

Cultural Discovery in Nursing Practice:  
The Experience of Nurses' Who Work with Vietnamese  
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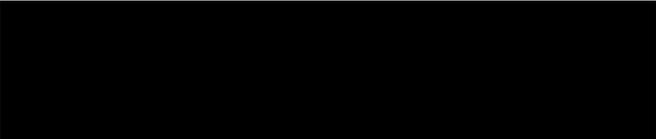
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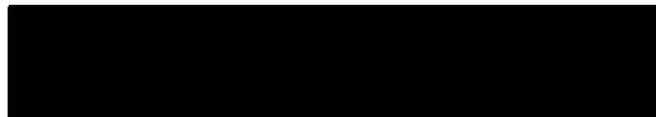
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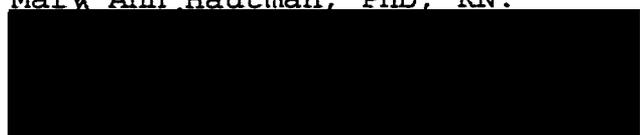
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## ABSTRACT

### Cultural Discovery in Nursing Practice: The Experiences of Nurses Working with Vietnamese.

The purpose of this investigation was to generate a substantive theory of cultural discovery among nurses who work with Vietnamese. A grounded theory approach involving dimensional analysis was employed. A purposive sample of 27 registered nurses with experiences working with Vietnamese in acute care, community, and clinic settings was interviewed using a semi-structured format. Data were analyzed for dimensions as well as conditions, context, action strategies, and consequences. The theory of *cultural discovery* described how nurses *learn to see* their Vietnamese clients, how they saw a *common humanity* with others, and how they learn to see *health*. Nurses who made cultural discoveries were able to *connect* with their clients. The conditions for connection included *using prior knowledge, learning to know* the Vietnamese, *taking extra care* when providing care, and being able to develop a *shared brokering* relationship with interpreters. Taking extra care included *being respectful* in a culturally appropriate way, *doing a bit more* than the usual nursing care, and *developing partnerships* with clients.

Shared brokering included working with *interpreters as translators* as well as using their expertise as *cultural professionals*. Nurses' experiences of cultural discovery affected their world view and taught them how to provide sensitive care for people who were different from themselves. Nurses learned to see their own culture and *redefine what was important*. Sensitive care involved *learning how much to push* a particular health approach, *using resources* in an effective way, *building bridges* with their Vietnamese clients and *dealing with glitches in the health system*. A consequence of the nurses' care was that Vietnamese were helped to take charge of their own health care needs. Nurses who were not connecting with their clients provided *standard care* that did not reflect the sensitivity nurses learned through cultural discovery. The findings of this study offer a theory of cultural discovery for nurses who work with Vietnamese. The theory has implications for nurse educators, practitioners, researchers, and managers working in multicultural settings.

February, 1997 Evelyn Labun

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## PREFACE

This study of nurses' experiences in working with Vietnamese comes out of a long standing personal interest in how immigrants and refugees adapt to their new surroundings in a new country. In a previous study Labun (1986) discovered how Vietnamese women understand health. The purpose of the present study was to explore how nurses, in both the U.S. and Canada, learned to work with Vietnamese over the past fifteen to twenty years.

The idea for this study arose out a discussion I had with my academic advisor, Dr Perri Bomar. I was hoping to do an assignment, in my ethnography class, that involved interviews with Vietnamese. However, that would have required finding a sample in a community and country where I was a foreigner. The alternative suggestion was to interview the nurses who work with Vietnamese. The suggestion proved to be a very fruitful one and helped me learn a valuable lesson in research - use the restrictions of your research setting to your best advantage.

During the process of data gathering for this class project I was singularly impressed by the depth of perception and caring that nurses' in both Canada and the U.S. brought to their work. Often starting from little understanding of Vietnamese, nurses learned about their clients and how to help them as individuals, families, and

as a community. They learned how people, different from themselves, can be happy, healthy, and meet their goals and expectations for a contented life experience for both themselves and their families. I was also, once again, impressed by the fortitude and willingness of the Vietnamese people to start a new life for themselves in a new and very different country. My hope is that this study of nurses will contribute to the discussion of how to provide culturally sensitive care.

I would like to acknowledge the support of my many friends and colleagues in both Canada and the U.S. as I undertook this adventure at this time in my life. Specifically I would like to acknowledge Jean Burrows, the Chair of Nursing at Red River Community College; Ruth and Woody Wirt of San Diego who opened their home to me; Nettie and David Geiger and Mary Giesbrecht who provided a home for me during data collection; and my Nurses' Christian Fellowship colleagues in Canada for their support. I would also like to thank my advisor Dr. Diane Hatton, and my committee members Dr. Mary Ann Hautman and Dr. Lance Nelson. Without their continued support, critique, and encouragement this study would not be possible.

TABLE OF CONTENTS

PREFACE . . . . . ii

TABLE OF CONTENTS . . . . . iv

LIST OF TABLES . . . . . viii

LIST OF FIGURES . . . . . ix

LIST OF APPENDICES . . . . . x

CHAPTER ONE THE FOCUS OF THE INQUIRY . . . . . 1

    Culturally Competent Care . . . . . 2

    Purpose of the Study . . . . . 4

    Crosscultural and Transcultural Nursing  
    Knowledge . . . . . 5

    Researching Culturally Competent Care . . . . . 6

    Significance of the Study . . . . . 7

    Conclusion . . . . . 10

CHAPTER TWO A REVIEW OF THE LITERATURE . . . . . 11

    Vietnamese Migrations . . . . . 12

    Refugee Beliefs About Health . . . . . 14

    Intercultural Relationships . . . . . 15

        Situation Based Intercultural  
        Literature . . . . . 16

        Competing World Views in Intercultural  
    Relationships . . . . . 19

        The Negotiating Model . . . . . 22

        Intercultural Relationships as a  
        Process . . . . . 27

	Intercultural Relationship Training	
	Models and Competencies . . . . .	33
	Conclusion . . . . .	41
CHAPTER THREE	EPISTEMOLOGY AND THE USE OF INTERPRETIVE RESEARCH IN THE DEVELOPMENT OF CULTURAL KNOWLEDGE USEFUL IN NURSING PRACTICE . . .	44
	Interpretive Research . . . . .	45
	Symbolic Interactionism . . . . .	47
	Grounded Theory . . . . .	49
	Researching Nurses' Experiences with Vietnamese . . . . .	50
	Conclusion . . . . .	52
CHAPTER FOUR	THE PROCESS OF INQUIRY . . . . .	54
	Sample . . . . .	55
	Data Collection Procedures . . . . .	62
	The Process of Analysis . . . . .	66
	Designation Phase . . . . .	67
	Differentiation Phase . . . . .	68
	Integration Phase . . . . .	74
	Conclusion . . . . .	74
CHAPTER FIVE	FINDINGS OF THE STUDY . . . . .	76
	Overview of the Theory of Cultural Discovery . . . . .	76
	Detailed Discussion of the Theory of Cultural Discovery . . . . .	81

Cultural Discovery . . . . .	81
Learning to See Them . . . . .	81
-Seeing communities and families . . . . .	82
-Seeing individuals . . . . .	83
Seeing a Common Humanity . . . . .	85
Seeing How They See Health . . . . .	86
Connecting . . . . .	88
Using prior knowledge . . . . .	89
Learning to know them initially . . . . .	91
-In the community . . . . .	92
-In clinics . . . . .	95
-In the acute care hospital . . . . .	96
Taking extra care . . . . .	97
-Being respectful . . . . .	98
-Doing a bit more . . . . .	100
-Developing partnerships . . . . .	101
Shared brokering . . . . .	104
-Interpreters as translators . . . . .	105
-Interpreters as cultural professionals . . . . .	107
Changes in the Nurse . . . . .	109
It Just Feels Worthwhile . . . . .	109
It Affected My world . . . . .	111
Redefining What is Important . . . . .	114
Learning a Balance . . . . .	116

	Providing Sensitive Care . . . . .	118
	Learning how Much to Push . . . . .	119
	Learning to Use Resources . . . . .	123
	Building Bridges . . . . .	126
	Dealing with Glitches in the System	130
	Helping Them Take Charge . . . . .	133
	Not Connecting . . . . .	134
	Standard Care . . . . .	137
	Conclusion . . . . .	138
CHAPTER SIX	IMPLICATIONS AND CONCLUSIONS . . . . .	140
	The Use of Grounded Theory in a Study of Nurses' Experience . . . . .	140
	The Literature and the Study Findings .	141
	Theoretical Contributions to Nursing Knowledge . . . . .	145
	Further Areas of Research . . . . .	146
	Implications . . . . .	149
	Nursing Practice and Administration	150
	Nursing Education . . . . .	153
	Conclusion . . . . .	154
REFERENCES	. . . . .	156

LIST OF TABLES

TABLE NUMBER	TITLE	PAGE NUMBER
1	CHARACTERISTICS OF PARTICIPANT'S WORK EXPERIENCE.....	58

LIST OF FIGURES  
FIGURE NUMBER

TITLE

PAGE NUMBER

1

SCHEMATIC REPRESENTATION OF  
THE MAIN DIMENSIONS OF THE  
THEORY OF CULTURAL DISCOVERY.

....80

LIST OF APPENDICES	PAGE NUMBER
APPENDIX A UNIVERSITY OF SAN DIEGO COMMITTEE ON THE PROTECTION OF HUMAN SUBJECTS.....	172
APPENDIX B UNIVERSITY OF SAN DIEGO CONSENT TO ACT AS A RESEARCH PARTICIPANT.....	177
APPENDIX C INTERVIEW GUIDE AND DEMOGRAPHIC QUESTIONS.....	179

## Chapter One

### THE FOCUS OF THE INQUIRY

The American Academy of Nursing (AAN) Expert Panel on Culturally Competent Care (AAN, 1992) has identified an immediate and growing need for culturally competent care in an increasingly multicultural society. The panel acknowledges the critical need for further development of appropriate theories and models which the predominately white, middle class, Western educated nurse in North America will use to provide nursing care to people of all cultural backgrounds or any ethnic group.

The Vietnamese are a significant ethnic group within a multicultural North American society. There are 614,547 Vietnamese persons in the United States (U.S. Department of Commerce, 1993a). This represents 0.2% of the total population. Vietnamese are found in all parts of continental U.S. in significant numbers. There are 60,509 in the Northeast, 51,932 in the Midwest, 168,501 in the South, and 333,605 in the West (U.S. Department of Commerce, 1993b). California, Virginia, Texas, and Florida are the states with the highest concentration. Moreover, of the Vietnamese living in the U.S. a high percentage were born in a foreign country (approximately 79.9%).

The numbers of Vietnamese coming to the United States

continues to increase dramatically. Between 1980 and 1990 69.7% of all Vietnamese residing in the U.S. were immigrants compared to 27.1% between 1975 to 1979 (U.S. Department of Commerce, 1993c). The population tends to be young (median age of 25.2 years) and male (52%) (U.S. Department of Commerce, 1993c; U.S. Department of Commerce, 1993d).

The total Canadian Vietnamese population was 84,005 in 1991 (Statistics Canada, 1993). In 1983 the total was 66,000 (Statistics Canada, 1985). Vietnamese are distributed in the major metropolitan centers in Canada such as Toronto, Montreal, Vancouver, Calgary, Edmonton, Ottawa-Hull, and Winnipeg (Statistics Canada, 1993).

The AAN Expert Panel's (1992) concern for culturally competent care includes care for the Vietnamese populations described above. A study of nurses' experiences with Vietnamese was done to further the AAN Expert Panel's goal of providing knowledge which can be used in providing culturally competent care.

### Culturally Competent Care

What is culturally competent care? The AAN Expert Panel has defined such care as "care that is sensitive to issues related to culture, race, gender, and sexual orientation" (AAN, 1992, p. 278). Culturally competent care is provided by nurses who use appropriate models and

theories of cross cultural knowledge to guide their practice within the cultural context of the client. Nurses who work with Vietnamese are within such a context.

DeSantis (1994) moves beyond "mere sensitivity" into "culturally informed" nursing practice in her definition of culturally competent care (p. 710). Accordingly nurses who use culture to inform their practice are (a) aware of their own cultural bias and how they shape their nursing practice, (b) open to cultural differences, (c) able to learn from the client and accept this new information as part of their practice, and, (d) able to utilize cultural resources and knowledge within the scope of their practice. Cultural competence involves sensitivity to culture and the individual within a specific cultural context. The nurse uses cultural knowledge gleaned from studies of culture as well as personal knowledge of clients as an integral component of assessment, planning, and implementation of care.

Campinha-Bacote (1991b) has proposed a culturally competent care model which views the development of cultural competence as a process, not an end-point. Competence involves cultural awareness, cultural knowledge, cultural skill, and cultural encounter. The culturally aware nurse develops an appreciation and sensitivity to the values, beliefs, practices, lifestyles, and problem solving

strategies used within the client's culture.

The nurse also comes to understand how personal values and biases may affect the care offered to clients. Nurses develop cultural awareness, knowledge, and skill through reading books, attending workshops, or through the media. More informal encounters such as providing client care and personal encounters with culturally diverse groups of people are additional ways that nurses learn about the effect of personal values and biases on their care. The nurse is able to gain an understanding of the *emic* or insider client world view as well as of the *etic* or outsider perspective of the client within the wider community and health care system through such experiences, and thus provide culturally appropriate care (Aguilar, 1981). There was, however, no researched theoretical base for understanding how nurses include culture as an integral component of their care (AAN, 1992).

#### Purpose of the Study

The purpose of this study was to examine how nurses have informed and shaped their practice when working with Vietnamese clients. Five aims provided a framework for the study and guided the examination of nurses' experiences with Vietnamese. The study analyzed:

1. What nurses learned from their experiences in working with the Vietnamese clients.
2. How nurses described their learning when working with Vietnamese.
3. How nurses perceived culturally competent care within their experience of working with Vietnamese.
4. What unanswered questions nurses had in relation to their work with Vietnamese.
5. How nurses changed their care as they gained experience working with Vietnamese.
6. What changes nurses made in their personal lives as a consequence of their work with Vietnamese.

#### Crosscultural and Transcultural Nursing Knowledge

How have nurses, who are educated within the Western bio-medical, English speaking, health provider culture, worked with Vietnamese clients who hold different cultural values? Nurses have written about their experiences with Vietnamese and provided descriptions of how they are attempting to provide culturally sensitive care to various cultural groups (Leininger, 1967; Orque, Bloch & Monrroy, 1983; Spector, 1991). There is, however, little clinically based research and there are no well-tested and -researched models for cross cultural care (AAN, 1992; Morse, 1987).

Leininger (1970; 1978; 1991) is one of the first nurse

researchers who made a concerted and longstanding effort toward launching the study of transcultural nursing in North America. Her model is based upon the theory of Cultural Care Diversity and Universality and examines the meaning of care for a particular culture in order to be culturally sensitive to that group. Her model is based upon the care knowledge and ways of caring found in a particular culture. Such care forms the basis for the nurse's care decisions and actions. Nurses use strategies which seek to preserve/maintain, accommodate/negotiate, or repattern/restructure caring patterns. The research generated by Leininger's model examined a specific culture and the caring practices of that culture (Leininger, 1991). Examples of cultures studied are Old Order Amish (Wenger, 1988) and Anglo-Canadian (Cameron, 1990).

#### Researching Culturally Competent Care

Nursing is a practice discipline which is concerned with the health and care of individuals, groups, families, and communities (Chalmers, 1989; Hanchett, 1988). It is holistic in that the practice of nursing is directed toward the health needs (broadly interpreted) of the whole person, group, family, or community. Nurses work within a relationship with clients and their families to maximize health or assist them to a peaceful death (Henderson, 1966).

In addition, nurses who work in cross-cultural situations are working with people who speak many different languages, have had many different life-changing experiences, and now find themselves in complex health care situations. Nurses are expected to care for these clients with the resources available and within the parameters of nursing practice.

The AAN (1992) has called for the development of expertise in culturally competent care and nursing research methodologies which will support the development of knowledge in this approach to care. Interpretive methods examine "the lived experience from the point of view of those who live it" (Schwandt, 1994, p. 118). All interpretive researchers watch, listen, ask, record, and examine what they see, hear, and experience. Such knowledge, generated from the experiences of nurses who work with Vietnamese, has further illuminated the answer to the overriding question of "What is culturally competent care?"

#### Significance of the Study

The importance of cultural knowledge in the provision of nursing care is well documented (AAN, 1992; Leininger, 1970; Morse, 1987; Muecke, 1992; Wilkins, 1993). Research on cultural knowledge among nurses indicated that nurses are still unaware of the importance of such knowledge

(Rothenberg, 1990). Morse (1987) has indicated that relatively little nursing practice knowledge is based on research. The bulk of cultural knowledge used in nursing practice is gleaned from other disciplines or is basic knowledge involving cultural beliefs and practices. The AAN (1992) has identified that terms, concepts, or methods borrowed from other disciplines often carry meanings and nuances that are not well understood and can create problems for nursing. As Capers (1992) has stated, "We need to move our knowledge ... to the full examination of cultural applications that have worked in various practice settings" (p. vi).

Berry (1984) stated that both the host culture and the refugee are changed in the acculturation process if there is to be successful integration with minimal acculturation stress for the refugee. Integration implies that the refugee is able to maintain an ethnic cultural identity while taking on some of the characteristics of the host culture. The host culture's attitudes and oneness with people from other groups is an important factor in integration and reduction of acculturation stress (Berry & Annis, 1974).

Dobson (1991) stated that nurses must develop proficiency in discovering and using cultural information if they are to provide culturally relevant care. To work with

different cultural groups nurses must learn to incorporate cultural assessment, in a very deliberate way, into the assessment aspect of care and then learn to use such information in providing culturally informed and sensitive care (Dobson, 1988; Dobson, 1991). Nurses must carry out this work in an atmosphere, and with an attitude, that is characterized by transcultural reciprocity (Dobson, 1989). Reciprocity involves mutual action and influence.

Nurses have played a role in assisting Vietnamese families in making a successful adjustment to life in North America. They have helped the Vietnamese family in its health care decisions and use of Western health care services. To be successful in their work with Vietnamese, nurses need to learn from their experiences and then make changes in how they provide care when working with Vietnamese (Cohen, 1982; Dobson, 1989).

Kanitski (1988) has called for a "transcultural world view of nursing care" (p. 10). Such a world view would form the basis for values and orientations for nursing care within a culturally diverse society. Such values provide for sensitive individual and group assessment processes and yield culturally appropriate care. A transcultural world view of nursing care would inform policy and system changes, enhance professional judgements, provide professional and consumer satisfaction and give direction to nursing

education programs (Burrows, 1983; DeSantis, 1988).

This study was an initial examination of the experience of nurses working with Vietnamese. North American nurses have had experiences with significant numbers of Vietnamese clients since the arrival of refugees beginning in the early 1980s. A specific perspective was taken, namely that of the experiences of specific nurses within a specific context. The study illuminated the experiences of these nurses and gave direction to further areas of research in the study of culturally competent care.

#### Conclusion

The AAN Expert Panel and others have called for the development of a well researched disciplinary knowledge base which would guide the delivery of culturally competent care. This study of nurses' experiences with Vietnamese extended the knowledge of how nurses provided care. The interpretive approach to research provided the philosophical underpinnings, for this study, of how nurses have informed and shaped their practice when working with the Vietnamese. The next chapter will review the literature related to the study.

## Chapter Two

### A REVIEW OF THE LITERATURE

The perspective taken in this study of nurses' work with Vietnamese was that of how nurses have informed and shaped their practice with Vietnamese because of their experiences. The researcher examined the process of cultural discovery as well as the conditions, context, and consequences. A review of the literature revealed little that spoke directly to the perspective taken in the study. A number of areas, however, provided information and insights which were helpful in understanding the nurses' experiences.

The literature reviewed was drawn from the immigration and health care fields as well as from the disciplines of anthropology, education, business, and management. Literature from across disciplines, which relates to a specific theme, will be discussed together thematically.

The themes used to structure the review of literature relate to background knowledge of Vietnamese migration patterns, Vietnamese health concepts, as well as more

general cultural concepts and their practical application.

### Vietnamese Migrations

Vietnamese refugees began to come to the United States and Canada in significant numbers in 1975 after the fall of the Thieu regime (Indra, 1987; Stauffer, 1995). Stauffer (1995) and Indra (1987) have identified three distinct waves of migration of Vietnamese refugees to North America. Prior to this, the only identifiable group of Vietnamese in North America were the "elites" who arrived before 1975 and were composed of scholars and highly trained professionals who lived in large urban centers.

The first wave of refugees arrived in North America between 1975 and 1978 (Indra, 1987; Stauffer, 1995). They were relatively well educated, often had military connections, or were related to former students who had come to North America to study. The resettlement of this group, as with the elites, who arrived before 1975, was generally fairly smooth because of their resources of language, understanding of Western culture, personal connections, and educational backgrounds.

A second wave of refugees arrived between 1979 and 1980. Both Canadian and U.S. Vietnamese refugees were similar in these years in that they were extended family groups of Chinese-Vietnamese ethnic origin. These refugees

were generally well educated, and had been part of the business community in and around Saigon (Indra, 1987; Stauffer, 1995). They tended to see themselves as distinct from other groups of Vietnamese refugees (Rutledge, 1992).

The third group of refugees known as the "boat people" began arriving in Canada in 1978 and in the U.S. during the 1980's (Indra, 1987; Stauffer, 1995). They were sponsored by government, private citizens, relief groups, or churches. This group of refugees had lived through tremendous economic, political, and social changes in their home country as well as life threatening situations at sea. They often spent months to years in refugee camps awaiting placement. Many arrived with poor health, little education, and considerable psychological trauma.

Since that time additional Vietnamese have come as part of family reunification or further sponsorship programs. Many of these families have spent years in refugee camps and the children may have been there since early childhood or been born there. Such programs continue until the present time.

Distinct groups can be identified within the three waves of refugees. One group that stands out are the Amerasians (Rutledge, 1992). Amerasians are children of Vietnamese mothers and American service men. They came to the United States either on their own or with their mothers

and other family members. They are of mixed race and may be either Caucasian-Asian or Afro-Asian. Generally they have grown up with strong influences from the maternal side of the family and so have a Vietnamese cultural background (Rutledge, 1992).

Another distinct group that can be identified among the Vietnamese refugees are those who are in ethnically mixed marriages such as households of Thai-Vietnamese or Chinese-Vietnamese (Statistics Canada, 1993). Their identification with Vietnamese refugee groups would vary according to their own circumstances.

Vietnamese boat people that arrived in North America were composed of both adults and children. Adults would most likely have at least a grade school education from Vietnam. They may have spent considerable time in refugee camps. Often their children were born there. In general these families came from urban or rural settings in Vietnam and belong to the middle to lower economic levels of society.

#### Refugee Beliefs about Health

It is almost twenty years since nurses first began caring for people of Vietnamese ethnic origin. During this time Vietnamese have continued holding traditional health beliefs and practices as well as using Western biomedical

health care (Rutledge, 1992). In a study of the Vietnamese concept of health Labun (1986) found that, among Vietnamese families in Canada, health decisions were made using a framework which included specific beliefs about the appropriate use of health practices originating in Western, Sino-Vietnamese, indigenous, and spiritual understandings of health and health care. Tung (1980), who writes out of his experiences with Vietnamese, supports this finding. These beliefs spring from a seamless holistic view of life which has roots in Vietnamese and Chinese social, philosophical, and religious traditions (Rutledge, 1992).

The availability and use of Western biomedical health care has affected traditional Vietnamese views and practices. Vietnamese in North America have shown a desire to adapt to their new homeland as well as to retain their traditional beliefs and practices (Rutledge, 1992). Nurses have been observers and care givers as Vietnamese in North America have made decisions about health and health care (Grosso, Barden, Henry & Vieau, 1981).

### Intercultural Relations

Different authors took different approaches in their discussions of intercultural relationships. Some authors focused on situation based cultural discussions and solutions. Others viewed intercultural relationships as

involving competing world views and suggested that negotiation strategies were needed in such situations. A third approach described intercultural relationships in process terms that involved learning, change, and mutuality. The final theme in this review involved education and training models which described a variety of different conceptual frameworks and competence based models useful in intercultural training programs. These models were applied primarily in business and management.

The literature in this review was chosen because of the relevance it had to the aims and results of the study. It provided a background of information for understanding the experiences of nurses.

#### Situation Based Intercultural Literature

A situation based approach to the discussion of cultural care was one approach taken by a number of authors. Situation based discussions were characterized by descriptions of specific health care experiences that were obviously influenced by cultural beliefs and practices. A number of authors used this approach in their deliberations of culturally sensitive care.

Calhoun (1986) provided a short general overview of Vietnamese history, religion, socio-cultural factors and health care beliefs and practices which should serve as a

basis for health care adaptations that the nurse must make in order to provide culturally sensitive care. She then described a number of health care situations (e.g. specific folk health beliefs, discrepancies in standard growth charts when used with Vietnamese children, and specific Vietnamese dietary habits) which would call for further modifications in the nurses' care. Calhoun's (1986) overall attitude toward culturally sensitive care was that the nurse should modify care "learned through formal education and experience with American clients" in such a way that their care for Vietnamese was "culturally appropriate" (p.22).

Three other authors who wrote about their studies of post-partum Vietnamese mothers used a similar approach to intercultural care. They examined specific health practices and discussed the implications these had for culturally sensitive practice. One study by Rossiter (1992) used both qualitative and quantitative methodologies (N of 70) and one qualitative study by Wadd (1983) used a convenience sample of 20. A third study by Henderson and Brown (1987) (N = 20), in a descriptive study of infant feeding practices in the U.S., advocated that nurses try to understand the meaning of breast and bottle feeding for Vietnamese mothers. In each case the authors examined specific health care attitudes and practices in the post partum period and then identified some implications and modifications for nursing

practice. All three authors described such traditional health practices as infant feeding, rest for the new mother, and how mothers tried to deal with these issues in their new homeland.

A study by Pham and McPhee (1992) examined Vietnamese women's attitudes toward breast and cervical cancer. The results of this quantitative study of 400 randomly selected Vietnamese women indicated that women did not have a sound knowledge base in cancer diagnosis or treatment. The authors suggested that a new approach to treatment was needed and that language and culturally appropriate educational programs be developed so that biomedical science approaches could be used to treat these women.

A situational approach to culturally sensitive care does take the culture of the client into consideration. These authors focused on the problem as being periodic or confined to one area and continued to see mainstream and biomedical values and practices as dominant and normative. The client's culture was seen as different from the mainstream or usual way of doing things. The authors also tended to remain on the behavioral level rather than develop an understanding at the values level.

The Japanese Economic Research Institute (1989) differentiated between civilization which is manifested by outward, material practices and ways of acting, and culture

which is characterized by words such as ethos, ideology, and a sense of value. Their position was that when two cultures meet in interaction there is cultural friction which can be resolved by a superficial adaptation in the civilization. However, such action does not create culture. The authors stated that historically nations that adhered blindly to their own cultures were unable to evaluate the merits of the other and therefore were doomed to decline. For a culture to benefit from intercultural friction it was necessary to be open to change at the core of the culture. A simple adaptation of care practices, therefore, would not benefit the parties involved.

#### Competing World Views in Intercultural Relationships

Another approach in understanding intercultural relationships focused upon the intercultural experience from the view that two very different and even competing world views are involved in an intercultural encounter.

Neiderhaus (1989), in a discussion of health care for immigrant children, recognized that competing value systems may be inherent in situations involving clients and nurses. She advocated that nurses learn to understand their own health care provider culture in order to recognize how and why conflict may arise during care.

According to Neiderhaus (1989) recognition and

acknowledgement of two world views paved the way for greater understanding and therefore the beginning of trust in the relationship. Health care adaptations involved such things as recognizing cultural bias in screening tools, being an active listener, and gaining knowledge of culture through cultural information in libraries and national nursing associations.

Leininger's (1991) model of intercultural relationships also recognized the aspect of competing values in a situation involving a nurse and clients who come from different cultures. Leininger (1991) strongly supported an in-depth knowledge of culture as necessary in order to avoid cultural imposition and ethnocentrism. Such knowledge must be grounded in a broad understanding of various cultural factors such as kinship, political and legal matters, economics, education, religious and philosophical beliefs and values, technological factors and cultural values and lifeways.

Nursing decisions and actions, according to Leininger (1991), must be based on an understanding of the health, care, and caring practices of the specific client. Culturally congruent nursing care decisions and actions are based on cultural care preservation and maintenance, cultural care accommodation and negotiation, and cultural care repatterning and restructuring.

Campinha-Bacote and Ferguson (1991a) applied Leininger's Cultural Care Diversity and Universality model in a theoretical discussion of care for African-American child bearing families. The authors, however, described how some African-American families make conscious decisions to reject the general attitudes, behaviors, customs, rituals, and stereotypical behaviors associated with being Black. Such acculturation, according to Campinha-Bacote and Ferguson (1991), was not seen as a negative concept but amounted to intercultural borrowing which was of benefit to both cultures. Within this environment the nurse needed to take an accurate culturalogical assessment and apply cultural care decisions and actions by listening to the individual client's perceptions of the health care problem. A final treatment plan was negotiated with the cultural aspects of care included in the process.

Campinha-Bacote and Ferguson (1991a) identified one of the difficulties of making a culturological assessment when the nurse is under the assumption that the client belongs to a specific cultural view and stereotypes the person from that culture. Barth (1995) and Schipper (1993) pointed out the need to view culture as fluid, changing and dynamic. A more fluid and changing view of culture would point to knowledge of "people's engagement with the world through action" (Barth, 1995, p. 66). Barth (1995) stated that a

dynamic view of culture would allow greater openness between knowledge of culture and the use of cultural knowledge in situations of practical application - one example being the practice of nursing.

Shipper (1993) argued that a better comprehension than the distinction between "insider" and "outsider" is required to comprehend peoples' self-understanding in today's world. Change takes place, not only between cultures, but also within groups. Shipper (1993) contended that a more extensive study of the theories that people have about themselves and how they express themselves is what is needed.

A further danger in holding to the competing cultures view was documented in a study by Blenner (1991). In this qualitative study of health care providers (N - 28), Blenner (1991) found that knowledge of culture and recognition of cultural differences, may but did not necessarily, result in cultural sensitivity in care. In some cases culturally different clients were labeled as "difficult", "unwilling", or "uncooperative" (1991 p. 26), and did not receive any treatment but were discharged from the care provider's caseload.

#### The Negotiating Model

A third approach to understanding intercultural

relationships involved the process of negotiation. Anderson (1990) identified the negotiation model as a way that nurses determine the client's perception of an illness and an acceptable treatment. The nurse learned about the client's understanding of the illness and explained the professional scientific model to the client.

Other authors have expanded on the negotiation model by drawing on the anthropological concept of brokering between two cultures. Dennis (1994) used such a descriptor to discuss his work in a Latin American study abroad program for a consortium of U.S. liberal arts colleges. He defined the cultural broker role, from the anthropological literature (Swartz, 1968; Wolfe, 1956), as a person who is competent in two cultures and languages and can relate the two different groups to each other. The person must be bicultural and bilingual in order to act as a go-between when two distinct and contrasting cultures are involved.

Dennis (1994) argued that the importance of the broker has to do with how communities integrate into a larger social system. Dennis (1994) learned, during his broker activities, that the single most important factor in promoting positive personal relationships between groups was resolving inter-group conflicts and problems.

Hopkins et al. (1977), in a study of the role of cultural brokers in an urban setting, supported Dennis's

(1994) observation. The cultural broker was seen as playing a "key role in urban and social processes" (Hopkins et al., 1977, p. 72).

Eisenhauer (1986), indicated that nurses were well suited to the "go between" brokering role consumers wanted as they faced increasing complexity and diversity in Western health care. According to this author, nurses served as cultural brokers between the popular and ethnic cultures of society and the orthodox and scientific cultures of the health professions. Nurses also served as health information brokers helping clients understand and access important health information. Eisenhauer (1986) argued that, as health service brokers, nurses assessed clients' needs, helped them decide on services, and then assisted them to access those services to meet their needs.

Tripp-Reimer and Brink (1985) identified strategies that nurses use in relationship to the brokering role. These authors argued that three strategies are needed for successful cultural brokering to take place. These are (a) taking power from the clinician and giving it to the client, (b) providing for sufficient time for the negotiation process to take place while using the client's non-technical language and maintaining a professional manner, and (c) treating the cultural assessment as a process of learning and gathering of cumulative data in a particular situation

rather than simply a content area.

Within the cultural broker role, according to Tripp-Reimer and Brink (1985), the nurse must call on a translator, if needed, to assist in creating the link between two parties. The authors stated that if an interpreter is present the nurse is still responsible for the meaning of the words and the emotional impact upon the situation.

Both Haffner (1992) and Hatton (1993) described the interpreter role as being one of brokering in intercultural communication. Haffner (1992), speaking from personal experience as a professional interpreter, described her experience in a health care setting. Haffner (1992) argued that the health care situation is too complex to rely on a family member or on cleaning staff with some knowledge of the language. Hatton (1992), in her qualitative field study (N= 34) of Spanish interpreters, found that although interpreters may be a *voice box* or an *excluder*, the best interpretation took place when the interpreter was also a *collaborator*. In other words the nurse and interpreter both took on some of the aspects of what Dennis (1994) defined as the broker role.

Jezewski (1990; 1993) has developed a model of cultural brokering based on a study of nurses' experiences with

migrant farm workers. In this model nurses take on an advocacy role using the intervening conditions of competing cultural values, powerlessness of the client, politics, the economics inherent in the health care context, and networking possibilities as important factors in the goal of providing culturally sensitive and needed health care.

Other writers have variously called the negotiating role of the cultural broker that of mediator (LaFarque, 1985), therapeutic ally (Kleinman, Eisenberg & Good, 1978), cultural bridge (Cohen, 1983), and as aspect of the case manager's role when caring for the chronically mentally ill (Schwab, Drake & Burghardt, 1988).

Weidman (1975) and Sussex and Weidman (1975) saw roles of knowledge development through research and training of staff as an essential component of the brokering role in the care of the chronically mentally ill. West (1993), writing out of an American Indian context, described the brokering role as one where cultural differences and uniqueness, within a meaningful relationship, was possible without changing the cultures of either party.

Barbee (1987) cited some tensions in the brokering role in her study of nurses in primary health care settings. This author found that the experience of native Botswana nurses working within Botswana culture, but within a Western bio-medical health system, raised conflicting and competing

values for these nurses. The nurses understood the Botswana culture, as well as the Western bio-medical health system, within which they were working. However, nurses were extremely ambivalent about cooperating with traditional healers. A small group of nurses rejected their Botswana culture outright. According to Barbee (1987) many nurses developed a position of peaceful co-existence with the conflicting feelings they experienced between some traditional healing practices and their professional Western bio-medical health beliefs. Accommodation within this context meant that nurses allowed spiritual healers to pray for the sick in the hospital if patients requested this. However, Barbee (1987) argued that a pervasive belief in the connection between sorcery and traditional specialists prevailed. As a result nurses had little desire to cooperate with traditional specialists.

#### Intercultural Relationships as a Process

The authors who wrote about intercultural relationships as a process described situations in which ordinary nurses, in multicultural practice settings, provided care from a Western biomedical understanding of health. England (1986) in Canada, and Lynch and Hanson (1992) and Wong (1993) in the U.S., pointed to the fact that an understanding of the demographics of North America must include an understanding

and acceptance of the multicultural nature of society. The concept of multiculturalism, according to these authors, included everyone in the society including the health professional.

Ahmann (1994), Dobson (1988; 1991), and Lynch and Hanson (1992) argued that the process of intercultural relationships in the health care situation begins with the exchange of information in the assessment phase. During this time the health professional or nurse finds it helpful to learn culture specific information or seek the help of a cultural mediator so that a collaborative relationship can develop. The nurse must be willing to enter into an understanding of the client's wishes in order to develop a partnership. Learning about clients, according to these authors, included learning about the physical and social context of the individual, family, or community.

Lynch and Hanson (1992) also described some specific ways that nurses can make cultural assessments more appropriate. Use of cultural mediators or guides, learning a few words or greeting forms that are used by clients, allowing additional time to work with interpreters, and, recognizing that some clients may be surprised at the extent that nurses are willing to collaborate with them were some examples. Lynch and Hanson (1992) also suggested that when working with clients who have limited English, written forms

are not helpful unless they are written in the language of the client. Relying on an interpreter, personal observation, and the nurse's own instincts of when the client is ready to move on to the next step in care, were cited by Lynch and Hanson (1992) as the best insurance to developing an effective partnership.

Dobson (1989) stated that intercultural relationships between nurses and clients must be one of mutual reciprocity or, according to Shareski (1992), include the formation of a therapeutic alliance. Mutual reciprocity implied "mutual action, influence, giving and taking, or a correspondence between two parties" (Dobson, 1989, p. 97). A therapeutic alliance involved "transcending our own culture" (Shareski, 1992, p. 10) in order to form a positive working and learning relationship with a person of another culture. Such a process required respect for the client's view of health and an open-mindedness to accepting the validity of the client's perspective.

Shareski (1992) and Dillard et al. (1992) added that health care workers do not need explicit detailed cultural information in order to provide safe and effective cultural care. What is needed is an attitude of openness in dealing with the reality of life and current practice. Shareski (1992) stated that although the care providers must recognize differences in clients because of culture it is

imperative that they recognize the "shared universal similarities of basic human needs" (p. 11).

Dillard et al. (1992), writing from an occupational therapy perspective, suggested that cultural competence is an evolving process that depends on self-reflection and the contributions of people from different cultures. Dillard et al. (1992) argued that a culturally competent therapist should be able to reinforce the beauty of culture as well as use different ways of engaging the client in therapy.

Bushy (1992) and Hautman (1987), from a nursing perspective, advocated a similar perspective in that the practices of culturally based traditional care should be viewed as self care. Bushy (1992) argued that such care must be evaluated by the nurse as to the therapeutic value and either encouraged, modified, or in some way incorporated into the total treatment plan. Such a process would require a collaborative relationship of trust with the client. In addition, Charonko (1992) advocated the development of shared background knowledge, so that both client and professional learn to have a greater understanding of each other.

Stevenson, Cheung and Leung (1992) described a child welfare training program which included training for ethnically sensitive services. A three dimensional proposal was described involving attitudes, knowledge, and skill-

building. Participants increased knowledge and skill through self-evaluation and the development of new knowledge and attitudinal changes based on corrective experiences of actual cultural encounters. The attitudinal questions that child protection workers learned to ask of themselves focused on the way the workers thought, felt, assumed, and perceived cultural and ethnic matters. Stevenson et al. (1992) argued that such experiences were seen as essential when working with a clientele that is often non-voluntary.

Butrin (1992) in a descriptive study of nurses and their ethnically diverse clients (N - 15 nurses and 15 clients), found that mutuality in nurse-client encounters transcended cultural differences and was not dependent upon exact knowledge of a culture. Even language differences did not impede mutual good feelings in the encounters. Butrin (1992) observed that the words used to describe mutually good feelings closely resembled those found in descriptions of caring found in other research.

Rothenberg (1990) outlined three specific skills that are needed in the intercultural relationship in order for mutuality to develop. To begin with nurses must recognize that "every person perceives things through several sets of variables" (p. 1361). The variables included those from the caregiver's background, the client's background, and the environment in which the interaction takes place. Nurses

must learn to cultivate an awareness of these factors while in conversation with the client.

Rothenberg (1990) developed her ideas by arguing that nurses must also learn to use all their senses during their conversation with clients. Doing so means that the nurse can learn to pick up the subtleties of tone and innuendo and make adjustments accordingly. Listening carefully and using a sensitive interpreter to assist with the interpretations of meaning are essential to understanding the situation according to this author.

A final guideline that nurses needed to cultivate was that of learning to ask the right questions (Rothenberg, 1990). Specific cultural information was important to asking the right questions in the individual situation. However, according to Rothenberg (1990), developing this skill opened up new insights and possibilities in understanding the similarities and differences within the group and for the individual.

The process orientation to intercultural communication described by the authors above was based on an attitude of realism in that it focused on ordinary social and health care providers, in multicultural settings, learning by experience. Ordinary nurses, however, must be willing to open up and consider the cultural factors in care. They must be given the time and resources to develop sensitivity

and expertise in culturally appropriate care.

### Intercultural Relationship Training Models and Competencies

A number of authors voiced concern and saw a critical need to help North Americans learn to live with a growing multiculturalism in order to become successful, caring, global citizens. The authors under review here approached this objective through identifying competencies and developing education programs that they felt would accomplish such a task. The literature is drawn mainly from education, business, and management.

Oztrurk (1991), a high school teacher, indicated that people in North America must become less culture-bound and that developing cultural pattern detecting skills was a good place to begin the globalization process. Pattern detection was accomplished through the use of cultural case studies in courses where the objective was to detect patterns in communication; role behaviors of individuals, families, and groups; and draw connections between these activities and the world view of the group described in the case. Students were team taught in order to model cooperation and collaboration. Ethical situations were raised and students were required to grapple with difficult ethical issues such as female infanticide. Oztrurk (1991) envisioned this

process as one which would help students to become multicultural people and build bridges of mutual appreciation and respect.

Salyer (1993), another educator, described a six stage model leading to cultural versatility. The six stages identified were ignorance, rejection, approximation, awareness, approval, and versatility. The process started with ignorance of cultural differences and moved to knowledge of difference which often led to rejection due to perceived differences.

Stage three (approximation) involved minimalization of differences and could result in misunderstanding or misinterpreting of information. Salyer (1993) argued that what was needed here was a more realistic view and a clearer understanding of diversity.

Stage four was characterized by cultural awareness of cultural behaviors. According to Salyer (1993), however, the values behind behaviors were not recognized at this stage. Further participation in the culture was required before greater cultural versatility was possible.

Stage five or approval involved being able to identify both similarities and variation in a culture. Acceptance did not mean assimilation but might entail the taking on of some customs. Deep and lasting intercultural relationships and marriages were, according to Salyer (1993), considered

possible at this stage because of a deep appreciation and understanding of social behaviors and values.

The final stage, versatility, was achieved by very few people. It indicated true bi-culturism and could not be compared to assimilation or adaptation. Salyer (1993) stated that even children of a racially mixed marriage were often only partially bi-cultural. However bicultural people are badly needed, according to Slayer (1993), as buffers and cultural brokers in order for a multicultural society to function.

De Wilde (1991), a professor of business management, proposed a two step process to becoming a global thinking manager. The first step was to gain a conceptual knowledge of strategically important information. The second was to develop skill in the use of such knowledge.

The conceptual knowledge that de Wilde (1991) considered essential to becoming a global strategic thinker was to learn to think globally about comparative categories, develop global strategic alliances, and learn to think in terms of increasing global strategic options. One question such a thinker might ask was, "How would someone from another culture approach this?" (de Wilde, 1991, p. 42).

Skill building for de Wilde (1991) involved practical experience in negotiating interculturally. Such experience helped the global manager to learn to read markets in

different cultures and understand comparative politics. It also provided experience in global ethics and value systems.

Knotts (1989) also advocated the use of comparative categories in learning to understand and work with both similarities and differences in crosscultural situations. Use of comparisons in intercultural relationships must, however, be balanced with flexibility, sincerity, adaptability, and genuine attempts to get to know people.

In a published interview, Clifford Clarke, president of an international business consulting company, identified the need for both cognitive and practical training in order to work effectively in crosscultural business situations (Galagan, 1990). Much of what is learned, according to Clarke, happens because of what the person learns to do when interacting crossculturally. Clarke argued that to be effective there needs to be an integration of knowledge, feelings and behavior. The person and the company being managed both need to move through an adjustment process with the goal of establishing a collaboration model of operation on both an internal and external level.

Reeves-Ellington (1993), in a discussion of cultural skills needed in a competitive Japanese setting, identified some basic competencies and how these might be taught in a skills training program. The purpose of business training programs, according to Reeves-Ellington (1993), is to solve

problems and increase the competitive market value of the company. With this premise in mind, the author identified five areas for intercultural training. The five areas were learning to understand and predict culture, developing a crosscultural understanding process, using ethnology and specifically participant-observer skills and techniques to help the manager to comprehend cultural information, and, developing specific plans based on information gained from participant observer information. These skills were taught and practiced in the actual work setting using a manager-anthropologist mentor and group debriefing sessions after meetings spent with Japanese counterparts with which the company was doing business.

Reeves-Ellington (1993) described a Japanese based training program as follows. Employees began the educational process by visiting cultural events and museums while in Japan. Such visits were followed by wide ranging discussions of Japanese culture which included discussions of social values and cultural logic. Employees were helped to integrate cultural experiences with cultural understanding.

Another area, according to Reeves-Ellington's (1993) description of the model, that should be included in the employees' learning, was a discussion of cultural artifacts. Examples of how artifacts were used included discussions of

how Japanese use business cards and what is appropriate protocol in terms of the social obligations and acceptance of gratuities within a business arrangement. According to Reeves-Ellington (1993) the objective of the training program was to help employees to become comfortable and successful business persons in a Japanese setting.

Mintu and Calantone (1991), in a comparative study of business negotiations in two Asian and two North American countries, identified the primary importance of first analyzing consumers' needs within the context of the consumers' environment and then applying that information to the marketing strategies used in those settings.

Implications for managers, in such settings, included anticipating how the issues would be challenged and dealing in an appropriate and acceptable way with those challenges. Knowing the individual negotiator and how to work with that person, preparing for negotiations by analyzing the issues, setting goals, setting the stage for the negotiations, and tactically planning the moves prior to negotiations, were also essential components of successful selling strategies.

Mintu and Calantone (1991) noted that the role of the interpreter was crucial in the negotiation. The interpreter must understand both the similarities and differences in both cultures as well as understand and respect the status and hierarchical positions of negotiators.

Lobel (1990) in a review of global competencies identified, among others, the ability to make decisions and take action when there was insufficient, unreliable, and conflicting information available. For Lobel (1990) problem solving should be viewed as a social process involving consensus and interpersonal influence rather than correct answers. Accordingly Lobel (1990) argued that training models should develop the ability to learn, focusing on learning as a process, rather than content. The learning should develop the generic skills of team building but within an intercultural setting. Learners should have the opportunity to determine personal styles of adaptation, information gathering, and hypothesis testing in an intercultural environment.

Grove (1990), in a discussion of how to optimize the expatriate success rate for business companies, made a number of suggestions. The expatriate business person must come to an understanding of culture that involved comparisons and contrasts of subtle differences and similarities in values. Openness and the ability to develop trust and cooperation, according to Grove (1990), were essential components of success in expatriate situations. Five years was seen as minimal in making necessary adjustments. During this time the expatriate business person should be assisted by a "guardian angel" who was

assigned to "look after " the person (Grove, 1990, p. 115).

Solomon (1993), in a discussion of the use of immigrant laborers in North America, identified the importance of managers being able to work with their employees for the mutual benefits of both. Solomon (1993), reasoned that persons who immigrate to this continent were unhappy in their country of origin and were generally leaders not followers. Their concerns were more family and group oriented than North America workers. Solomon (1993) argued that managers must not only develop awareness of such differences but move beyond that to personal adaptation to crosscultural experiences. Similarly, crosscultural training must move beyond diversity training to the development of an international crosscultural style.

Training models and educational programs reviewed above emphasized the need for two components within a successful training program - personal knowledge about culture and practical skill development in a crosscultural situation. The emphasis was on the process of learning resulting in the development of a crosscultural style. The learner must be curious, willing to learn, and able to make personal changes in thinking and doing. There was an emphasis on group discussion with a knowledgeable mentor or leader. A number of authors emphasized learning to think strategically and in comparative categories with an emphasis on personal

effectiveness.

### Conclusion

The literature revealed little which spoke directly to the issue of nurses' experiences in working with Vietnamese. The nursing and health related literature was largely focused upon the values, beliefs, and practices of cultural groups such as the Vietnamese followed by a discussion of the implications for nursing practice. Some authors examined cultural health practices on a behavioral level while others focused upon the values and beliefs in which health practices are grounded. A number of authors recognized and expanded on the need for mutuality and reciprocity in the nurse client relationship. The nurses' own ethnocentrism was acknowledged as a factor in the nurse client relationship which hindered the provision of culturally competent care. Authors recognized the need for learning and change for both clients and nurses. There was, however, little discussion on how nurses can or should change or on the process that nurses need to undergo in order to make the changes required to provide culturally competent care. All authors, however, recognized and acknowledged the need for sensitive, culturally appropriate services.

Many authors acknowledged that there are contextual

aspects in providing culturally competent care. There was, however, little discussion of how nurses can effectively and sensitively organize their work within a system. The concept of cultural brokering provided some insight into the broader contextual issues of care but did not address the issues of interpretation and language which are inherent in the situation with North American nurses working with Vietnamese.

The rise of globalization has given rise to literature in the education and business areas which speaks to the issues involved in intercultural relationships. The education and business literature described a number of approaches, used mainly in training programs for overseas assignments, which provided insight into some of the processes and competencies involved in crosscultural work.

Only several authors, in the education field, wrote for a North American situation. Most were intended for training of business personnel who were being prepared to work as expatriates in a particular foreign country. Evaluation studies of these training programs were not readily available. Although the emphasis was on effectiveness, caring, and the special considerations required in crosscultural situations, the underlying premise in the business literature was that of maximizing profits and managing a business enterprise in a foreign county. These

are not the underlying premises of nursing.

## Chapter Three

### EPISTEMOLOGY AND THE USE OF INTERPRETIVE RESEARCH IN THE DEVELOPMENT OF CULTURAL KNOWLEDGE USEFUL IN NURSING PRACTICE

Wood (1992) stated that what is needed in nursing research is the generation of a theory which provides a basis for practice. Tripp-Reimer (1984) contended that cross-cultural nursing research is rarely clearly articulated with the practice of assessment, diagnosis, and intervention in nursing. Leininger (1991) argued for the necessary shift to qualitative research approaches for the discovery of knowledge necessary for culturally sensitive care. To date this theory base has not been well established (AAN, 1992). The interpretive approach of grounded theory, based on the theoretical tenets of symbolic interactionism, as described by George Herbert Mead and further developed by Blumer (1969) and others, is one qualitative approach which can guide the development of knowledge needed for nursing practice in cross-cultural situations. This chapter will outline the basic tenets which underlie interpretive research, symbolic

interactionism, and grounded theory. The appropriateness of such a theoretical base to the exploration of nurses' experiences with Vietnamese will conclude the discussion.

### Interpretive Research

Schwandt (1994) described interpretive research as an approach which examines the lived experiences of those who are under study. The principle concern is with knowledge and being. The truth of reality is to be found within the context of the lived reality rather than discovered to be already present within the context. In other words, this is not the received view of science and truth, but truth is found in the living present. Interpretive science has taken on some of the characteristics of art and reveals truth through interpretation of data which finds truth at the level of interaction and meaning for the participants.

The purpose of a particular interpretive research project dictates how the methods are employed and what focus the end products will take (Lowenberg, 1993). The variation in methods used is found in how the researchers focus their observations and how they interpret and structure the examination of their data. Ethnographers, for example, may study culture within a framework looking at structures that create order. In a similar way phenomenologists study the lived experience of individuals and how they live within

time, space, and their own personal history (Stern, 1994).

The researcher's epistemological and methodological commitments also shape the research (Schwandt, 1994). One such commitment is how the researcher deals with the tension of researcher as subjective interpreter and researcher as disengaged, objective analyzer. The tension here is between the objective-subjective interpretation of data and how the researcher places the self within this tension. According to Schwandt (1994) the symbolic interactionist approach is that of an empirically based, interpretive approach which views "truth and meaning not as expressions of relationships of correspondence to reality but ... the consequences of a purposeful action." (p. 124). This view is contrasted to the interpretive interactionist view which is more "self-consciously interpretive" (Schwandt, 1994, p. 124) and engaged in cultural criticism. Interpretive interactionists must incorporate elements of critical theory and expose ideological and political meanings inherent in the text.

Lowenberg (1993) described the lived reality of the research situation as a "buzzing chaos" (p. 65) composed of multiple realities, relativistic constructs of reality, and the postmodernist perspectives of ambiguity and complexity, all of which must be interpreted cognitively. The researcher must, in this context, situate the self so as to be able to examine the power, status, and inequality

inherent in the researcher role in order to bring forward a new and better understanding of the situation and the complexities involved.

The interpretive approach to the study of lived experience, according to Lowenberg (1993), is a creative and innovative way to begin to understand present day realities. Lowenberg (1993) further contends that methodologies found within the interpretive approach begin to satisfy the need to address these everyday experiences. The assumptions underlying symbolic interactionism support this interpretive approach to the study of everyday experiences without necessarily taking on the thinking inherent in critical theory or the need to specifically expose ideological and political meanings inherent in the text (Lowenberg, 1993; Schwandt, 1994).

#### Symbolic Interactionism

Symbolic interactionism as developed by Blumer (1969) is based on three premises: (a) human beings act toward things on the basis of the meanings that things have for them, (b) the attribution of meanings to objects is a continuous process, and (c) meaning attribution is a product of social interaction in human society. In this context symbols are signs, language, gestures, or anything that conveys meaning (Woods, 1992). The person is the

constructor of meaning, not the structural forms in society nor the internal drives in the person. The context, however, is important in that the structures influence the person, and, in turn, the person influences the structures. People, for example, do not act towards social class but towards situations which they interpret (Woods, 1992).

In symbolic interaction the entire research process, not just the data collection, should keep faith with the empirical world under study (Woods, 1992). The problems formulated for study, specifications of categories, relationships among data, explanatory concepts, and interpretive frameworks must all be tested for closeness of fit with the data. In order to see beyond the first layers of reality the researcher must stay in the field and foster curiosity. The researcher must also develop sufficient rapport in the field so that the research participants roles can be entered into and understood. The researcher needs to become so familiar with the research situation that the ethos or ambience of the situation or the cultural context becomes clear. The researcher develops an understanding of the "insider" perspective as well as maintaining a critical edge for analysis.

Symbolic interactionism examines the small scale everyday approaches to life but provides a window by which a wide view of life may be understood (Woods, 1992). By

understanding the processes, relationships, group life, and adaptations of a small situation larger processes can be understood. Such an understanding has particular relevance to nursing practice.

### Grounded Theory

The research methods most appropriate for symbolic interactionism are those that fall within the sociological understanding of ethnography (Lowenberg, 1993). The researcher is central within this framework of methodologies. Meaning or reality is constructed within the interview as the researcher and the participants communicate. The results of the initial analysis of the data are descriptions which are "theory laden" (Woods, 1992, p. 382) and may be further analyzed to provide substantive theory (Strauss & Corbin, 1990). Grounded theory is well suited to such a substantive theory development approach and falls under the umbrella of interpretive research (Lowenberg, 1993).

Grounded theory is the discovery, development, and verification of theoretical statements which are derived from the data and gleaned through the systematic process involved in the method (Strauss & Corbin, 1990). The researcher is central to the process of unearthing theory and requires theoretical sensitivity in order to understand

the subtleties of meaning in the data (Strauss & Corbin, 1990).

Theoretical sensitivity is the researcher's personal quality of being able to "see what is important in the data and to give it meaning" (Strauss & Corbin, 1990, p. 46). Theoretical sensitivity is developed through reading the literature pertaining to the questions under study and through the professional and personal experiences which give the researcher sensitivity to the important issues under study. How the researcher uses these learning experiences to gain insight into the data and in conjunction with the steps in the research process is crucial to the outcome of the study. The process requires that the researcher is self-reflective and consistently moves between the emerging theory and the data so that the resulting theory is well grounded in the data.

#### Researching Nurses' Experiences with Vietnamese

Morse (1991) identified three potential contributions which qualitative research can make to the practice of nursing. These were (a) providing a theoretical framework or the variables for subsequent researchable situations, (b) challenging the status quo or identifying new paradigms or directions for inquiry, and, (c) providing rich descriptions of the complex situations in which nurses find themselves.

Grounded theory, a qualitative method, also has the potential for these contributions. In addition Chenitz and Swanson (1986) have identified the symbolic interactionist perspective of grounded theory as "particularly useful in conceptualize behavior in complex situations, to understand unresolved or emerging social problems, and to understand the impact of new ideologies" upon the health care system (p. 7). Health care, in the 1990's, is in the situation these authors describe. Grounded theory is, therefore, an appropriate research method for examining these problems (Chenitz & Swanson, 1986).

Chenitz and Swanson (1986) contend that nurse researchers must explicate the processes in nursing and thus generate theory regarding nursing if the discipline is to develop and be able to give direction for nursing care. Culturally competent care is situation based care and enacted within the nurse-client interaction within the wider health care context. The client may be an individual, family, group, or community. Care usually involves an interpreter and other health care and social service providers as well as community workers within the health and community social services. Such situations have the many perspectives within multiple cultures and sub-cultures which Lowenberg (1993) described.

The concern for culturally competent care (AAN, 1992)

speaks to the need for a study of multiple realities, and a recognition of the position of the researcher within the research process. There are many constructions of reality within the nurse's multicultural practice. Nurses continually face the challenge of making choices among competing realities and structuring their realities in order to provide culturally competent care. The researcher, within this context, must also choose what is most salient, what must be acknowledged, and what can fall away. Both the nurse in practice and the nurse in research must make choices on the most salient aspects of the situation. As the researcher examines the experience, from the viewpoint of the nurse in practice, the results of the research remain grounded in the context of care and reflect the experience of the nurse in practice. The use of grounded theory, therefore, seen from an interpretive research perspective, should provide a method whereby new and better understandings of the process of care are developed. It should bring new insights and knowledge to bear upon the discussion of culturally competent care.

#### Conclusion

Grounded theory, an interpretive approach based on the theoretical tenets of symbolic interactionism, provided the basis for this study of culturally competent care. The

study specifically examined nurses' experiences in working with Vietnamese. The following chapter will describe the specific process of inquiry used in the study.

## Chapter Four

### THE PROCESS OF INQUIRY

This chapter will describe the process of inquiry used in this study of nurses' experiences with Vietnamese. The question addressed in the study was, "How have nurses informed and shaped their practice when working with Vietnamese clients?" The grounded theory method was used to formulate a substantive theory.

The focus of the study was on nurses and their experiences working with Vietnamese clients. The researcher positioned herself as an observer of nurses and their experiences and not on the experiences of Vietnamese as such. Nurses spoke often of their perceptions of Vietnamese and how their interactions with Vietnamese influenced their work. The researcher observed, questioned, probed, analyzed, evaluated, and dimensionalized the interactions and inter-relationships that participants described. The focus of this study was on the nurses and not their Vietnamese clients.

A constant comparative approach was employed to provide a continual interaction among the data, analysis of the data, findings from the literature, and the researcher's

interpretations of the data. Dimensional analysis was used concomitantly with the constant comparative approach. Dimensional analysis brought density to the data by delineating properties and dimensions (Robrecht, 1995; Schatzman, 1991).

### Sample

The sample consisted of 22 participants. Data also included interviews from five participants involved in a previous study (Labun, 1994). The total number participating in the study was 27. The participants were all female registered nurses who worked in multicultural settings in North America with Vietnamese being one group for whom services were provided. Participants were located in large metropolitan areas in the north, central, and south western United States (N = 17) as well as two western cities in Canada (N = 10).

Participants all had bachelors degrees in nursing. Various educational pathways were used to obtain these degrees. Thirteen participants had additional education at the post-bachelors level in the form of certificates, masters level courses, or masters degrees. Most worked in community health or clinic settings except for one who worked in labor and delivery and one who had worked in postpartum during the time of her experiences with

Vietnamese.

Participants reported a wide variety of lengths of experience in nursing (a few months to 20 years) as well as experiences with Vietnamese (3-4 cases over a year to a caseload of 90% Vietnamese at all times of the year). Nurses also varied in lengths of time spent working with Vietnamese (several months to almost 15 years). Some had worked with Vietnamese on an intermittent basis. Most worked with specific groups of clients such as a family grouping of mother, grandmother, and infant; a mother and her young children; or an adolescent and the parents. Some nurses worked with individuals. Nurses who worked with mothers, infants, or children at home or in schools, were involved with health concerns related to feeding, growth and development, family relationships, and health problems related to growing families. In addition to such groupings, community and clinic nurses were also involved in caring for persons with general acute medical conditions, new immigrant health issues, and community issues such as safety and health teaching. Nurses had experiences in working with all groups of Vietnamese in North America from the time that Vietnamese came to North America in the early 1980's up until the present time.

Only one respondent spoke Vietnamese. All others had used interpreters in order to give satisfactory care.

Although the clients length of time in North America varied most of them knew little or no English except for those school age children who had been in North America for some time. None of the nurses were Vietnamese and only one was Southeast Asian. Table 1 represents a summary of the participant's work experience.

Table 1  
Characteristics of Participant's Work Experience

No.	Position / Present Work Setting	Involvement with Vietnamese Clients
		<u>Canadian Cities</u>
1	nurse practitioner outpatient hospital clinic	4 years of 2 - 4 cases/year
2	public health nurse neighborhoods	2 years of 30 - 40 cases/month
3	nurse practitioner community medical clinic	3.5 years of 5 - 15 cases/month
4.	public health nurse community clinic	10 years of 70% of work load
5	public health nurse community clinic	10 years of variable numbers
6.	public health nurse community clinic	10 years of 95% of work load
7.	public health nurse client's homes	4 years of 2 - 4 cases/month in previous employment in post partum
8	public health nurse neighborhoods	7 years of 15% of case load

No.	Position / Present Work Setting	Involvement with Vietnamese Clients
9	labor and delivery nurse tertiary care hospital	10 years of 5% of work load
10	public health nurse neighborhoods	2.5 years of 15% of caseload
<u>U.S. Cities</u>		
11	public health nurse multicultural team	3 months with 3 - 4 families
12	public health nurse multicultural team	5 years of 50% of caseload
13	public health nurse multicultural team	supervision of nurses with Vietnamese clients
14.	school nurse multicultural team	15 years varied
15.	nurse practitioner pediatric clinic	4 years of 5% of caseload
16	community nurse home visits	4 years of 5% of caseload
17	community nurse home visits	1.5 years with several families
18.	community nurse home visits	2 years with several families

Table 1  
Characteristics of Participant's Work Experience

No.	Position / Present Work Setting	Involvement with Vietnamese Clients
19	nurse practitioner community medical clinic	30% of caseload
20	mental health nurse supervisor and clinician community medical clinic	10 years of 10% of caseload
21	nurse practitioner hospital outpatient clinic	4 years of 15% of caseload
22	nurse practitioner medical clinic	15 years of 25 - 35% of caseload
23	school nurse school	15 years of 1% of school
24	school nurse school	4 months of 10% of school
25	school nurse school	4 years of 80% of school
26.	school nurse school	4 months of 40 - 45% of school

Table 1  
Characteristics of Participant's Work Experience

No.	Position / Present Work Setting	Involvement with Vietnamese Clients
27.	school nurse school	11 years of 20% of school

Most participants were accessed through their respective agencies and asked by their supervisors if they would like to participate in the study. The supervisors were approached by the researcher and asked if they were aware of nurses who worked with Vietnamese who might participate in the study. If the nurse expressed interest the researcher contacted her. In one case the participant contacted the researcher personally.

#### Data Collection Procedures

After verifying by telephone that the participant was willing to be interviewed, the date, time, and place for the interview were mutually agreed upon. In all but three cases the interview or part of the interview took place in the participant's place of work. In one case the participant came to the researcher's home and in two interviews the researcher went to the participant's home. In most cases the interview was conducted during the participants' work day.

All interviews lasted at least one hour and most interviews were one-and-a-half hours in length. Three participants were involved in a second interview which lasted approximately half an hour. The three participants were involved in a second interview due to a malfunction in the tape recorder during the first interview. Some of the

data from each of the first interviews was lost. The researcher therefore requested permission for a second interview in order to clarify the information already received. All three participants agreed to a second session and the lost information was obtained at that time.

The study was explained prior to the interview and each participant signed the consent form in accordance with the University of San Diego Committee on the Protection of Human Subjects requirements (Appendix A). After reading and signing the consent form (Appendix B) the researcher used the interview guide to provide the basis for the interview. Additional questions which arose during the course of the interview provided opportunity for the participants to elaborate on areas to provide clarity of data. The questions which guided the interview are found in Appendix C.

Data analysis of interviews provided direction for questions in subsequent interviews. These new questions were more focused and provided more information and clarification of emerging categories, processes, and dimensions in the data.

Initially and throughout the study the researcher attempted to find participants who had worked in various health care situations, geographic locations, and had a

variety of experiences with Vietnamese. Such sampling was an attempt, by the researcher, to "provide the greatest opportunity to gather the most relevant data" (Strauss & Corbin, 1990, p. 181) available to the researcher. The appropriateness of participant's work with Vietnamese was evaluated in terms of length of time involved, dates of experience, intensity of experience, and type of clients seen in practice. The researcher attempted to interview nurses who were able to talk meaningfully about their practice as well to as bring breadth, depth, and variation into the data.

Of the 27 participants in the study, nineteen of them talked of the significant difference that their own personal cross-cultural experiences made in their nursing practice. Only seven of the 27 participants indicated that they had no experience with other cultures prior to their involvement with Vietnamese. These seven were from the mainstream cultural group in their respective locations in both the U.S. and Canada. Nurses with previous cross-cultural involvement had a variety of experiences. Five nurses had worked in Southeast Asian refugee camps; 10 had experienced living or working in a third world country; and the remaining participants, who identified having significant cross-cultural involvement, had either close family members with cross-cultural experiences or were involved personally

with groups outside of mainstream North American culture.

Examples of personal experiences that nurses described were calling themselves an "ethnic" or saying they were from another country outside of North America, being influenced by a colleague or husband who was born and raised outside of North America, work experience in a refugee camp or other country, or, being "Western" but having lived in a non-Western culture as a child. These experiences added further diversity to the sample.

Sources of data other than participants included articles, books, participant-observation experiences in clinic waiting rooms, meal time experiences in Vietnamese restaurants, and walk-about in Vietnamese communities. Such experiences provided additional insights into Vietnamese life in North America as well as of the work of nurses within these settings.

As dimensions began to emerge in the data the researcher sought to sample further for relationships, variations, and processes within the identified code groupings or categories (Strauss & Corbin, 1990). At a later stage in the data collection process, as the code groupings began to develop density and identifiable relationships, the researcher was able to validate the emerging theory and build in further variation (Strauss & Corbin, 1990).

### The Process of Analysis

Analysis began when the problem under study was outlined, the ethical concerns were cleared, and data from the first two interviews were collected. New data were incorporated into the analysis throughout the study.

The constant comparative method was used throughout the data collection and during the analysis in order to be able to ground the developing theory in the data. Memos written following one interview were used to inform and guide the interview process in the following interview especially when similar or opposite circumstances were observed. Content in the memos included discussion on the process of inquiry, the emerging themes in the interview, processes that needed further exploration in succeeding interviews, and, future directions and possibilities in the data collection procedures. In this way the researcher sought to bring depth and breadth to analysis of the data.

The focus in the following pages of this chapter will be on the process of analysis. The steps involved in the grounded theory method will be used to frame the discussion. Analysis, however, did not follow step by step in a linear manner in the actual situation. It is a dynamic process.

Dimensional analysis (McCarthy, 1991; Robrecht, 1995; Schatzman, 1991) was used to inform and guide the analysis

phase of the method used in this study. It is a way of analyzing and reconstructing data which is "an extension of a person's natural analytic processes" (Robrecht, 1995, p.172). Dimensional analysis calls for an inquiry into the parts, attributes, interconnections, context, processes and implications of a particular set of data in order to provide a logical explanation of the situation. The dimensions indicate the various complexities of the situation. Phases or steps in dimensional analysis include designation, differentiation, and integration.

#### Designation Phase

Designation involves the process of breaking open or "fracturing the data" (Strauss and Corbin, 1990, p.97) and is similar to open coding (McCarthy, 1991). The data were initially examined by the researcher keeping the question in mind, "What is all going on here?" A line by line examination was used and data were coded and named (Strauss & Corbin, 1990). Each code was named and analyzed for properties and dimensions. Properties and the accompanying dimensions helped the researcher ascribe meaning and definition to the code. The researcher attempted to use "in vivo" codes as much as possible in order to capture the essence of the meaning of the data, as expressed by the participant (Strauss & Corbin, 1990).

New codes emerged as data were collected. The researcher began writing memos after the second interview was transcribed. The memos described, hypothesized, and questioned the ongoing analysis as well as the process of analysis. Nine interviews were analyzed and coded in the designation phase prior to the initiation of the differentiation phase. At this point the researcher was able to cluster the data into groupings and therefore began the differentiating phase. The designation phase continued with the designation of new codes as data collection proceeded but at this point codes were also examined with a view to how they clustered around a concept or grouped together in a theme (McCarthy, 1991).

#### Differentiation Phase

The differentiation phase involved the process of clustering codes around a central concept; designating the subdimensions in the concept as conditions, context, action/strategies, and consequences; and then deciding on a perspective, from among the many dimensions, that would best explain the emerging theory (McCarthy, 1991). All codes gleaned from the data in the first nine interviews were placed in groupings around a central concept and designated as conditions, context, actions/strategies, and consequences (Schatzman, 1991). Initially the researcher identified nine

central concepts which were *common humanity, connection, a profoundly changed nurse, resources, offering care, health, adaptation to North America, health care system, and interpretation*. Additionally, data from another 6 interviews were coded with properties and dimensions, placed within designated categories, and identified as conditions, context, action/strategies, and consequences.

As the analysis progressed the researcher continued to group the codes together until a critical mass of complementary codes were assembled. As the codes were clustered together they were evaluated for fit and eventually grew into larger concepts that were seen to pertain to a particular category (Schatzman, 1991).

Initially the researcher isolated nine categories with their central concepts as identified above. The dimensions and properties of these central concepts were then compared and several were collapsed.

During the process of collapsing the categories the researcher had some difficulty separating the categories of connection and common humanity. In fact she tried to collapse these two categories into one category designated as common humanity. The properties and dimensions, however, were too divergent and did not easily fit into the explanatory matrix of conditions, context, action

strategies, and consequences. She again saw them as two separate categories. This process helped the researcher clarify how these categories were similar as well as different. Further data were collected around these two categories and thus they achieved greater dimensionality. Other categories were examined in a similar fashion.

When the categories were finalized, at this stage in the analysis, they were identified as *common humanity, connection, interpretation, nurse profoundly changed, health care system, health, and offering care*. Some attempt was made to further integrate these concepts but the properties and dimensions seemed too distinct and so were not easily grouped together. Grouping the data, however, helped to give a more complete picture of the various phenomena involved and added to the properties, subproperties, and the number of dimensions along a dimensional continuum (Schatzman, 1991). Greater density was thus achieved.

Mini frames and matrixes were used to help the researcher to visualize the relationships within a concept during this process. The concepts were diagramed for their properties, dimensions, and subdimensions (Strauss & Corbin, 1990). After being visually diagramed the researcher sought to transform the word pictures into written memos for further specificity. These were then examined and verified

with the data.

The differentiation phase also involved the choosing of an overriding perspective that gave direction to the remainder of the analysis (McCarthy, 1991). The researcher chose the perspective that provided the greatest explanatory power to "all that is happening" in the data. Initially the perspective chosen was that of the nurses and their view of caring for the Vietnamese. At a later stage the perspective became that of nurses' discovering culture. When the critical perspective was chosen it served as an integrating focus for all the other dimensions (Robrecht, 1995; Schatzman, 1991).

The development of a grounded theory is not a linear process. The researcher, therefore, at this point in the analysis, reaffirmed the general direction, aims, and title of the research proposal as being descriptive of the themes identified to this point. A story line was then written to assist the researcher to focus more specifically on the critical perspective with the accompanying dimensions, attributes, and designations.

The researcher does not come to the field *tabula rasa* (Schatzman & Strauss, 1973). Although it is important not to inject previous experiences into the data it would be equally important to use those experiences to work out

models and to look for parallels and differences in the data being analyzed (Schatzman & Strauss, 1973). The earlier experiences of this researcher had sensitized her to the difficulties that Vietnamese face in their adjustment to North American society. Initially it was difficult to remain focused on the nurses and analyze only their experiences. In addition an earlier research project with school nurses and their experiences with Vietnamese provided valuable insight into the experiences of nurses. It served to develop theoretical sensitivity in the researcher (Strauss & Corbin, 1990).

The researcher's experience as a psychiatric nurse and her particular perspective on the nurse-client relationship was also a factor that influenced the analysis process. The establishment of rapport is central within the psychiatric nursing context. With this focus clearly in mind it became easy to get "stuck" during the search for a critical dimension which would serve to integrate the other dimensions. It seemed that connection should be the critical dimension since all interviews indicated such a concept was present. However, it appeared that this dimension did not give adequate explanatory power to the data and the other dimensions did not easily fit into the explanatory matrix when this perspective was considered critical. There was a poor fit in the linkages of the

concepts when identifying the conditions, context, strategies, and consequences (Strauss, 1987). The theory did not seem to hang together.

Although connection was a very important dimension within the emerging theory it was not seen as central on further examination of the data. At that point various concepts were tried for their "fit" as competing perspectives in providing an explanation for the theory. Finally the dominant dimension of *cultural discovery* was developed and incorporated the concepts of finding a common humanity and health.

During the differentiating phase the researcher continued to verify the emerging theory with the participants. There were also some areas within categories that needed additional clarification. An additional 6 interviews were conducted during the final stages of the differentiating stage. The interviews involved the general interview guide as well as selected and more specific questions which validated the matrixes, the selection of a critical dimension, the linkages to other dimensions, and additional data which strengthen areas of weakness in the developing theory.

### Integration Phase

Data analysis during the integration phase overlapped with the final stages of the differentiation phase and served to lead into integration. Data from one participant were verified by other participants. The emerging theory was also verified and readjusted according to the data collected from the participants at this time (Strauss & Corbin, 1990). The writing up of the research was begun even while analysis continued and served to identify further areas which needed development (Strauss & Corbin, 1990).

During further attempts at integration the researcher continuously evaluated the emerging theory for "fit" among the data, the story line, the perspective taken and the organization of dimensions according to the explanatory matrix (McCarthy, 1991; Robrecht, 1995; Schatzman, 1991). The dimensions and their properties were reconstituted or integrated in order to provide a coherent and parsimonious theory.

### Conclusion

The purpose of this chapter was to describe the process of inquiry and the analytic procedures employed in this study. The grounded theory method and the operations of the constant comparative approach and dimensional analysis were described as they were used in this study. The next chapter

describes the substantive theory derived from the use of  
this method.

## Chapter Five

### FINDINGS OF THE STUDY

Cultural discovery for nurses is a continuous process and is embedded within the day-to-day care nurses provide. The purpose of this chapter is to describe the discovery process that nurses experienced in their work with Vietnamese. The process will include the conditions, context, and consequences of the action/strategy employed in the discovery process. An overview of the theory of cultural discovery will be followed by a more detailed discussion of the theory with specific illustrations from the data. The nurses' own words will serve to ground the theory in their experiences.

#### Overview of the Theory of Cultural Discovery

Nurses became involved in *Cultural Discovery* as a result of their work with Vietnamese. Such discoveries changed nurses' perspective of their Vietnamese clients from one of limited understanding to one of greater understanding of their clients as individuals, families, and as a community. As components of cultural discovery nurses *Learned to See Them* (the Vietnamese) as a people and as

individuals in their uniqueness as well as in how they shared in a *Common Humanity* with other groups and individuals. In particular nurses learned how Vietnamese *See Health* and what practices they employed to have good health.

The central action/process in the nurses' discovery was that of *Connecting*. Connecting for nurses involved communication with clients and other workers involved in the *Nurse-Client Situation*. Nurses who were able to connect with their clients developed an understanding of human, cultural, and health issues within the Vietnamese community. There were also nurses within the nurse-client situation who were *Not Connecting*. Such nurses were unable to develop this level of understanding. Connecting resulted in a *Changed Nurse* and *Sensitive Care*. Not connecting resulted in *Standard Care*.

The nurses who were able to connect with their clients experienced changes in their personal and professional lives. Nurses described their experience of those changes by saying that their work with Vietnamese "*Just Feels Worthwhile*", that it was "*Affecting My World View*", that it helped them in *Redefining What's Important*, and that they were *Learning to Balance* the various aspects of their life and work. Nurses also explained their experiences of

learning to provide sensitive care by describing how they were *Learning How Much to Push, Learning to Use Resources, Building Bridges, Dealing with Glitches in the System, and Helping "Them" (the Vietnamese) Take Charge.*

Standard care, the consequences of not connecting, as described by nurses in the study, involved providing care that would normally be given to any client without special consideration for the person's cultural perspective. The special considerations and needs of Vietnamese clients were, therefore, not evidenced by standard care as described by the nurses in the study.

The conditions under which nurses were able to make connections involved *Using Prior Knowledge, Learning to Know Them Initially, Taking Extra Care, and Shared Brokering.* Nurses described taking extra care as *Being Respectful, Doing a Bit More, and Developing Partnerships.* Sharing a brokering role with interpreters involved developing partnerships with interpreters which resulted in using *Interpreters as Translators* as well as working with *Interpreters as Cultural Professionals.* The cultural professional aspects of the partnership involved working with interpreters in developing an understanding of the crosscultural communications between nurses and clients and in sorting out the cultural significance of those

communications.

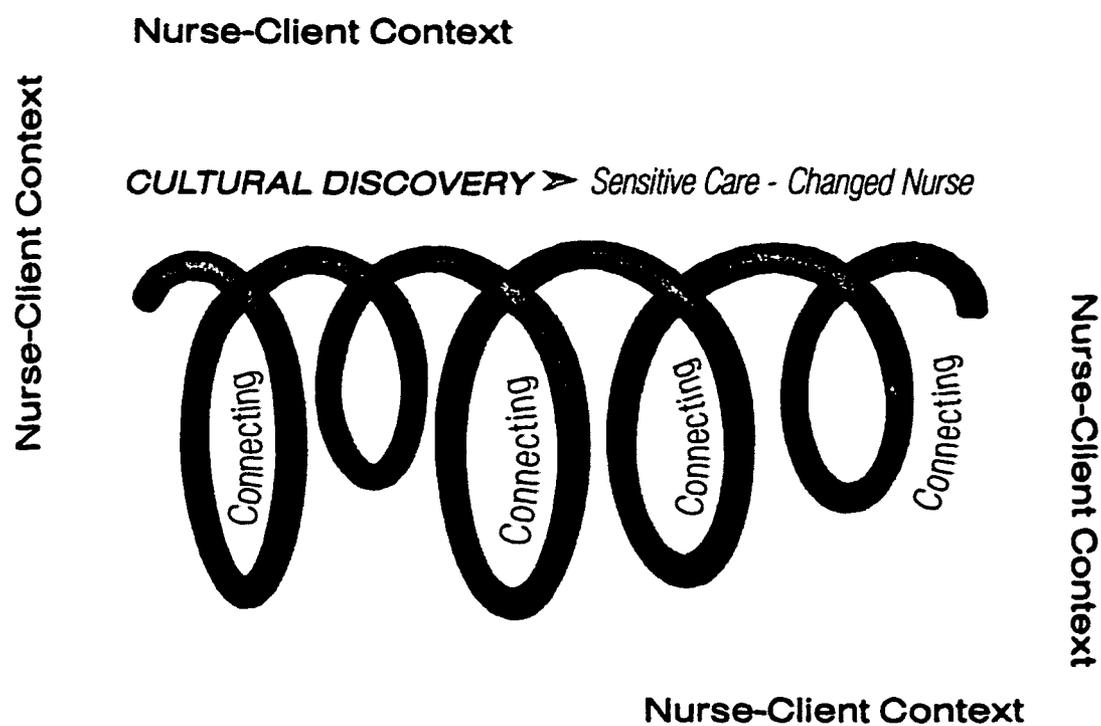
Conditions where connections did not develop were not universally identified in the experiences of the nurses in the study. Nurses did, however, identify situations where connection did not occur and where communication was difficult. Nurses expressed the feeling that these situations probably involved different cultural understandings, and a lack of acceptance within the relationship.

Cultural discoveries were made within the nurse-client context which include many different client situations. Nurses in this study worked with *Individuals, Communities, and Families* of Vietnamese. Nurses also provided care within various *Communities, Clinics, and Acute Care Hospitals*.

An integrative diagram was developed to show a schematic representation of the major dimensions of the theory of cultural discovery (Figure 1). The concepts identified in the figure are cultural discovery, connecting, sensitive care, changed nurse, not connecting, and standard care. All of these dimensions are found within the context of the nurse-client relationship. A more detailed discussion of the various dimensions will follow below.

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FIGURE 1. SCHEMATIC REPRESENTATION OF THE MAIN DIMENSIONS OF THE THEORY OF CULTURAL DISCOVERY.



## Detailed Discussion of the Theory of Cultural Discovery

Nurses, in this study, brought with them into their care the experiences, values, and ways of working which they had developed in their educational preparation as well as in their nursing practice and personal life. As nurses worked with Vietnamese, they utilized their own personal framework to give care suited to the particular situation in question. In addition nurses discovered how to work with Vietnamese in specific ways. The next section will elaborate on the specific discoveries nurses made within the process of discovery.

### Cultural Discovery

Nurses were involved in cultural discovery as they worked with their Vietnamese clients and tried to provide the sensitive and individualized care needed in the situations in which they worked. Three dimensions characterize nurses discoveries. Nurses made these discoveries in a variety of settings in the community, in clinics, and in acute care hospitals.

### Learning to See Them

Nurses who worked with Vietnamese made important and critical discoveries in their understanding of the Vietnamese. Those nurses who had no prior experience with

Vietnamese said that initially they saw a group of clients who were different from themselves and yet the same as other Southeast Asians. One nurse described her experience in this way:

I really tended to see them [Vietnamese] as one group with the Laotians and Cambodians initially.... And once you work with them for the longest time you learn from them and you realize that there are some differences.... Once I realized that the Laotians and Cambodians were different I also noticed that each community goes in its own group. Not that they are one group of people. Like Southeast Asians.

Another nurse spoke of her first experiences with Vietnamese noting the differences among South East Asian cultures. She said: "They have their own culture.... It is a little bit different [then the other Southeast Asian cultures]."

Seeing Communities and Families. Community nurses who were able to see the Vietnamese as a group still found that they needed to sort out the more subtle patterns of community and family. Nurses used various strategies to overcome this difficulty. One nurse, who worked in a neighborhood community health setting, described how she learned about the community. This nurse said: "I think it is helpful to go to the restaurants, to go to the stores, to do some of the [cultural activities] so you can understand just a little bit of what it's like." This nurse went on to

explain how doing this helped her see the community. She said: "[I will gain an] appreciation of the culture because I don't often see the men. There [in the community] you see more the families and the inter-generational interaction in the area."

Some nurses had prior experience of Vietnamese through their involvement with refugee programs or because of living in Vietnam and the surrounding area for various periods of time. Nurses in this group, as well as those without prior experience, also learned to know Vietnamese within the North American culture and with the added experience of being refugees in a new culture.

Seeing Individuals. Nurses who were able to see the Vietnamese as a group still found it difficult to sort out the more subtle patterns and individual situations within their practice. Some nurses talked about how hard it was to see the individual's health needs when thinking of that person as part of a cultural group. One nurse described her experience, when assessing a woman's needs, in the following way:

But it was harder to see them [as women with their own special health needs] because it is easy to take the cultural group and to try and think about them as being in similar circumstances to [other women of that culture in order to] make it less confusing, you know! (Laughs) I thought, "No! They are having the whole

gamut of problems [just like women who might be from some other culture]."

Another nurse talked about how difficult it is to separate out the individual situation from the culture. She said:

It is dangerous to attribute everything to culture. And there is a temptation to do that. It is very easy to stereotype and generalize and I find myself doing that a lot but you can see patterns and you can see what you could assume are cultural ways of dealing with things and ways of thinking about things so that if you see it in several people you can assume that it might be more cultural than individual. There are always individual variations. Always. So I try and keep in mind to approach each situation and each family and each child as an individual knowing in the back of my mind what the culture is like and as far as I know it. As a pattern that I have seen. But realizing that they may not think the same way as that.

The process of learning to know the Vietnamese as a community with families and individuals took time, careful examination, and persistence. One nurse who worked with mothers and their children, in a public health context, talked about her own situation and that of her colleague in understanding the complexities of each individual and family experience. This nurse said:

What they have come through just kind of blows me away but if you have done it for so long it becomes a part of you rather than stands out. So you have to almost think about it. But I know the other nurses come in and do the clinic for me once in a while and they are blown away by how complicated some of the backgrounds are but they (the clients) don't seem that way to me anymore. Because I've done it for awhile.

### Seeing a Common Humanity

As nurses learned to see the Vietnamese they came to see a common humanity between the Vietnamese and other cultural groups. All nurses had experience with a variety of cultural groups. The Vietnamese clients they saw had common goals, problems, and aspirations with their other clients. Areas of commonality identified were: wanting to be healthy, wanting the best for their children, and wanting to do their best to make a new life for themselves and their families in a new country. One nurse described her experience by saying, "I think that a lot of what I see is common to humanity and so it's not like there are major areas that puzzle me." Another nurse described her experience by saying:

I will say ... not really particularly just with the Vietnamese ... working with other groups, other cultures, it has just made me open my eyes more about how we have so many different customs but in general, all in all, we are all kind of searching and trying to do the same: raise our children, be healthy, in general do our best.

As nurses learned to understand the Vietnamese community they learned to recognize health problems and how to provide care for them. The problems nurses saw were similar to those they saw in other cultural groups. Vietnamese were desirous of the health care that nurses had to offer and of learning the North American way of getting

care. "They want it!" was the comment of one nurse.

One nurse described the importance of nurses learning to see the common human elements as learning to bond with clients in order to provide care. She said: "You have to bond with all of the different aspects of the people that you're taking care of."

### Seeing How They See Health

Although nurses saw a common humanity they also saw differences in how the common goals of raising children, being healthy, and doing their best were expressed within the Vietnamese community. The nurses' biomedical approach to health provided a marked contrast to that of their Vietnamese clients with Eastern views and practices. Nurses were forced to re-examine their concept of health, their definitions of what it means to be healthy, and how to have a healthy lifestyle. Nurses learned to work with clients who had their own ideas of health and to become tolerant of the simultaneous use of a variety of approaches to health.

One nurse described the issue of different views of health within her experience. She said: "For sure, the Vietnamese culture has its own way of looking at health and looking at appropriate treatment and the whole concept of Eastern and Western medicine is very much an issue and that can easily be misinterpreted."

Another nurse described her changing view of health as she worked with Vietnamese. She commented on how the nurse might have to change her views by saying: "[The nurse] would really have to change notions, or have a good look at her notions about what she defines as quality of living and standard of living and a healthy happy way to live."

Another nurse, in talking about her changed concept of health said that nurses needed to re-evaluate their concept of health in the light of a different way of being healthy. She said:

I think sometimes we as Western [educated] nurses can be very rigid and think that there is only one way to do things and from my perspective as the years have gone on is that there are lots of ways of doing things. And in the whole scheme of the world most of it doesn't really matter.

Another nurse talked about how she tried to be open to issues that came up in the caregiving situation. She explained her experience of talking to a Vietnamese mother about getting a toddler out of the family bed into a crib in the following way:

I think a lot of the health factors that we perceive should be happening aren't necessarily what has to happen. I think the sleeping arrangements are a classic example. ... And ... before [the nurse] starts lecturing to the family to get the toddler out of the parent's bed and into the crib, find out if the mother really wants to do that. Or believes in it. Because typically, and I've had it happen, I admit, you lecture to them about doing it and they nod, smile sweetly, and I say, "This really isn't an issue to you is it?" And

(interpreter) says, "No! She think it fine!!" And I've been nattering on when I've really missed the boat on this one. (Laughs.) And I turn to them and say, "When it is an issue do come back. But forget what I've said.

Another nurse described her way of seeing health in situations with Vietnamese clients. She described the scope of her tolerance for a different view of health and her reaction to the limitations of her tolerance in the following way:

I practice Western medicine and I don't claim to know all of the types of medicine that that culture practices. But I don't see any harm being done in that practice. I would not object to it. I may have my specific goals in Western medicine....If there is a safety or personal harm issue I'd have to say something.

### Connecting

The central action process of the theory of cultural discovery was connecting. Nurses in the study, who were able to connect with their clients, described their experiences and how they learned through them. Nurses also observed situations in which there was no connection. In these situations nurses provided care without special considerations for the culture of their clients. The categories related to the nurses' ability to connect with the resulting consequences will be discussed first. Not connecting and the resulting care will be described

following this discussion.

Nurses used a variety of strategies in their attempts to connect with their Vietnamese clients. Some of the strategies that nurses used were their own personal history as a point of contact, knowledge gained through specific personal and professional experiences, and specific knowledge of Vietnamese culture. One nurse said: "And all of this [care] is affected by what the nurse brings into it all; in terms of her experiences, education, and assumptions; all those things that we bring into our jobs everyday; and to every human interaction."

#### Using Prior Knowledge

Nurses drew on their past experience for knowledge or tried to gain new knowledge of Vietnamese culture when they began to work with Vietnamese. Alternatively, nurses would try to understand their Vietnamese clients by thinking of how they had worked in other situations where their clients were from a culture other than their own. Nurses generalized from those experiences in order to develop a connection with their Vietnamese clients.

Nurses brought their past experiences into their provision of care for Vietnamese clients. One nurse spoke of how her past experience prepared her for her present role. She said:

I guess having been out of the country so much and having met the obstacle so much that ....I mean if they come without an interpreter and without someone I use a lot of sign language and I point and (here interviewee put her hands to her pelvic area and moved her hands around) and I guess my past experience has prepared me for that and if we don't communicate I'll just go with one word like just with syllables or one word. Like I'll say "baby kick" (as she motions with her hands). And I do a lot of hand motion.

Some nurses had Southeast Asian experience and spoke of how their experiences influenced them in their practice.

One nurse spoke of her experience with "coining" and how her approach was different from that of other care givers in the community. When speaking of the situation she said: "I am not quite sure how it was handled. But I knew of the coining from being in Asia myself so I am a different person from [the others]."

Nurses also used their prior experience as a strategy in helping Vietnamese feel comfortable in nursing care situations. One nurse said:

When I try to do that, [develop a connection] I'll tell them that I worked in the refugee camp in Thailand. That usually works pretty well too because they say "Oh, she knows the situation I came from". I think they know that you have a basic understanding of what's going on.

Prior knowledge involved the nurses' knowledge of cross-cultural situations, knowledge from the media, and personal knowledge from their own situations which helped them understand the Vietnamese situation. One nurse used

her personal situation to help her understand how to connect. She said: "I usually try to find out something about their [ethnic] background. My husband did two tours of duty in Vietnam and he told me a lot of things." One nurse also said she had worked with a Cambodian nurse friend at her place of work and so became interested and later involved with Southeast Asians, including Vietnamese, at her work. In addition to using prior knowledge, nurses also found ways of getting to know their Vietnamese clients on their initial contact with them.

#### Learning to Know Them Initially

Learning to know the Vietnamese required that nurses be open to cultures other than their own. One nurse emphasized the need to be open by saying, "I just know an important factor is an openness to other cultures. Because it is a very obvious attitude to others if you're not open to other cultures."

The openness that nurses needed was a day-to-day attitude and was described by one nurse in the following way: "So always day-to-day being open for and watching for opportunities to learn. And it's taking advantage of every opportunity to learn because there isn't that much that's written."

When nurses found that they were not connecting with

their clients they used various strategies, in different contexts, to overcome these negative situations. Nurses attempted to overcome the obstacles by trying to understand the situation. Sometimes they were surprised at their inability to read a situation even though they were connecting. One nurse described her experience of not knowing in the following way:

I think that there is more of a connection there than I realize because people that I think could care less whether I visit or not [do care]!...[One woman] said to the social worker ... that my visits were really important and she really looked forward to them. I had no indication that that was true by her behavior and the way she was with me. So it always surprises me that there is probably more of a connection than I realize.... That's my inability to read them the way I would an American.... It's my standards. The only thing that I know to go on is the way I look at things through my eyes and so sometimes I am really surprised.

The openness was not just toward the client but included the interpreter. One nurse explained how she was open with the interpreters. She said: "Talk to them. And pick their brains and I have learned a lot. A lot of things that aren't written down."

In the community. Public health nurses worked either in community programs, in teams with a multicultural client focus, or in contexts which were organized as geographic neighborhoods, composed of large populations of Vietnamese.

Some of these nurses talked of their special efforts to find a connection by asking Vietnamese how they do things. It was a way of learning to know them. One nurse described how she asked about their health traditions by saying:

I felt that [I] wanted to be flexible and be sensitive to their traditions and their cultural values and customs. But initially I don't know them. I don't know what they mean when they talk about health. I didn't know exactly how they were taking me. Now I do have a bit more of an idea. So in that sense I can probably connect more faster with them. I know the way they see things and the concept of health and what do they do after ... they are pregnant or are raising their family.

Nurses also used strategies of learning to connect through their special efforts in learning to know someone from the community. One nurse said: "I think it's really helpful to know someone from the country like the [interpreter] to just get, like, an orientation from someone." This nurse also talked about getting to know the community through observation. She said:

I think it is good to have, like, hands on experience. To go to the restaurant, to go to the stores, to do some of the [folk festival] types of things so you can understand just a little bit of what it's like. [I think that you can get] an appreciation of the culture....So we have a better idea of what it's like and listening to some of their struggles. Or reading of the background of Vietnam and the wars.

Nurses used strategies that showed respect as they learned to know the community. One nurse described how she very consciously showed respect in order to gain acceptance

in the community. This nurse talked of using greetings such as smiling, bowing, and accepting the hospitality offered when she and the interpreter made visits to her clients.

She said:

And they are often wonderful hosts and want you at least have a drink of 7-Up ... and it is very important to have that so they can at least give you something so I usually will have half a 7-Up and the interpreter will have the other half. Poor as they are they [honor you] as the guest.

This nurse spoke of how she tried to show a respectful attitude and to welcome the Vietnamese to her country as she met them. She said: "To make them feel welcome I always say, 'Welcome to Canada!' If they have been here a year or more. I always say, 'Welcome to Canada.'"

The nurse also described how she showed respect through politeness as she entered the homes of Vietnamese clients. Although this strategy took additional time, especially when using an interpreter, the nurse indicated that this approach was one she used on a regular basis. She said:

Of course you take your shoes off when you go into [their homes]. Right at the door. And I will bow.... A lot of the Vietnamese ...will often bow and I often will bow to the most senior and I will not offer my hand unless he offers his hand ... if its an older man. And I will bow to a senior woman....And you are not as forward. A little bit more soft toned and laid back. Not pushing things on them. Just more relaxed and the interviews often take very long because of the interpreter.

Nurses in communities worked most often with new

mothers and their infants. Grandmothers were often in the home and involved in the care of both mother and child. Nurses in these situations learn of ways to work with all three in order to provide care. One nurse described the situation in the following way: "The mother-in-law was the real observed source of power in the home and you had to go through her even though there were other male members of the household that would come and go. She was still ... the power."

In clinics. Nurses, who worked in the context of clinic settings, provided care for specific groups of clients. One nurse in a pediatric clinic spoke of how she learned to know the young boys in her clinic. She drew on her prior knowledge of children and her observations when she said:

It seems to me that the kids I do talk to want to be cool, want to do things, want to be tough and they don't want to be pushed around. And they're smaller physically and so I feel this a lot. When they're younger they tell me all about their friends and school....This is one of the ways I start them talking, I just talk about their school. Once they let me know that they speak English they can't go back and tell me they don't understand.

Another nurse in an obstetrical clinic spoke of how she drew on prior knowledge of how to show openness as she worked with pregnant women to help them feel comfortable in

the clinic. She said:

Well, usually I will definitely smile and you can usually tell by your smile. And I definitely make a point ... I usually take their hand, tell them who I am, and I just say M. I never bother with my last name because that will lose it for sure. And kind of say, "How are you?" And, ... if the interpreter is there, tell them who I am. I always do it but if the interpreter is there definitely ask them to do it. Then I ask them how they are doing and kind of invite them to sit down and those are just some of the things.

One nurse spoke of the difference in the context between hospital care and her work in a clinic. She found it easier to learn to know clients in hospital over a longer period of time. It changed her strategy in getting to know then initially. She said:

Well, now I'm in a clinic setting as opposed to inpatient. So then you see people that come in, you deal with the problem and they go home and you don't have as much control in some ways, or length of time. You have days with patients when they are inpatients and you can build trust that way. Here you have to see a patient for a number of visits.

In the acute care hospital. The hospital nurse used different strategies to initially get to know the Vietnamese clients. Nurses in this setting learned to use family, other staff members from the same ethnic group, or other clients.

One nurse, who worked in the post partum area, described her way of developing strategies of working with

new mothers. She described how she would find out what they wanted and then offer that. She said: "Well, I guess I found out from talking to some of the husbands and meeting some other nurses and then talking to some other people that I knew [were knowledgeable] about the Vietnamese culture and just sort of seeing them." She continued to talk about how she worked without an interpreter. She offered the new mother some warm water because she had heard that this was what the mother would want. She would then watch for the mother's reaction to see if it seemed appropriate. The nurse described her way of working by saying:

So I would bring them hot water to the bedside when they arrived. Like a pitcher of boiling water rather than a pitcher of ice water. I would bring a mug rather than a glass. So that at least there was something hot there should they want something before the family brought something in.

#### Taking Extra Care

Developing a connection with clients involved nurses in taking extra care so that the needs of their Vietnamese clients were met. One nurse described this extra care in the following way: "Well I think the one thing that probably has impressed upon me is that if I can be a care giver to these women who otherwise would not get the care they want, I want to take extra care that they just get the best care possible because they need it. Whatever I can do

to make their stay in the clinic better."

Being respectful. Taking extra care involved being respectful in all aspects of the nurses' work. Nurses tried to be respectful in ways that clients could identify. One nurse stated: "Be respectful and in such a way that they pick up on that." This nurse went on to say that respect should include the interpreter. She said: "You need the bilingual staff on your side or they need to at least feel that you respect them and you have confidence in them and that you consider them an important part [of the team]."

A clinic nurse, in public health, described how she would show respect with a new mother. She described her perspective of what it meant to be respectful with regard to respecting the views of the mother on health and her way of providing a healthy way of life for her children. She described her strategy by saying:

I think respect is really the basis of what I would talk about [to a new nurse]. And working within the cultural context. Not coming in heavy handed with the Western perspective and saying this is the way it needs to be done and you are doing it wrong! To acknowledge all the good things that are happening and to be very careful about coming in as the heavy handed person. Where my strongest point that I'll probably make is the alcohol and pregnancy to say that's wrong and it's not a good thing to do. I'm pretty strong on milk in toddlers but I talk around the whole thing and I acknowledge that milk is a good food and, yes, the baby needs it etc. But rather than just coming in and

saying you're feeding your child wrong to talk about what they are doing right. About things they might try. And sort of acknowledging all of those issues.

Nurses in clinic settings spoke of their strategies of showing respect when time and the client's ability to understand were difficulties to overcome. The difficulty of getting to know a client and providing care led to compromise and needed the nurse's constant vigilance to steadfastly pursue the goal of providing health care. One nurse spoke of this pressure in the following way:

To be respectful. To never assume just about anything. ... To take the time to make the people understand what you are trying to get across. And find ways to double check that the education has been accepted. To allow people to refuse care. To make it their choice but to try to be clear of all the pieces. Of all the consequences.... And not judging and being accepting is extremely important.... But it does require more patience to do with an interpreter. Because it does take time and you do have a lot to do and you want them to hurry.

Nurses also saw areas where respect was not shown to clients. Sometimes the context did not provide for a respectful atmosphere. One nurse described her situation in a clinic with regard to giving clients information on results of their clinical tests. She said: "A lot of times you just tell them that if there's something abnormal or something we need to address before your next appointment, I'll have the interpreter call you ... It's not very respectful, I don't think."

Doing a bit more. Doing a bit more involved the nurse's concern with going that extra mile in order to connect with the client whether this is the individual, family, or the community. A nurse with little experience, who worked in a public health setting, spoke of her strategy to connect with her clients by doing something extra. She said:

And I had been feeling that maybe she didn't like me....But you know you have to go through the interpreter and you don't know what they exactly feel towards you. And then the third visit I was ...doing something ... more like social work for her and ... at the end of the visit I asked her, "Would you like me to come back again? But if you don't want me to come back again that is OK."... "Oh you can come back again." [she said.] ... I figure if you could do a little bit more then nursing like ...social support.... they don't mind if you [are] going in. You feel that they trust more. You can help them more. Not just nursing.

One of the needs identified, by nurses working in a community health neighborhood setting, was the isolation that the Vietnamese community experienced. Doing a bit more meant getting the Vietnamese community out of its isolation. One nurse said:

And this is something that we are working at all of the time. We need to get them out. Out of their isolation. We need to expose them as new immigrants to other cultures. For other cultures to learn their culture. Because other cultures, I feel, don't know an awful lot about their culture.

Another strategy in doing a bit more was to devote more

time. One nurse described her experience of working in a clinic situation where appointments were scheduled at specific intervals. She said:

Well, I guess if you can sit down and relax and just convey that fact that, "You are the patient now I am going to devote all my time to you." I think just have an unrushed feeling because it's pretty obvious in your body language whether you are relaxed and able to devote your time to them or whether you have to.... Because if you appear rushed it really doesn't help the situation any.

Developing partnerships. Nurses worked at helping their clients learn to use the health system so that they could begin to meet their health needs independently. One nurse, from a program oriented public health clinic, spoke of how she employed a strategy of developing partnerships with clients so that they could begin to help themselves when in need of health care services. She described her approach in the following way:

[I] try and tell them specifically what I'm here to do and see how we can work out a partnership. And I just stick to my agenda [in the clinic]. But let them know that there will be times that I don't know why it's hard for them and I would really like to find out. And maybe things that have happened to them get in the way. ... Because they don't know my role and if I'm not really specific and I don't define our tasks together I don't think they are going to understand what I'm up to if I seem really interested in their backgrounds.

Taking extra care by developing partnerships meant that nurses made judgements on the ability of clients to adapt to

the North American health system and the Western way of doing things. Working in a community setting with clients, public health nurses attempted to teach clients how to be healthy and how to provide a healthy environment for their children. A nurse in the community setting spoke of her way of taking extra care and judging the ability of clients to connect by considering how long they had been in North America. One nurse spoke of her approach to care, under such conditions, in the following way:

I guess my expectations would be different of them if they were brand new than if they were someone who was here for five years. But I think that I give them a lot of leeway and I am a lot more patient, I guess, for a long time before I really feel like I have to start saying things about how they are doing things differently than I would....That there isn't really a right way or a wrong way but ... here is a different way that you could think about.

Nurses in public health and maternity settings also talked of how they tried to develop a partnership with the family. In many cases the family group involved the new mother, grandmother, and infant. One nurse described her strategy of involving a grandmother in teaching about newborn care. She said:

And you do a lot of explaining and I find that with the breast feeding that I also have to explain to the grandma because grandmas say, 'In North America we bottle feed.' ... And the grandmas do a lot of the care and stuff so ... if you can get them involved then they will agree to let you try to breast feed.... It's kind of a cultural compromise.

Taking extra care sometimes involved developing partnerships with the community. One nurse spoke of finding a community leader and developing child rearing classes for young mothers and grandmothers. This nurse described her strategies, and the consequences, in this way:

[I] worked with [community leader] who was the [main Vietnamese organizer of the event]. There is a Vietnamese newspaper and we put notices in that.... We used actually one of the generic programs [on parenting in North America] and just did more of the translation part of it so that was more of the baseline.... And they tended to feel more comfortable in quite a structured relationship. More rather than a free flowing discussion. Teachers are very revered and respected so it was more of a didactic.... I think that probably was the best thing. It was building a little bit of the community both inside of the building and outside of it.

School nurses also spoke of helping Vietnamese parents to understand the North American approach to child raising. One nurse spoke of her vision for connecting with Vietnamese parents through a partnership among Vietnamese parents, mainstream American parents and health care workers in developing community parenting class in her work setting. She did not have time to start such a project but saw a clear need for it. She said:

Here we have not done well at helping the parents parent their teenagers.... We have parenting groups and classes for parents of little kids and there are more all the time but in fifteen years....Only recently, that I know of, have there been the beginnings of groups for parents of teenagers. And yet I think that period has been the hardest for the kids and the

parents....And they think that - that is according to the interpreters .... A lot of them feel that Americans don't discipline their kids at all. That they can do anything they want. And of course we know that is not true.... What I think would be nice is groups where you have got half Vietnamese half American and where there can be a sharing. "Well, my kid does this and that's how I handle this problem." We American parents can share how we have handled problems that are universal pretty much. At least in American society the Vietnamese parents just simply don't know what to do!

### Shared Brokering

Almost without exception nurses relied on interpreters to help them make a connection with their Vietnamese clients. If no interpreter was available, nurses, to a large extent, were unable to do what they considered essential to their work. The breadth and depth of work that nurses were able to undertake remained narrow and superficial and only very obvious health needs were met. Nurses needed help with language and in understanding the culture of their clients. One nurse said:

If she [the interpreter] is not there we just could not make a visit I don't think. I could probably go with a family member in an emergency but.... The level we are at now with some of [these] clients I just could not do what I am doing without her. It's more than a link.... I would say ... she is a bridge but if she is not there the bridge would fall.

One nurse described how she used the interpreter even though the interpreter was absent when care was being given. Both the language and an understanding of the health needs and care provided were important factors in providing care

in a labor and delivery situation. In this case the interpreter assisted in setting the stage for care although she was not there for delivery of the care. The nurse described the situation by saying, "I can remember, very vividly, one of the first experiences that I had with a Vietnamese lady. That it really struck me that, how you were when you did not have the language." The nurse went on to describe how she had to work with the laboring woman using minimal language skills. The nurse said:

I had a lady who came in....Her husband was at home with the toddler....History was that she had had three sons in Vietnam [and all were now dead]. And here she was, me with no Vietnamese and her with no English. So I remember saying to the translator like, I need one word that she is going to tell me that I know that it is time. And it was very crucial that we had to go to the delivery room because there was thick meconium and this baby had to be delivered in very safe circumstances....The translator had explained all this to her in her own language so she understood. Well the word that we agreed on was that when she needed to push she would tell me. And the only Vietnamese word that I have ever remembered was *prung*. ... It was kind of an explosive P with a little bit of a rolled R and an "ung" sound. OK. She would tell me that word and I would check her and she would go to the delivery room. And I felt comfortable with that [and] she felt comfortable.

The nurse went on to explain a safe and successful delivery without the presence of an interpreter.

Interpreters as translators. Nurses were helped to

make a connection with their clients by interpreters who provided the translation needed to convey health explanations. Sometimes it was done through a direct translation of the conversation between nurse and client. One nurse described this condition by saying:

I find that very much when I work with ... S., and I told her this a long time ago [that] she is ... an extension of me....I look at the patient and talk to her and S. is right over here and she just repeats. Of course I don't understand the language but I have great faith in her that she is just, in her own way, she will communicate to the patient what I want her to....And I very much find that works.

Nurses also spoke of the difficulty of translation and of conveying the thoughts that they wanted to convey. One nurse described the difficulties of finding the right words to convey the complexities involved in translation. She described how she tried to help the interpreters get a clearer and more accurate interpretation of the meaning of words she used. She said:

The other part that seems that people need to do more with is the whole interpretive process.... To learn to ask [the interpreter] things. "How would you have said this? Is that hard for the patient if I say this or what's a better way?" They're not going to be really direct but at least if you keep wondering aloud you're going to get some data.

Another nurse described working with the difficulty of interpreting specific words. She described a situation where interpreters themselves did not know how to translate

at the level of the client. This nurse came to see that she needed to think of how to convey concepts and how to level those concepts for the translation process. She said:

Now I have the interpreters coming to me and saying, "I understand what the words say that you have written here in English but this is what my patient knows in connection with what [you are wanting translated]. Help me to make the connection between the English words and what the patient knows." So it's the concepts that we're trying to work with.

Nurses also learned to recognize how the interpreter's thinking affected nurses' ability to connect with their clients. One nurse described her strategy for dealing with this condition by saying:

The more you know it (that the interpreter does not agree with what you want to do in a particular case) the more you try to find some ways. I might say to somebody, "You don't think this is really a good idea, do you? I have a feeling you're not going to want to do this." I sort of make it humorous. I think it's harder when you know somebody is very traditional and that you can't get past that on this issue. It's just going to go the way they'll have it go. ... The piece in this that is so critical is the interpreter's view of all that too. And how they bring their own adaptation, their own understanding, their own cultural piece .... And again if the interpreters trust you they convey that trust and that helps a whole lot. If the interpreter isn't with you, as hard as you might try to connect, it might not work.

Interpreters as cultural professionals. Nurses also described their strategies in using the interpreters to help them make a connection in the area of understanding culture.

Interpreters not only interpreted language and the concepts within language but also the culture itself. Such interpretation was only possible if there was a trust relationship between the nurse and interpreter as well as a good understanding of both cultures by the interpreter. One nurse described her experience in the following way:

I couldn't live without (interpreter).... She tends to present very much the cultural perspective to me throughout the visits. Throughout the appointments if it's needed. If I have missed something.... I definitely depend more on the interpreters as the multicultural health workers now than I did before. I really do see us as a team with the family. I see me as the medical professional. I see [interpreter] as the cultural professional and I don't begin to have her expertise in understanding the community. She doesn't have my expertise on the nursing side. We bounce off each other.

One of the ways nurses learned to understand the culture was by spending time developing a working relationship with the interpreter. One nurse, who worked in a clinic, expressed frustration at not having enough time to develop a relationship with the interpreter. She said:

I'm still trying to separate out what is important. And what I'm needing to deal with again is my connection to [interpreter]. She is so busy that it's really hard to have more than a hallway conversation with her and .... It just takes more time than that. For her to understand what I really want to know and to get it back we just have to spend more time together. So that we can work as a team.

The interpreter affected all aspects of the nurses'

work with Vietnamese. Without the positive effects of a shared role in brokering which helped nurses to provide health care in these crosscultural contexts nurses found that they were limited in their ability to connect with the client.

### Changes in the Nurse

The consequences of nurses' cultural discoveries were that they began to experience changes as they heard the stories and tried to understand the health needs of their Vietnamese clients. The changes involved their personal lives as well as their professional practice. Some of the changes involved minor shifts and some were profound changes in thinking. They involved personal values and beliefs as well as changes in the perspective from which nursing care was provided.

### It Just Feels Worth While

As the nurses' understanding of the Vietnamese evolved they experienced changes within themselves. Changes involved feelings, values, and beliefs. Throughout these changes, nurses described their work as worthwhile and meaningful in spite of the frustrations. One nurse said:

They touch my heartstrings.... Listening to them talk and the graciousness....And it just feels worthwhile to

be with them even though I just wish I could talk and the negatives are just the feelings and difficulties of the barriers and frustration of language.

A further effect on nurses was that they felt a sense of satisfaction at being able to offer effective care. They had a sense of work well done. One nurse described this feeling in the following way: "I ... think that once these things are done and done correctly, and the sense of delivering effective care. The satisfaction of being able to offer care [means a great deal]."

Nurses not only enjoyed their work but also learned to enjoy the Vietnamese as people. One nurse described her enjoyment in the following way:

I love to sit and visit with them. If one could become fluent in speaking Vietnamese by the amount of Vietnamese food one eats, I would be so fluent in Vietnamese you would think I was Vietnamese because I eat a great deal of Vietnamese food. I like their food. I like to socialize with them.... I just enjoy the Vietnamese people very much.

Nurses also gained a great deal of pleasure from their exchanges with the interpreters. If the relationships were positive they found the experience to be both very enjoyable and humbling. One nurse described her feelings in the following way:

And in some ways it's a real plus. And its really great fun.... And [the interpreters] have gotten through the transition of becoming English-speaking Canadians but are bridging the gap constantly for other people and are really proud of being able to do that.

And are really positive role models in their communities. So it's really a treat to work with people in that setting. It's a pleasure. I am left thinking, "What am I bringing? (Laughs.) The Canadian point of view! And health care information and willingness to work with them. But they are bringing both. All in one package. And they are so excited to be able to do that.

The personal satisfaction and enjoyment that nurses experienced in their work with Vietnamese was very exciting for them. One nurse said:

Well, I think one of the big areas is how much I enjoy it. And the fact that even if I wasn't being paid I'd be doing this work so I find it very rewarding to work with the population that is so receptive, responsive, and appreciative.... If I wasn't being paid for the work I would probably be doing it anyway because I enjoy it so much.

Many nurses also worked with Vietnamese or other Southeast Asian groups on their own time, doing volunteer work. They talked about sponsoring refugee families, working in refugee camps, working with refugee organizations, and mentoring Vietnamese student nurses.

### It Affected My World View

Nurses not only had experiences with Vietnamese but were also confronted by experiences with their own friends and acquaintances. They were forced to reflect on their own situation and see the contrasts as they compared what they saw in the Vietnamese community with their own communities.

Initially, as nurses observed the Vietnamese community they were amazed and excited. One nurse, when asked how working with Vietnamese had affected her personally said, "How can I put that into words? Every day is a new learning experience! Particularly in the area of communication, around issues and values, and traditional culture."

The contrast nurses experienced when in their own culture was a personal reaction. One nurse described her feelings as a personal conflict. This nurse said:

Sometimes it is hard for me to go back to my own culture. It seems so materialistic and soft. I can remember at Christmas time and I had a real tough day at work just because of what I had seen in the community and I ended up going to somebody's open house like one of my friends....An acquaintance had a Christmas open house and it was so extravagant and so upper class that it just completely bothered me. I could hardly even stand it to be there.

Nurses found that within the cultural learning experience they were forced to examine their situation and to begin to deal with their feelings. One nurse described what happened to her by saying:

Well you know again it makes me realize how lucky I have been. And how privileged I am in many ways. It has affected my world view. I know about suffering in the world and so on but, and in fact, these people have not even told me their stories and so on, but, just somehow when you have personal contact every once in a while one will say I lost my last baby in a refugee camp in Hong Kong. And there are just little hints of stories that just makes me feel like I'm having my consciousness pushed.

Another nurse described her experience as one of feeling lucky to have had a cultural experience with Vietnamese people. She felt it had helped her to examine her own culture. She said, "So I feel very lucky to say that I have worked with them.... I grew up on the west side of [a large Canadian city] and had no concept of what multiculturalism was or what the rest of the world did and what was important."

Another nurse described the experience as one which expanded her horizons similar to a trip abroad. This nurse said: "Well it does expand your horizons so much. It's like traveling abroad. It gives you a sense of having been somewhere else."

Nurses also identified personal issues such as discovering that they had racist tendencies and a belief that war was wrong. They re-evaluated their North American child rearing practices and commented positively on the respectful attitudes they found in many Vietnamese children. One nurse said: "But again I will say it has changed me in the fact that I didn't realize that possible I was a little bit racist. Had racist thoughts. And I have got to the point where on my coat I wear a button, 'Let's stop racism!'. And I value my [country] because we are accepting of different cultures [compared to some other countries]." Another nurse said:

It has made me step back and take a better look at what the war was about, and what's happening now because of it. That they can have good feelings towards us and want to be here after what happened. ... Well [I] re-evaluated war too. I have become much more of a pacifist. Not that I probably wasn't before but even more sensitive.

A school nurse speaking about Vietnamese child rearing practices had this to say.

I see [the children] as more appreciative of the opportunities.... And it kind of impresses me and I wish I would see more of that in the general population. I see the general population of kids not take school seriously. Not take responsibility. And it is refreshing to see young people be more appreciative of the advantages that are in front of them. Growing up in the American culture the kids are like they are because of it. But there is just a dramatic difference between the two when you see them together.

### Redefining What Is Important

As nurses began to enter into their clients' situations they began to re-define what was important to them. For some of the nurses, changed views brought changes in their ideas of multiculturalism. One nurse explained her position in this way:

Oh, I think it's made me a very big fan of the salad bowl theory. The multiculturalism. You know if there is a group of refugees and different cultures to make you very pro a multicultural country, they are one.... They give you a very good feeling about what you do about immigration.... So that's what it's done for me personally and really realize in social circles where I perhaps have friends who have not had that experience because they have very different attitudes about the

immigration issues.... And it really has helped me to define what is important.... It's changed me over the last fifteen years.... Because I have a much more, I think, a keenness to help them work with the two cultures but I don't have this need to make them into the Canadian culture. And yes I do think I am more sympathetic to where they have come from and the struggle to try and make their own way here. I think it helps a lot. Without actually turning them into North American British based individuals.

A nurse from the U.S. described a similar experience of multiculturalism in this way:

So I think I am just much more in tune to ... the Asian kids at my daughter's school.... I am much more interested in them. And I think when some of my friends say some negative stuff about the people I usually can say something in my experience how I have seen the people. And kind of point out the positive things that I am seeing. So I think I have educated a lot of my friends too. Because in this country there ... is very few people like me that have the experience where they are meeting with someone so completely different from a different country, culture, everything that is different and I don't think very many American's have that experience. And I think that it seems like the division is getting more and more.

Although the level of change varied among nurses, all nurses experienced changes which made a significant impact on their life and thinking. The change that nurses experienced began with feelings of doing worthwhile and enjoyable work. It caused them to examine their values and beliefs and led them into a restructuring or re-ordering of some of their formerly held values and beliefs. It required some nurses to become introspective regarding their feelings

of acceptance of a person different from themselves.

One nurse, when talking about how to deal with her feelings, described some of the conflict areas and how those needed examination. She explained her experience in the following way:

And I think you need to deal with the feelings that you have within you. Am I willing to take care of someone that's different from me? Is he really different than me? Just because his skin is a different color is he different from me? Maybe yes. Maybe because his culture and belief is different from my culture and belief.... You have to look at yourself from within and see if you can understand and accept. You can outwardly speak understanding but if you don't really accept it I don't think that you can provide good health care. Or show that you're a caring person. Yes, my patients have seen me frustrated and they have seen me angry. But they know that it is the particular situation and the fact that I can't control what's causing this.... It's not the patients I'm angry with. And I think they know that. ... So you have to look at yourself to know if you can deal with those things.

### Learning a Balance

Nurses needed to learn to accept clients who were different from themselves and to embrace them as human beings with human needs. However, they also needed to bring balance into their thinking in order to prevent burnout and to remain sensitive to the everyday reality of the Vietnamese situation. One nurse expressed the overwhelming nature of her shift in thinking and constant pressure it put

upon her by saying:

One thing that is a daily thing is I think I have developed a third ear. And this is sometimes a real burden for me. But I think I'm always listening to how other people that have a different framework or other people who don't have English as a first language, how they hear things.... Over the years I've been able to witness a lot of misunderstandings or different ways of looking at things. So I feel like I listen a lot in a different mind set. That's affected my personal life too.... I think that's one constant that's inside of me from that experience. If it's something about the bus or the telephone company I'm quick to think, "How do you do all of this if it is new to them? ... That's the consistent way in which it's affected me. I hope it has broadened my view of the world. There isn't one way at all of looking at things. It's pretty fascinating to think "How would M. think about this?"

Another nurse described the overwhelming involvement she had experienced and how she dealt with her feelings:

"Hearing the stories was hard and not being overwhelmed by what the personal experiences of the family have been."

This nurse then described what she perceived as the effect on her personal life. She said:

So I'm not sure how much of it is my own personal history and how much of it is internalizing the stories of the families and it's probably a mixture of the two.... Trying to balance the role of friend and nurse is a problem for me.... So because they have never been in that kind of professional relationship before so ... especially new families I think, see me as a bit of a lifeline. "Oh at last here is someone who is fully in touch with the Western community but understands my past!" So ...it's not as much now as it used to be.... But often feeling almost smothered by how much they needed me. And that kind of feeling is something to have to come to grips with.

She went on to say that she no longer attended Vietnamese community and family celebrations or cultural event because she needed to involve herself in activities not connected to the Vietnamese.

Other nurses also discovered their own personal limitations in their work with Vietnamese and found different ways to prevent burn out. A nurse who worked in the mental health area and received referrals from other health facilities said:

Maybe because I've been in the mental health area, I have heard some terrible things. I don't know how that affects me.... I often try to tell somebody. "Oh my God, you won't believe what I heard." It's been worrisome. I don't know how I've dealt with it because it's been pretty constant. I try to take care of myself. I used to go to a lot of Asian functions. People were always asking me. I rarely go now because I need to heal myself in ways that don't involve more of that.

#### Providing Sensitive Care

The change in nurses' personal lives also resulted in a change in how they provided care for their Vietnamese clients. Nurses learned new ways to provide a level of care which was satisfying and effective in meeting the needs of their clients. Nurses learned how much to push an issue and when to stop pushing. In addition they learned how to use the health care system to provide the care needed in a

specific situation.

### Learning How Much to Push

The tensions under which nurses worked were both personal and relational. Nurses saw ways of providing care, for health problems, from a Western nursing and health perspective. Although Vietnamese wanted Western health care their perspective and understanding of Western health approaches was often different from that of the nurses' perspective. Nurses also worked within the ethical and legal boundaries of professional nursing practice. The ethical and legal standards that nurses followed required that clients be informed and give consent to treatment. Additionally, nurses were required to protect children from abuse and neglect as defined by North American standards.

Over time, nurses learned how much to insist or push a particular approach or understanding of a health problem. One nurse described her approach by saying:

I think you learn over time how far you can push someone or insist. I don't believe in insisting for the most part. I believe in giving information, making sure that they know that it's their choice and making them know why we are suggesting this. That's always my approach and I think it works better.

Nurses also learned about the limits of their ability to push in a situation. Trying to work in a situation where the two parties came with different perspective of health

brought frustration and at times ended the relationship.

One nurse described such a situation when she related:

I was with this family for a very long time. I feel that nothing ever really changed....It was a very complicated case.... I tried to educate the family. They never really were compliant. I was very frustrated. Eventually I just closed them. It was like talking to a brick wall. I think it was the concept of health, it was so different.... They don't see medicine that way. They see health as more transient or something like that. If you're sick you take the medicine, if you're feeling better you don't take it. I think it was that.

Nurses faced the difficult task of making decisions on the ethical and legal boundaries of their care. A school nurse with a brief experience working with Vietnamese described her situation involving the child protection agency. In this situation the nurse described how she and the other health care workers in her team tried to remain in a caring relationship while proceeding against the parent's wishes. She said: "So we proceed as the law would have us do and as we would naturally. We try to do it on a more caring, helpful approach rather than a dogmatic, judgmental approach. ... At least I hope we don't come across as being offensive and overbearing!"

Another experienced school nurse described how she deliberated about reporting to the child protection agency. This nurse had had to struggle with the responsibilities of pushing a family into involvement with the child protection

agency, trying to work out a culturally acceptable compromise in the care provided, or finding some other creative solution to the care she felt was required in a particular case. She said:

I have never ever personally reported to [child protection agencies] for medical neglect and I could do it every day. If I was going to be a real pusher.... I've worked with it and it's gotten easier but I have had many struggles with it many times. Should I be reporting this or not? And usually in life threatening [situations] .... [But] for just... an eardrum repair I am not going to get excited about that. But then there are situations where it has not been easy. To make a decision not to report.

A nurse who worked in the area of mental health described her experience in drawing the ethical and legal boundaries of care and how that decision involved the interpreter. This nurse said:

There's a lot of frustration around all of that. Wondering where to give and where to not give.... I think my experience now is a little bit helpful. I have a pretty good sense of when something is serious and our intervention is just not going to cut it.... So I think ... I was much more careful in the beginning. Over ten years of time makes me less.

One of the effects of learning how much to push was that nurses had to work out their own feelings and reach a personal comfort level with their decisions. During these experiences nurses felt a loss of control over situations but also learned to be flexible in care situations. One nurse, in a clinic setting, described her frustration with

how her clients presented problems, her restrictions with appointment times, and with not having the language. She said: "I would feel frustrated. I would have fifteen minutes. Give me a problem. And I think it was my wanting them to present in a Western cultural manner in terms of 'I have an ear ache.' One problem at a time. Set it into a box. [But] there's just so much more than meets the eye!"

Another nurse described her feelings of loss of control and learning to being flexible in the following way:

I feel like I have learned to be very flexible and I have a lot of tolerance. But I push my limits. I need to be real careful. When I hire people that I know are going to be working with [Vietnamese] I really look for people that can be that way too. If you have to be in control a lot then forget it. But it is really frustrating when you kind of think you know the way the situation should go or the way that it has to go.

This nurse goes on to speak of the frustrations of working with clients and interpreters who have different views of health and health practices, of time, and, differences of opinion in child protection cases.

A further area in which nurses learned to be flexible was in the area of language. One nurse described the frustration with language in the following way:

So I guess it was hard and still is hard because there is so much ... because I have an agenda and I have certain things that I want to teach and to assess and there is just a limited amount of time and I think, like I mentioned,

interpreter skills are crucial.

### Learning to Use Resources

Nurses learned to use the resources available to them, within the health care system, to meet the health needs of Vietnamese clients. Often nurses had to adjust their care in order to provide the quality of care they thought was needed for their clients. One nurse described the use of the interpreter and the contingencies which arose while working in a clinic context with limited resources. She said:

All of our appointments or any referrals that our patients need are scheduled automatically with the appropriate interpreter. It has to be. Our doctors don't want family members interpreting. Sometimes we need to do this. If we've had a crisis in the emergency room, that supersedes any clinic visit. The interpreter must go to the emergency room. But you don't want the wife interpreting for the husband at his psych appointment. It's not going to help the psychiatrist or psychologist at all. We need an independent view from the patient. Not the opinions or beliefs of the person interpreting.

Nurses used whatever resources they could to provide care for their clients. One nurse described how she was able to use the resources while working in the community, in the context of an acute care hospital. She had established a good working relationship with a community facility and was able to use this resource in her care. She said:

But if nothing else we will phone the [local] immigrant and refugee committee and leave a message with the Vietnamese speaking translator and say, "This lady has had a baby. This is her address. You should check it out and see if things are OK." From my experience ... we have not had complaints from public health.

Nurses will also use the resources within their own health facility. One nurse described the resources she had in her own clinic with her colleagues. She said:

I have most of the control over my own schedule and they [the appointments] are set up at half hour increments which is very long. But we will overbook into that. Cut that into half if it's a sibling that needs to come.... I wouldn't do that probably in any other setting. But the [doctor] is so good about it and if they know the families then you can get away with that.... We have the luxury of doing that.

Several nurses described the value of peer teaching as a resource that they used. One nurse in an acute care maternity ward described her strategy with regard to the commonly held misconception of the value of bottle feeding as opposed to breast feeding using this approach. She said: "There is a bit of teaching you have to do and sometimes I use other patients [who have breast fed babies] if I have to."

Sometimes nurses adapted the resources available to them. They found innovative ways to use written communication in a particular situation because of the persons involved. One nurse in a clinic setting described her approach in a community, were networks where well

established, in the following manner:

What I do is write the appointment on a card. ... And then I write the date because I know also that their interpreter will be in contact with them and I put down the date and the time and let them know. ... And I know that for sure because if they did not have an interpreter they would not know to come here. And I really believe that ... there is a community out there and word gets around that way and I think the interpreters are very much involved. And the interpreters are the ones that make the initial appointment.

Time is one resource nurses needed in order to provide care to clients. One nurse spoke of the revised expectations that a new nurse should have when providing care. She said:

Not to expect on a one-to-one what you would normally be used to. She would need a lot of patience in order to complete a physical, especially the history. And even if you have an interpreter those visits are double of what the other ones are because you have to, you know, go from one to the other....So the calmer you are and the better you can accept the fact that, "Heh! I will not get this patient done in ten minutes!" I think you can just be more relaxed and do a better job that way. Even though someone says, "Are you almost done or how much longer?" You know you just can't. So not to let other environmental forces influence you.

Nurses also described the diminishing resources they had to work with and how that had affected their care. One nurse said: "We need to go back to the way we were in the 80's when we had money to set up courses for even these seniors and transportation to get them there." She then went on to describe what was missing from the services in

her community. She concluded by saying, "So these people are more isolated in the end and those things are needed."

A major condition in the nurses' ability to provide sensitive care was the interpretive service available to them. Nurses often saw different interpreters and therefore saw variability in how well they were able to do their work. One nurse, in a clinic context, described her experience in the following way:

So much of the information you get is dependent on your interpreter. There are very good interpreters and there are interpreters that aren't so good. So you feel kind of dependent of them and their ability to get a good history. As a health care provider 90% of the information you get is really from the history. ... So a good history is real important.

A contingency, within the interpretive service, was having the service available at a convenient time. One nurse, in a clinic setting, spoke of the problems of trying to make good use of the time and services of the interpreters. This nurse said:

Even if I have time to do [patient education] in a busy day often the interpreter is being beeped to get away from me and to go to radiology or something. That's a frustration. I might have someone canceled and I find out I have forty minutes to spend with a patient and ... the interpreter is being beeped away.... So I end up prioritizing. "What does this patient really need education for today?"

### Building Bridges

One of the nurses' primary action strategies within the

health care system was to build bridges. One nurse described her strategy in the following way: "It is a way of building bridges as far as I am concerned.... There is a network being built. And the community is being built. And there are ties." Another nurse described the work of building bridges as that of being a liaison. She said: "I see myself as a liaison between them [the Vietnamese] and the clinic; [them and] the hospital and other health care providers in the community; or, between them and other community services [such as health related] classes, food shelves, and the like."

Advocacy was another word nurses used to describe their nursing care. One nurse said: "I think I try and be an advocate for them in every way that I can be." The bridge with the interpreter was crucial if the relationship was a positive one. One nurse described the importance of this bridge when she said: "I think the biggest thing is helping to connect them with the interpreter at their clinic."

In order for nurse to help clients to begin to develop bridge building strategies of their own it was important for clients to understand the health care system. This included the role of the nurse. Unless the clients understood this relationship it was difficult to build bridges. One nurse described her situation in the following way:

I think you have to really define why you are there and

try and tell them what our health care rules are because they are going to have to use those as they work their way through the system. So I am hoping there is some education going on there.

Nurses also tried to explain the North American way of life and accepted ways of child rearing in order to help families to adjust to society in North America. One nurse described a community health project in child care she conducted in the community. She said:

What usually was done was it was recommended or let them know what happens here in Canada. This is the way that it's done here in Canada. And if some of the concerns with the child are with [the child protection agency this is what happens]. If your child is left alone or [there is a] physical touching of your child [which] could be considered unsafe [then this is what could happen] .... [And] I think that was a good experience.

This nurse was also building bridges within the community. She went on to describe how the intervention helped build networks within the community itself. She said:

There was about 20 different young moms that came together both from within the [Vietnamese apartment] building and outside of the building. There was older grandmas that came to help with it. So it was a nice blending of people that maybe did not feel secure to go out of the building with people that were living out in the community.... And they often would bring food with a nice sharing with food after the session. So it was a very nice social session.

School nurses worked with the family through the schools and the children. In these situations families did not bring their children for health care. Rather, school

nurses provided care through referrals from teachers, health aides, and their own assessments. School nurses were not attached to a health facility but needed to develop a way of providing care through referrals and inservices to school personnel. One school nurse described her strategy of trying to develop a way of providing care when this involved the family and other health care workers. She said:

I try to work with the family and work through the interpreter. Try to find different ways of approaching the situation that maybe the family would be more accepting of. ... Try to work with the hospital and the medical facility and that kind of thing.

One school nurse described an experience she had in working with a family and the health care system in her community. She said:

And I made a home visit and I got them to agree to go at least for an X-ray, ... and I called ahead, and .... I have contact people in a lot of the medical resources that I work with and that has been very helpful, so I asked my contact person who would be the best physician and could she, ... somehow arrange it so that he would be the one to see that [client]. And she had it all set up and he was willing. He is much more culturally sensitive then a lot of physicians are, and he was willing to [carry out the treatment that the family had agreed to].

This nurse then went on to describe how the bridge she had built did not work, what went wrong, and what she learned from that experience. She said:

And then the whole thing got botched up because somebody else was involved with the case. Told the family if they didn't [do the traditional Western biomedical treatment] that the [child protection agency] was going to take the child away from them....

And so for a very long time [the family was] very angry. And I can't blame them. We had it all set up and it would have worked fine. Would have been a good compromise....Most of the medical facilities at least the larger ones, the clinics, I have a contact person. Private doctors is a whole different ball game. And I really would prefer that they go to the clinic.

### Dealing with Glitches in the System

Nurses in this study were drawn from both the Canadian and U.S. health care systems. In addition, nurses provided care in community settings such as neighborhood medical clinics, large multiservice medical clinics, home visiting agencies, and public health settings. The public health services where nurses worked were organized in a variety of ways depending on the needs and resources of the community. Nurses in this study worked in community health clinics, geographic neighborhoods, and school health programs in a single school as well as school health programs for children of one cultural group across a number of schools. Some public health nurses visited mainly in homes and some worked in health clinics. Nurses who worked in geographic neighborhoods included the health needs of the total community within their scope of practice. This approach involved nurses in home visits, community centers, local schools, and seniors centers. Of the two nurses who worked in acute care hospitals one provided follow through care from labor to delivery and one provided total care in the

post partum area. All nurses worked in a team approach either with other nurses, health professionals, teachers, or community workers such as police or translators.

The pressures and problems related to the community and health care systems and how to access and tailor them for use by Vietnamese was common to both Canadian and U.S. nurses. Nurses in all systems of care in both countries experienced similar glitches in the system. Such problems often arose due to the misunderstanding of team members as to the needs of Vietnamese clients and due to financial cut backs which resulted in cuts in services. The intensity of the problems was more keenly felt by some nurses than by others but was not specific to either Canada or the U.S. Nurses in both countries expended a great deal of effort in their attempts to provide the services needed within the systems available to them. They evaluated their care and sought new and better ways to meet clients needs when possible.

Because of the experiences that nurses had with the health care system, they were able to describe contingency situations or glitches which needed to be accounted for when working within a care facility. One nurse, in a clinic, described her situation in the following way:

There's some glitches in the system that don't work. I think a lot of times when patients fail their appointments it's because they get an appointment card

that's written in English that says when their appointment is. Maybe they need to save that card until someone who speaks English can read it to them. And that might be two days from after the time they get it [in the mail] and they might miss their appointment. I think that that's really frustrating. I wish we had a better system of informing people about when their appointments are....A lot of times you just tell them that if there's something abnormal or something we need to address before your next appointment, I'll have the interpreter call you.... It's not very respectful, I don't think.

Nurses expressed their frustration with the system and let clients know that they were angry with the system and not at the clients. One nurse said: "Some of them I have even told. They come back again and say, 'I am very sorry to bother you'. 'No you are not bothering me. I know what you want. My problem is that I have [not been able to get it']."

Sometimes nurses saw clients that were in critical situations because of the inability of the system to care for their needs. The linkages that were in place were inadequate to meet the needs. One community nurse described her experience of a new born baby and the mother by saying:

The cupboards and refrigerator were bare except for about a fifty pound bag of rice and that was it. So that's why she had not been eating.... Later I found out that she fell through the cracks of the system at the hospital because she went home on a Saturday. So she didn't get on the [special] program and it took us two visits to really understand that she wasn't enrolled in the program. When I first asked she said she was. That's why she didn't have any formula. She only had enough formula for the next three or four days and didn't have an [appointment for the special] program.

### Helping Them Take Charge

Over time, nurses were able to see the results of their efforts in working with Vietnamese. Their clients learned to look after their own health needs and to use the services available in the larger health care system. One Canadian nurse described her experiences of working with Vietnamese over the years. She described her first experiences with Vietnamese on arrival, in a general health clinic, and then some eight years later in a mother/baby clinic. She said:

When it started off ... it was a real global health clinic. ... They didn't have a great understanding of health or their bodies. And they brought in all kinds of questions. ... A lot of very malnourished kids, and a lot of very tiny children.... And pregnancies that had not had any pre-natal care at all.... It's more like a standard baby clinic now as opposed to a health clinic that it was before.... The ones that come here don't seem to need the health care like they did. They don't need the doctor.... The services are there for medical treatment for non-English speaking people.

An American nurse spoke of changing health need in terms of waves of Vietnamese new into the country. She described her experiences in the following way: "And now we are getting a new group and we will need to start all over again from the beginning [in meeting their needs]."

A consequence of the nurses' ability to give sensitive care was that nurses experienced the pleasure of seeing Vietnamese who were able to take charge of their situation. One nurse described her experience with a young Vietnamese

mother and her Downs Syndrome baby. She said: "She [became] very proficient in English. She was very much in charge of her life and she knew what she had to do."

Another nurse described her work with a disabled boy and his family. She said:

And by the end of it, a year and a half later, they were making their own appointments. They were calling up the [interpretive ] service.... They were doing it all. They had become the case managers of their own care which is just what you really want to happen. So it was just really neat to see....that they got it together.

#### Not Connecting

The central action process of connecting involved an opposite action - that of not connecting. The process of not connecting will be described below.

At times nurses observed situations in which it seemed impossible to connect. The difficulty in connecting was attributed to a variety of problems. Either the nurse, the Vietnamese client, or both, were seen to be part of the difficulty in some situations. One nurse said,

Some people will never be effective in taking care of Vietnamese patients as some will never be effective in taking care of people who have AIDS or HIV. Because they can't go beyond themselves and their fears or what they see as insurmountable differences between them and the people they need to take care of.

Sensitive nurses also learned to know when, in fact, they were not connecting with their clients. Although all Vietnamese clients were very respectful, the knowledgeable

and sensitive nurse learned to recognize that clients who missed appointments or who gave only brief answers to questions were not connecting with the nurse. One nurse, in a clinic setting, described some of this behavior by saying:

The parents that you do not connect with keep less of their appointments. Fail more appointments. That's one real obvious sign. Also, they are the ones that are in a hurry to get out of the room, they barely let you explain about medicine before they're out the door. They've got the kids dressed and you're talking while they're walking out the door. Sometimes, literally, I have one hand on the interpreter and say "Come here, we have to go out in the parking lot and do this." Or I say, "Please come back and I'll tell you about this medicine." They'll say it in their language, "No, I know about it."

Sensitive nurses used various strategies to find a way of connecting if they failed in their efforts. One nurse described how she learned to connect with her clients when she said, "We find this out by groping and we find it out through our interpreters and just our experiences." Another nurse, in a hospital context, described her way of groping in the following way: "Well I guess I learned from talking to some of the husbands and meeting some of the nurses and then talking to some other people that I knew [had] a little bit [of knowledge] about Vietnamese culture and just sort of seeing them." The nurse continued to describe how she tried to connect with the Vietnamese client. She said: "And I would try to show her where things were so that she could help herself. And also if she wanted more towels well here

is the cart."

Another nurse talked about using a knowledgeable nurse to help her to know what was going on. She said: "So I need to get in touch with A. [a knowledgeable nurse] and see whether we can have another go around about this. And try and get more insight."

Nurses used interpreters, if possible, to help them understand situations if they were unable to connect with the client. One nurse described her approach in the following way:

Well, I think that's what my interpreter and I talk about when I can't figure out where a person is coming from. I will ask her what kind of vibes she is getting 'cause I can't assess that very well. Is this a cultural thing or is this just this woman's problem dealing with whatever it is?

Nurses were sometimes unable to make connections because of the problems in interpretation. At best, interpretation was a cumbersome and time consuming process. One nurse described the time it takes for a home visit in the community, with an interpreter in whom she has confidence, in the following way: "[An English language family visit would take] about an hour but we would cover twice as much because we would not have an interpreter. So it would take much longer to cover things [if using an interpreter]." When working with an interpreter in whom the nurse does not have full confidence the nurse described the

following feelings: "You know that if you don't have a good trained interpreter that you work well with you can't [give the care you want to]."

Nurses also described frustrations related to the context in which they provided care. Not connecting was sometimes related to the inability of the health care system to bring together all of the complexities of working with a group of people that did not understand English. One nurse described her frustrations in the following way:

Frustrations! My own personal ones.... not having interpreters when I need them. Not knowing if what's being interpreted is kind of what's going on....[The clients] not finding things; or getting to places because of language. Having to reset it all! And the time it takes!

#### Standard Care

All the nurses in the study identified how much they enjoyed working with their Vietnamese clients. Some expressed frustration with the lack of sensitivity they observed in some of their peers. Although the care they observed was adequate and generally therapeutic, by North American standards, it was not culturally sensitive nor always culturally appropriate. One nurse said, "You also have other nurses that help staff the clinic and they're the ones that you have a little bit of a problem with. They're just not very sympathetic. They're polite to the patients. They are not rude to them. They don't go that extra step."

Other nurses spoke of experiences where health care workers called the child protection agency instead of trying to find a culturally appropriate way to provide care.

The dimensions of not connecting and standard care were grounded in the data but were not strongly supported.

Further study is needed to enhance these categories and develop a fuller explanation for the question, "What all is going on here?"

### Conclusion

A theory of how nurses work with Vietnamese was developed. The theory of cultural discovery described what nurses learned from their work with Vietnamese. Nurses learned to distinguish Vietnamese and their view of health from other groups of clients. Concomitantly nurses were able to see how Vietnamese share a common humanity with others. Nurses were able to make these cultural discoveries by developing connections and using those connections to help them learn to know and work with Vietnamese. The consequences of cultural discovery for nurses were that they were able to provide sensitive care and their clients were able to get the health care they wanted and needed. In addition to receiving health care, Vietnamese were able to learn how to use the system to get the services that they wanted. They became their own case managers.

Nurses also experienced changes in their personal lives as they entered into experiences with their Vietnamese clients. Nurses described such changes as the development of new priorities for themselves, personally, as well as changes in their priorities for their client communities.

## Chapter Six

### IMPLICATIONS AND CONCLUSIONS

The purpose of this study was to examine how nurses' have informed and shaped their practice when working with Vietnamese clients. This was accomplished through the use of grounded theory coming from a symbolic interactionist perspective. The substantive theory generated has implications for nursing. Chapter Six will include a discussion of the contribution of grounded theory in explaining nurses' experiences, a discussion of how the study findings expand on the literature, and a discussion of how the theory furthers nursing knowledge of crosscultural care. The implications for nursing practice, education, and administration will be included in the discussion.

#### The Use of Grounded Theory in a Study of Nurses' Experiences

The researcher used the constant comparative method (Strauss & Corbin, 1990) during the data collection and analysis phase of the study but also followed McCarthy (1991), Robrecht (1995), and Schatzman (1991), in the phases of analysis and in the discovery of the dimensions within the emerging theory. The complexity and diversity of data were most easily understood using the perspective offered

originally by Schatzman (1991) and developed further by others (McCarthy, 1991; Robrecht, 1995). This approach helped the researcher to clarify and bring sense to the data without becoming paralyzed by concern with steps and procedures in the method. The result was a theory of how nurses work with Vietnamese in crosscultural situations.

Dimensional analysis as outlined by Schatzman (1991) and Robrecht (1995) focused not on the precision and strict adherence to the method of finding a core concept, as outlined by Strauss and Corbin (1990), but on the plausibility, cohesive detail, and coherence of a constructed story, as told from a particular perspective. Schatzman's (1991) approach allowed for a fluid easing of concepts and subconcepts into the overall whole. Relevant "considerations" or "dimensions" of experience (Schatzman, 1991, p. 307) which influence the theory can be woven into the fabric of the theory thus adding complexity and density without sacrificing parsimony. The overall effect is a saturated, natural theory, with high credibility and explanatory powers. Dimensional analysis was, therefore, a very effective alternative for this neophyte researcher in bringing the elements of the theory together into a unified whole.

#### The Literature and the Study Findings

The literature reviewed in this study included (1)

situation based discussions of the cultural impact on care for the Vietnamese and the implications for practice, (2) literature with a competing world views approach, (3) a model for negotiating in intercultural relationships including cultural brokering, (4) intercultural relationships as a process, and, (5) intercultural relationship training models and competencies. All approaches were helpful in understanding how nurses work with Vietnamese and were part of the participants' experiences at various times in their care. The details of the nurses' descriptions in the study, however, added valuable insights into the discussion of crosscultural communication in the literature.

The situation based literature explained specific situations which stood out and presented particularly puzzling behaviors for nurses. Nurses, in this study, began to recognize both differentness and sameness within their clients as they tried to grapple with specific issues. As nurses continued to worked with clients they began to recognized two very different points of view - theirs and the clients - and from that growing understanding learned how to avoid cultural imposition and ethnocentrism.

One of the themes within the theory of cultural discovery was that of learning to understand the complexities involved in the differences and commonalities between themselves and their clients. In a discussion of

cultural universals, Wiredu (1995) described the problem of identifying cultural universals in cross-cultural communication. Wiredu (1995) began with the premise that inter-cultural communication would be impossible if there were no cultural universals.

Nurses, in this study, found that their Vietnamese clients held common human concerns with other groups of clients and humanity in general. However, for nurses to begin the communication process, they found it necessary to use their prior knowledge, take extra care in their communications, and work at developing partnerships with their clients. This finding from the study would support Wiredu's (1995) assertion and indicated how nurses were able to find and develop an understanding of the universals in their crosscultural communication with clients.

The negotiation model and the ideas of cultural brokering were very much evident in the experiences of nurses. However, if the nurse did not speak the language, both the nurse and the interpreter shared the brokering role, provided that a partnership developed between them. Nurses felt that their contribution within the brokering relationship was toward the health or nursing aspects of care and that the interpreter was the expert in Vietnamese culture and language.

The process orientation to intercultural relationships was the approach most clearly related to the experiences of

nurses in the study. Ordinary nurses, in multicultural settings, learned to develop a partnership of mutuality that involved respect for the client's world view, an emphasis on commonalities, and working together to solve mutual problems. The rich descriptions of nurses' experiences, in this study, provided further elaboration of the process orientation to crosscultural communication.

The management training models reviewed in the literature identified practical approaches to crosscultural situations found in business and management situations. Both formal knowledge and the application of practical knowledge were used in intercultural training. Learning was a process and centered on some specific cultural as well as general skills applied in a multicultural setting. Nurses, in the study, also learned through practical experiences in decision making, providing care, and evaluating their work. They consulted with their interpreters, a "knowledgeable nurse" in their vicinity, work groups within a multicultural team, and through formal educational sessions. Similar skill training and knowledge development approaches were described in the literature. A further understanding of what nurses need and the various levels of understanding required in nursing practice can be gained through the results of this study.

The results of the study of nurses' experiences, therefore, provided a framework for the integration of the

literature as well as specific examples from nursing practice which illuminated those writings. The study can enlighten both the issues and the implementation of concepts in crosscultural nursing.

#### Theoretical Contributions to Nursing Knowledge

The theory of cultural discovery provided a framework for understanding how nurses work with Vietnamese, a group different from themselves. The crosscultural interactions within the nurse-client relationship were described with all the richness, complexity, and ambiguity inherent in the real life situations in which nurses find themselves. The theory developed from the data provided an abstraction of that description resulting in a coherent, integrated, explanation of nurses' experiences as they worked with Vietnamese. The various dimensions were organized into a framework which described the conditions, context, action/strategies, and consequences of the nurses' experiences with Vietnamese as they lived in the day-to-day care situations.

A further contribution of the theory of cultural discovery lies in the explanation of the consequences of discovery for the nurse. The theory described a changed nurse who provided sensitive care. These descriptions were grounded within the context of client situations and the North American health care system. No researched explanation of the nurse's personal changes, when connecting

with clients, was found in the literature. Similarly sensitive care was not found to be well researched or contextually described in the literature.

#### Further Areas of Research

The purposeful theoretical sampling in the study involved a broad base of nurses from two countries and two health care systems. Nurses interviewed were drawn from a wide variety of settings in community health, public health, school health, home visiting, local community health clinics, and large medical clinics and hospitals. They were involved in a variety of services to individuals and groups of Vietnamese.

The nurses had great variation in the depth and breadth of their experiences in nursing and with Vietnamese. Their clients included school age children, couples in the birthing experiences of labor and delivery, post partum mothers and families, clients with infectious diseases and new immigrant health problems, communities with public health issues, mothers and children, and, individual care for men and women in large and small health clinics. All worked in multicultural settings with Vietnamese clients being only one aspect of their work.

Few nurses in the sample worked in acute or chronic hospital based situations. There was some indication that such a setting would have provided another perspective on

nurses' experiences with Vietnamese. One participant stated that while nursing in an acute care pediatric setting, she was able to get to know her clients because of the intensity of the situation and the constant attendance inherent in inpatient settings. A study involving nurses who work in such situations would provide further data and add richness to the theory.

There were also no nurses who were educated exclusively at the diploma or associate degree level. Rooda (1993) found in her exploratory study of practicing nurses in acute care hospitals that the only significant difference that nurses had, in relationship to cultural knowledge and attitudes, was level of educational preparation. Further examination of diploma and associate degree nurses would illuminate their experiences in working with Vietnamese. The inclusion of more nurses, in the sample, who were drawn from acute care hospital wards, would probably include nurses with diploma and associate degree preparation.

All of the nurses interviewed spoke of their enjoyment and pleasure in working with Vietnamese. Additionally, a number of nurses identified special abilities and interests in working with Vietnamese clients. Nurses, however, are not always able to choose the populations they care for. Additional interviews and observational experiences with nurses who would not choose to work with Vietnamese clients would add another dimension to the study.

The strategy used to collect data in this study was primarily the interview. Nurse were interviewed about their experiences. In most cases the interviews took place in the work setting. There were no specific provisions for observational experiences or use of written documentation other than the literature. Future studies could include other data collection strategies such as the observation of nurse-client interactions.

All the nurses interviewed said they very much enjoyed their work. They described their experiences in esthetic and creative terms. Cunningham (1981) in a discussion of crosscultural communication identified the need for a creative process if the applied arts are to transcend the linguistic barriers to crosscultural communication. Further investigation into the creative process and into intercultural relationships, as an esthetic experience, would stimulate critical thought, imagination, the development of a greater conceptual capacity, and the ability to solve problems (Cunningham, 1981).

Further investigation into the characteristics or experiences of nurses who enjoy working with a specific cultural group, such as the Vietnamese, be of interest and provide insight into the effects of job satisfaction and pleasure for nurses. An additional area of interest would include investigation into the effect of different crosscultural educational experiences or other critical and

life changing experiences on nurses who work with Vietnamese.

A substantive theory of nurses' experiences with Vietnamese was generated from the study. The theory would serve a wider purpose with additional study of other practice disciplines and professionals. North America is a multicultural society. Many of the challenges encountered by nurses are also those experienced by other workers in the health fields and beyond (Cunningham, 1981; Ungerleider, 1989). Further study of intercultural relationships in a wide range of professions and occupations such as human ecology, and law enforcement relationships would serve a wider audience and help raise the theory to a more formal level (Strauss & Corbin, 1990; Woods, 1992).

#### Implications

The theory of cultural discovery holds implications for nursing practice, education and administration. A growing number of authors have challenged the nursing community to develop nursing practice models that will support and guide care for different cultural groups. Chinn (1992) has called for a serious look at cultural differences and similarities as a needed beginning to the "development of a future for nursing and health care that truly values health for all" (p. 54). Donnelly (1992) has called for both a "lens and spandex jumpsuit to adjust the view and to ease the movement

in care for the culturally diverse" (p. v). The changes must occur in nursing administration, nursing education, primary care, and in care of culturally diverse clients with special problems.

#### Nursing Practice and Administration

Nurses, in this study, were able to describe their experiences which led to a theory of cultural discovery. The theory articulated "taken-for-granted common sense knowledge and provided a language for discourse" (Woods, 1992, p. 392). The theory also provides knowledge for further discussion among practitioners and a spring board for the application of theory to intercultural practice issues. Several examples of the possible issues raised for practicing nurses include nurses' clinical decision making, communication strategies used in practice, and introducing change in the understanding of health and health practices in crosscultural situation.

Watson (1994) in a study of decision making by nurses, found that inexperienced nurses stated that experience was what they needed to make informed decisions in clinical practice. The theory of cultural discovery could assist both experienced nurses and inexperienced nurses to examine their approach to decision making in crosscultural relationships.

Brown (1994) found that expert nurses in clinical

practice used particular approaches within their interactions with clients. Brown's (1994) findings of how expert nurses communicated could be enhanced by an examination of the communication of nurses in this study. The theory of cultural discovery described a way of relating to Vietnamese clients which resulted in sensitive care.

Parry (1984) identified the need for health workers to understand the values and beliefs of a culture and not just a few health practices. He stated that in today's fast changing world it is not helpful to study only traditional culture. Knowledge is also needed of the changing dynamic nature of a situation.

The theory of cultural discovery has implications for practicing nurses who work in dynamic and ever changing multicultural settings. The theory described how nurses learned to develop a connection with their clients and provide sensitive care. They learned to make personal changes in their lives so that they were able to balance the demands of care, make nursing decisions, and bring creativity, energy, and great satisfaction into their work.

Perry (1984) called on health care workers, in crosscultural situations, to introduce changes at the fringe areas of society where central values are not threatened. Modern health care providers must practice with sensitivity and in such a way that their care is empowering as well as health promoting. Change will be more accepted, and a

cultural group will be able to make the necessary adjustments without undue pressure or disruption, provided that the nurse will be able to preserve the practices that are not harmful and at the same time introduce changes that are related to the traditional ideas in the culture (Perry, 1984).

Nurses who made cultural discoveries were able to make cultural compromises and became comfortable with clients who had a different view of health than their own. They learned to accept a wide range of health beliefs and yet provide safe and effective care. They were able to introduce changes in their clients' health practices as advocated by Perry (1984).

Woods (1992) has stated that research from the symbolic interactionist perspective is able to inform policy by providing knowledge and an understanding of everyday life. Such knowledge can be used to evaluate the effect of policies and inform administrators on how to build in safeguards to prevent policy failure. Grounded theory examines the context for action (Schatzman, 1991; Robrecht, 1995). A description of the context outlines the environment in which action takes place.

Ungerleider and McGregor (1993), in a discussion of police training for intercultural sensitivity, concluded that training alone can not establish an organizational climate or ethos in which equitable service is available to

all. Organizational changes are also needed. Blackburn (1992), D'Avanzo (1992), Lam and Green (1994) and Uba (1992), elaborated on the need for policies, procedures, and an organizational structure and services which would achieve a cultural orientation for cultural groups like the Vietnamese.

The knowledge and understanding generated through this study of nurses' everyday life experiences with Vietnamese clients can be used to inform a discussion of how the context influences the care provided. Application of such understanding can be used to shape policies and develop systems which will lead to more effective cultural care. Nurses, in this study, worked in many health care settings and delivery systems. They worked within their context of care and were able to identify the difficulties in providing ideal care as they perceived it. Participants described innovations as well as failures which came about because of the contextual circumstances. The partnership relationship that nurses developed with interpreters is one example.

#### Nursing Education

A number of authors have indicated the need for students to have practical experience in crosscultural relationships in order to work successfully in a crosscultural setting (Bartz, Bowles & Underwood, 1993; Carroll, Carter & Hayes, 1993; Zimmermann, 1995). Students,

however, need both general and specific cultural knowledge as well as knowledge on how to apply practice principles in a work setting. Kaufert, Koolage, Kaufert and O'Neil (1984) and Earley (1987), in their studies of the use of critical incidents as a teaching strategy, found that such an approach was very helpful in developing sociological as well as cultural reasoning in their students and that the use of both general cultural information as well as critical incidents was superior to just presenting general cultural knowledge.

The theory of cultural discovery draws on rich, experientially based data of nurses' experiences with a particular cultural group. The results of this study may be used as an adjunct to the practical experiences nurses need to become crossculturally effective. It would also provide nurse educators with insight into how the skills and experiences that nurses need can be effectively taught in both educational and practice settings.

### Conclusions

The theory of cultural discovery in nurses provided a descriptive explanation of how nurses work with Vietnamese. It provided valuable insight into the process, conditions, context, and consequences of such care. Nurses' experiences were described from the nurses' perspective. This perspective provided further knowledge in understanding the

care that nurses provide in crosscultural contexts.

The results of this study can make a significant impact and be used to inform crosscultural care in nursing and health care generally. The study results described the changes that nurses experience when they discover the clients' culture. These changes were both personal and practice based. The study provided information on the nature of cultural discovery as well as the process that nurses undergo in order to provide sensitive care. Additionally the study described how nurses give sensitive care in various context of practice.

Many professionals are providing services for clients in crosscultural settings. Nurses' experiences can provide important information in understanding how other professional groups can successfully and sensitively serve crosscultural populations such as the Vietnamese. This study can serve as a beginning in extending the knowledge needed by nurses, as well as other groups, who work in a variety of settings in both Canada and the United States.

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APPENDIX A  
UNIVERSITY OF SAN DIEGO  
COMMITTEE ON THE PROTECTION  
OF HUMAN SUBJECTS

## PROJECT INFORMATION:

NEW:     X    CONTINUATION:           ID#:     06-049-94    UNIVERSITY OF SAN DIEGO  
COMMITTEE ON THE PROTECTION OF HUMAN SUBJECTSPROJECT ACTION SUMMARY\*TO: Dr. Diane Hatton (Evelyn Labun)  
School of NursingDATE: June 7, 1994PROJECT TITLE: Cultural Discovery in Nursing Practice:  
The Experience of Nurses Working with the  
Vietnamese.TYPE OF REVIEW:     X     Full            ExpeditedACTION TAKEN     X     Approved  
ON PROJECT:            Approved Pending Modification  
           Not Approved

## MODIFICATIONS REQUIRED/REASONS FOR NON-APPROVAL:

## NEXT DEADLINE FOR SUBMITTING MATERIALS FOR FULL CPHS REVIEW:

N/A Expedited reviews may be submitted any time.[REDACTED]  
Dr. Carole E. Logan, Chair  
Committee for the Protection of Human SubjectsNOTES: (See CPHS Policies and Procedures Document for details.)

1. Should the decision not to pursue the proposed research be made, CPHS must be so informed in writing.
2. A summary of the completed project must be submitted to CPHS.
3. Projects not completed within one year of approval must be reviewed annually by CPHS for continuation approval.
4. In order to fulfill USD graduate degree requirements, evidence of CPHS approval must appear in bound copies of thesis/dissertation projects involving human subjects.
- \*5. All CPHS correspondence related to student research will be mailed to the faculty advisor.

PROTECTION OF HUMAN SUBJECTS:

174

Committee on the Protection of Human Subjects  
University of San Diego

FORM A - PROPOSAL COVER SHEET

To be completed for all research involving human subjects conducted at the University of San Diego, and for all research involving human subjects conducted by or under the direction of any employee or agent of this institution in connection with her/his institutional responsibilities, including research conducted at or in cooperation with another entity. This form must be attached to research proposals submitted to the committee.

1. Title of research: Cultural Discovery in Nursing Practice:  
The Experience of Nurses Working with Vietnamese

2. Will the subjects in this research be at risk? YES \_\_\_ NO X

Subjects at risk means any person who may be exposed to the possibility of injury, including physical, psychological, or social injury as a consequence of participation as a subject in the research or belonging to populations identified as at risk groups.

3. In the course of this research, will:

a. Questionnaires, personality tests, or inventories be administered? YES X NO \_\_\_

b. Subjects include any of the following (check all that apply)?:  
Minors \_\_\_ Aged \_\_\_ Mentally Disabled Persons \_\_\_  
Fetuses \_\_\_ Prisoners \_\_\_ Pregnant Women \_\_\_  
USD Employees or Students \_\_\_ Members of Minority Groups X  
Persons Known to Have AIDS \_\_\_

c. Tissues, body fluids, or other organic materials collected for other purposes be used? YES \_\_\_ NO X

d. Data collected for other purposes be used? YES \_\_\_ NO X

e. Informed consent obtained in accordance with USD's human subjects policy? YES X NO \_\_\_

f. The risks to the subjects be outweighed by the potential benefits derived from the research? YES X NO \_\_\_

The issues identified above should be addressed in the proposal submitted to the Committee on the Protection of Human Subjects (See Appendix 1, CPHS Document).

## PROTECTION OF HUMAN SUBJECTS:

FORM A continued:

4. Anticipated date on which data collection will begin: Oct. 1, 1994  
 or as soon as possible.  
 I agree to follow the procedures with respect to safeguarding the rights and welfare of human subjects in this research as established by the University of San Diego.

[REDACTED]

Researcher (Signature)

5-23-94  
Date

[REDACTED]

Faculty Advisor if Researcher is Student  
(Signature)

5-23-94  
Date

The project described above has been approved by the Committee on the Protection of Human Subjects.

[REDACTED]

Chair, Committee on the Protection of  
Human Subjects (Signature)

06-07-94  
Date

PROJECT INFORMATION 176  
NEW:  
CONTINUATION: X  
ID#: 06-049-94

UNIVERSITY OF SAN DIEGO  
COMMITTEE ON THE PROTECTION OF HUMAN SUBJECTS

PROJECT ACTION SUMMARY

\*TO: Dr. Diane Matton  
DATE: November 6, 1995  
PROJECT TITLE: Cultural Discovery in Nursing Practice:  
The Experience of Nurses Working with  
the Vietnamese  
TYPE OF REVIEW:  Full  Expedited  
ACTION TAKEN ON PROJECT:  Approved  
 Approved Pending Modification  
 Not Approved

MODIFICATIONS REQUIRED/REASONS FOR NON-APPROVAL:

NEXT DEADLINE FOR SUBMITTING MATERIALS FOR FULL CPHS REVIEW:  
N/A Expedited reviews may be submitted at any time.

  
Dr. Jane Friedman, Chair  
Committee on the Protection of Human Subjects

- NOTES: (See USD Protection of Human Subjects policy for details.)
1. Should the decision not to pursue the proposed research be made, CPHS must be so informed in writing.
  2. A summary of the completed project must be submitted to CPHS.
  3. Projects not completed within one year of initial approval must be reapproved annually by CPHS.
  4. In order to fulfill USD graduate degree requirements, evidence of CPHS approval must appear in final bound copies of thesis/dissertation projects involving human subjects.
  - \*5. ALL CPHS correspondence related to student research will be mailed to faculty advisors who are requested to share this correspondence with students.

APPENDIX B  
UNIVERSITY OF SAN DIEGO  
CONSENT TO ACT AS A RESEARCH PARTICIPANT

Consent to be Interviewed in a Research Study on the Experiences of  
Nurses Working with Vietnamese by  
Evelyn Labun, R.N., D.N.Sc. (Cand.) Philip Y. Hahn School of Nursing,  
University of San Diego, San Diego, California, USA.

I have been asked to be interviewed by Evelyn Labun for a study of nurses' experiences in working with Vietnamese clients. Evelyn Labun is a doctoral student at the University of San Diego and this is her dissertation. She is conducting this study in order to find out how experiences with Vietnamese have informed and shaped how nurses give nursing care to Vietnamese clients.

I understand that the interview will take from 1 to 2 hours and will be conducted in a place convenient for me. If a follow-up interview for clarification on any question is required Evelyn will contact me.

If I agree the interview will be audio-tape recorded and Evelyn will also take notes. I also understand that at any time I may quit the study and that doing so will not affect either my employment or status in any nursing association or network. I understand that I may ask questions before I sign this consent form and that I may call Evelyn at [REDACTED] or [REDACTED] collect if I have any further questions about the study.

I understand that the interviews will be coded and locked up and that all information is confidential. I understand that information derived from the study will be presented in such a way as to maintain my anonymity.

I realize that there are few risks to myself. If there are any questions I do not wish to answer I do not have to do so. I understand that the benefits will be for nurses who work with Vietnamese as well as health facilities and student nurses who can learn from the results of the study.

I have received a copy of this form. There is no agreement, written, or verbal, beyond that expressed in the form.

I, the undersigned, understand the above explanation and on this basis, I agree to my voluntary participation in this research.

-----  
Signature of Subject

-----  
Date

-----  
Location

-----  
Date

-----  
Signature of Researcher

-----  
Date

-----  
Signature of Witness

-----  
Date

APPENDIC C  
INTERVIEW GUIDE AND  
DEMOGRAPHIC QUESTIONS

Interview Guide for  
Cultural Discovery in Nursing Practice: The Experience of Nurses  
Working with Vietnamese.

1. Face Data:           Information about the Participant
  - Gender
  - Educational Background
  - Years in Nursing Practice
  - Previous Nursing Experience
  - Length of Time Working with Vietnamese  
  - General Information About the Work Setting
  - Type of Setting
  - Numbers of Clients Seen or Case Load
  - Numbers of Vietnamese and Types of Problems
  - Other Ethnic Groups Seen and Numbers
  - Location of Facility eg. location in the nation; location in a city
  
2. How did you begin your work with Vietnamese?  
Tell me about some of your first experiences.  
How is your work different now?
  
3. What stands out for you when you think about your work with Vietnamese? Tell me about some positive experiences; some negative ones.
  
4. Do you find differences within the Vietnamese group which affect how you give nursing care? If so what would they be?
  
5. In your experiences what problems related to health and health care need further study? What puzzles you? What makes you wonder?
  
6. What helpful things would you tell a new nurse just starting work with Vietnamese?
  
7. How has working with Vietnamese affected you personally?