussed in Chapter Six. Considering the paucity of formal preparation and mentorship available to the participants for their cross-cultural work, I suspect that the more experienced nurses' ability to assess for personal risk and cost may have been developed over time as their familiarity with cross-cultural settings increased. Of the six participants, Masako is the least experienced, having worked for three years recently in Bangladesh. The lived experience of Masako highlights the cost of unpreparedness and lack of mentoring.

TRAILBLAZING: Being Un-prepared and Un-guided

I met Masako during the data collection phase of this study when we were both attending a Nurses Christian Fellowship International conference in Edinburgh, Scotland. Masako is a soft-spoken nurse from Japan who was, at that time, studying for a Masters in Public Health at the London School of Hygiene and Tropical Medicine. We found a quiet

corner in the university hosting the conference and she related to me an early experience in her recent assignment to Bangladesh, first apologizing for her difficulty articulating her thoughts in English.

MASAKO:

> [M]y supervisors were not really knowledgeable in health care services, they don't give me any direction... I just figure out that my role was expected to support local nurse who work as in charge of the center... That center has been there for the last 10 years but closed once before I came... because of the [financial] corruption... So the organizational expectation was for me to watch... 'that the same thing would not happen... I just figure that that was my responsibility.

While Masako was given three months of language school training in Bengali, she was not oriented to her actual role - she tried to figure out on her own what was expected of her since she had no job description. Masako worked for two months in the 20-bed nutrition rehabilitation center supervising three Bangladeshi support staff. Then

MASAKO – (in Bangladesh):

I am sick with fever.
I can't sleep.
I am losing weight.

My supervisor has agreed
To close the center at the end of this week.
While I recover.

I know we agreed not to admit more patients this week
But two year old Shapna is so skinny,
she looks like an old person.
She has a large necrotic ulcer on her scalp.
If this gets infected, she will die.

I cannot explain clearly in English
How my decision to admit her
is *not* incongruent with my request to close the center.

So, my American director is furious at me.

As I listened to Masako relate her story, I found myself becoming angry toward the sponsoring agency. How could they allow an inexperienced nurse to find her own way in a supervisory position, communicating with her staff and boss in different languages - neither of which she is fluent in - in an organization with a history of financial corruption that she is obligated to prevent from happening again? And all without support or direction from her own sponsoring agency? That Masako became ill is not surprising. Being un-mentored came with a personal cost.

Unlike Masako, I have had collegial guidance. I felt privileged to follow Vicki around Guyana for two weeks. Vicki knew that I was there to critically observe and eventually incorporate what I saw into a conceptual framework for a Master of Nursing course, yet she didn't once seem uncomfortable with my presence. She invited me into every aspect of her work - from behind the closed doors of meetings with the country's nursing leaders, to her classroom of Canadian nursing students, to her informal discussions with local nursing staff. We shared accommodations, taxis and excursions to the grocery store. As we talked constantly about the meaning of what we were experiencing, I was privy to something that none of the participants of this study have had: ...a mentor. Yet, I do not feel fully prepared to be a cross-cultural nurse. Is it possible to be fully prepared?

Vicki regrets not having formal transcultural preparation or collegial guidance. After finishing work in Bolivia, she sought out continuing education in Canada.

VICKI

> I chose ...a Masters degree in Adult Education because...you do a lot of ...those kinds of courses that I felt were really suited to overseas work. [However, I] didn't have a mentor, someone I could turn to and say what kind of courses should I take? And the program itself [was] really focused on what's happening in North America rather than [internationally].

Lack of formal preparation opportunities and nursing mentorship necessitated self-directed learning during Vicki's 30-year career. She has learned to be comfortable with this independence, referring to her cross-cultural practice as being *on the cutting edge*:

VICKI

> ...again, that was a situation where I was taken to the edge - to the cutting edge of my understanding, my personality, my prejudices in life....

SONYA

> You've often talked about being on the cutting edge, ['about being] the one that [is] cutting out the trail and with a sense of moving forward, or moving out, whichever way - 'that you're being, constantly being pushed into new directions...'that there's always more to learn, there's always more to be cutting...

VICKI

> Yeah, I think that you've understood correctly. For me, I even wake up at the beginning of the day ...in my own quiet sort of devotional time, preparing myself for the day mentally, I'm just aware that I'll probably be faced with new situations, new encounters in terms of culture.

Not being fully prepared has not stopped Vicki from developing a successful cross-cultural practice. Venturing into the unknown has become an expected aspect of her practice – a form of risk-taking. Having courage and sensitivity has served her well because she has had to "learn it on my own", as exemplified by the following story.

<u>VICKI – (in Zaire – presently Republic of Congo)</u>

I want to teach my nursing students
the basics of nursing care
such as checking a pulse,
and taking a temperature.

But I realize that first I must teach them how to tell time
and what "temperature" is.

Learning to adapt foundational nursing concepts to the local culture was necessary

for Vicki's success in teaching Zairian nursing students. Becoming aware of the differences in their worldviews was important. But, like Masako, Vicki found herself in a position of authority over local nurses - a role she was not comfortable with:

VICKI

> [E]verything had to be locked up. [The issue wasn't] stealing, but [a belief that] what you have, you share with others... I felt that I was put in a position of being a... policewoman...and I didn't like that role.

While Vicki strives to work within the constraints of the local culture, in doing so she is often testing her own limits - she has often been out of her comfort zone. Experience continues to prepare her for differences in cultural expectations and resources.

The participants speak of different types of unpreparedness, particularly for their first experiences. In Bangladesh, Masako was unprepared for her role (administrator). She struggled with articulating her thoughts in 2 different languages. She became physically ill when she reached her personal limits. In Zaire, Vicki was unprepared for her role (teacher) because, even with a Masters degree in Adult Education and fluency in French, she did not know how the local cultural conditions would impact her nursing.

Edith's story of feeling unprepared also occurred at the beginning of her career

EDITH (in Africa)

I really don't know
how to treat this woman's possible congestive heart failure.

There are no books or resources here.
I am learning what I can from a gal who isn't actually a nurse.

What do you do?
The patient is going to die.
I put her on some digoxin.

...I pray a lot, you know.

The professional border that usually separates nursing from medicine becomes blurred when cross-cultural nurses like Edith take on the role of medical practitioner Undergraduate nursing education does not prepare nurses to diagnose and treat illness. yet cross-cultural nurses may be called upon to practice medicine, as the following cross-cultural nurses have been:

Debra Edwards:

> *We [outpost nurses in Northern Canada] have a tremendous amount of autonomy...We function as a nurse practitioner, although we're not called that.*
>
> Canadian Nurse 1997, 93 (8) p. 20

Daria C. Ruffolo:

> *As my background was in trauma, I was eager to jump in. Little did I know I would see innumerable laceration-from-bush-knife accidents, broken bones requiring setting and casting, incidents of domestic violence, self-mutilation with ceremonial amputations, and abscesses requiring incision and drainage...In Papua New Guinea, nurses customarily diagnose and treat.*
>
> Journal of Christian Nursing 1993, 10 (4) p 18

Meagan Fox:

> *My first day in Nebobongo...I tagged along with Ruth Haynes [nurse-midwife] ...[There was] a woman with severe abdominal pain and weak vital signs. She was laying on a low, hard, bamboo cot, barely conscious. She had told the staff that she had missed her last menstrual period. Ruth went quickly to work, using a large needle and syringe to penetrate the woman's abdominal wall, immediately aspirating frank red blood into the syringe. This confirmed her suspicions: the woman had a ruptured ectopic pregnancy...The ensuing rush to prepare for emergency surgery unfolded like a scene from M.A.S.H.*
>
> Canadian Nurse, November 1992, n.p.

That cross-cultural nurses have an expanded scope of practice seems an understatement. As I read through 50 published first-person narratives by cross-cultural

nurses and physicians, I was struck by how many of these authors are describing their first/ early cross-cultural experiences - mostly on short-term projects - and by how many of the nurses (who are not typically prepared as nurse practitioners) practice medicine. The theme of *Un-prepared-ness* runs through nursing narratives... but is it possible to be fully prepared for cross-cultural work? It seems unlikely that Virginia Schneider could have prepared for this role:

> *Joan, my English nurse friend, is responsible for all burials [in this hospital compound in Gabon, Africa]. The body is first wrapped in a sheet, then wrapped again in palm leaves and placed in a crude coffin. Several deep graves are always on hand, always ready, and caskets are placed one on top of other with a little dirt in between until the hole is filled. The cemetery is a beautiful spot set aside by [Dr. Albert] Schweitzer. Sometimes the pastor is present, but quite often the nurse says the graveside prayer.*
>
> American Journal of Nursing 1965, 65 (10) p.130

It seems clear from Masako's story regarding the nutrition center in Bangladesh that being un-prepared and un-guided may come with a personal cost. Yet what is remarkable about Masako's story is her response to the director whom she feels has abandoned her. Her response speaks to the theme of *Being Persistent and Resource-full:*

FINDING A WAY: Being Persistent and Resource-full

Masako recalls the physical, mental and spiritual distress she felt after trying to fulfill what she thought were her professional (administrative) obligations to her sponsoring agency in Bangladesh. While a period of rest for her to recover was imminent, a seriously ill child and malnourished mother at the nutrition center. Masako strongly believed that it was her nursing obligation to make sure this small family was looked after, even if it meant going against the order of her director (to not admit any new patients):

MASAKO:

> I as a nurse felt that I needed to protect them from any harm as possible from their lack of food, accommodations and lack of getting respect, lack of right to, how can I say, protect themselves...

Masako realized that her director would not likely understand her decision to put the needs of this particular patient before her own and that he might interpret this decision as an indication that she was not as ill as she proclaimed to be. But she chose to accept the personal consequences of making sure this patient was attended to at the nutrition center. And, she chose to privately forgive her director:

MASAKO:

> He was Christian too, and I am Christian, so it was a Christian dilemma but also a professional dilemma. But I knew I had to forgive ...my country director in order to continue...my faith not only in my profession, because as a Christian I cannot leave my anger anywhere. I had to resolve this issue [by forgiving] the country director and then ask for his permission to continue working. It was very difficult. I had to fight against my pride because I knew that I was right.

Masako does find support, however. To seek it, she must go against the director's orders not to return to the (now closed) nutrition center:

<u>MASAKO – (in Bangladesh)</u>

I sneak back
to see the Bengali helpers
who are cleaning the center

They hear my dilemma
And cry with me.

Because of this sign of support from the Bengali helpers, Masako decided to stay in Bangladesh. Her persistence resulted in the improved health of the previously critically ill patient. Masako went on to complete her three-year term in Bangladesh, eventually gaining the director's respect. At her farewell dinner, the country director unexpectedly

apologized to Masako, and asked for her forgiveness. In the long run, Masako *found a way* to meet her personal obligations (Christian imperative to forgive), professional obligations (nursing imperative to care for ill patients) and personal emotional health needs (seeking support from Bengali nurses).

Nancy, too, demonstrates persistence in her cross-cultural nursing practice. I originally met Nancy on an immunization project in Uganda in 1988, her first international nursing project. Since then, Nancy has gone on an average of three short-term medical missions projects per year, including to India, Guatemala, and Nepal. Serendipitously, Nancy planned to visit Banff (from New York) for a ski vacation within the time frame of my data collection phase. My family packed up our car and drove to Banff to spend the weekend. Nancy and I had not seen each other in three years and I found it awkward to ferret out an appropriate time to interview her. We eventually found a comfortable spot together on a couch in front of a fireplace in the hotel foyer and she related this incident:

NANCY (in Guatemala)

I see the mother with her severely dehydrated infant
as we start to pack up our bus to leave.

Our clinic time is over. It is dark. We are tired
She is not demanding our help
She will accept our instruction to "Come back tomorrow"

But something clicks in my mind.
God intervenes, and makes it very clear
to "Drop everything.
This is a life and is important
no matter what."

We gather the mother and child
onto the bus with us
and bring them to the hospital.

Like Masako, once Nancy decided to "go the extra mile" for a patient, she followed it through, even when doing so might have resulted in personal discomfort or reprimand (e.g.: for not using the "proper" forms or protocol). Since all of her projects are short-term, Nancy has become adept at gathering information about resources available in the community so that she can refer patients to facilities or professionals who will be able to follow-up on their care. Most of her projects involve mobile medical clinics where she works with a team of local and expatriate health care providers to attend to the immediate physical needs of patients who attend the clinic. I wondered how Nancy dealt with the constraints of short-term projects:

NANCY

> It's not easy because you're pulled in two directions [like when] you have a line of 100 people outside your door. Do I make sure that I get all 100 people in and give everyone a very short period of time? Or do I go through every channel? And I'm still not to this day convinced which is best... I'm always asking questions, constantly.

In addition to finding a way to get patients to the long term help they may need, even when this is not expected of her as a short-term worker, Nancy has learned to look for opportunities to practice nursing in unlikely places.

NANCY (in Nepal)

I no longer give toys or money
to beggar children.

Instead I am sitting on a sidewalk
with a street child,
sharing a piece of fruit
as we look at a picture book together.

Nancy's resource-full-ness has strengthened her cross-cultural practice. Creativity and resource-full-ness become useful characteristics when practicing in areas where medical provisions are in short supply - particularly in less-developed countries, as the following quotes testify:

Margaret Bonnette (in Haiti):

> *One poor mother came to see me with a large breast abscess, which was especially painful when she walked. My solution was to devise a sling for the breast. Most relieved, she merrily went her way after receiving the medication. That sling idea caught on, and soon I found other women with painful breasts using the device.*
>
> Journal of Christian Nursing 1993, 10 (4) p.5

Gerald Hankins, (physician, in Nepal):

> *I had to be willing to improvise...an ordinary coat hanger twisted and bent into the proper shape served to make a satisfactory banjo splint to keep fingers straight after surgery.*
>
> Christian Medical Dental Society September 1999, p. 27

Persistence has also characterized the cross-cultural practice of Lynn, a Canadian nurse and Scottish-trained midwife who worked for 10 years in Northern Canada, mostly as a staff nurse on a maternity ward. I met Lynn when she was a student enrolled in a transcultural nursing course after her cross-cultural experiences. During our first interview in her home, Lynn had a few carefully preserved cards on the table beside her. They were thank-you cards from patients that Lynn pulled out to jog her memory of significant events she experienced while living up north. One story highlights how she *found a way* to meet the perceived needs of a patient, even when doing so meant standing up against the prevailing opinions of the attending physician and Lynn's supervisor:

LYNN - (in Northern Canada)

The newborn has Fetal Alcohol Syndrome
and needs to be medivac'd to a larger hospital
because of breathing troubles.

The mom is giving this boy up for adoption
and the doctor is telling the supervisor and myself
that the mom should not be asked sign the consent form
because she has relinquished the child.

I disagree.

I know the mother is giving up her baby
because she wants what was best for him.
She knows I understand
that *she is still his mother*

In this situation Lynn was compelled to follow her nursing judgment to do what she perceived as being best for the patient, even when it meant taking a stand against authority and institutional protocol to do so. The physician and supervisor attended to the demands of the child and the hospital protocol, but at the mother's expense. Lynn considered the needs of both the seriously ill child *and* his mother. At first glance, it might seem that the mother - who harmed her child by drinking heavily during pregnancy and now was relinquishing the child for adoption – did not care about the fate of her child. Lynn did not make this assumption because she *knew* the mother cared about her baby.

LYNN

> I saw her as kind of helpless . . she communicated to me through her manner and her eyes, her looking, her quietness, and something that I could connect with inside. I think it took two of us to make that connection. It was not that I was able to see through her in any way or that she was able to verbalize to me what she was feeling - but between the two of us there was this meshing of feelings and, knowing that came across without anybody saying anything. It was almost as if it was vibrations in the air or floated between like an aura.
>
> Lynn believes that she could not have stood up on behalf of the mother if she

didn't "know what I intuitively knew", that is, that the mother cared about her baby. The mother signs the consent. When she is discharged, she gives Lynn a warm hug.

Nancy, Lynn and Masako were compelled to advocate on behalf of their patients even when doing meant going against the tide of their agency/ institution and involved standing up against authority. They were so convinced of their own judgment that they took the chance of personal repercussions to "do the right thing". Rather than submitting to local authority (human or institutional), these nurses seem to acknowledge a higher authority. Nancy, Masako and Lynn each responded to a human call from a suffering person. In Guatemala, Nancy responded to a particular call from God. By choosing to alleviate the suffering they fulfilled a nursing (professional) calling.

When faced with a choice to stay within the boundaries of institutional standards or to step beyond them to attend to the suffering of their patients, these participants chose the uncomfortable position of stepping "outside". In doing so, these nurses used their professional and personal framework to assist them with ethical decision-making. Perhaps it is their courage to risk personal discomfort (such as being reprimanded) that the graduate student in the hermeneutic phenomenology class was referring to when she said that cross-cultural nurses were risk takers.

Some of the participants in this study refer to another type of Resource-full-ness. Nancy, Vicki, Edith and Masako referred to times when they received insight or strength from a supernatural Resource, that is, God. For Nancy, God intervened in "making it very clear" to make the effort to care for a dying child after the clinic was closed in Guatemala. Edith, Nancy and Masako mention their

use of prayer, seeking God's omnipotence in situations where they felt impotent (providing medical intervention; desiring to communicate compassion when unable to speak Guatemalan; when desiring to forgive). Vicki speaks of her daily devotional time where she asks God for sensitivity and wisdom to appropriately deal with what lays ahead. Spirituality as a "way of knowing " will be further explored in Chapter Seven.

EPILOGUE

The lived experience of cross-cultural nursing can be exciting, exhilarating even. Cross-cultural nursing can be an adventure in that it involves uncertainty, but it is not an exotic vacation and the participants are not thrill-seekers. Rather, care-full planning and decision- making characterize the participants. Nursing knowledge influences decision-making, yet a critical lack of formal transcultural education, mentoring and collegial guidance is perceived as a barrier to a more effective and satisfying practice. In this study, cross-cultural nursing involves using personal values and religious principles in addition to nursing knowledge to frame decision-making, and the participants draw on these to define their professional and personal boundaries and to guide their nursing practice. Once decisions are made, participants find ways to follow through, being persistent even when there is potential or actual personal cost to do so (giving up time, finances, physical comfort or collegial support). The phenomenon of *caring* in cross-cultural nursing may involve personal cost, as in *caring enough to* plan carefully and follow through on decisions, even when to do necessitates self-reliance (dependence on personal values frameworks without benefit of collegial nursing guidance) and personal expense.

CHAPTER SIX

STRADDLING BORDERS: LIVING BETWEEN WORLDS

Physician *March / April 2000* 19

Though we travel the world over to find the beautiful
We must carry it in our heart or we find it not.

Ralph Waldo Emerson (1803 –1882) Oxford Dictionary of Quotations

CARLA (in the Canadian Arctic):

I am dropped here
off a tiny airplane
three days a month to do public health.

They all greet me formally by shaking hands,
all dressed in traditional Mother Hubbard parkas
in brightly colored cotton.

The women are all wearing engagement rings.
I find that funny in this isolated place-
an adaptation
of Inuit to southern Canadian culture.

They accompany me to my trailer,
a horror show with no toilet,
no running water...
Well, it *has* toilets and sinks,
they just aren't connected to anything.

They come in the nursing station
and they have these god-awful melmac cups and saucers
that are hard to clean
but I have nothing to clean them with
and there is no hot water anyway.

There are community elders
And the babies, and the moms, and everybody
They keep sitting there
And at midnight I am still making tea for these people.

A lot of them don't speak English.
There is more non-verbal communication.
They finally leave
and I clean all these cups.

When I open the clinic at 0830h the next morning,
nobody shows up.
I have a terrible day
thinking I made this horrible cultural faux pas.

But they start showing up at 1500h
...and keep coming until 2300h.

Carla's vivid recollection of one of her early experiences as a cultural outsider is a poignant example of what life as a cross-cultural nurse *is*. Cross-cultural nursing, for Carla, has involved not knowing how to behave, not being able to communicate, self-doubt, relief at finding out that no harm was done and choosing to adapt to local customs. Carla gives a glimpse of what it is to *be-in-the-world* of another culture.

What is left unspoken in this story is the reality that Carla has necessarily had to leave one "world" in order to be in another "world". To cross geographic and ethno - cultural borders essentially includes both exiting (one's former community) and entering (the new community). However, even the use of the words "exit" and "enter" suggest permanence not characteristic of the lived experiences described by participants in this study. Instead, nursing practice involves making an initial decision to exit/ enter followed by ongoing decisions to re-exit/ re-enter (*Choosing to Depart and Yearning to Return*). It also involves experiencing life as a "guest" in an unfamiliar community (*Perpetual Boarders*). The participants describe a sense of not fully belonging in either world. That is, they are *Straddling Borders*.

CHOOSING TO DEPART and YEARNING TO RETURN

Do all the good you can, by all the means you can, in all the ways you can, in all the places you can, at all the times you can, to all the people you can, as long as you ever can.

-John Wesley (quoted in World Vision pamphlet, 2000)

Why would someone choose to nurse cross-culturally when the cost can seem so great? The logistical headaches of planning; the ongoing risk assessment and decision-making and the exposure to unfamiliar values and customs can seem overwhelming.

While the experienced cross-cultural nurse might choose to return to a cross-cultural setting because of positive or meaningful previous experiences (benefits), what draws nurses to work cross-culturally in the first place?

The concept of a "calling", particularly for Christian health care professionals, is clearly identifiable in the published first-person narratives used as data for this study:

Tom Elkins (physician, Nigeria):

> *What is this "call" that we say comes from God that compels us to go to some far away place to do His work? I had no vision, no direct plan of action of "how I would help God" at any time over the past 20 years. But since that first time Carolyn and I went to Nigeria for the Mission board in 1975, we both knew that the burdens of West Africa were ours, forever...It was a pact with God, with an unknown endpoint.*
>
> Physician, Mar/ Apr 2000, p. 5

Dorothy Scheffel (Somalia):

> *I don't consider myself brave or heroic for being willing to go into that kind of situation [among the starving in Somalia], I believe God has a heart of compassion toward those in need. And I believe his people should, also. If Christians can't respond to the poor and needy, who's going to? I believe it is something God has called me to do.*
>
> Journal of Christian Nursing, 1993, 10 (4) p. 11

Andrina Paper Pasternak (Zaire)

> *As things fell into place [to go with a medical missions group to a project in Zaire], I said, "Uh oh, Lord, you want me to do this, don't you?"*
>
> Journal of Christian Nursing 1993, 10 (4) p. 14

Meredith L.B. Kerker (Balkans)

> *I was a nursing student when the media accounts of atrocity and suffering in the Balkans began to unfold, and my heart ached for the seemingly hopeless situation. My older sister, Kameron, and I both felt the urgency of the call to go and work among the ethnic Albanian refugees suddenly flowing out of Kosovo.*
>
> Journal of Christian Nursing 2000, 17 (3) pp 24, 25

Meagan Fox (Africa)

> *After nursing in Canada for 10 years, I realized I had thought and prayed about missionary nursing long enough. In the fall of 1990, I knew it was time to face the challenge: Could I be an effective nurse for the cause of Christ in a developing country?*
>
> Canadian Nurse November, 1992, np

These authors are responding to a call – an entreaty – originating beyond themselves. For some, the decision to do cross-cultural work is in response to a specific need (to help Albanian refugees). Others are drawn to a particular country (Nigeria, India). Still others are responding to an entreaty by God to be available to go anywhere where there is a need that they can meet – the primary goal being a religious one.

"Choosing to depart" in response to a religious calling is interesting in that it's value may come as much from the presumed self-sacrifice involved as from the health care providers' specific ability to meet a health need. *To be willing* to leave behind one's family, familiarity and security for the "cause of Christ" has utmost significance, regardless of the specifics of where or when or what. The biblical imperative to "deny your self and take up your cross and follow me" urges those who would be followers of Christ to devote their lives to Jesus and his teachings. The contemporary singing group "Point of Grace" exemplifies this ancient message:

> *We will go down any road, at any cost*
> *Wherever You lead we will follow*
> *Because we know*
> *That You've called us to take up our cross*
> *Down any road, at any cost...*
>
> Scott Krippanye & Tony Wood
> Copyright 1996 BMG songs, Inc (Gospel division) Above the rim music

The allure of cross-cultural nursing for Christian nurses in particular may include

the opportunity to act sacrificially – a position consistent with the Christian worldview The first-person narratives were written predominantly by Christian nurses and physicians. While the participants were not specifically asked about their religious affiliation, four identified themselves as Christian. Does cross-cultural work hold a particular appeal for religiously devout individuals, as presumed in the following quip?

> *Besides, everybody knows as soon as you surrender your will to God, he packs you off to the Congo, where you spend the rest of your life teaching cannibals not to eat you. I didn't want to go to Africa, and I didn't want to be a missionary. Case closed. Leave me alone.*
>
> Nancy Kennedy, Today's Christian Woman 2000. 22 (5) p. 62

Interestingly, while the authors of the first-person narratives reviewed almost always described how they originally came to work cross-culturally, the participants of this study did not. Indeed, as the animating question for this study was "what" is the lived experience of caring in cross-cultural nursing rather than "how" do nurses come to choose cross-cultural practice, the interview was framed around stories of what cross-cultural nursing is like. Rather than focusing on what *initiated* their desire to do cross-cultural work, the participants described what *maintained* that desire. I asked Carla about the enticement of cross-cultural practice:

CARLA:

> Part of it is just the selfish part...the stimulation, the personal growth. I couldn't abide not learning and doing different things and seeing the world no farther than ...the borders of Alberta, what have you. That to me would be hell. [Also], anything you contribute in a developing world you're contributing to growth and to making things better, and it's a really nice feeling if you can do that.

Carla's desire to be personally and professionally stimulated and challenged reflects a type of respectful curiosity. The allure of cross-cultural practice for Vicki is

similar. Vicki finds pleasure in the daily anticipation of learning something new even if it involves a negative experience:

VICKI – (in Belize)

The bus driver is charging me
Three or four times the normal rate
For taking me and my Canadian students
To the market.

I think he sees me
As a dumb North American.
But I know what the rates are

I am irritated at being ripped off.
Until he says,

"If you were having your fence painted,
wouldn't you ask me the price before I painted it?"

Although Vicki is annoyed that she has been overcharged, she is simultaneously pleased to have been "taught a lesson" by the taxi driver. She loves to learn.

VICKI:

> Every time I come to Guyana I'm learning something new. And this is why I talk to the taxi drivers and chat with lots of people, 'go into the market where we would be every day. 'Talk to the shopkeeper. Just because I realize there's something that I can learn...[and] I see it as being able to care for that person in the taxi cab as much as if he were a patient in the hospital.

For Vicki and Carla, part of the enticement to keep re-entering cross-cultural practice is the opportunity for personal growth. For Vicki and Edith, part of the allure of cross-cultural work stems from their desire to respond to an ongoing call from God to work internationally. Edith's sense of having a role to play in God's plan sustains her:

EDITH:

> I can go home [to Canada] and do my work there... But I'm here because I feel that the spiritual side of it is just as important as the physical side and I'm here to be a testimony for the Lord ...even with all the frustrations and bureaucracy...[it]

> could be very easy to say "forget it...I'll go home and get a job where I can...put in my eight hours... [But my] eyes are on a goal further down the road.

For Edith, nursing practice is a vocation, a calling. While she has lived in Africa for the better part of 30 years, she does not consider herself as belonging there. For Edith, Canada is always "home". What is it like to live in a community where you do not "belong", even after decades of residency?

PERPETUAL BOARDERS

Participants spoke of "being a guest" in their host countries. Guest-ness seems an accurate descriptor when projects (such as the ones Nancy participates in) are short-term, but I wonder if the position of longer-term cross-cultural nurses is more like that of boarders? To be a guest signifies receiving hospitality and politeness from the community, and perceiving the community at it's most polished and courteous. It is a superficial relationship, albeit satisfying (at least, for the guest). In contrast, to be a boarder suggests a longer-term relationship with mutual obligations and responsibilities. Unlike a guest, the boarder may be expected to live as the host family lives without special treatment. The boarder may be given more freedom than a family member would, but there is still a sense that she is being tolerated rather than embraced. The possibility of fuller acceptance into the family hovers – but may not be desired by the boarder or the family. The extent of the relationship between the nurse and the community may differ in different settings.

What is it like for the participants to be in an unfamiliar setting?

Some of the participants described situations where they were able to see beneath the polite face of a new community, to look beyond first impressions. Carla was invited to a Middle East country as a mental health consultant. While there, her hosts brought her

along on a tour of a new mental institution. She relates this story:

CARLA – (in the Middle East)

They are probably banking
on the belief that I am not observant.
After all, I am female, and a nurse.
Harmless.
Otherwise I doubt they would have taken me here.

They have given me access
to visit their only mental hospital.
(There seems to be a sudden need for one).

The patients, all male,
are receiving immunizations
drawn out of glass vials
the tops of which have been flicked onto the floor
and the patients are walking on the glass.

A couple of patients try to speak with me
in English.
A language of power and control,
of the politically powerful.
Not of the mentally ill.

Carla was fascinated by what she saw, particularly since she sensed that she was unintentionally given access to a setting usually hidden from foreigners. Since she cannot imagine that officials would have purposefully admitted her into a building housing political prisoner, she wonders if they assumed she would accept their explanation that these were mentally incapacitated men requiring institutionalization. Carla valued this opportunity for her to observe a deeper layer of the community – to see beneath the surface impression intended for guests – even though it seems it was a mistake of her hosts to expose her to this.

Carla also describes a cross-cultural situation in which she earned the trust of

community members. In this case, being "allowed in" to deeper layers of the community was intentional – it was a choice exercised by an Inuk mother who decided Carla was "worth investing in" even after she made a faux pas of reprimanding the mother for feeding her baby Carnation milk when it was the only milk available:

CARLA:

> So a couple of years later when I knew that woman well I asked her about it [the Carnation milk incident] and I asked her if she remembered and she did and I asked her if she remembered me and she did and I guess at this point what I probably said was, "why did you bother listening to me? I mean, like, what I was saying was just so inappropriate" And she laughed and said, yeah, she knew that I didn't know what I was talking about. I mean, that wasn't the issue, she was very clear of that. But she said that there was something about me that made her realize that I had hope. That she had hoped that I would learn and change.... That I had potential to learn and to integrate and to enjoy being part of the culture...I felt that it was a tremendous compliment.

There was something about Carla that influenced the mother's decision to accept her – to allow her access into deeper layers of the community. What is this *something*? An attitude of respect? Vulnerability? Open-ness? Genuine interest? It appears that there may be gatekeepers of communities – those who guard secrets or protect blemishes. Individuals may also have secrets or blemishes to hide from strangers or guests. Lynn describes being "allowed in" to the life of the Dene woman who was giving up her newborn with Fetal Alcohol Syndrome (FAS):

LYNN:

> I know I had empathy...[but how did she come] to know that she could trust me? It must have been something I portrayed to her and might have developed through just physical support and emotional support during her labor... she just had to be able to sense that I was open – she had to be open to see my caring.

Lynn was allowed into the life of this Dene woman: She felt empathy, she recognized the complexity of the woman's decision to relinquish her child with FAS, and

she was genuinely interested in the welfare of this woman. In return, the woman was open to receiving her care: She let Lynn in. In our second interview, Lynn reflected on how cross-cultural caring differs from caring in nursing practice in general. She spoke of the existence of her own racial prejudices towards First Nations members and how she struggles to overcome stereotypes she was reared to believe. The notion of prejudice and stereotyping is present in cross-cultural nursing practice:

LYNN – (in Northern Canada)

Drunken Indian.
I've understood this to be the reality
Of being Native, being Inuit.

I've always considered myself
To be very open
And non-prejudiced.
But they still exist, these ideas.

You think "drunken Indian"
Without any thought to the whole context
It's easy to judge someone who you don't have contact with.

I am afraid that my patients might perceive
the prejudice in me.

It is not easy to admit to having prejudicial thoughts toward a particular racial group. Lynn's insights are particularly poignant considering the historical cultural imposition experienced by First Nations peoples in Canada. It is interesting to review comments made by nurses working in aboriginal communities in Canada and Australia to get a sense of the historical relationship between cross-cultural nurses and their own nation's indigenous members:

Anna Rokegy-Thomas (Cambridge Bay, Canada):

Not only is there cold and famine to contend with, but disease as well, for that is one of the less desirable aspects of civilization that has come to [the Eskimos]... It is to be hoped, however, that the Government will in the near future see it's way to make available for these people some of the scientific knowledge, medical and nursing skill, which other parts of the Canadian Arctic already enjoy.

Canadian Nurse, 1938, XXXIV (12), p. 694

Kathleen Dier (Cambridge Bay, Canada):

For the Inuit... the [27] years since I left Cambridge Bay have been tragic. I am glad I had the opportunity or catching a glimpse of the old ways before the full impact of the outside world crashed in upon them

Canadian Nurse, 1984, 80 (1), p. 22

Corinne Hodgson (Northern Canada)

It is not surprising that many Inuit remember the medical care given by the missionaries with fond nostalgia, even though the quantity and quality of this care was very different from today. The nursing missionary or nun cared about your soul as well as your broken arm, and generally lived in close contact with the native people. It is interesting to note that the modern Inuit work for nurse is "nayanguak" which translates as "fake nun".

Canadian Nurse June, 1980, p. 24

Julia Woolf (Aboriginie community, Australia):

I am left with a sense of unease about the time I spent there. Did I do further damage by inflicting my white, middle class, Western medicine on a culture struggling to cling to it's roots?

Nursing Times (no date)

For Lynn, to be a white nurse in First Nations community meant realizing her own place in the history of white/native relations. She does not wish to perpetuate cultural imposition, so it is an ongoing process to recognize and confront her own prejudices:

LYNN

So you really have to let go of all of that which, when you really get down to it is not as hard as you think. It could be easily done if you just open, just take those blinders away, I think. And as you, I mean, it's easy to judge someone that you don't have contact with but once you start working with people and...

SONYA

'Being in the moment face to face with a live human?

LYNN

Yeah, right. That's when these things really start to sort of melt away...[with] exposure to people. To Dene people and Inuit people or whatever culture it is.

Lynn carried with her a stereotype of First Nations peoples as being alcoholics. Yet, it struck me during our interview that this Dene woman who relinquished her FAS baby *was* addicted to alcohol and thus *fit* Lynn's stereotype. I commented on this, noting that Lynn could have judged the mother as such:

LYNN

If you didn't go beyond the obvious, I guess, [but being] with people at such an intimate level [in nursing] is different than walking down the street and seeing a bunch of people behind the garbage bin...that's a different situation altogether... So whether that was ...a nursing responsibility or a ...personal desire ...it's probably both that led me to go beyond what seemed to be obvious

"The obvious" was the patient's alcoholism. There was something about the intimacy of the *nursing* relationship that urged Lynn to look below the surface – to suspend her pre-judgment and value the mother simply for her human-ness

Later I asked Vicki if she had any similar experiences of prejudice.

VICKI

I could feel my own...prejudice when I met up with...Rastafarians. They've got the dreadlocks and they don't wash... and I don't know where the boundaries are, because once they start talking to you they see you as a [promiscuous] person... [M]y sense is to put the barrier up first and not really accept them for who they are...I realized that my caring...was cut off from them [out of]a sense of [self] protection and...fear of not knowing them but having heard so many things.

Vicki was fearful of this particular identifiable ethnic group because of what she had heard. Her pre-judging influenced her nursing practice because she believed she needed to be less vulnerable and open than usual in order to protect herself from harm.

Being able to recognize when to put up personal borders for protection seems necessary in cross-cultural nursing. These barriers, however, extended into the practice of Lynn and Vicki and were seen to (potentially) impede their nursing care. Like Lynn, Vicki realized this, and made an effort to confront her prejudice when in an actual nursing situation:

VICKI - (in Belize)

"This guy shouldn't have been drinking"
is the thought that jumps into my head
when I see this man
from one of the islands
as he receives treatment
for a cut he received in a fight.

Vicki immediately realized that she was being biased, and "quickly breathed a prayer that God would remove my prejudice". For Vicki, prejudice is not so much an ethnic or racial issue as much as one of being offended by certain lifestyle choices (drinking, violence, promiscuity). When an identifiable group of people is associated with a particular (offensive) lifestyle, it is easy to presume that any individual from that group chooses to live a similar lifestyle Lynn perceived the Dene mother as being a member of a group associated with alcoholic or violent lifestyles, but suspended judgment until she knew the mother better. When she learned that the mother had limited choices regarding leading an alcoholic lifestyle it was easier to overcome her own prejudicial barriers to care

Carla recognizes that there are situations in cross-cultural nursing where one must be wary of others in order to protect one self. I asked her about experiences with racism:

CARLA

> Prejudice and racism is certainly alive and well, as is stereotyping. [Cross-cultural nurses have stereotypes, but they are] prepared to *confront* them...I think it's wrong and stupid not to be fearful if fear is warranted... The things that would make me more fearful [than ethnocultural differences] would be ...violence.

For Lynn, Carla and Vicki, prejudice is thus associated with being fearful or offended. If a certain identifiable group has a history of being violent toward the cultural or religious group that the nurse identifies with, the cross-cultural nurse may take measures to protect herself, including not being initially open (caring) in a nursing setting until she can evaluate for physical danger – that is, if fear is warranted. This type of prejudice is perceived as discerning and wise (protection first).

Another type of prejudice involves an identifiable group of people being linked to certain lifestyle choices that the nurse finds offensive (e.g.: drinking, promiscuity). This type of prejudice can also act as a barrier to caring-as-connection or compassion. The participants perceived this prejudice as being harmful to the patient so they try to identify and confront prejudicial thoughts as they occur – to set them aside in order to fully evaluate the person before judging their individual character. Judgment is seen to be appropriate, *pre* - judging is not

Being a Room-mate

If "being a guest" is an integral aspect of cross-cultural nursing, so is "being a room-mate". The participants in this study tend to join particular projects or sponsoring agencies independent of other nurses. That is, they do not generally go into another cultural community accompanied by nursing colleagues. Vicki, Carla and Lynn have lived with family members in cross-cultural settings and Vicki has worked closely with her husband (a physician), but there seems to be much opportunity in their cross-cultural nursing practices to work with unfamiliar expatriates. As I reflect on this relationship between cross-cultural nurses, I recall living with the team of four American nurses during

an immunization project in Uganda. We shared accommodations, meals, transportation, and toilet facilities.... in short, we were roommates. While cross-cultural nurses may not have to share physical accommodation with other expatriates, they may find themselves in unintended relation with each other.

When participants spoke of other expatriates I got the impression that they were more wary of other health care professionals (even from their own country or cultural background) than they were of unfamiliar community members. Kristel Vorpahl, a Canadian nursing student in Belize, wrote comments that reflected some of the participant's views of other expatriates:

> *After we had been in the village for about thirty minutes, a group of American doctors, nurses, dentists and med students came hiking down the hill. We did not know that they were going to be in the village... The group had come to Belize for one week and had brought a very large supply of medications. The people in the village were very excited to see them and they all wanted medicine, even if they weren't sick....[These medical volunteers] did not seem to be very culturally sensitive. As I watched them talk quickly to the patients and give them complex instructions for taking a variety of medications, I was... thankful[to be]giving care to the villagers under the guidance of Belizean nurses.*
>
> ELEOS Newsletter, Trinity Western University Nursing Student Association, October 30, 1998, p. 3

Kristel touches on a few themes alluded to by participants, including being wary of Americans (i.e.: Canadian nurses not wishing to be identified as American); disliking volunteers/ groups who rush in and dispense medical treatment and then leave; annoyance at perceived cultural insensitivity; and desire to work alongside indigenous health care professionals. The participants are cross-cultural nurses who value building trust and building relationships with local community members. All but one has experienced living in unfamiliar communities for a minimum of three years and could be considered "long-term"

nurses. Even Nancy, the exception, does short-term projects with such frequency that her practice is not typical of "short-termers" who do sporadic projects. That the participants perceive a difference between their own "long-term" practice and other expatriate's "short-term" practice is exemplified by the following:

CARLA:

> Nurses and doctors at the hospital came and went. There were a couple of long-term positions and they were there because of their interests in the culture and their work and from a myriad of other reasons. Um, but most of [the doctors and] hospital nurses were people who had a short adventure and then left.

EDITH:

> [S]ome of the doctors, nurses that go out [to Africa] with say, M.S. F. – Medicine Sans Frontiers, or go out with Oxfam...go on the humanitarian level [with the question] "what can I do to improve the health standard or the health of people that I'm dealing with...?" [or thinking] "maybe I can make a difference in some of these areas where kids are dying and they don't have to die"...[whereas] I'm here because I feel that the spiritual side of it is just as important as the physical side.

These participants also commented on the effect on non-American expatriates when a host country is experiencing political tension with the United States:

EDITH:

> [I]f the U.S. does something that [Africa] doesn't like and the people get a bit riled up and so they tell the Americans to lie low – well we all sort of lie low then because they can't tell an American from a Canadian or an Australian or a British..

CARLA

> I would not be comfortable certainly two years ago in Karachi because people were targeting expatriates...with white skin and particularly those who were American and I don't look that different.

Cross-cultural nurses do take notice of the behaviors of other expatriates and may stereotype health care workers associated with particular nationalities or sponsoring agencies as being insensitive, aggressive or selfish. Other expatriates may stereotype these cross-cultural nurses. Either way, the relationship between expatriates may be strained.

Other expatriates may also become sources of support for cross-cultural nurses. Masako described the encouragement given her by other Japanese expatriates in Bangladesh during her crisis at the nutrition center. Carla speaks of a significant friendship with a white teacher when living in the Arctic. Vicki refers to the inspiration she felt by the work of a Hungarian couple in Bolivia. And, the enduring friendship between Nancy and myself was built on our "room mate" experience in Africa:

SONYA & NANCY (in Kenya):

We have been dropped off here
without explanation.

This local Inn,
is in stark contrast to the luxury hotels
catering to European safari-tourists.

Our rooms are entirely brick and concrete
just large enough for a cot and table and toilet.
They are adorned with one candle
and a pair of rubber sandals.

The need for sandals
is explained after trying to flush the toilet.
And the futility of flushing is confirmed
By the man entering without knocking,
carrying a bucket of water.

He chats with me
and does not seem fazed by the fact
that I am half naked.

Nancy and I were both anxious about staying in this Inn. Being able to tell her my awkward experience immediately after it occurred provided some relief. Being Room-mates with other expatriates may involve sharing intense cross-cultural experiences. be they embarrassing, frightening, funny or disturbing.

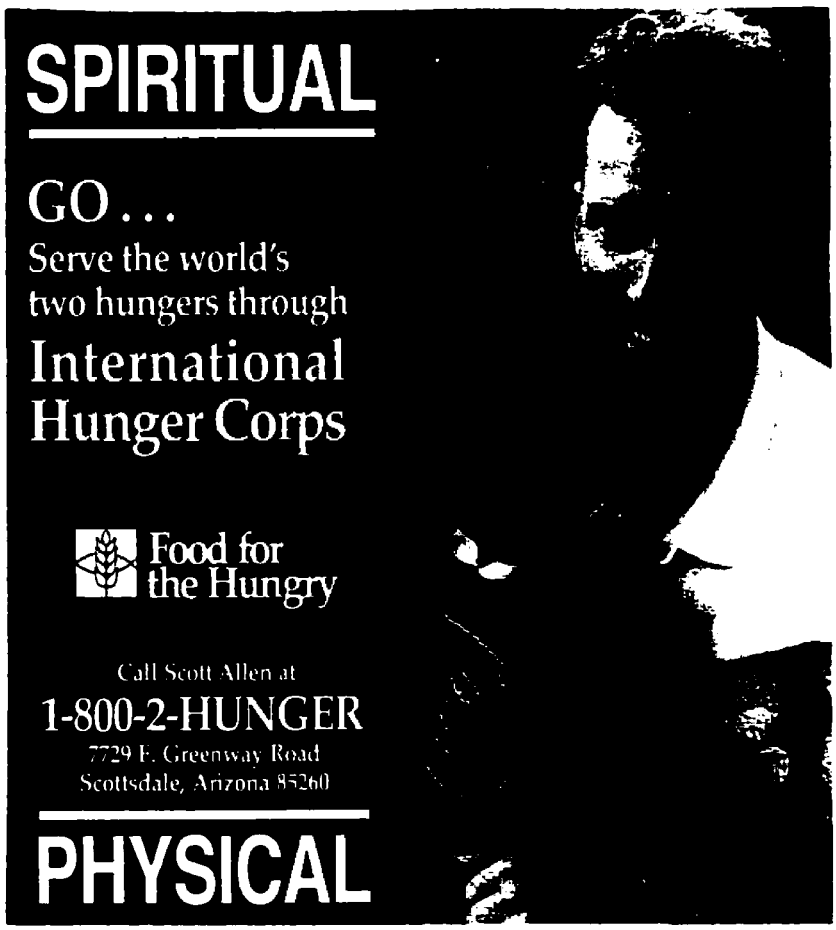
EPILOGUE

Part of the lived experience of the cross-cultural nurses in this study includes a choice to depart from their home. The original choice to work cross-culturally may be a response to a religious and/or humanitarian call and respectful curiosity. The desire to continue cross-cultural work may be sustained by the reward inherent in this work, including ongoing personal and professional growth. Once the participants enter a new community, they become perpetual guests and boarders – never quite belonging. They might only gain superficial entrance into the community, or they may get beneath the surface to gain a better understanding of the emic reality of community members. Even with much experience, there is a sense that nurses will never fully comprehend another culture. The nurses consider the *process* fascinating, none-the-less.

Some of the participants revealed their struggle with prejudice toward local community members. Some participants applied caution when encountering members of groups thought to be violent. Pre-judging was seen in potentially violent circumstances as being prudent. In contrast, to pre-judge based on lifestyle behaviors associated with particular groups was seen as harmful to patients. Stereotyping other expatriates occurred, but was not recognized as similarly harmful. Relationships with other expatriates may be uneasy at times, but may also be deeply meaningful and enduring.

CHAPTER SEVEN:

BEYOND BORDERS: LIVING WITH A FOURTH DIMENSION



God does not shout, scream, or push. The Spirit of God is soft and gentle like a small voice or a light breeze. It is the spirit of love.

Henri J.M. Nouwen, Here and Now: Living in the Spirit

SONYA (in Guyana)

We've been asked to sing a song.
One of the 10 Canadian students behind me whispers
"I don't really know any church songs"
"Just mouth the words," I whisper back
as we walk up the church aisle.

We start slowly, shyly
The church keyboardist stumbles to find the notes
and I think, "This sounds awful"

But then the keyboardist catches the tune
and the congregation stands
as we sing to them
and they sing back to us:

Shout to the Lord all the earth let us sing
Power and majesty praise to the King
Mountains bow down and the seas will roar
At the sound of your name

Darlene Zschech/ Hillsongs Australia, 1993 (Integrity's Hosanna!Music) ASCAP

Some of the most profound and interesting data emerging from this study has to do with what I call the 4th dimension: The spiritual realm of human experience. Participants described meaningful instances of deep human connection that were at once intuitive (expected) and startling (unexpected). These experiences involved meaningful - if fleeting - relationships with members of the 'other' culture that were regarded by the nurse as precious, and presumed to be similarly valued by the other person(s) (*Sacred Moments).* Some participants described disturbing experiences of being with patients suffering intense spiritual pain (*Encountering Spiritual Torment).* Finally, participants described their nursing response to the spiritual dimension particularly spiritual health promotion and protection (*Spirituality and Religion as Ways of Knowing in Nursing).*

SACRED MOMENTS

Dear God, May the walls which keep me separate –
from my brothers, my sisters, my self, and You – now melt.

-Marianne Williamson, Illuminated Prayers 1997 p. 36

NANCY - (in Uganda):

They scatter as it flies toward them
Thrown by a stranger.
Can they be thinking it will hurt them?
These children who have only known war?
My heart drops as they duck behind huts,
Afraid
Of my Frisbee.

Nancy's goal in bringing along Frisbees to Uganda was to connect with the children whom she would be immunizing as part of a UNICEF project – to play with them, laugh with them and watch them enjoying themselves. Instead, the children ran away in fear, misinterpreting her toy-throwing as an injurious act. This was also a poignant lesson for Nancy that catalyzed a significant change in her cross-cultural nursing practice, starting with that same project in Uganda:

NANCY:

> I really remember and still have a photo of it, of that in the jungle area of Uganda where I brought out a tennis ball out of my backpack and had learned my lesson of showing it to a child...he just stood there and looked at it and had no concept of what it was, what to do with it, he just held it in his hand. He had never seen a ball.

As I read through the transcripts of Nancy's descriptions of events that happened in her nursing practice over the subsequent twelve years, I am struck by the tenderness of her manner with strangers, the unhurried nature of her practice. When she speaks of her experiences she often refers to her belief in the intrinsic worth of all humans and her desire to convey that belief to those she meets. In order to do so, she now takes a gentle approach:

NANCY - (in Bolivia):

'Just holding their baby tenderly
in your arms
shows them that you know
how precious this little one is.

Nancy's goal and reward in her cross-cultural practice is to connect with other humans in a deep and meaningful way. She is drawn toward those whose life circumstances have left them materially or physically destitute. She volunteers as a project nurse in developing countries, looking for individuals whom she can touch physically, emotionally and spiritually. She hopes that her genuine concern and compassion will bring a sort of healing to those she encounters:

NANCY:

> There's more emphasis on [caring] in [developing] countries because if you don't heal them physically, at least they will have a lifetime to remember that you cared about them, and while there's nothing tangible about touching, I think the memory of knowing that somebody really cared is every bit as important...

SONYA:

> You've used the word healing a couple of times now but I don't think you're talking about physical healing are you?

NANCY

> Right, right. ' More on spiritual healing and mental healing. Exactly I almost think that in a cross-cultural experience more emphasis should be placed on that.

To connect with another human who is suffering is interpreted as a spiritual nursing intervention by Nancy. She speaks of deep connection with other humans as a type of spiritual balm for troubled souls.

Lynn also speaks of deep interpersonal connection. When Lynn reflected on her experience with the Dene mother who had just given up her newborn for adoption, she described the connection between herself and the mother as "meshing of feelings" and

"vibrations in the air" or "floating like an aura between us". I asked if she thought that this experience might be a spiritual connection:

LYNN:

> I wouldn't have put maybe the word spiritual but I can understand that, that sort of helps me put it into words as well – this connection, this flow of information that is going back and forth – you can't see it and it is not verbalized, but you can feel it.

Lynn has come to value this type of connection in her practice:

> [T]he more rewarding experiences are the ones where there is a connection for sure, so um, you want to be rewarded... we all act in ways that will benefit us in some way. Yeah, I think that I go in hoping for that connection.

There is something sacred about the moment where the nurse connects with her patient or members of the culturally different community. Lynn and Nancy refer to a state of readiness – looking for opportunities to connect. Nancy speaks of being able to "see in someone's eyes" that they need an extra measure of compassion, or empathy or love.

LYNN:

> I don't think we would have achieved the level of connection that we did [if I hadn't seen a caring attitude within the Dene mother, too], and I would have had to work much harder at, uh, being caring and loving. Should I say loving?

Lynn and Nancy speak of looking for a response from their patients to indicate that they, too, desire to connect. Nancy speaks of an ability to "focus" on her patients. Lynn refers to gathering an impression about a patient, noting whether she "takes a dislike to [a patient] for some reason". One reason for dislike, she speculates, may be the patient's "not being open to let you in". Thus, connection has occurred in situations where she is open at the same time that the patient is open:

LYNN:

> You have to read people's reactions. [You] perceive this barrier...and so you have to be able to pick up on non verbal cues. ...I think that opening up yourself [as a nurse] actually gives you more power to have an effect. ['Not] as in controlling them, but power to help them because when they trust you and feel comfortable with you, [you] have much more influence...So in that sense, being open is not really being vulnerable – it is being effective.

Vicki, too, speaks of looking for a response from Bolivian patients as a way to judge how receptive they might be to her closeness or connection:

VICKI:

> They watch your face because they don't have the language and so they, they can read your face so well. They can read your body language...[including] where you stand next to them...[I would stand as] close as I could as an outsider.

SONYA:

> You're using your hands to show me. You're pushing one hand up against the next as if you were feeling for that sense of boundary around the person.

VICKI:

> That's right.

Vicki desires to be as close to her patients as would be considered appropriate in that culture. For Vicki, Lynn and Nancy, connection with patients is a goal, but intimacy is not imposed. These nurses describe a personal readiness for openness and connection, but also a sense-ability to determine the readiness of patients to participate in that connection. Vicki and Lynn refer to barriers to connection that originate from patients.

Barriers to connection may also originate from the environment or the nurse herself. When I visited a pediatric ward in Guyana, I felt no desire to connect with the patients there:

SONYA - (in Guyana):

I am repulsed
and the thought of touching anything
makes me cringe.
I cannot distinguish
the children from the filth
like so many broken toys
tossed onto a garbage heap.

My guide tours me quickly around
the decaying hospital rooms
with dozens of sick or injured children
crowded into two large open wards.

Five or six abandoned children
Lay in a separate room.
Their vacant eyes staring.

One boy lying in the corner
appears to be about five years old.
He is naked except for a diaper.
One gray sheet is tangled around his arms...

Back at our living quarters
I begin to cry in the shower
I cannot stop sobbing
for hours.
Surprised, yet relieved
that I can feel *something*

Guilt, pain,
because I couldn't bring myself
to touch that boy.

How does one learn to separate out the people from the setting – the children from the filth, perhaps – particularly when doing short-term medical projects? The setting, like the one in Guyana, can seem so surreal that the people themselves also may not seem real. As a Canadian nurse, I have been exposed to images from developing countries. Scenes of war, of famine, of illness and of natural disasters stare back at me routinely from

newspapers, magazines, and television. When a cross-cultural nurse is first exposed to a scene of suffering in a new setting, it may be overwhelming to absorb all that the scene *is:* Being on a medically oriented project in a poor community may mean being exposed to untreated diseases progressed to stages never seen at home, including gross limb and facial deformities, gaping and draining wounds, unhealed fractures or extreme malnutrition. It may mean dealing with dirty bodies, clothing, and supplies. It may mean smelling a myriad of repugnant odors intensified by humidity and heat. It may involve hearing a cacophony of incomprehensible language. The setting becomes foreground - in focus; the patient in his full human-ness becomes background...'blurry.

In contrast, when the setting is familiar, it becomes a background to the daily human drama of illness and suffering. Canadian nurses may be used to human suffering - but the suffering we are exposed to in Canada is generally contained in clean hospital rooms, in predictable (and controllable) environments. Beds, sinks, intercom systems, and intravenous pumps that are in working order become taken-for-granted instruments that support the acts of nursing. One can trust that adequately prepared resource personnel will be available when summoned to clean operating suites, transport patients or perform Advanced Cardiac Life Support. Warm meal trays arrive in the hallways at set times. Each patient has an assigned physician responsible for his medical care. Lighting is available at the flick of a switch. Toilets flush. Ventilation or deodorants cover odors. And there is a clear time limit to the nurse's working day. The nurse may focus on the person she is caring for.

In an unfamiliar setting, the nurse may become focused on and distracted by the

environment. In cross-cultural nursing in developing countries, the setting may distract the nurse from *seeing* and caring for the people she came to serve. This may change as the nurse becomes more familiar with the living and working conditions.

In Nancy's practice over time, patients themselves come into clearer focus while the settings blur. Similarly, the inner nature of the patients comes into clearer focus while the physical manifestations of their illnesses blur. The patient becomes recognizable as a person – distinct from their environment, more than their physical body.

When I was in Guyana with Vicki, I did not expect to be overwhelmed by the deplorable physical conditions of the pediatric ward since I have been in similar hospitals in other countries before. What was new for me was that I *re-cognized* human-ness in the sea of children's faces on this ward. When I worked last in a developing country I did not have my own children. Perhaps the children in those hospitals did not seem quite real – being in a hospital ward was like experiencing a three dimensional version of the two dimensional media images. This time, however, I *re-cognized* my son in the body of that abandoned boy lying on the soiled mattress. His human-ness – his spirit – added a fourth dimension to the setting. I had to return to the ward – to force myself to *see* the children as more than their setting, and to respond to them as human souls:

SONYA – (in Guyana)

I enter the ward timidly
gaining courage
when I see some familiar faces-
The Guyanese nursing students.

I assist one student as she weighs a child
`a seven-year-old girl with severe burns
who screams as we lift her onto a scale.

Once she's resettled in bed
I ask her name.
"Teressa"
"Oh, that's like my daughter",
I tell her,
"She's seven also
and her name is Janessa".

Teressa smiles,
"Is she fair-skinned like you?"

This is the beginning
of an hour of conversation
as she chats about girlfriends,
schoolyard games and favorite songs.

And I read her a story
while other kids scramble onto her bed
to listen.

ENCOUNTERING SPIRITUAL TORMENT

I believe that part of what makes us uniquely human is not only our ability to see and respond to the needs of others, but also our inner need to do so.

Gary Morsch & Dean Nelson Heart and Soul 1997, p.99

VICKI – (in Bolivia):

From our home above the clinic
We could hear her crying out,
Calling out, panic-stricken.

My husband could find
no medical explanation
for her choking
But kept her overnight anyways.

By morning she had left the clinic with friends.
Two days later we find out she has died.

The people say a curse had been put on her,
And that she was frightened to death.

Vicki recalled this incident as we sat together on the terrace of our host's home in Georgetown, Guyana. Although it has been more than 2 decades since the experience, Vicki began to weep as she re-lived it:

VICKI:

> She literally had no physical symptoms but we didn't know enough about cross-cultural caring at that point to be able to discern what was wrong with her [voice falters, cries], and as Christians we weren't even sensitive enough to pray for her and pray for her healing or pray for her protection and she left.

Neither her Canadian nursing education nor her missionary orientation had exposed Vicki to spiritual causes of physical illness. Vicki still does not completely understand the cause of death of this woman, and presumes she died because of the curse itself (spiritual cause) or because she believed so strongly in the existence of a curse (psychological cause). A few years later in Zaire, Vicki and her husband cared for a patient who had a bowel disease requiring surgery. He refused treatment despite his deteriorating condition. The Zairian chaplain recognized his problem as a spiritual one:

VICKI - (in Zaire)

After 10 days back in his village
The patient has returned,
At peace, and ready now for surgery.

The chaplain had recommended that this patient go home
to find out *who* caused his bowel problem –
who may have placed a curse on him.

Vicki learned to recognize spiritual torment, to realize it exists in ways that she cannot fully comprehend, and to accept the judgment and intervention of local community members when they identify spiritual causes of physical symptoms. She says,

VICKI:

> [I]t was such a powerful lesson of being able to listen without him necessarily saying anything to us, but listening, I guess, to our own spirit, our own sensitivities that something was not right. He was refusing his surgery for some reason.

Vicki learned that the scientific/ medical model could not explain everything she encountered – that some suffering is of a spiritual nature and does not respond to Western medicine. Carla similarly encountered a patient experiencing spiritual distress:

CARLA - (in Northern Canada)

The docs in Emergency keep panicking
and phoning me for help with psychiatric patients:
If they can't give it an antibiotic
or put a cast on it
they are totally out of their league.

Even though I am on leave from my job
I traipse over to the hospital
taking my baby with me.

Well, tonight they are ready to charter a plane
to send this lady to the southern tertiary hospital
because they are terrified
of her strange, inexplicable behavior.

I look carefully.
And I remember something
That convinces me she is not psychotic:

Her grandmother is a Shaman
Who is dying
And this patient
Is struggling through the process
Of receiving her grandmother's powers.

Here Carla was able to distinguish a mental manifestation of a spiritual process from mental illness itself. The Western medical model could not account for this woman's behavior, but the physicians were not looking beyond the "bizarre" symptoms and were

anxious to abandon the problem by abandoning the woman. Carla considered the long-term implications of sending the woman out of her home community for treatment and was not eager to resort to this solution:

CARLA:

> T]his would have been another case of a little old Eskimo lady who was going to spend a lot of time in a hospital down south and end up being excluded from her own community, never able to return.

Like Vicki, Carla recognized and took seriously the possibility of alternative explanations of symptoms, even if being a cultural outsider to the community meant that she could not fully comprehend the meaning of the spiritual anguish or torment underlying the symptoms. Edith, too, has encountered people who are experiencing spiritual torment. Unlike Vicki and Carla, Edith's struggle is with cultural or spiritual solutions to physical problems that might be more easily and effectively treated by Western medicine:

EDITH - (in Africa)

The family has decided to take this gal out of the hospital
despite our concerns that she might die
or not be able to walk again
Because of her broken femur.

This is frustrating and makes my heart just weep
because we know they will probably take her to a witch doctor

Traditional medicine in this country includes
Treating tapeworm with boiled tree blossoms
that, in overdose, damage the optic nerve
and cause the child to go blind.

Traditional healers also cut out the uvula
Or dig out the eyeteeth to treat diarrhea.

In one tribe
If a child's top teeth come in before the bottom
they will leave the child out for the hyenas.

While Vicki and Carla described situations where Western medicine inhibited health and healing, Edith describes situations where *traditional* medicine inhibits health and healing. How do cross-cultural nurses attend to the unfamiliar subject of spiritual health? What is their response to human suffering of a spiritual nature?

Vicki, Carla and Edith described two possibilities. Vicki and Carla acted as *advocates* in the narratives about the man requiring bowel surgery and the Shaman's granddaughter: They supported or set into motion local cultural resources such as traditional healers and spiritual leaders. Vicki acted as an *observer* in the situation of the woman frightened to death: She monitored without intervening. These two responses do not require the nurse to act as a change-agent, but rather to support or allow the existing cultural resources to take action. The assumption underlying *advocating* is that the action taken by the local healers or community members is congruent - or, at least not terribly incongruent - with the values of the nurse. The assumption underlying *observing* is that the nurse has nothing to contribute to the situation at that moment.

What about situations such as those described by Edith where the local cultural response to human suffering is *extremely* incongruent with the cross-cultural nurses' values – such as when local families leave a child out for the hyenas to kill because of a local belief that the top teeth coming in before the bottom ones is a sign that future harm (a sort of spiritual torment) will come to the family if the child lives? Edith describes the response of one nurse in her mission organization to a situation in an African village where twins were being left out to die because of local fear that twins were an evil omen. The belief was that, if the children lived, the families would experience spiritual torment:

EDITH – (in Africa)

She couldn't stand the thought
that these twins were being killed
in response to a tribal belief
that if one twin lived,
it would bring a curse on the family

So she would rescue them
From under bushes.

I struggle with the question of how and when to intervene as a cross-cultural nurse, a cultural outsider. Considering the historical cultural imposition committed by Westerners on particular indigenous cultures, and considering the expressed desire of the participants to respect the local customs when working cross-culturally, I wondered how they made their decisions about when to observe, when to advocate and when to act as a change-agent, particularly in situations regarding spiritual health where there seems to be much room for controversy.

Acting as a change agent presumes that the nurse perceives a situation as one requiring change: She has judged the situation as "not good enough" This judgment suggests intolerance, and intervention teeters on the edge of cultural imposition. The nurse described by Edith judged the situation of leaving twins out to be killed by animals as intolerable. She imposed her own beliefs on the family, perhaps causing some spiritual distress as they anticipated having to deal with evil spirits. As a *change agent* she introduced alternative ways to address the problem. When the rescued children survived and nothing bad happened to the families, the tribe began to change their customs.

I asked Edith, a Christian missionary, about cultural imposition historically committed by Christian missionaries:

EDITH:

> [S]ometimes it's hard for us coming from a Western viewpoint to separate out what is our culture [from what may be universal truths]...and we tend to put our culture on [others]and say that's not right because it's just not the way *we* do it. ...And that's maybe why these anthropologists and others are saying "well, you're trying to change the culture" and ....we probably have been at fault in the past.

Edith is aware that missionary influence in Africa has, at times, been harmful. She tries to differentiate between behaviors requiring change, and behaviors that are simply unfamiliar. Different situations require different responses based on whether the health behaviors by community members are considered to be neutral (calls for *observation),* beneficial (calls for *advocacy)* or harmful (calls for *change-agency).* For example, she perceives feeding butter to a child as neutral; breastfeeding a child as beneficial; and scraping children's infected eyes with tree bark as harmful. Edith believes that her nursing should focus on changing the harmful behaviors. Carla agrees:

CARLA:

> I remember one faculty member [in southeast Asia]...talking about her daughter after she had her baby and they had to get her this great thing to bind her abdomen. So, your first thing is "What? These are educated people!" This new mother was a medical student. So you learn to bite your tongue over the "What?" and not say it...I think there is always a balancing act of "does it hurt them or annoy me?" .. If the matter is just annoying me, I don't have the right to be annoyed.

Prevention of behavior that causes physical harm is clearly within the boundaries of nursing practice. Carla refers to this as "the whole health promotion argument" indicating that, for her, the nursing profession has provided a framework that she may use to guide her practice regarding cultural situations that are potentially harmful. What about prevention of behavior that causes spiritual harm? In the imprecise field of spiritual health, participants have turned to non-nursing frameworks to guide their practices.

SPIRITUALITY and RELIGION as Ways of Knowing in Nursing

It's a spiritual battle, not just a situation where a bunch of people are starving

Dorothy Scheffel Journal of Christian Nursing, 1993, p. 13

EDITH (in Africa)

This particular tribe
used to take trophies
from the bodies
to prove they had killed a male.

The other tribes were very much afraid of them.
But that is slowly changing.

The Government actually said
they have noticed a decrease
in homicides, assaults, stab wounds and gunshot wounds
where our mission organization works.

Edith perceives her primary purpose for being in Africa for the past three decades as a religious one: She is a missionary with an evangelical imperative working as a nursing administrator. For Edith, addressing spiritual health is as important as addressing physical health. Supporting religious conversion to Christianity ("people coming to the Lord", "advancing the gospel") is seen as one way to promote spiritual health.

EDITH:

> [Some patients come to us and say], "We didn't come [for pills]...we came to have our demons taken out"...it was an area where there's a lot of demon worship and Satan worship and they wanted that spiritual release....
>
> What I'm doing helps [the other nurses] to accomplish what they're doing, then the church of Christ is expanding and the gospel keeps moving...[S]ometimes we have to look at [it as] a spiritual battle...I mean, Satan knows that too, and he'll throw in all the...monkey wrenches and [try] to slow us down and discourage us.

It is clear that Edith's Christian paradigm guides her nursing practice, particularly as it relates to spiritual matters and ethical dilemmas. When faced with moral decisions –

for example, how to respond to a cultural practice of killing twins – Edith uses the teachings of the bible as her ultimate standard:

EDITH:

> On this whole idea of the twins, to me I would err on the biblical side because of [biblical teachings regarding] the sanctity of life, and God created those little babies and who are we to end a life?

Nancy and Masako also described situations where they used a Christian framework (biblical standards) as a Way of Knowing. In Bolivia, Nancy considered the life of a severely dehydrated child to be of the utmost importance. She was willing to do what it took to make sure the child received medical help, because, even if her "job description" did not obligate her to do so, the bible's teachings on the sanctity of life, do. Masako's choice to forgive her director in Bangladesh was in response to the biblical imperative to "forgive your enemies" The bible gave direction to their nursing practices.

Participants also described situations where their spirituality (which may or may not be informed by a religious framework) guided their practices. Nancy stated "I just think that in certain cases God intervenes and makes it very clear that you just don't walk out". Vicki spoke of being "nudged by the Holy Spirit":

VICKI – (in Guyana)

I listen to the nurse administrators
as they plan how to gather information
to develop nursing job descriptions.

I suggest that they consider holding nursing forums
or round table discussions
and invite the nurses themselves to participate.

The administrators seem pleased,
and I am privately surprised at my insight
which I attribute to God.

Vicki gives credit to God for intervening in situations that are beyond her limited understanding or ability – 'where she does not have the nursing background or experience to draw upon in her decision-making. This "prompting" takes the form of an idea that comes to mind at a remarkably appropriate time. Vicki has learned to "listen" for the Holy Spirit's "whispers", and when she recognizes a thought as being from God, she trusts it intuitively. Being willing to "listen" to God is a significant aspect of Vicki's practice:

VICKI:

> [I]t's easy to give people an answer to a question in a difficult situation and it takes more energy, more effort to be, I find, to be a listener and to be a good listener.

SONYA:

> What's just jumped to my mind when you said that is – you're listening in two ways, then, are you not? You're listening to God in being sensitive to the leading of the Holy Spirit – Listening sort of vertically and at the same time listening horizontally. Would that be accurate?

VICKI:

> Yeah, yeah. It's not like I live my whole day necessarily consciously listening vertically. I think that's part of who I am. But sometimes, lots of times I'm just so busy that I'm just – I find that when I'm listening the most intently horizontally then I'm also listening the most intently vertically. Those go hand in hand.

Vicki perceives "nudgings" by the Holy Spirit as significant and worth heeding However, the insight she receives does not replace her nursing knowledge in nursing situations. Rather, it is supplemented by Spirituality as a Way of Knowing:

VICKI:

> [L]istening to the Holy Spirit in terms of knowledge or insight...doesn't negate a [nursing] knowledge base [or] allow me to slack off and...wait for the inspiration of God to speak to me...[A]s I read nursing textbooks or read in other areas and gain insight and information through a scientific, academic kind of knowledge base, in those kinds of situations I can be prompted by God's Spirit as I take that knowledge and use it in practice.

For participants in this study, religion and spirituality as Ways of Knowing supplement

their nursing knowledge, and provide guidance when they are faced with moral dilemmas and when seeking ways to promote spiritual health and prevent spiritual harm.

EPILOGUE

Some of the participants described experiences of sharing Sacred moments with patients or community members. These involved caring as a deep, possibly spiritual connections and were identified as profound and significant occasions. Some of the participants described encounters with patients who were experiencing or fearing spiritual torment. These nurses responded by simply observing, advocating for use of local resources, or acting as change-agents to introduce alternative solutions to spiritual problems. In these and other instances, participants used religious and spiritual paradigms to supplement their nursing knowledge. *Caring* as a phenomenon in cross-cultural nursing might involve deep connection with others, or being a spiritual change-agent.

CHAPTER EIGHT

INJURED BORDERS LIVING AMONG HUMAN BROKENNESS

A BEATING Lightfine is comforted by Dutch doctor Haumann (above, left) after seeing bruises on a man (left) who says he was tortured by Serbs.

The worst sin toward our fellow creatures is not to hate them
But to be indifferent to them.
That's the essence of inhumanity

George Bernard Shaw (1856 – 1950) Oxford Dictionary of Quotations

MASAKO – (in Bangladesh)

The doctors had given up.
They didn't have resources to treat this dying infant.
The nurses came and went
just saying "oh, she is dying"

Most patients are lower caste
and it is considered impurity
for nurses to touch their patients.

I spoke with that mother
and held her briefly.
But that was considered too outstanding in this setting.

My heart has since become numb.
I am not too emotional or sensitive anymore.
Other foreigners might see my practice now
and consider me cruel.

What is it like to be among human brokenness and suffering? Nursing exists in relation to suffering - that is, to prevent, alleviate, and help find meaning in human suffering. Extreme suffering exists in all parts of the world, but is particularly poignant in areas characterized by excessive poverty, natural disasters and war Cross-cultural nurses can be found in areas of extreme need, among woundedness. In this study, participants described personal suffering (*Personal Pain)* associated with living among human brokenness as well as personal pleasure or meaning-finding (*Surprised by Joy)*

PERSONAL PAIN

> *The only good thing left to me*
> *Is knowledge that I, too, have wept*
>
> Alfred De Musset (1810 – 1857) Oxford Dictionary of Quotations

Some of the descriptions of cross-cultural nursing experience collected for this study were painful for me to read (or hear). I, too, have lived in close proximity with

human suffering and there have been times when I have felt too raw from my own experiences to be willing to *really hear* the descriptions by other cross-cultural nurses. Nancy sent me a book entitled "We wish to inform you that tomorrow we will be killed with our families" – an account of the genocide in Rwanda by journalist Philip Gourevitch (1998). It took me months to build up the courage to read it. In his book, Gourevitch describes an encounter with a cross-cultural nurse (p. 194, 195):

> *It was on my fifth day in Rwanda, I as was getting a ride south from Kigali, that I came upon the car wreck in which the young man was killed. There were several injured survivors, and the people I was riding with took them to the hospital in Butare. Some Norwegian Red Cross Nurses came out to chat. The nurses were tending to a special emergency wing that had been set up for Kibeho [genocide] casualties...Only the worst cases remained. "Want to see?" one of the nurses asked, and led the way. Twenty or thirty cots were crowded beneath weak neon light, in a stench of rotting flesh and medicine. "the ones who're left," the nurse said, "are all machete cases" I saw that – multiple amputations, split faces swollen around stitches. "We had some with the brain coming out," the Norwegian said quite cheerily. "Strange, no? The RPA [army] don't use machetes. They did this to their own". I felt woozy and moved out to the hall, where I lay down flat on the cool concrete floor beside an open window...[The nurse said] "talk to people. They're scared. They say, what about the Zaire camps, Burundi, Tanzania? What about revenge? What about justice? OK. When people are scared like that they're also hopeful. They're saying they have something to lose- some hope" I said, "I can see you'd be a good nurse".*

If listening to accounts of human suffering is painful, writing about them is no less so. I find myself skimming over Philip's description – there are words I cannot bring myself to read again. Similarly, some of the authors of first-person accounts described particularly heartrending situations and their own response to these:

Kathleen Dier (Canadian Arctic):

> *The next morning Lucy arrived at the nursing station, having walked the three miles with the new baby in her parka, and announced that it was to be named Kathleen Gwen Ekagena. Of course Gwen and I were delighted with our new godchild. Two days later the baby's father appeared at the door looking*

uncomfortable. He reported that the baby had 'Stopped breathing". We rushed to see Lucy who resignedly informed us "yes, the baby was dead and already buried". [Later] Corporal Jones shook his head: [The father]had too many girls; it was a case of infanticide"

Canadian Nurse,1984, 80 (1), p. 22

Carey Fayne McCarthy (Nursing student in El Salvador):

For me, there was a definite separation between what I could get used to and what I felt I would never get used to – the abject destitution of the people and the suffering they endured daily. It was always difficult to see a beautiful child with the blank stare and listlessness of malnutrition or a young adult hobbling on makeshift crutches without money to have a broken leg cast.

Nursing & Health Care Perspectives, 1999, 20 (6), p. 31

Daria C. Ruffolo (in Papua New Guinea):

One day, a tribal man wearing a loincloth arrived carrying his daughter across his shoulders. He had hiked for eight hours to get her help after a falling branch had crushed her. It was apparent to the nurse in charge and to me that she had intra-abdominal bleeding. There was no radio contact or phone available for further intervention, and she quickly slipped away.

Journal of Christian Nursing, 1993, 10 (4), p. 19

Re: Mary Lightfine (Macedonian refugee camp):

At times she feels the sense of detachment developed by years in emergency rooms slipping, and once she loses her composure. It happens when Dutch pediatrician Tehi Haumann helps a 52-year-old farmer lower his pants. The man's buttocks are a hideously discolored mass of yellow and purple bruises, the result, he says, of being beaten with an iron bar by a group of Serbian men. Men he knew. Some his neighbors. He thought he was going to die. [Mary] Lightfine's face contorts, then she breaks down sobbing. "It's shocking, I know", Haumann says, comforting her, "but, Mary, these things are happening".

Tala Skari, Nurse without borders, Life, June, 1999, p. 78

In Mary Lightfine's words:

If I move fast and don't think about [the profound suffering], I'll be able to perform my work.

Tala Skari, Nurse without borders, Life, June, 1999, p. 73

Reflecting on human suffering evokes intense emotion. Gazing fully at suffering is painful in-the-moment. It is also painful on remembrance. To suffer is a universal phenomenon, perhaps manifested in different ways among different places and times. When we encounter suffering, we re-cognize it, that is, we *know again* what it is to hurt and to be tormented. In his classic novel "Cancer Ward", Aleksandr Solzhenitsyn describes human suffering in his study of how Soviet people confront terminal illness:

> *Moving his body very carefully, [Pavel Nikolayevich] turned over. The tumor was squatting on his neck, pressing against him like an iron fist. He clamored out of the bed with its sagging mattress, put on his pyjamas, slippers and spectacles and set off, shuffling quietly across the room... At the top of the staircase a hefty, long-armed, long-legged Greek, newly arrived, was writhing and groaning in agony on his bed. He couldn't lie down. He was sitting up as if the bed was too small for him. He followed Pavel Nikolayevich with his sleepless, horror-stricken eyes. On the middle landing a small, yellow-looking man, his hair still neatly brushed, was half sitting in his bed, propped up by two extra pillows and breathing oxygen out of what looked like a waterproof canvas container.*
>
> -Translated by Nicolas Bethell and David Burg, Penguin, 1969, p. 215

We recognize Pavel Nickolayevich's torment – even if we have not experienced a tumor "squatting" against our own neck, we comprehend and believe his subjective pain. His anguish is compounded by his repeated confrontation with the raw agony of others. To read Solshenitsyn's words evokes compassion or revulsion – *something*, a response.

To fully enter into another's pain means to feel pain oneself. To be in close proximity with suffering – what could be more difficult? Dominique LaPierre recognizes that it takes courage to share suffering – to choose to stay beside it. His novel "City of Joy" describes the ministries of those who have left affluent and middle-class lives to live among terrible poverty in a Calcutta slum. His character Stephan Kovalski is a priest living next to a 10 year old Muslim boy named Sabia who is dying of osteotuberculosis:

Every night at about eleven o'clock, it started up again. First came the tears. Gradually they increased in intensity. The rhythm became more accelerated and developed into a series of rattles which cascaded through the dividing wall... "Why this agony of an innocent in a place already scarred by so much suffering?" protested an indignant Kovalski. During the first few evenings the priest had succumbed to cowardice. He had stopped up his ears with cotton so that he would not hear....It took several nights before Stephan Kovalshki could accept the experience of listening to Sabia's cries and several more for his to listen to them not only with his ears but also with his heart. He was torn between his religious faith and his very human feelings of revolt.

City of Joy, Warner Books 1985, pp 106, 107

LaPierre speaks of listening "with his heart" as something distinct from merely listening. To listen this deeply is a willful act. When a nurse attends to a patient during his "work" of suffering, she is in close proximity to his woundedness. Is closeness a willful act? A choice? Is moving closer to pain an involuntary reflex?

Vicki wept at the remembrance of certain cross-cultural experiences. Other participants described particular situations as "grabbing at your heart" and "wrenching" (Lynn) and "makes your heart just weep" (Edith). The phenomenon of *weeping* is also part of the lived experience of cross-cultural nursing practice. Crying in some situations is an expression of personal pain felt or remembered. To cry in the midst of human suffering may be an expression of *Kara* caring, that is, to lament with, to grieve with, to feel another's pain as Mary Lightfine did in the Macedonian refugee camp. The feeling of detachment Mary feels in the emergency room at home "slips" and she "loses her composure". Somehow the barrier, or personal border usually separating Mary from her practice, is lowered - or expanded - to encompass the pain around her in Macedonia. There is something profound and memorable about being with another human during their suffering. To weep may be an expression of that profundity.

During our second interview, I asked Vicki about the phenomenon of weeping in cross-cultural practice. As she contemplated this, Vicki explained that to weep is her response to feeling deeply about situations, and is not limited to cross-cultural nursing practice – although perhaps there are more opportunities to be deeply affected while working in a devastated country. Vicki recalled feeling helpless after witnessing post-cyclone desolation in India in 1977. At that time, frustration, compassion, revulsion and a deep sense of injustice drew tears:

VICKI:

> My system was in shock because of the devastation...I remember that night...crying quite a lot because it...was just so overwhelming.

To cry is to release, to let go, to impress deeply, and to feel the full weight of an experience. For Vicki, feeling helpless can draw forth tears. So can feeling satisfied:

VICKI

> [The Canadian nursing students in Guyana] were standing there ...at the bedside rubbing [the laboring mothers'] lower backs, talking with them, obviously comforting them, bonding with them. That moved me to tears to think that...the students were absolutely able [to]...practice that kind of caring [which is] not just doing the task of taking the blood pressure or checking the fetal heart...but [also] standing alongside. being there for the patient, rubbing the patient's back.

Tears may be associated with a sense of wonder and joy. It seems a human paradox that even the most difficult and painful times can be the most meaningful ones. In the midst of intense pain can also be intense joy. My first request of the six participants was to "tell me a story about your cross-cultural experiences that stands out for you". Each participant chose a story that involved personal pain and struggle and, at the same time, deep personal meaning and growth. These were, it seems, significant, formative events in the lives of the participants. This significance is also mirrored in the words of Meredith Kerger, a student

reflecting on her experiences in an Albanian refugee camp:

> *I can feel the still-strong arms of a toothless Kosovar giysha (grandmother) as she kisses me... Although the language barrier between the woman and me was formidable, sitting and crying with her seemed to mean more than the medication for depression she was waiting to receive.*
>
> Journal of Christian Nursing, 2000, 17 (3), pp 24, 27

Witnessing and attending another's suffering was profoundly meaningful for the nurses: While the nurse ministers to the patient, she finds herself ministered to. It is not surprising that pain is present in the midst of suffering, but what about joy?

SURPRISED BY JOY

I make myself laugh at everything for fear of having to weep.

-Pierre-Augustin de Beaumarchais (1732 – 1799) Oxford Dictionary of Quotations

What is joy, then? A sense of deep contentment? Of personal satisfaction? Of a life well-spent? The word "joy" conjures up images of delight. This particular understanding of joy is incongruent with the lived experience of cross-cultural nurses in their painful encounters with suffering. However, laughter and humor is not absent:

VICKI (in Bolivia)

We are participating in a hunta in the highlands,
a kind of gathering of fishing people and the various churches,
and my husband is eager to use his newly acquired Spanish.

Since the society is very warm and demonstrative,
He grabs a rather rotund woman
And as he hugs her with both arms he says,
"I want an embrace"
("Lacedro embrasso").

The women break out hooting and laughing:
"Embrasso" is a word for pregnancy.

Vicki laughed as she recalled this incident. To spontaneously laugh can be to express delight. In Vicki's story, uncontrived laughter triggered a deeper connection with the people in the community as the delight was shared:

VICKI:

> Of course, everybody in the group, all the women just hooted, laughed and laughed and, of course, we had no idea what had happened... We were very popular early on [laughter]... They are excited that you are willing to try their language to use the words that you know even if you make mistakes.

While Vicki describes a situation that triggered laughter in-the-moment, Carla describes an experience that struck her as funny afterward, that is, in-the-remembering.

CARLA (in the Canadian Arctic)

The seven or eight month old twins
are being fed with "Cream"
and are very overweight.

I tell the mom that cream is an inappropriate food for babies.
She seems to acquiesce, and leaves.

Then I find out that "Cream" is Carnation milk,
and it is all the local store sells!

The humor intrinsic to Carla's story is self-deprecating, as if to say "can you believe I did that?" Self-deprecating humor was perceptible in many of the participant's stories, particularly when relating a discovery of a cultural difference between themselves and their patients:

LYNN (in Scotland for midwifery training):

> I helped [a patient] with her bath and she wanted her "tranny", [and] I had no idea what a tranny was at all! And I picked up the wash cloth, which they call a flannel, not a wash *cloth*, a lot of people call it the face cloth, and I picked up about four or five things. It was getting really frustrating 'cause I wanted to... pass her what she wanted, and I was feeling really stupid... [S]he wanted her [transistor] radio!

Humor seems to be a significant aspect of cross-cultural nursing practice. Published first-person accounts collected as data for this study also included funny stories:

Margaret Bonnette (in Haiti):

One day, we noted [that all] the fecal results were showing the exact same (and not so common) parasite...I went out to one of our clinic workers and asked if...[there was] a group of people in the waiting room who had come in from the same area? Thirty minutes later he returned laughing. It seemed that many of those sent to the latrine for a specimen couldn't produce. One enterprising young man succeeded in doing so and was selling small amounts of feces for the equivalent of five cents per sample!

Journal of Christian Nursing, 1993, 10 (4), p. 6

Andrina Raper Pasternak (nursing student) in Zaire:

[T]he Zairian nurse decided to delegate [the preparation of streptomycin injections]...I saw this group of patients in the nursing station, vigorously shaking their own medication vials to dissolve the medication in the sterile water!

Journal of Christian Nursing, 1993, 10 (4), p. 16

Kathleen Dier (in the Canadian Arctic):

[A] woman was sent from another settlement who had been bitten and required rabies treatment...One night she woke up screaming. I was sure she was rabid and frantically wondered what one did for humans in a case like this. It turned out, however, that a cockroach had stowed away in a borrowed mattress and she had apparently never seen such a thing before.

Canadian Nurse 1984, 80 (1), p. 22

Meagan Fox (in Zaire):

Learning to concentrate on [suturing wounds] while masked and gowned in 35 degree heat was all part and parcel of coping. And, as if that wasn't enough, flies would regularly land on our instruments or gloves. Some days we'd even see a small parasitic worm emerge from a wound! ...We'd laugh and carry on.

Canadian Nurse, November, 1992, p. 23

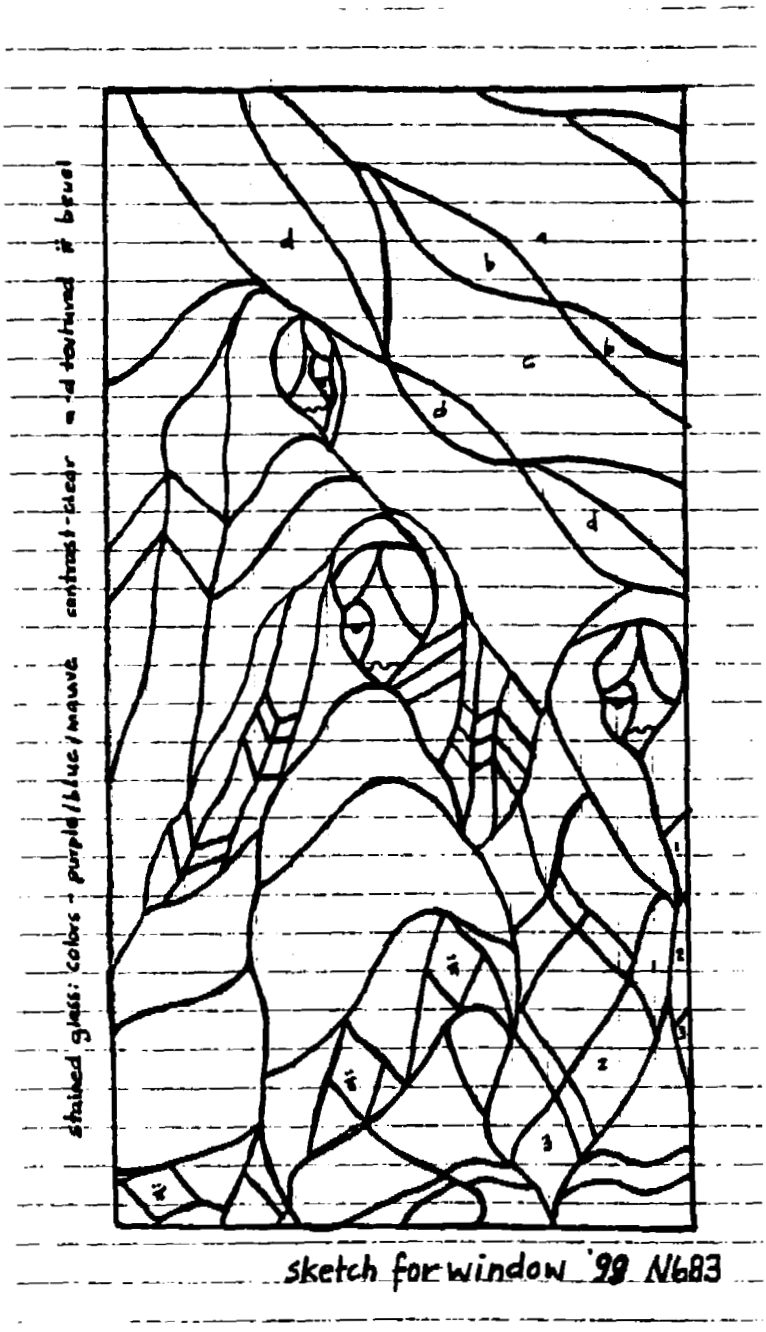
Looking for humor seems a significant characteristic of these cross-cultural nurses. Joviality may characterize some of the nurse's personalities, or, laughing may be a way to release strained emotions. Either way, humor is part of cross-cultural practice.

EPILOGUE

Cross-cultural nursing experiences may evoke intense emotion including deep compassion and concern, amusement and delight, joy and satisfaction. There is a sense that to live among human brokenness is to *really live*. Being among suffering calls forth a genuine-ness of emotion that cannot be easily guarded. There may be something freeing about "letting go" of cultural constraints about crying or laughing. To experience a range of human response to tragedy or even absurdity may be a form of caring.

CHAPTER NINE

DRAWING BORDERS: REFLECTING ON CROSS-CULTURAL ARTWORK



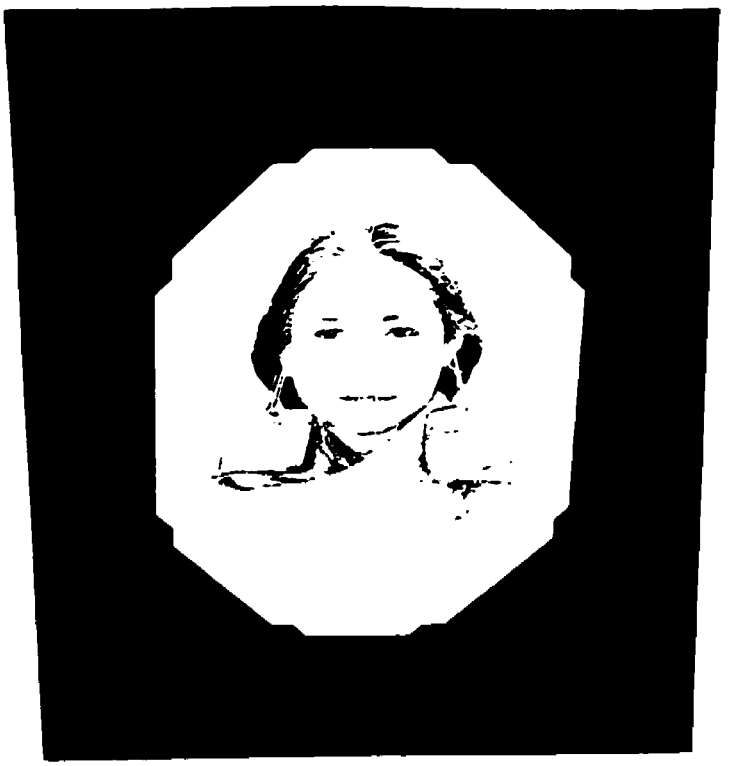
Art never expresses anything but itself.

Oscar Wilde (1854 – 1900) Oxford Dictionary of Quotations

The goal of phenomenology is to capture the "what-ness" of a phenomenon – to bring the pre-reflective experience of the phenomenon to words (van Manen, 1999). Language is used to uncover and describe the phenomenon. The artistic ability of the researcher is important in phenomenology. The final research report becomes a written creation – a work of art – that includes the presence of the researcher in its signature style (van Manen, 1999). In this study, linguistic art has been used both as data (transcripts, narratives) and as interpretation (prose). Non-linguistic (or non-textual) data has also been collected in the form of artwork: They include two professional paintings, a professional serigraph, two personal drawings and a personal stained glass window. Artwork was sought that depicted the life of members of one culture as interpreted and created by a member of another culture. The artwork will be presented sequentially, with interpretation following each piece and a discussion of themes after the last piece.

Girl with Braids (drawing by S. Grypma – nee Visser)

I sit alone in my living room trailer, having just arrived in the First Nations village where I am to live. I see people all day – in their homes, at the school, at church, in the nursing station – but I am not really a person to them. I am a nurse. "Nurse", not "Sonya". I am overwhelmed by the sense of poverty here. And abuse, alcoholism, despondency. I don't know how I'm going to make any difference – such huge problems. This girl, the one emerging under my pencil, looks back at me with big sad eyes, imploring me to do something. I like her braids, there is satisfaction in their tightness, their preciseness, their orderliness. As I draw, I feel close to her. I imagine her hair – a bit dirty, straw-like. I can almost feel it between my fingers. I make the shadows by rubbing the pencil lines with a twisted piece of paper. Shadows under her eyes. A shadow passing over her face.

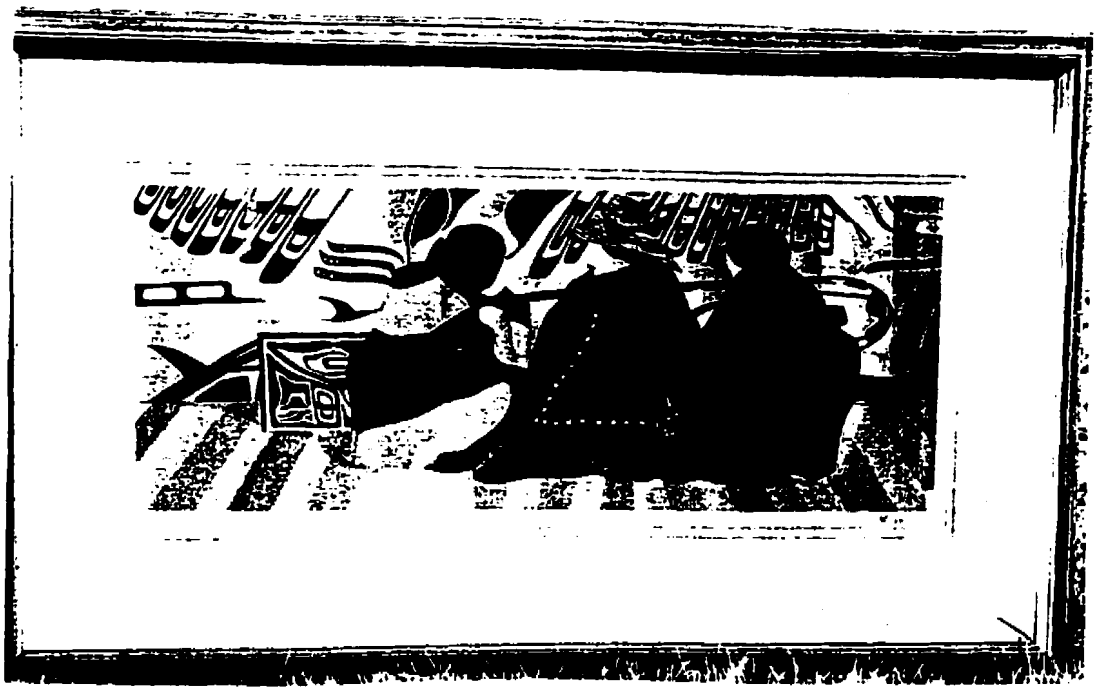


Abalone Earrings (drawing by S. Grypma – nee Visser)

She is strong, beautiful – such high cheekbones, a barely perceptible smile. She is confident and timeless in her attractiveness – even the roughly hewn abalone earrings and coarsely woven blanket to not take away from her beauty. If anything, they accentuate it. I smile as I draw, again in my trailer living room, looking out over the nursing station where I have been for over a year. I think of Reuben, an elder whose face is always shining – whose vivaciousness is not hidden behind 80 years worth of wrinkles, myopic glasses, necrotic teeth and arthritic body. I wonder if he would let me take a photo of him so that I could capture his beautiful face in a drawing. No, I dare not ask – I am not confident that he would understand my intentions.

Hutterite Boys (watercolor, Vincent Luykenaar, family physician, Alberta)

I've wanted to buy this painting from Vincent for a while – well, not this one, but one like it that was sold to another physician at an art auction last year. It reminds me of the German-speaking boys running around with my English-speaking son behind Brenda's house. Brenda is a single Hutterite woman who I met 4 years ago on her colony after her mother's knee surgery. We have become friends, she phones me almost weekly. I have moved past fascination with colony life – the polka-dot kerchiefs and black aprons; the slaughterhouse with chains to hang the chickens when they are being plucked, the walk in freezer stocked with canned beets and carrots taken from their garden, the sparse communal dining room where the men eat on one side and the women on the other. I now imagine what it is like to be living with her ill parents, taking care of her mother through diabetes, fall and spring-cleaning the chicken barn, being grateful that her thyroid cancer was discovered in the winter so that she can rest while recovering from throat surgery.



First Nations Women in Longhouse (serigraph, Irene Klar)

When I see this serigraph hanging in the art gallery, I am so taken that I take it home for a "test drive" – something I have not done before or since. My husband doesn't see what I see, and I return it to the store. I see not only the distinctive west coast art on the longhouse wall – art that I have but am not fond of – but the women themselves, wrapped tightly in cedar blankets, conversing together. This could be a scene from 100 years ago, from yesterday. I want to be part of that circle. Gazing at it allows me vicarious entrance into their lives – without the possibility of unintentional intrusiveness. I wonder what it is to be a First Nations woman. I will never know. But I receive the serigraph for Christmas.

Dance Day Ladder (watercolor print, Irene Klar)

Since discovering the Klar serigraph, I am attracted to Klar's work – mostly of indigenous women wrapped in colorful blankets. There is a timelessness to her work. I am attracted to the bright colors, the flowing lines. I can sit at my kitchen table with two kids playing beside me and imagine the impossible while examining her work, that is, being in a cross-cultural community again. There is something about her work that resonates with my soul, and I am thrilled to discover an art gallery at Granville Island in Vancouver highlighting her work: I buy 2 prints and some cards – not with the intention of sending them, but of savoring them. I do not imagine myself in the picture with the women, however. I am happy to be able to study them – how this little line, small curve peeking from under the blanket hints at the high cheekbone of an aboriginal woman. How this line denotes a hair parting that is tight, strained, but tucked into a loose bun. How this bump suggests the start of a braid. I do not realize at first that they are climbing a ladder – ah yes, a stucco house, are these Southwestern Indians? It does not matter what they are doing, but that they are together: Four distinct women, yet together.

Transcultural Caring (Stained glass window, Sonya Grypma)

Irene Klar's work inspires me to design a window featuring 3 women with colorful blankets. The challenge is to get the hard, cold, sharp glass to transform into something soft and warm. I sketch and re-sketch the design, trying each time to have more flowing lines. Flowing lines signify life, breath, and spirit. There is something about drawing these women that make me feel close to them. To me they are indigenous, not necessarily First Nations. Irene Klar does not show faces, but I must – ' a bit tricky to figure out how to make eyes out of cut glass. I find a wonderful marbled glass at the supply store, and work all the other colors around that. As I work, cutting the pieces, wrapping them with copper foil, soldering the puzzle together, I imagine the women sitting peacefully, blankets wrapped tightly over their shoulders. Am I part of the picture? If so, only as the onlooker. These women are not connecting with each other, but the potential is there.

Drawing the two pictures of First Nations girls was therapeutic for me while I was living as an outpost nurse on a Northern Canadian reservation. I kept a written journal, but drawing was satisfying at a deeper level: There was something about my lived experience that I was at a loss for words to describe. It struck me afterward how different these two portraits are: the first depicts a sad and oppressed girl, which is probably an accurate reflection of my first impression of this community of people I was living with. The second portrait, drawn almost a year later, depicts a proud and beautiful girl, also an accurate reflection of my later impression of the community. By the time I create the stained glass window, I am ready to celebrate indigenous women – and I tentatively place myself in the portrait, looking on.

Three themes emerge for me as the interpreter of these six pieces of artwork. Perhaps none of these are "accurate" interpretations according to the original artist. However, my intention here is to celebrate these works of art as possible expressions of the lived experience of cross-cultural nurses. The themes are: Humanness, Timelessness, and Relationship.

Humanness

Each of these works depicts shapes recognizable as human beings. They are not abstract to the degree of being only shapes and forms, nor are they detailed to the degree of color and texture that a photograph, or a Rembrandt, might be. Rather, they leave an impression of being human while leaving out more than they include. For example, the two paintings and serigraph do not even show the faces of the Hutterite boys or Aboriginal women. Yet we recognize them as such from such externals as clothing and

backdrop. These are not specific people – they may be anyone. Anyone who is a female Aboriginal or male Hutterite, that is. In cross-cultural nursing, there is also a sense that patients cannot be fully known. We are left with an impression. We recognize a person as fully human, but more of a group (culture) member than an individual. There is much that we miss, but still much that we appreciate about the other.

In contrast, the drawings are more particular. They, however, are also incomplete. They are in black and white, and are of faces only. Yet, they depict specific individuals. Nancy speaks to the importance, and the difficulty, of seeing patients as individuals rather than as part of a human sea. It is easier to dismiss a sea of (unrecognizable) faces than an individual. The face gives expression, even without language, to pain, suffering, joy. Lynn speaks of the importance of looking fully into another's face, of eye contact, in her cross-cultural nursing practice. For me, to really know another is to know their face. This is why I add faces to the stained glass design.

Timelessness

There is little in these five pieces of art to indicate a particular time frame. While it is not likely that one would find an Aboriginal girl wearing abalone shells dangling from strings around her ears, it is not impossible. Nor does one expect to see a group of four Aboriginal women in brightly colored blankets to be climbing onto the roof of an adobe. There is a sense that these portraits could have been created a hundred years ago, or maybe a hundred years from now. Human character, it seems, has not changed much since the beginning of time: we expect it to be so as cross-cultural nurses. We expect to encounter the same range of human emotion and human relationship in our patients as we

experience ourselves (comforting, hurting, delighting) regardless of time or place.

Relationship

To draw or paint another human brings the artist into a particular relationship with him. One can stare at a portrait in a way that would not be respectful toward a live human being. When I draw, I must look carefully at my model (usually a photograph) – the eyes are not the same, this one is more rounded, the light falls on this pupil at a different spot than that pupil; I can only see the tip of this ear, this wrinkle must be placed just so or the whole face will be out of proportion. If I can get the eyes right, then the shape of the face, then the nose, the mouth, the ears... The hair is really just shading, as are the clothes. What distinguishes the portrait are the eyes, the whole character depends on the eyes. To draw well means to be able to look carefully and be willing to leave some parts out: an artist may intentionally shade out an ear, an upper lip, even an eye – and the audience will automatically fill it in without noticing it is not there. To draw allows me to enter into a relationship with another person that is time-consuming and reflective. As I draw and erase and redraw, I consider who this person is, what makes him unique, what makes his portrait appealing. As such, I enjoy a vicarious relationship that may allow a deeper and different kind of knowledge of the person before me.

The women in the window are wrapped in blankets – perhaps representing their culture or personal comfort zones. They protect themselves with the blankets, their true selves somehow hidden. To expose oneself – to become vulnerable – may be uncomfortable... but it opens up the potential to connect more deeply with another, to enter into meaningful relationship.

Art as a Way of Knowing in Nursing

The phenomenologist takes a stance of "wonder" at the world and tries to draw out that sense of wonder in the mind of the reader of the report (van Manen, 1997). The "revocative" dimension (van Manen, 1999) of this chapter is an attempt to *bring back* vividly into presence or nearness the lived experience of cross-cultural nursing in such a way that the reader recognizes it. The "evocative" nature of aesthetic expressions of human experience (such as art) invites the reader into a *feeling understanding* (van Manen, 1999) of the lived experience of cross-cultural nurses.

The idea of using non-linguistic art forms as a way to express lived experience is not new. One just has to walk through an old cathedral or art gallery to see that artists throughout history have used various forms of art to reflect lived experience – in visual art (paintings, sculpture, quilting), dramatic art (plays, movies), and musical art (musical arrangements). However, art is not used as much today as a common "way of knowing". We are much more used to interpreting the written or spoken word (linguistics). Yet, the allure of art is that it allows the artist to express experiences that defy linguistic description while appealing to the reader to look beyond words to the more immediate experience being depicted. Art has the added advantage of appealing to a cross-cultural audience in that it does not require translation into a particular language.

One disadvantage of using art as experiential data is that interpretation, if left solely to the reader without direction from the researcher, may be "open" to the point of being rendered vague and, it would seem, useless. Using aesthetic expressions of lived experience is aided, I suggest, by the accompaniment of some linguistic description and/or

interpretation that brings the art into the context of the phenomenon being studied. Thus, the drawings of the Aboriginal girls become more "convocative" or *possessive of revealing power* (van Manen, 1999) when the reader is privy to the context in which they were drawn (outpost nursing station) and the reflective interpretations of the artist-as-researcher.

Finally, art as experiential data has the potential to be "provocative" (van Manen, 1999) if it's inclusion in the research report *incites the reader to action.* The value of including aesthetic data in this report will be in part determined by the response elicited from the reader.

EPILOGUE

Non-linguistic data can provide additional insight into a phenomenon under study. In an artist/ subject relationship, the artist may perceive beauty in the other, even when he is not fully known or fully knowable. Similarly, the cross-cultural nurse may expect to discover qualities and characteristics in the patient that transcend time and place, but that are recognizable as profoundly human.

CHAPTER TEN
NUDGING BORDERS: CREATING SPACE FOR CARING

You're blessed when you care.
At the moment of being 'care-full', you find yourselves cared for.

Attributed to Jesus Christ, The Message: The New Testament Psalms and Proverbs

The human potential to care, like human potential to be authentic, cannot be classified or characterized as a single "thing", nor can it conform to classifications... As a human potential, it can be envisioned, it can be imagined, it can be experienced, it can be learned, it can be nurtured. Caring can be called forth; it can be inspired.

Peggy Chinn. Being Called to Care, 1994, p. vii

The aim of this study has been to describe the phenomenon of caring in cross-cultural nursing practice. To do so, I started with the assumption that caring not only *exists* in cross-cultural nursing practice but that it is somehow *essential* to it. I did not propose to deliver a definitive answer to the question "What is caring?" but rather aimed to describe the lived experience of cross-cultural nurses while simultaneously asking the question "How might *this* be caring?" In this chapter I intend to tease out "caring" from the lived experience of cross-cultural nurses, highlighting some new possibilities for understanding this "worn-out" concept by comparing the findings to extant nursing literature. This chapter is divided into three sections: *Caring as Connection; Caring as Competence* and *Caring as Fostering Relationship with God.*

CARING AS CONNECTION

An understanding of caring-as-connection was evident in the descriptions of all of the participants. Lynn and Nancy's stories of deep, interpersonal connection with distressed parents of suffering children are particularly poignant. The phenomenon of caring-as-connection parallels my original understanding of "caring" as based on the gothic root Kara – that is, to cry out with, to lament with, to feel (to enter into, to share) another's pain (Blockley, 1997). Caring-as-connection for the participants involved subjective experiences of compassion and sympathy as a response to a deeply human or spiritual call. As will be discussed below, none of these constructs are new to nursing

literature: The findings of this study affirm the significant presence of caring-as-connection in nursing practice.

What is new is the *context* of connection-as-caring: This phenomenon is described in the literature in the context of North American and British (Western) health care systems, with nurses being of a similar culture as, if not their patients, at least of their employment agencies (i.e.: hospitals). In contrast, participants' descriptions affirm that caring-as-connection *also occurs* in settings where nurses are cultural outsiders to the patients' culture and to the local health care system, even in the midst of language barriers. Additionally, caring-as-connection for the participants extends beyond the walls of health care agencies into the streets – to taxi drivers and customs officers and vegetable merchants. Finally, what is new to nursing literature is an exploration of *barriers to care* encountered by the participants – particularly subjective experiences of prejudice (originating from the nurse) and lack of an engaging response by the patient/ community member (originating from the "other").

The notion of caring in nursing practice has re-gained considerable attention in recent nursing literature. In the book "Being Called to Care" (Lashley, et al, 1994), five nursing scholars speak of caring as a response to a "call" – an inner sense of longing, desire, yearning or wonder; a direct invitation; or an awakening to a sense of purpose in our lives. Participants and first-person narrators in this study describe a similar originating and sustaining "call to care" in cross-cultural nursing in that they spoke of being moved by media images of poverty and illness, of being called by God, and of being drawn to the sense of meeting a personal destiny for their lives.

The call to care requires a response. Roach (1997) describes caring as "a response to the call to be human" (p. 5). Compassion and sympathy are possible responses. Compassion and sympathy preceded caring-as-connection for Lynn and Nancy in their descriptions of connection with distressed parents of suffering children in Guatemala, Bolivia and northern Canada. Nancy and Lynn perceived the parent's love and concern for their children, and mirrored it by going "the extra mile" to meet their particular needs for medical intervention for their children, and to be involved in that process.

The concepts of compassion and sympathy are not new to nursing literature. Travelbee, in her classic work "Interpersonal Aspects of Nursing" (1966) highlights the centrality of these constructs in nursing practice. She describes sympathy as "warmth, kindness, a type of transient type of compassion, a *caring* quality experienced on a feeling level and communicated to another. It cannot be feigned or pretended, despite the most elaborate communication techniques" (p. 147). Participants depicted feeling, as Travelbee describes, "genuine concern about the misfortune or distress of another, combined with a desire to aid the afflicted individual". Nancy perceives injustice at the unavailability of medical resources for people in developing countries. She expressed deep concern over the welfare of some of the children she encountered, including the burned child carried by her father through the mountains, the severely dehydrated infant, and the malnourished child requiring hospitalization. Lynn describes her feelings of empathy for the Dene mother of the FAS newborn – she perceived the helplessness and lack of choice available to the mother who was caught in a cycle of alcohol abuse and violence. Vicki is still

troubled by the memory of the Bolivian woman who was "frightened to death", and this experience heightened her sensitivity to the influence of curses on patient's spiritual well being and physical health.

Lashley et al (1994) echo Travelbee's (1966) emphasis on personal authenticity. Data from this study affirms the centrality of authenticity to compassion. What is authenticity? Lynn speaks of the patient's ability to "really know" if a backrub, for example, is genuine or not. Vicki poignantly recalls experiencing personal pain when entering into the suffering and the joys of her patients and students. Tears cannot be summoned - they validate authenticity, as does heartfelt laughter. To weep or to laugh reveals the true self, makes one vulnerable. Authenticity and vulnerability are identified by Lashley, et al (1994) as major themes in the notion of caring. While authenticity may precede caring, caring may also precede authenticity: Roach (1997) underscores the possibility that, in caring, a nurse may become a more authentic (revealed?) human being.

Caring-as-connection occurred for the participants in the presence of compassion and authenticity. Lynn describes the deep, possibly spiritual connection with the Dene mother – a type of communication transcending verbal language. Nancy also describes deep, healing connections with some of her patients in medical clinics in Guatemala, Nepal and Bolivia. Like "caring" and "compassion", caring-as-connection has received considerable attention in nursing literature. Benner and Wrubel (1989) highlight the being-in-relation with a patient that is interpreted by the patient as "caring". That is, more than mere physical presence, caring-as-connection reflects being "in tune" with each other through eye contact, body language and tone of voice. *What* is said is not as significant as

how it is said. If so, it should not be surprising that Lynn and Nancy experienced connection with patients without having opportunity to communicate verbally (e.g.: because of language barriers). However, nursing research that has found caring-as-connection has assumed that verbal communication is necessary:

In a qualitative study exploring the experience of giving spiritual care, Pamela Cone (1997) highlights the "connecting" quality of caring. Spiritual care, she contends, involves accepting (establishing trust: assessing spirituality; valuing individual choices), supporting (identifying a spiritual need; validating the spiritual concerns; and acting by assisting or encouraging) and caring (becoming vulnerable: reaching deeper; and transcending). The cross-cultural nurses who described situations involving caring-as-connection emphasized experiences similar to Cone's third phase of "caring". As such, Lynn and Nancy described a special "inter-connectedness" with patients, a willingness to enter into an intimate relationship and a sense of being in tune to the very core or nature of another. Unlike Cone's participants, however, this "caring" phase was not necessarily preceded by "accepting" and "supporting" as described in Cone's study: Cone's participants had opportunity and ability to verbally communicate with their patients whereas Lynn and Nancy did not. Instead, Lynn and Nancy's experiences highlight the possibility of seeking and responding to deep human needs without verbal interaction.

Phenomenological studies by Smith (1994) and Butrin (1992) of American nurses working with culturally diverse clients in the United States confirm that caring-as-connection between nurses and clients is possible in the midst of language or cultural differences. Butrin (1992) found that, while clients in nurse-client dyads sometimes felt

they could not express everything they wanted, "language differences did not... appear to impede the mutual good feelings expressed in most of the encounters" (p. 246). Butrin challenges researchers to consider how and why there was a mutual satisfaction in certain nurse-patient encounters when sometimes they could barely communicate verbally and came from diverse backgrounds. Experiences described by the cross-cultural participants suggest that caring-as-connection involves listening beyond words. Participants describe an *outer seeing* and *hearing* involving noticing the context (clothing, mode of transportation, marital status) and non-verbal cues (gestures and voice inflections) of the Other person. Participants also describe an *inner listening* involving trusting intuitive understanding and spiritual inspiration arising from the Self or Supernatural Other.

The aesthetic experiential data in the form of various pieces of art depicted in the chapter "Drawing Borders" supports the significance of a relational aspect of caring in the lived experience of cross-cultural nursing. The three identified themes, that is, *Human-ness*, *Timelessness* and *Relationship* reveal an attraction to human beauty, a fascination with the range of human expression, a yearning for meaningful interpersonal connection, and a hesitation to enter into a relationship that is not welcomed by the Other. As the artist cum nurse cum researcher, I seek out alternative expressions of my attraction to, fascination of, and yearning for the humans I encounter because to acknowledge my own responses to the Other in-the-moment seems too forward, brazen...'presumptuous. I settle for being surrounded in my home by art that serves to implicitly express my inexpressible experiences.

Cross-cultural nurses in this study identified themselves as being engaged in

nursing interactions even when not "on the job". Participants clearly perceive nursing as what they *are* rather than what they *do*. Vicki emphasizes this by describing interactions with taxi drivers and merchants as potentially as therapeutic as "nurse-patient" interactions. Thus, the possibility of caring-as-connection is not bound by setting. Caring-as-connection with local nursing colleagues, students, and community members may be as inspiring, rewarding and satisfying as with patients.

For participants, caring-as-connection did not occur without the presence of nursing compassion and sympathy. Compassion and sympathy, however, did at times occur without the presence of connection. For example, in Masako's description of the Bengali mother holding her dying child in a hospital ward, Masako reached out to the mother in compassion, but the mother did not respond. In this case, the patient's personal or cultural barrier prevented caring-as-connection. Lynn and Nancy identified open-ness and responsiveness of the patient to their caring advances as key to a mutually satisfying relationship. Vicki identified the possibility of patient boundaries as determinants of how far or how deep the relationship could go. She spoke of sensing for these boundaries as part of assessment in a nurse-patient encounter. That the patient's responsiveness to the nurse influences their care seems intuitive, but the possibility of patient barriers to care has not been addressed in the nursing literature reviewed.

Finally, the participants identified personal open-ness and willingness to enter into relationship with another as necessary for connection to occur. This open-ness was, at times, hindered by the nurses' prejudice of a particular individual. Canadian researchers Clarke (1997) and Reimer-Kirkham (1998) identify an urgent need for exploration and

explication of racial or other prejudice in cross-cultural nursing practice. Lynn, Vicki and Carla speak eloquently and candidly about the presence of prejudice in their own practice. This is surprising since there seems to be a prevailing assumption in transcultural literature that the presence of racism is something not present in the practice of competent practitioners. In her classic categorization of health care practitioners, Leininger (1991) distinguishes the "genuinely interested practitioner" (the ideal) from the other types of cross-cultural health care practitioners, such as the "practitioner with a hopeless image" or the "over-protector" or the "curious practitioner" who each nurture stereotypes or prejudices toward another cultural group: Being genuinely interested is presumed to be mutually exclusive from possession of prejudice (p. 33 – 36).

Similarly, Reimer-Kirkham (1998) - in a descriptive study of Canadian hospital nurses caring for culturally diverse patients – distinguishes three types of nurses: Impassioned (the ideal), generalist, and resistant. The resistant nurse is not interested in working with culturally diverse clients, and practices both overt and covert racism. The assumption here, too, seems to be that being "impassioned" and prejudiced are mutually exclusive phenomena.

The cross-cultural nurses in this study are capable, compassionate practitioners. Yet, they also struggle with stereotypes and fears of culturally different others. They do not deny or ignore these prejudices, however. Instead, as Carla noted, they recognize, acknowledge and confront them. They distinguish between sound judgment (assessing for possibility of personal physical harm) and pre-judgment (assuming someone has characteristics often associated with others of the group he is visibly identified with, or

being offended by lifestyle choices without taking into account the context of those choices). This is an ongoing process, founded on a belief that prejudice is simply wrong and that it impedes good nursing care.

CARING AS COMPETENCE

Some of the participants emphasized the phenomenon of competence as an indicator of the presence of "caring" in their practice. Carla spoke of care-full-ness as being a thoughtful, through, skilled and reliable practitioner. Masako spoke of being compelled to act professionally in cross-cultural nursing situations – that is, being trustworthy, principled and dedicated to the role given her. Edith spoke of staying focused on an ultimate goal in the midst of bureaucratic frustrations. Nursing literature addresses the need for professional and cultural competence in nursing practice (American Academy of Nurses [AAN]1992; Andrews, 1992; Canadian Nurses Association [CNA], 1997; Canadian Public Health Association [CPHA], 1990; Princeton, 1993). What is new is the finding that caring, professional competence for the cross-cultural nursing participants involves self-direction, trailblazing and trusting one's judgment - because there is little mentorship or accessible resources to lend direction to nursing practice questions. The participants turn to personal and religious frameworks to lend direction to their practice.

Benner and Wrubel (1989) describe two aspects of "caring": being connected and having things matter. These authors contend that "Caring sets up the condition that something or someone outside the person matters and creates personal concerns. Care sets up a world and creates meaningful distinctions" (p. 1). Edith and Carla refer to this phenomenon as "caring enough [about oppression, illness, poverty, distress] to bother

[making the considerable effort to leave home, to practice in difficult circumstances]". This implies an underlying moral imperative and a highly developed self-awareness. In other words, to *care enough about* human suffering to leave one's cultural comfort zone seems morally driven. Then, to develop and sustain clinical competence in [isolated] nursing practice necessitates a clear understanding of one's own strengths and weaknesses, privileges and limitations. Participants cannot rely on direction and insight from nursing supervisors or colleagues. They have to rely on their own judgment.

Carla, Nancy and Edith speak about their decision-making as slow and methodical. This care-full-ness is reflected in Carla's phrase "stop, sit, and think". Carla thinks carefully before making a decision to attend a particular project, weighing out the personal costs and benefits. Nancy takes time with her patients coming to mobile health clinics for treatment of physical ailments, assessing them for a need for encouragement. Edith pays close attention to the numerous governmental reports she must fill, taking care not to "fudge" the answers. This is in order to preserve the integrity of her practice and the reputation of her sponsoring mission organization. Masako and Lynn honor the expectations of their agency superiors, but recognize a nursing professional obligation to first honor the perceived needs of their patients. Vicki adapts her teaching methods to accommodate the learning needs of Zairian nursing students unfamiliar with the concepts of measuring time and temperature. These decisions are made individually, without consultation with other nurses, colleagues or mentors. The participants speak of trying to do "the right thing" based on personal ethics, professional obligation, and profound respect for others. Specific virtues valued by the participants include honesty, respect,

sensitivity, compassion, forgiveness, equality, reliability and authenticity. The self-identified Christian participants use the bible as their ultimate guidebook: When faced with nursing dilemmas, they attempt to adhere to the ethical standards outlined therein.

Campinha-Bacote (1998) defines the notion of cultural competence as a process including developing *cultural awareness* (sensitivity), *cultural skills* (ability to complete an assessment), *cultural encounters*, and *cultural knowledge* (of customs & beliefs). She suggests that *cultural desire* (wanting to work with other cultures) is essential to cultural competence. I propose to extend Campinha-Bacote's model of cultural competence by expanding her concept "*cultural skill*" to include persistence and ability to find a way to meet nursing needs even without mentorship or guidance; and her concept "*cultural desire*" to include respectful curiosity and a desire to connect meaningfully with others.

CARING AS FOSTERING A RELATIONSHIP WITH GOD

While all of the participants described experiences of connection with other human beings, Vicki and Edith additionally described nursing experiences where they witnessed or catalyzed patients' spiritual connection with God. As I try to understand these events, trying to tease out spirituality from religion, I recognize that my own understanding of spirit is utterly intertwined with my personal religious values and beliefs. I am not trying to understand religion here, though, as much as relationship. Tournier (1986) asserts that what is spiritual in a person is the need for relationship. Swenson (1992) describes three types of human relationship - to self, to others, and to God. If Caring-as-Connection describes a relationship *between* the nurse and patient, Caring as Fostering a Relationship with God describes a *transcendent* relationship.

A Modern Perspective

While I struggle to interpret the experiences described by Vicki and Edith, I realize that I am wandering back and forth between three worldviews – Modern, Postmodern, and Biblical. For example, if I look through a Modern lens to interpret the phrase "Expanding the kingdom of God" as used by Edith, I find an objective explanation useful: A missionary nurse may be convinced of the authority and absolute, literal truth of the bible, and strongly identify with the scriptural imperative to go out to "all nations, baptizing them in the name of the Father and the Son and the Holy Spirit, teaching them to observe all that I have commanded you" (Matthew 28:19). Her ultimate mission may be to see others convert to Christianity [cause] as a means to establish their relationship with God [effect]. Objective (and measurable) rituals such as prayer for remission of sins, public profession of faith, and baptism are understood as necessary for both membership in the church and as evidence of the new relationship with God. Vicki and Edith speak of promoting spiritual wholeness through initiation and support of rituals such as prayer, bible reading and leading others through a set process of conversion.

A Postmodern Perspective

If I use the Postmodern lens to interpret the notion of "Coming to know Christ", I find subjectivity a useful concept. The nurse's perception of what her patients are experiencing is personally constructed, as is the patient's perception. Since the existence of God or the reality of Divinely-generated spiritual transformation is not fully knowable, proof of these may not be as significant as the patient's subjective *experience* of fellowship with the Divine. To witness a patient's transformative event may be profoundly

meaningful for the nurse, too, regardless of the religious or cultural paradigm that supports the event. For example, a Christian nurse may find inspiration in a Buddhist patient's experience of spiritual harmony as understood within an Eastern paradigm.

The strength of using the Postmodern lens to interpret the phenomenon of spiritual transformation is that it moves us away from reductionistic, causal and detached thinking. Postmodernism invites us to open up new possibilities of understanding rather than closing down thought. The Postmodern worldview challenges the absolute/ism that has characterized Western civilization, including Western Christianity. Cultural and personal relativism are founded on Postmodern tenets (Beckwith & Koukl, 1999) and are attractive in that they respond to and protest the absolute objectivity that devalues personal experience and ultimately devalues persons.

The difficulty of using Postmodern thought to interpret the notion of "coming to know Christ" is that radical cultural relativism does not acknowledge the possibility of transcultural truths, ethics and standards (Shelly & Miller, 1999). If truth is socially constructed, then to "come to know Christ" has no ultimate value because the significance of a relationship with God lies not only with the subjective experience of relationship, but also with an acceptance of the existence of objective reality and absolutes (e.g.: "biblical truth" that God is omnipotent, omniscient, omnipresent, and that Christ is Divine). Looking through either a Modern or Postmodern lens to understand the lived experience of Vicki and Edith seems inadequate.

A Biblical Perspective

A Biblical worldview seems to most closely parallel the worldview of Vicki and

Edith. Nurse scholars Shelly and Miller (1999) distinguish a Biblical worldview from both the Modern and Postmodern worldviews by contending that it values both subjective and objective truth, providing both are tested by Scripture. The difficulty is that, while the Bible is understood to be God's Word, holy and sacred and true, ultimately individual human beings with multiple perspectives interpret it – and interpret it differently.

An undated class handout entitled "Interpretive Principles (Hermeneutics)" from Reagent College in Vancouver declares that, since the bible is an Eastern (Hebrew) form of religious literature, those of us who have a Western (Greek) mindset must make a mental shift from Greek to Hebrew to "properly" understand the bible. Western Christians bring their background, education and tradition – that is, their culture - to scripture interpretation. Edith seems to recognize this when she describes the historical missionary approach to cross-cultural work as promoting the Western paradigm. Vicki and Edith seem open to new understandings of the biblical foundations essential to their work.

It is striking to me how much "Greek" thinking, as discussed the Reagent College handout, resembles the Modern paradigm. Similarly, "Hebrew" thinking resembles the Postmodern paradigm (as postulated by Harman, 1992, as "wholeness science"). Greek thinking is general, ideal, rational and detached, while Hebrew thinking is particular, realistic, intuitive and involved. Where Greek thinking asks about cause and origins, Hebrew thinking asks about meaning and destiny. Greek thinking defines, while Hebrew thinking describes. A Biblical perspective may include both Modern (Greek, Western) and Postmodern (Hebrew, Eastern) thought.

Historic Christian missionaries (including nurses) have been criticized for

reflexively practicing Western cultural imposition. In contrast, Vicki and Edith (indeed, all of the participants) portray a profound sensitivity to and respect for local customs, beliefs and practices. Vicki and Edith believe that fostering a relationship with God is a *transcultural* phenomenon: It *trans-cends* cultural differences. They emphasize feeling a responsibility *to* rather than a responsibility *for* patients.

The apparent shift in thinking away from Western colonialism in missionary nursing noted in the practice of Vicki and Edith is also reflected in nursing literature. Literature from specifically Christian sources (e.g.: the Journal of Christian Nursing) clearly supports nursing as an evangelical ministry in cross-cultural situations. For Christian nurses, the vision of nursing may be to "Bring Jesus Christ to Nursing Worldwide" (Nurses Christian Fellowship International conference brochure, 2000).

As I browsed through nursing literature written by self-identified Christian authors, I expected to find guidelines for "leading patients to Christ" (initiating religious conversion to Christianity). Instead, I found directives that challenge Christian nurses to provide the peace of "shalom", a state of spiritual wholeness in which a person dwells at peace in all relationships (Shelly & Miller, 1999; Bradshaw, 1994). Bradshaw emphatically contends that "shalom" is best offered *not* by words, but in the sensitivity and skills of the nurse's actions. The nurse comes alongside her patient, "sharing his burdens in unconditional love by a free giving of herself in all her own limitation[s]" (Bradshaw, 1994, p. 326). Bradshaw insists that nurses may *not* impose their beliefs on the patient, who she sees as vulnerable and captive.

Similarly, Shelly and Miller (1999) offer guidelines to Christian nurses for practice

in a pluralistic world, including: Avoidance of ethnocentrism; practicing modified cultural relativism (appreciation and respect for other cultural practices); seeking humility and tolerance (trying to understand difference); acceptance of people where they are; and praying (for wisdom, understanding, and discernment). Shelly and Miller recommend that Christian nurses pray for "an opening to talk about Jesus Christ" (p. 113), but clearly find religious imposition objectionable.

Vicki and Edith value the ongoing nurturance of their own (transcendent) relationship with God. Their practices reflect their belief that a sustained relationship with God is central to spiritual health and wholeness, that relationship to God is achieved through belief in the divinity of Jesus Christ and his message as recorded in the bible, and that spiritual care involves fostering a relationship with God. For Vicki and Edith, fostering this spiritual relationship is seen as a definitive response to spiritual torment, distress and emptiness. They describe three possible outgrowths of a restored relationship with God: 1) the negation of and protection against curses and possession of evil spirits; 2) a new relationship with one's body – seeing it as a holy place (a vessel indwelled with the Holy Spirit of God), and thus a "temple" worth caring for and taking responsibility for; 3) restored relationships with other human beings. Thus, Fostering a Relationship with God is understood to promote physical, spiritual and community health.

NURSING IMPLICATIONS – Continuing the Conversation

It is impossible to summarize phenomenology, and to reduce the findings into categories of Caring-as-Connection, Caring-as-Competence and Caring-as-Fostering a Relationship with God already diminishes the rich data into abstracts that in themselves

may not accurately reflect the lived experience of the cross-cultural nurse participants. However, the question inevitably remains: "So what?" What is the significance of these findings to the larger body of nursing knowledge? Themes regarding cross-cultural nursing practice that strike me as valuable for wider dissemination include:

1) Being unprepared and unguided

2) [Non] Risk-taking

3) Relationship between expatriates

4) The existence of prejudice and racism

5) Encountering spiritual torment

6) Fostering a relationship with God: A nursing imperative?

1) Being Unprepared and Unguided

None of the six participants had undergraduate education in transcultural nursing concepts prior to their cross-cultural experiences. All have sought out courses and resources to supplement their basic nursing knowledge, but they believe that a lack of critical educational preparation is potentially harmful to themselves and their cross-cultural patients. Participants lamented not having nursing mentorship. Two recommendations arise from this study:

1) Undergraduate nursing curricula should incorporate guided cross-cultural clinical experiences and transcultural nursing concepts.

2) Ways to better connect cross-cultural nurses (in practice and academia) into a supportive network should be sought (e.g.: using the Internet for newsgroups).

Academic and practicing nurses with extensive experience in cross-cultural nursing should consider how they could be more accessible to cross-cultural nurses in practice and to students interested in cross-cultural work. Creative ways to connect experienced and novice nurses (e.g.: via the Internet) should be further explored. One strategy to share practice knowledge could be to develop and distribute a practical "guidebook" including a list of sponsoring agencies, packing lists, risk assessment, and transcultural concepts.

2) [Non] Risktaking

The perception of cross-cultural nurses as risk-takers (i.e.: extraordinary) may diminish the attraction of "ordinary" nurses into cross-cultural work. The nurse participants in this study are extremely competent and care-full in their assessment of risk factors involved in cross-cultural practice, but much of their preparatory work remains hidden and taken for granted. To articulate the work involved in setting up a trip would be useful in the creation of a guidebook (above), and would also alert potential nurses and schools of nursing to the amount of organizing involved – for their own preparation and to help determine course value accredited to students and instructors.

3) Relationship between Expatriates

To be able to anticipate the close proximity with other expatriates may be helpful for those preparing to do cross-cultural work. Relationships may be a source of stress or comfort, and the "success" of a project may be related to the ability of expatriates to work with each other as well as with local health care professionals. Research on the inter-relationship between health care professionals may explore ways to best collaborate.

4) The Existence of Prejudice and Racism

It is surprising, yet somehow reassuring, to find that compassionate and competent cross-cultural nurses struggle with racist, prejudicial and stereotypical ideas. It is valuable to be able to differentiate between situations where fear and caution is warranted (potential personal harm) and where it is unwarranted (offense at presumed lifestyle choice). Participants in this study recognize personal prejudice and confront it in-the-moment. Revealing and admitting to prejudice by cross-cultural nurses opens up opportunities for all nurses to discuss this phenomenon candidly, with the hope that honesty may be a first step to addressing racism in nursing practice.

5) Encountering Spiritual Torment

Cross-cultural nurses may be called to respond to situations of extreme spiritual distress in the lives of their patients – often in ways not typically encountered in Canadian nursing practice. It is not clear if spiritual sources of illness such as curses or spiritism are not as prevalent in the dominant Canadian culture as they appear to be in indigenous cultures, or whether they are somehow hidden. Two implications arise from the findings:

1) Further research into the response of indigenous nurses to spiritual torment of same-culture patients could give important insight into alternate ways to address issues influencing spiritual health, including spiritual issues affecting physical health.

2) Further research into the life ways of indigenous and non-dominant cultural groups living in Canada may elucidate the existence of and community response to prevention and treatment of spiritual torment, and promotion and restoration to spiritual health.

6) Fostering a Relationship with God: A nursing imperative?

While there is increased attention being paid to spirituality in North American nursing practice, not much attention has been paid to the role of nurses' religious values. beliefs, and practices. Some participants experienced more freedom to explore and integrate their religious beliefs into their practices in unfamiliar cultures than when practicing at home: Religion seemed to be more of a contentious issue in North American nursing than in non-Western cultures. Fostering a Relationship with God using a Biblical perspective is a controversial construct, and it may be tempting to dismiss this as a non-nursing phenomenon, or a narrowly defined one. However, there seems to be much value in opening nursing practice to conversations of God.

Further study of the nature of spiritual transformation as understood within diverse worldviews and from patients' perspectives is warranted to help understand whether or when different forms of spiritual transformation are beneficial to human spiritual health in nursing practice.

PARTING WORDS

The paradox of phenomenology is that the actual lived experience of the participants in this study is necessarily different from what is presented in this report. The words I chose to evoke understandings of the phenomenon of caring in cross-cultural nursing practice reflect my perspective – my interpretation – of the participant's stories. The stories themselves are reflective interpretations of the actual events they describe. The best I can hope to offer, as a researcher, is a "snapshot" of the lived experience, realizing that the lived moment I have tried to capture is long gone, forever changed, and never-to-be-repeated.

But snapshots can be valuable, timeless even, when they evoke us to Re-cognize ("know again"), Re-flect ("turn one's thoughts upon"), Re-consider ("ponder anew") and Respond ("answer").

In the end, the readers will determine the value of this study. If a cross-cultural nurse re-cognizes herself in these words, if aspects of this report cause the reader to pause and reflect and reconsider, if, in short, the reader *responds* to what is written, I will consider this study a success.

cross-cultural nursing calls me

to embrace the full range of human experience...

to embrace life itself

REFERENCES

Alpers, R.R., & Zoucha, R. (1996). Comparison of cultural competence and cultural confidence of senior nursing students in a private Southern university. Journal of Cultural Diversity, 3 (1), 9 - 15.

American Academy of Nursing Expert Panel on Culturally Competent Care (1992). Culturally competent health care. Nursing Outlook, 40 (6), 277 - 283.

Andrews, M. M. (1992). Cultural perspectives on nursing in the 21st century. Journal of Professional Nursing, 8 (1), 7 - 15.

Beckwith, F.J. & Koukl, G. (1999). Relativism: Feet firmly planted in mid-air (2nd ed.). Grand Rapids, MI: Baker Books.

Benner, P. & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Menlo Park, CA: Addison-Wesley.

Bernal, H. & Froman, R. (1993). Influences on the cultural self-efficacy of community health nurses. Transcultural Nursing Society, 4 (2), 24 - 31.

Bernal, H. & Froman, R. (1987). The confidence of community health nurses caring for ethnically diverse populations. Image, 19 (4), 201 - 204.

Blockley, C. (1997). A Christian perspective of caring. Christian Nurse International, 13 (1), 8-9.

Bradshaw, A. (1994). Lighting the lamp: The spiritual dimension of nursing care. Harrow, Middlesex, UK: Scutari Press.

Butrin, J. (1992). Cultural diversity in the nurse-client encounter. Clinical Nursing Research, 1 (3), 238 - 251.

Campinha-Bacote, J. (1998). The process of cultural competence in the delivery of healthcare services: A culturally competent model of care (3rd ed.). Cincinnati, OH: Transcultural C.A.R.E.

Campinha-Bacote, J. (1995). The quest for cultural competence in nursing care. Nursing Forum, 30 (4), 19 - 24.

Canadian Nurses Association (1997). Code of ethics for registered nurses. Ottawa, ON: Author.

Canadian Public Health Association (1990). Community health /public health nursing in Canada: Preparation and practice. (3rd ed.). Ottawa, ON: Author.

Chinn, P. L. (1994). Foreword. Being called to care. Albany, NY: State University of New York

Clarke, H. (1997). Research in nursing and cultural diversity: Working with First Nations peoples. Canadian Journal of Nursing Research, 29 (2), 11 – 25.

Cone, P. (1997). Connecting: The experience of giving spiritual care. In B.M. Artinian & M.M.Conger (eds.) The intersystem model: Integrating theory and practice Thousand Oaks, CA: Sage.

DeSantis, L. (1994). Making anthropology clinically relevant to nursing care. Journal of Advanced Nursing, 20, 707 - 715.

Elliot, T. S. (1971). The four quartets. Cited in M. B. Clark and J.K. Olson Nursing within a Faith Community: Promoting Health in Times of Transition (2000) Thousand Oaks, CA: Sage.

Gourevitch, P. (1998). We wish to inform you that tomorrow we will be killed

with our families: Stories from Rwanda. New York, NY: Farrar, Strauss and Giroux.

Grossman, D. (1994). Enhancing your cultural competence. American Journal of Nursing (July). 58, 60, 62.

Grypma, S. (1999). Initiating the process of cultural competence: Examination of a First Nations clinical field placement. Presented at Western Region - Canadian Association of University Schools of Nursing Conference, February 21 - 23, Kananaskis, Alberta.

Hadwiger, M.C.& Hadwiger, S.C. (1998). International perspectives: Transcultural nursing experience in the Philippines. Nurse Educator, 24 (1), 12 - 15.

Harman, W. (1992). Assumptions, corollaries, and characteristics of two sciences: A comparison. Institute of Noetic Sciences (class handout, N605, University of Calgary).

Hayes, L., Quine, S. & Bush, J. (1994). Attitude change amongst nursing students towards Australian Aborigines. International Journal of Nursing Studies, 31 (1), 67 - 76.

Kulwichi, A. & Bolonik, B.J. (1996). Assessment of level of comfort in providing multicultural nursing care by baccalaureate students. Journal of Cultural Diversity, 3 (2), 40 - 45.

Lashley, M.E., Neal, M.T., Slunt, E.T., Berman, L.M., Hultgren, F. H. (1994). Being called to care. Albany, NY: State University of New York Press.

Leininger, M. (1994). Culturally competent care: Visible and invisible. Journal of Transcultural Nursing, 6 (1), 23 - 25.

Leininger, M. (1991). Classic: Becoming aware of types of health practitioners and cultural imposition. Journal of Transcultural Nursing, 2 (2), 32 - 39.

Munhall, P. L. & Oiler Boyd, C. (1993). Nursing research: A qualitative perspective. New York, NY: NLN.

Morsch, G. & Nelson, D. (1997). Heart and soul: Awakening your passion to serve Kansas City, MO: Beacon Hill

Murphy, K., & Clark, J. M. (1993). Nurses' experiences of caring for ethnic-minority clients. Journal of Advanced Nursing, 18 (3), 442 - 450.

Nouwen, H. J. M. (1994). Here and Now: Living in the Spirit New York, NY: Crossroad.

Ogilvie, L. & Paul, P. (1999). International dimensions of nursing education in Canada. Unpublished report, University of Alberta, Faculty of Nursing.

Outlaw, F. (1994). A reformulation of the meaning of culture and ethnicity for nurses delivering care. MEDSURG Nursing, 3 (2), 108 - 111.

Oxford University Press (1978) The Oxford Dictionary of Quotations (2nd ed. of 500th anniversary edition). Oxford, UK: Author.

Peterson, E. (1995). The message: The new testament psalms and proverbs (3rd ed.). Colorado Springs, CO: Navipress.

Polit, D. F. & Hungler, B. P. (1995). Nursing research: Principles and methods (5th ed.). Philadelphia, PA: Lippincott.

Pope-Davis, D. B., Eliason, M. J., & Ottavi, T.M. (1994). Are nursing students multi- culturally competent? Journal of Nursing Education, 33 (1), 31 - 33.

Princeton, J. (1993). Promoting culturally competent nursing education. Journal of Nursing Education, 32 (5), 195 -197.

Reimer Kirkham, S. (1998). Nurses' descriptions of caring for culturally diverse clients. Clinical Nursing Research, 7 (2), 125 - 146

Roach, M. S. (1997). Reflections on the theme. In M. S. Roach (Ed.), Caring from the heart: The convergence of caring and spirituality. Mahwah, NJ: Paulist Press.

Rodriquez-Wargo, T. (1993). Preparing for cultural diversity through education. Journal of Pediatric Nursing, 8 (4), 272 - 273

Rooda, L. A. (1993). Knowledge and attitudes of nurses toward culturally different patients: Implications for nursing education. Journal of Nursing Education, 32 (5), 209 - 213.

Shelly, J.A., & Miller, A.B. (1999). Called to care: A Christian theology of nursing. Downers Grove, IL: Intervarsity Press.

Smith, C. A. (1994). The lived experience of care within the context of cultural diversity. Journal of Holistic Nursing, 12 (3), 282 - 290.

Spector, R. E. (1996). Cultural diversity in health and illness (4th ed.). Stamford, CT: Appleton & Lange.

Swenson, R. (1992). Margin. Colorado Springs, CO: Navpress.

Talabere, L. R. (1996). Meeting the challenge of culture care in nursing: Diversity, sensitivity, competence, and congruence. Journal of Cultural Diversity, 3 (2), 53 - 61.

Tournier, P. (1986). A listening ear: Reflections on Christian caring. (translated by E. Hudson - original French edition Editions de Caux, 1984) Minneapolis, MN: Augsburg.

Travelbee, J. (1966). Interpersonal aspects of nursing. Philadelphia, PA: FA Davis.

van Manen, M. (1999). Phenomenology Workshop. Presented at Advances in Qualitative Methods Conference, February 18, 1999, Edmonton, Alberta

van Manen, M (1997). Researching lived experience: Human science for an action sensitive pedagogy (2nd ed.) London, ON: Althouse Press.

van Manen, M. (1984). Practicing phenomenological writing. Phenomenology and Pedagogy, 2 (1), 36 - 69.

Williamson, M. (1997). Illuminated prayers New York, NY: Simon & Schuster.

FACULTY OF NURSING

Research Project Title: Exploring Caring in Cross-cultural Nursing (Master of Nursing thesis)

Investigator: Sonya Grypma. B.N., M.N. student Telephone: (403) 220-7460

Sponsor: Dr. Beverly Anderson (supervisor) University of Calgary, Faculty of Nursing Fax: (403) 284-4803

Email: banderso@ucalgary.ca

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand the accompanying information.

The purpose of this study is to better understand the concept of cultural caring and it's place in actual cross-cultural practice by exploring the experiences of nurses who choose to work cross-culturally.

If you decide to participate, the study will involve you participating in a 1 - 2 hour interview at a time and place of your convenience. You will also need to be involved 1 - 2 subsequent phone or email interviews that will focus on discussing the analysis of the interviews with the researcher. These interviews will be audio-taped and transcribed to allow for more thorough reading of the information. You may request that the interview not be audio-taped, in this case, the researcher will take detailed notes during the interview. The audiotape will be coded with a number so that no names or personally identifying information will appear on the transcriptions. Both the audiotape and a list of code numbers and names will be kept in a locked cabinet, available only to the researcher. The audiotape will be erased and all other material destroyed after seven years. Because the nature of the study is to elicit highly personal practice stories, there is a minimal risk of emotional discomfort in the sharing of sensitive information. No other risks or discomforts are expected to result from the interviews.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission.

The information you provide may assist nurses in their work with culturally diverse clients. It may also assist in the direction of future nursing research and education. The study has no direct benefit to you, and you will not receive any compensation for your participation. No financial costs will be incurred to you as a condition of participation.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigator, sponsor, or involved institution from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have any further questions related to this research, please contact:

Sonya Grypma (MN student) at (403) - 380 -3706, or
Dr. Beverly Anderson (Supervisor) at (403) - 220 - 7460.

If you have any questions concerning your rights as a possible participant in this research, please contact the **Office of Medical BioEthics, Faculty of Medicine, University of Calgary, at (403) - 220 - 7990.**

Participant's Signature	Date
Investigator and/or Delegate's Signature	Date
Witness's Signature	Date

A copy of this form has been given to you to keep for your records and reference.

UNIVERSITY OF CALGARY

APPENDIX B

FACULTY OF MEDICINE

Office of Medical Bioethics
Heritage Medical Research Building/Rm 93
Telephone: (403) 220-7990
Fax: (403) 283-8524

2000-01-20

Dr. B. Anderson
Faculty of Nursing
University of Calgary
PF 2230
Calgary, Alberta.

Dear Dr. Anderson:

Re: Exploring the Phenomenon of Caring inCross-Cultural Nursing
Student : Ms. Sonya Grypma Degree: MScN

The above-noted thesis proposal has been submitted for Committee review and found to be ethically acceptable. Please note that this approval is subject to the following conditions:

(1) a copy of the informed consent form must have been given to each research subject, if required for this study;
(2) a Progress Report must be submitted by 2001-01-20, containing the following information:
    (i) the number of subjects recruited;
    (ii) a description of any protocol modification;
    (iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
    (iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
    (v) a copy of the current informed consent form;
    (vi) the expected date of termination of this project;
(3) a Final Report must be submitted at the termination of the project.

Please note that you have been named as a principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Ian Mitchell, MB, FRCPC
Chair, Conjoint Health Research Ethics Board

cc: Dr. M. Reimer
Ms. Sonya Grypma