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FIRST YEAR HERE:

A study of non-New Zealand-trained
Registered Nurses in their first year of practice
in New Zealand

A thesis presented in partial fulfilment
of the requirements for the degree of
Master of Arts
in
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Abstract

The aim of the research is to explore how non-New Zealand-trained Registered Nurses (RNs) perceive their transition experience, 0-12 months after commencing work in one of Auckland's public hospitals. As there is currently a shortage of RNs not only in New Zealand but worldwide, it is important to ensure New Zealand is a desirable destination for RNs to migrate to. The research illustrated that both non-New Zealand-trained RNs and also New Zealand RNs¹ experience culture shock. The need for cultural competence to occur amongst nursing colleagues and the importance of good support systems in alleviating culture shock was highlighted by the interviews. The disciplines of both anthropology and psychology provide the theoretical base for the research, with particular reference to the constructs of culture and culture shock. The concept of culture shock has been used as a foundation from which to develop insight into the transition experience of the participants. Culture shock has also been utilised to assist in interpreting my observations and also the experiences of non-New Zealand-trained RNs in their first year of practice in public hospitals in Auckland, New Zealand.

The body of data was analysed and codes generated from the data using a General Inductive Approach (Thomas, 2000). Critical social science provided the framework for analysing and identifying the factors underlying or contributing to the data resulting from the interviews with participants about their transition experience. Lastly, the findings of the research are discussed and the conclusion sets out the implications of these for both nursing and the transition experience of future non-New Zealand-trained RNs.

¹ New Zealand RNs refers to New Zealand-trained RNs and RNs who have been working in New Zealand longer than 12 months, and are acculturated to Auckland's public hospitals.

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List of Abbreviations

ADHB	Auckland District Health Board
AEC	Auckland Ethics Committee
CMDHB	Counties Manukau District Health Board
CNAs	Clinical Nurse Advisors
CNEs	Clinical Nurse Educators
COOs	Chief Operating Officers
CORD	Chronic Obstructive Airways Disease
CV	Curriculum Vitae
DHB/s	District Health Board/s
DON/s	Director/s of Nursing
EBP	Evidence Based Practice
ECA	Employment Contracts Act
HRC	Health Research Council
ICU	Intensive Care Unit
IELTS	International English Language Testing System
MHS/s	Maori Health Service/s
MUHEC	Massey University Human Ethics Committee
NHS	National Health Service
RDO	Research Development Office
RN/s	Registered Nurse/s
SOAP	Subjective Objective Assess Plan
UAE	United Arab Emirates
UK	United Kingdom
US	United States
WDHB	Waitemata District Health Board

Introduction

My interest in exploring the experiences of non-New Zealand-trained RNs, who have immigrated to New Zealand, and are in their first year of practice within a public hospital in the Auckland geographical area, evolved from my own experience working as a Registered Nurse (RN) within a public hospital in New Zealand. Firstly, my interest stemmed from my perception of an increase in the number of “foreign” RNs recruited to fill vacant staff nurse positions. Secondly, a new area had been commissioned in my place of work and was staffed by a large proportion of non-New Zealand-trained RNs. The new area had been running for nine months at the commencement of this thesis.

My work as a RN across the medical and surgical areas of the hospital brought me into contact with a large number of RNs. Comments were made to me regarding how the new area had not “gelled” yet, and that the problem was in part caused by the variety of cultural backgrounds of the nursing staff (M.P., personal communication, January 17, 2002; P.G. personal communication, December 10, 2001). The expectation was that the area should have “gelled” within six months. A number of bureau staff voiced dissatisfaction and frustration when working in the area and some made the decision not to accept further work in this area (S.G., personal communication, 9 December 2001; J.T, personal communication, January 4, 2002). The perception of the New Zealand RNs that there was a problem intrigued me as the comments made to me had all been from RNs who did not work permanently in the area.

This led me to formulate a series of questions.

- 1) Did the RNs who had completed their nursing training overseas and worked in the area perceive a problem?
- 2) Was the area being viewed and judged from an ethnocentric Western standpoint?
- 3) What role, if any, did horizontal violence have in the attitudes and behaviours towards non-New Zealand-trained RNs by other RNs?
- 4) Did the work environment provide adequate support, acknowledgement and understanding of cultural differences?

From this point my research progressed to studying the experiences of non-New Zealand-trained RNs in their first year of practice within public hospitals in Auckland, New Zealand.

Exploring the “experiences, feelings, and perceptions”, the emic perspective, of non-New Zealand-trained RNs and utilising an ethnographic approach to tell the participants stories, provides the means of obtaining data relevant to the aim and objectives of the research (Holloway & Wheeler, 1996: 1). The area that prompted this research was not utilised for this study, to avoid placing further focus on the area, or causing stigmatisation. The research data is an accumulation of the experiences of participants working in the Auckland District Health Board (ADHB) and Waitemata District Health Board (WDHB). Although aspects of their experiences may be similar to other non-New Zealand-trained RNs, as each individual comes from a different background, there may equally be other experiences that have not been encountered in the course of this research. All the names of participants, initials of people from which personal communication was received, and ward names have been changed to maintain confidentiality and anonymity.

The aim of the research is to establish how non-New Zealand-trained RNs in Auckland’s public hospitals perceive their transition experience, 0-12 months after commencing work.

The specific objectives of this research are:

- To identify the differences and similarities non-New Zealand-trained RNs experience between nursing in their home country and nursing in public hospitals in Auckland, New Zealand.
- To identify the factors which helped or hindered the participant in the transition from nursing in their home country to nursing in public hospitals in Auckland, New Zealand.

During the course of carrying out the research I was, both in my everyday work and social interaction outside of work, asked by numerous RNs what the topic of my thesis was.

When I told them I was exploring the transition experience of non-New Zealand-trained RNs in their first year of practice in public hospitals in Auckland, they all thought it was a very relevant topic and had comments to make regarding their experiences of working with

non-New Zealand-trained RNs. As New Zealand employs RNs from overseas to ameliorate its very real shortage, it is important for the recruited nurses, their New Zealand colleagues, and patients, that research is undertaken to identify strategies to improve the recruitment and retention of RNs.

Chapter One

Literature Review

Overseas Registrations

The Nursing Council of New Zealand (2000a²) statistics for 1998 identifies overseas RNs/Midwives as comprising 16% of the workforce, compared with 13% of the workforce in 1994. In 1994 290 RNs immigrated to New Zealand compared with 1400 in 1998 (Nursing Council of New Zealand, 2000a). There is a discrepancy in the 1998 figures as the number of overseas trained RNs for 1998 is also given as 1523 (Nursing Council of New Zealand, 2001a). In the 2001/02 registration year 1355 overseas nurses gained New Zealand registration or enrolment.

For overseas trained RNs to gain New Zealand registration, applicants need to illustrate they “have comparable nursing education and qualifications to New Zealand registered nurses” (Nursing Council of New Zealand, 2003), and to provide evidence of their ability to write and speak in English. If English is not their first language, applicants for New Zealand registration are required to undertake, and pass, an approved English language competency test (Nursing Council of New Zealand, 2003). If the nursing qualification is not comparable, applicants have the opportunity of attending a competency course. The criteria for qualifications accreditation and demonstrating English language competence by examination are also required by Australian nursing authorities (Hawthorne, 2001).

According to the Nursing Council (Nursing Council of New Zealand, 2000a: 20) “The [1998] retention rate of overseas trained nurses and midwives is approximately 45 percent in the first three years of registration. This compares with 36 percent in 1990. Nurses and Midwives active three to five years after registration increased from 41 percent in 1990 to 56 percent in 1998”.

² Latest published figures.

The Nursing Council of New Zealand (2003: 6) has identified the countries of origin of overseas-trained RNs, based on 2001/02 figures, as set out in Table 1.

Table 1. Where do they come from?

United Kingdom	634
South Africa	177
Australia	115
Philippines	92
Fiji	75
India	42
Canada	24
Other	196

As evidenced by the above table, overseas-trained RNs migrate from a diverse range of countries, but the majority are from English speaking countries. Ethnic diversity within nursing is not unique to New Zealand but is an international trend (Nursing Council of New Zealand, 2000a). In 1998 the number of active RNs and midwives in the Auckland region was 9131, of which 1073 stated their ethnicity as other European (not New Zealand European), and 683 identified as other ethnicity. These two figures constitute 19.23% of the active RNs and Midwives. The next largest number of active RNs and midwives was in Canterbury where there were 4603, of which 316 self identified as other European and 100 as other ethnicity, which makes 9% of active RNs and Midwives in the region. Wellington had the third largest number of active RNs and midwives at 3771, 366 of these identified as other European and 181 who identified as other ethnicity, which constitute 14.5 % of active RNs and Midwives in the region. (Nursing Council of New Zealand, 2000a). The above figures illustrate that RNs and Midwives have diverse cultural identity. As the Auckland Health Boards are the largest employers of RNs in New Zealand, and the Auckland region also has the largest percentage of ethnic diversity, it is important for public hospitals in Auckland to provide a work environment, which is conducive to the recruitment and retention of RNs, in order to remain competitive in the world market.

What is culture?

As stated in the introduction, the number of non-New Zealand-trained RNs in the new area and their culturally diverse backgrounds, was identified by other RNs as a contributing factor to its divisiveness. Definitions of culture according to the psychology literature, which dominates the field of research on culture shock and also a large proportion of the literature on communication, revolve around the concepts of shared beliefs, patterns of values, production of shared meaning, and a common “verbal and nonverbal symbol system” (Mantovani, 2000; Neuliep, 2000: 30; Zapf, 1991; Cohen, 1994). Cultural values guide people’s perceptions and behaviours and are a means of reducing uncertainty (Cohen, 1994). Political, historical and economic processes manipulate culture (Marcus & Fischer, 1986; Geertz, 1973).

According to Cross (1995) and Ryder, Alden and Paulhus (2000), culture moulds the structure and content of the self. Cohen (1994) acknowledges the interlinking of the culture and self but his focus is on the effect of self on culture not culture on the self. This is illustrated by Cohen (1994: 154) stating “Culture requires us to think, gives us forms – metaphors, dogmas, names, ‘facts’ – to think with, but does not tell us *what* to think: that is the self’s work”. Situations are interpreted through utilising the codes and categories which have been culturally learnt, to make sense and give meaning to the situation (Mantovani, 2000).

The different cultural emphasis or interpretation of situations was highlighted to me with one of my participants. The participant had forgotten about the first interview appointment. When I turned up at the new appointment time she was very apologetic. My attitude was “Never mind these things happen” and I could leave it at that as I felt I was partly responsible for not reconfirming the appointment. She explained to me that it wasn’t all right as in her culture it was very rude if you invite someone to your house and are then not there.

“Culture is not an intractable social force imposed on members, but is continuously recreated by their interpretative prowess” (Cohen, 1994: 135). The primary culture of a person provides the inherent values and beliefs from which ethnocentric viewpoints may stem. Within cultures it is ethnocentrism which is the “peripheral prism through which cultures interpret and judge all other groups” (Samovar & Porter, 2003: 11). A person may belong to different cultures concurrently, which may provide a source of either conflict or cohesion amongst the variety of cultures. According to Geertz (1973) exploring culture anthropologically involves interpretive analysis of culture in search of meaning. Geertz (1973: 5) describes culture as “webs of significance” the person has created him/herself and is then suspended in. Therefore culture is not only values and beliefs but also the interpretation we give to situations and circumstances and the thick description utilised to describe it.

Although all participants are members of the nursing culture, they, along with every other RN, also identify with both an ethnic culture/s and the myriad of sub-cultures, in which they participate. Different cultural realities can occur due to the culture each individual is enmeshed in. Conflict arises through cross-cultural contact, as each person believes their reality is right, and is unable to see that more than one reality can co-exist.

Nursing Culture

RNs are individuals with a common culture in nursing, as nursing has its own set of values, beliefs and shared meaning. The practice of RNs in New Zealand is governed by the Nurses Act (1977), the Health Practitioners Competency Act (2003) and by professional standards (New Zealand Nurses Organisation, 1997; Nursing Council of New Zealand, 2001b). The legal, ethical, and professional standards of nursing have contributed to the values, beliefs and practice of nursing within New Zealand. In New Zealand nursing education has followed the British system due to colonisation and the arrival of the first Nightingale nurses in 1883, and is aligned with the Western biomedical model (Abu-Saad, 1979; Lambie, 1950).

The culture of nursing is shaped by the “nursing-medicine power relations”, political, and economic factors (Roberts & Group, 1995: xvi). The oppressive nature of the patriarchal system within hospitals has contributed to the manifestation of horizontal violence within nursing. The concept of horizontal violence is explored later on pp. 9-11. Nursing remains a female-dominant profession in a patriarchal system, in which medicine has power and authority. Joralemon (1999: 64) has drawn on the work of Paul Starr and states “a healing profession gains power and prestige when it acquires social and cultural authority and converts that authority into economic and political control over the medical domain”. Starr (1982: 13) defines social authority and cultural authority as:

Social authority involves the control of action through the giving of commands, while cultural authority entails the construction of reality through definitions of fact and value. Whereas social authority belongs only to social actors, cultural authority may also reside in cultural objects, including products of past intellectual activity, such as religious texts, recognised standards of reference (dictionaries, maps, mathematical tables), scholarly or scientific works or the law.

The medical profession has both social and cultural authority. Social authority as it decides the trajectory of treatment and informs other health professionals of this to enable the needs of the patient to be met, and cultural authority due to the dominance of the biomedical model and the professional standing of medicine. Nursing also has social and cultural authority as evidenced by the hierarchical formation of nursing positions, the nurse patient relationship, and nursing knowledge and research. The power differential between medicine and nursing occurs due to the economic and political control of medicine.

Cultural and societal values and beliefs influence the public perception of both women and nurses, and therefore impact on the position and role of nurses within hospitals (Roberts & Group, 1995). Although there are male RNs they are still very much the minority. For example, in my first year of nursing training there were 8 males and 136 females and 4 of these males graduated as RNs. In my 15 years of nursing practice there has only ever been 1 or 2 male RNs on the wards I have worked on out of a total nursing staff of 20-30.

The historical factors influencing the role of women in society and the place of nurses within the health care domain are inexorably linked. Legislation and healthcare policies also directly and indirectly impact on the culture of nursing. The health reforms in the 1990s, with their restructuring of the health system and the shift in focus to a competitive, for-profit marketplace, and the Employment Contracts Act (1991) (ECA) which gave power to the employer in contract negotiations impacted on both nursing and RNs. The lack of consultation and poor communication between management and health professionals, the constant changes, and the focus on profit rather than patient outcomes which occurred with the health reforms led to dissatisfaction and low morale amongst health professionals (Boston, Dalziel & St John, 1999). The ECA (1991) led to the erosion of the benefits in the conditions of employment for nursing staff, which again impacted on morale. The Employment Relations Act (2001) promotes negotiation and good faith in employer/employee relations and there has been a gradual increase in the benefits in the conditions of employment for nurses.

Other factors influencing nursing culture are the ideals, views, and myths of nurses, such as being a born nurse, virtuous, pure, an angel (Jones, 1988). Within the RN role, it is the concept of individuality which enables RNs to practice in different ways whilst upholding the legal and ethical responsibilities of being RNs. Within the context of this research, nursing is a culture where bonds are established between nurses as a result of working together and having a shared identity based on the values, beliefs and professional expectations of what constitutes being a RN.

From working as a RN in public hospitals both in Auckland and London over the past 15 years, I am aware of the usage of the term 'horizontal violence' in nursing and the very real role this behaviour plays in nursing relationships. Whether the research participants experienced horizontal violence being directed at them in their transition period was another point of interest to me in the research. Horizontal violence occurs in oppressed groups as a result of the subordinate position forced on them by the dominant group. According to Freire (1972: 38) "Because the oppressor exists within their oppressed comrades, when they attack those comrades they are indirectly attacking the oppressor as

well". Within hospitals the medical profession has traditionally been the oppressor and nurses the oppressed.

Street (1992: 45) describes horizontal violence as violence which "is perpetrated by frustrated members of an oppressed group against their peers and becomes the institutionalized oppression of nurses by nurses". The causes of horizontal violence are the patriarchal system and the power differential between medicine and nursing. Street (1995) talks of the disempowering habitual language patterns of nursing which assist in keeping nurses in their position. Behaviours and comments by nurses in the workplace are often attributed to 'bitchiness' or a result of the 'system', but can also be overt and covert forms of horizontal violence. Horizontal violence can be expressed psychologically or physically. Psychological forms I have observed are, undermining a person's nursing practice to fellow nurses and/or patients, derogatory comments to colleagues, forming alliances and creating outcasts and inappropriate reporting to management. Roberts and Group (1995: 298) state "Oppression of nurses may produce self-hatred and dislike for other nurses; divisiveness and lack of cohesion; and low participation in professional organisations, which reflects a lack of pride and a desire to be disassociated from other oppressed and powerless persons. The horizontal violence in struggles between nurses is a safe way to express aggression, which is actually meant for the oppressor". Oppression occurs at an administrative level also with poor provision for conference leave and study leave, cancellation of study days, and lack of managerial consultation. Nurses say 'Nurses are their own worst enemy'. We are damaging to ourselves and nursing colleagues through our perpetuation of horizontal violence and our language patterns.

Within nursing there is an overall view that all nurses in a particular work environment should do tasks and practice in the same manner. Provided safety is achieved and maintained, and confusion prevented then different ways of achieving the same outcome require acknowledgment. Where individual or cultural idiosyncrasies are not appreciated or understood this can lead to horizontal violence in the work environment.

Acknowledging and understanding cultural difference rather than marginalising it, understanding the power relationships, and the political, economic and historical forces

underlying the culture of nursing will assist in decreasing the incidence of horizontal violence in nursing. Shaull (cited in Freire, 1972: 12) states a person can “perceive his personal and social reality as well as the contradictions in it, become conscious of his own perception of that reality, and deal critically with it”. Through critical reflection, change in behaviour and thought needs to come from within nursing in order to make changes to the perceived or actual oppressed position of the profession.

Within nursing, both in New Zealand and overseas, emphasis has been given to RNs being culturally competent (Ramsden, 1992; Leininger & McFarland, 2002). As an extension of culturally competent care there needs to be not only an understanding and awareness of the culturally diverse backgrounds of patients to ensure their cultural needs are met, but also an awareness and understanding of the cultural background of nursing colleagues. Cultural safety is the concept developed by Ramsden to ensure nursing care was culturally appropriate in New Zealand. In the United States (US) the term ‘transcultural nursing’ has been developed, the aim of which is to provide “culturally congruent, meaningful and beneficial health care to people” (Leininger & McFarland, 2002: 6).

The majority of the literature on culturally competent care discusses the nurse-patient relationship and the necessity of the nurse to deliver culturally appropriate care to the individual. To enable nurses to become culturally competent it is necessary for them to be aware of “how their own cultural origins affect personal beliefs, behaviours, and ways of interacting with people on a professional and personal level” (Hickey, Ouimette & Venegoni, 2000: 255; Leininger & McFarland, 2002). There also needs to be education on other cultures’ values, beliefs and practices. As previously stated, RNs need to not only have an understanding and awareness of the culturally diverse backgrounds of patients to ensure their cultural needs are met, but also an awareness and understanding of the cultural background of nursing colleagues. It is not necessary to know all the intricacies of the cultural background of every nursing colleague, but to be open and acknowledge the possibility of different frames of reference is important. Reflective practice contributes to cultural awareness and cultural awareness and sensitivity are preconditions for the development of cultural competence (Hickey, Ouimette & Venegoni, 2000).

Reflective practice focuses on developing professional expertise and competency through professionals taking responsibility for their practice, ensuring knowledge is valid and evidence-based, practice is critiqued and plans made for future nursing care delivery. (Cooney, 1999). Williams and Lowe (2001: 1485) state “The ultimate goal of reflection is to enable nurses to become more perceptive of every nurse/patient encounter and ‘fine tune’ their skills and knowledge for the better, which may coincidentally result in a change of practice”. Differing ways of being and doing need to be understood, respected and validated. This understanding and awareness would improve the transition process of future non-New Zealand-trained RNs by better providing for individuals’ needs within the work environment.

Migration across cultures

Migrating to another culture brings people into contact with different values, beliefs, ways of communicating and different meanings. Furnham and Bochner (1986) acknowledge the stress associated with immigrating to a new country, combined with adaptation to a new work environment, in their work on culture shock. The stress and challenges associated with immigration, and subsequently a new work environment, requires acknowledgement and understanding by both the migrant and the host. Samovar and Porter (2003: 45) point out that to understand people “(1) you need to have a fund of knowledge about the people of other cultures; and (2) you must learn to appreciate their diversity”. Different cultural values, practices, and belief systems can be a source of friction between people. The difficulties and stresses associated with “social contact between culturally disparate individuals” may have psychological, sociological, physiological, and/or economic effects (Berry, 1997a; Winkleman, 1994; Ward, Bochner & Furnham, 2001: 9). One Charge Nurse spoke of the cultural conflict on her ward between Fijian Indians and Filipinos. This had been addressed by having the Fijian Indians working the morning shift and the Filipinos the afternoon shift. Her perception was that the Fijian Indian’s training was not very good and that they didn’t question medical or nursing treatment or care. Filipinos were good nurses with good practice but not interested in the cultural aspects of care. For them it was a way to earn a wage. It is important to be aware of the factors which may cause stress or culture

shock for immigrants and the variety of areas in which it can manifest, to enable early identification and alleviation of stressors and stress.

Whether the impetus for immigrating was for personal, economic, social, political, religious or cultural reasons affects the degree of culture shock experienced (Ward, Bochner & Furnham, 2001; Sussman, 2000). Running parallel to the reasons for immigrating are the reasons for choosing a particular country to emigrate to. These will include, the entry criteria for migration, barriers to migration such as the ease of the migration process, and whether the country was their first choice or not (Ward, Bochner & Furnham, 2001). The duration of time a person spends in another country also directly affects their stress level, therefore the group of people who are potentially subjected to the greatest stress are the migrants (Winkleman, 1994). Stress can be generated by grieving for the loss of familiar surroundings and also the loss of roles central to one's identity. The majority of the literature on culture shock has been written with regard to sojourners rather than migrants. Sojourners have moved to another country, albeit temporarily, and the duration of living in another culture may vary from months to years. The points of reference are similar but the impetus to fit into the secondary culture is stronger for immigrants who have committed their lives to the new environment.

Culture Shock

Due to my own experiences travelling and working in other cultures I started exploring the literature on culture shock as a means of gaining some form of understanding and framework of reference for what I was observing. Culture shock was a term I had previously used to describe some of my experiences when travelling and working in different cultures. The concept of culture shock provided an explanation for what I was observing and experiencing in my place of work, and a theoretical framework for the exploration of key concepts.

Oberg (1960) first described the term culture shock in 1954 (Furnham & Bochner, 1986). Aspects of culture shock have been identified as a sense of loss, deprivation, rejection,

confusion, anxiety, and feelings of helplessness (Oberg, 1960). Most of the aspects of culture shock identified above have negative connotations and there is no mention of the potential for growth that has developed in later work on culture shock (Pedersen, 1995; Furnham & Bochner, 1986).

A culture shock experience may provide an opportunity for personal growth and development, which may result in positive insights (Pedersen, 1995; Mantovani, 2000). Growth occurs through reflective analysis and critique of experiences. Sussman (2000) describes the culture shock experience as a continuum on which the initial negative affective response progresses to increasing positive adjustments as people progress through adjustment to adaptation.

As culture shock is a profoundly personal, multifaceted experience which causes an internal, individual response or reaction, the culture shock experience could have negative or positive outcomes depending on the individual's reaction to the events or incidents precipitating their experience of culture shock (Pedersen, 1995; Winkleman, 1994). The experience of culture shock is a normal process, may not be constant, and can occur at a variety of levels at any one time (Pedersen, 1995; Winkleman, 1994).

The literature on culture shock is written with reference to individuals leaving their country of origin and moving to a secondary culture either temporarily or permanently. There is no mention of the effects this transition may have on members of the secondary culture. It is important to note that cultures are subject to change over time through environmental changes, globalisation, and the very nature of people and culture.

The literature on culture shock has grown since the 1960s and incorporates a broader view than when it was first described by Oberg (1960). The literature reviewed identifies the variables affecting culture shock, stages of culture shock, means of reducing culture shock, and ways of managing culture shock. As nursing qualifications are globally transportable and international migration has increased over the last 10 years, ways of minimising culture shock and its effects are very important within nursing to assist in the recruitment and

retention of RNs. Maintaining a stable workforce of adequate number and skill creates a happy work environment, which then impacts positively on nursing care delivery.

Other authors have used alternative terms to culture shock such as role shock, culture fatigue, or language shock (Smalley, 1963; Guthrie, 1975; Furnham & Bochner, 1986). I have used the term culture shock rather than one of the other terms identified above, as culture shock is more inclusive. This is because culture shock encompasses the psychological, sociological, and economic aspects which may formulate the experience of culture shock, whereas the other terms tend to focus more on one of the aspects which contributes to culture shock, such as language or life roles.

Berry (1997a) utilises the term 'acculturative stress' as opposed to 'culture shock'. Acculturation is "a process of cultural change that results from ongoing contact between two or more culturally different groups" (Berry, 1997a: 7). Robert Redfield, Ralph Linton, and Melville Herskovits (cited in Garbarino, 1977: 72) defined acculturation as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of both groups". According to Berry (1997a: 7) "acculturation tends to induce more change in one of the groups... than the other".

The two main issues associated with acculturation are cultural maintenance, and contact and participation. Ward and Rana-Deuba (1999: 423) identify the "two fundamental dimensions of acculturation; maintenance of original cultural identity and maintenance of relations with other groups". Different strategies are utilised to achieve acculturation but these will be in different forms according to the choice made by individuals – assimilation, separation, integration, or marginalisation. These four categories provide a useful tool in identifying and understanding the position of individuals experiencing culture shock. In their research Ward and Rana-Deuba (1999: 434-5) found that "sojourners who adopted an integrated style experienced significantly less psychological distress than did others; by contrast, those who preferred assimilation reported less social difficulty".

Assimilation takes place “when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures” (Berry, 1997a: 9). Separation occurs when “individuals place a value on holding on to their original culture, and at the same time wish to avoid interaction with others” (Berry, 1997a: 9). With integration “there is some degree of cultural integrity maintained, while at the same time seeking to participate as an integral part of a larger social network”(Berry, 1997a: 9). Marginalisation occurs when “there is little possibility or interest in cultural maintenance... and little interest in having relations with others” (Berry, 1997a: 9).

Although Berry (1997a: 13) utilises the term acculturative stress rather than culture shock because (a) “it is closely linked to psychological models of stress”, (b) shock has only negative connotations and, (c) source of the problems are intercultural not cultural, I have used the term culture shock as it is the most common term, is utilised in every day language, and it is defined in *The New Oxford Dictionary of English* (Pearsall, 1998).

The U-curve has been used to describe the sequential process of culture shock through a number of stages (Pedersen, 1995; Neuliep, 2000; Furnham & Bochner, 1986). The number of stages varies between 3-7 depending on the author. Although the number of stages varies the initiation and progression through the culture shock experience is similar, it is how the author has chosen to delineate the points, which differs. The common phases are;

- 1) Honeymoon stage or tourist phase – characterised by feelings of elation and euphoria. The person may be “naïve, uninvolved, and unknowing about the local culture as well as about themselves” (Pedersen, 1995: 78).
- 2) Disintegration-culture shock phase – disintegration of familiar cues, and feeling disillusioned/disappointed, confusion or self-blame.
- 3) Adjustment/reorientation phase “ involves a reintegration of new cues and an increased ability to function in the new culture...the conformist phase” (Pedersen, 1995: 3).
- 4) Adaptation, resolution phase –autonomy – more balanced perspective, impartial view of whole situation, legitimacy of differences.
- 5) Reciprocal interdependence – a person is comfortable in both cultures.

However, Ward and Kennedy (cited in Ward, Bochner & Furnham, 2001) in their research found the opposite to be true and that instead of the honeymoon phase in the first month people were, in fact, feeling more depressed. According to Ward, Okura, Kennedy and Kojima (1999) entry to new cultures is the greatest time of adjustment difficulty with accompanying psychological effects.

The U-curve was extended by Gullahorn and Gullahorn (1963) into a W-curve to take into account the adjustment period, on returning home. As this research will not be exploring the re-integration of participants into their home culture this aspect of the W-curve is not relevant to this research. Both the U-curve and the W-curve imply that the progress through the culture shock process is an ongoing progression along its path but the reality can be quite different. As stated earlier, culture shock may occur at many levels simultaneously, and may also move backwards and forwards through the various stages. According to Pedersen (1995) and Ward, Bochner and Furnham (2001) there are studies which support the U-curve hypothesis but other studies fail to confirm the U-curve hypothesis. The U-curve suggests that a person will reach a point of adaptation where they feel as comfortable in the secondary culture as in their primary culture, but according to Pedersen (1995) a person will never reach this same level of comfort.

Another model of culture shock discussed by Pedersen (1995) is the disease model. The disease model is problem-based and limiting as it categorises cause and effect, and the viewpoint is narrower than the U-curve, which caters for progression and change. Reading about the disease model brought to attention the limitations of my initial approach to the research topic where the assumption was made that lack of support and language difficulties would be the two main contributing factors highlighted by the participants as problems in their transition experience. These assumptions stemmed from my thoughts on what could have been contributing factors to the 'lack of gelling' in the work area, which prompted the research. The disease model, by its very name, suggests culture shock to be a disorder and medicalises the experience.

Furnham and Bochner (1986) identified six predictors for the degree of culture shock likely to be experienced;

1. The control of conditions for initiating contact with the host culture is important.
2. A range of interpersonal factors such as age, previous travel, language skills, resourcefulness, independence, fortitude, ambiguity tolerance, appearance, and other personal factors will make a difference.
3. Biological factors relating to physical condition and general state of health will determine the outcomes of culture shock.
4. Interpersonal variables, such as having support and a clearly defined role, are important factors.
5. The characteristics of the host culture itself will be an important factor.
6. The geopolitical conditions in the host culture itself at the time of contact will be an important factor.

Other authors (Pedersen, 1995; Ward & Kennedy, 1999) also discuss the above factors and their impact on culture shock. The majority of the literature on culture shock and associated terms is embedded in psychology, which is entwined with the Western biomedical model. (Furnham & Bochner, 1986; Berry, 1997a; Ward & Kennedy, 1999). The simple aim of the biomedical model is to identify the biological cause and effect of alterations in the normal functioning of the human body.

Furnham and Bochner (1986) discuss the research on expectancy value theories and come to the conclusion that although research suggests that people with high expectations have poor adjustment and people with low expectations have high adjustment, they say the area of research is relatively new and the links are unclear. Furnham (1988) says there is no proven relationship between unfulfilled expectations, poor adjustment, and the culture shock experience. Later articles identify expectations as a contributing factor; “culture shock is more or less sudden immersion into a non-specific state of uncertainty where individuals are not certain what is expected of them” (Pedersen, 1995: 1; Sussman, 2000). Expectation can be the migrant’s expectations of the culture but also the secondary culture’s expectations of them. People’s expectations of how the area, which prompted this

research, would be and would function illustrated the generalised expectation of New Zealand RNs.

Another factor, which may have an impact on culture shock, is higher education. Higher education has been associated with positive adaptations as people have learnt the skills of problem analysis and problem solving. As an extension of this, income and status can also impact on culture shock (Berry, 1997a). Berry (1997a: 22) notes “one’s “departure status” is frequently higher than one’s “entry status”, and one’s work experience is often devalued on arrival, which may be due to ignorance and/or prejudice, or due to “a real difference in qualifications”.

There are numerous tools mentioned in the literature for measuring the different aspects, which can contribute to culture shock. The Cultural Distance Index, Interactive Acculturation Model, Acculturation Index, and sociocultural adaptation scale. These tools, and others mentioned in the literature, would be useful to measure culture shock, or aspects of the culture shock experience. This research does not aim to assess or measure the level of culture shock experienced by the participants, but has drawn on the culture shock literature to gain an awareness and understanding of some of the factors which may impact on the participants’ transition experience. The concept of culture shock has been used as a foundation from which to develop insight and assist in interpreting my observations and also the lived experience of non-New Zealand-trained RNs in their first year of practice in Auckland’s public hospitals

Management of Culture Shock

To assist in the management of culture shock, it is important culture shock is viewed as a normal response or reaction to change. Recognising, identifying, and acknowledging the patterns of adjustment, responses and reactions, which characterise culture shock, may assist in the learning process which can result from a culture shock experience. Since culture contact is a learning experience it can be facilitated by preparation, orientation, and acquisition of appropriate social skills. Prior learning about the secondary culture - its

language, history, climate, and environment, assists in preparing oneself for secondary culture contact. Such preparation and exposure reduces the level of culture shock experienced (Berry, 1997a; Churchman & Mitrani, 1997). Learning the language of the secondary culture is necessary for effective intercultural and interpersonal communication within the new environment (Pedersen, 1995). Although the points above are made with reference to the immigrant, preparation of the host environment (ward) is also important. This may involve informing ward staff about new staff members, organising appropriate orientation, and creating a supportive environment.

Being self-aware, especially of one's own values, developing intercultural relationships, learning social skills, and maintaining an intimate social network all assist in facilitating culture contact (Neuliep, 2000; Furnham & Erdmann, 1995; Furnham & Bochner, 1986; Winkleman, 1994). We are constantly immersed in our own culture and therefore we can have trouble seeing, or choose not to see the cultural dimension and its day-to-day impact on our lives. It is easier for outsiders to view the cultural dimension of an individual than it is for the person who has been habituated in the culture since birth as "cultural identity is not explicitly recognized" (Sussman, 2000: 9). Therefore, we can learn about ourselves from others' experience of ourself, as it will be different from our own view (Brislin & Pedersen, 1976; Neuliep, 2000). According to Marcus and Fischer (1986: 1) anthropology "serves as a form of cultural critique of ourselves". This is achieved by "using portraits of other cultural patterns to reflect self-critically on our own ways" (Marcus & Fischer, 1986:1). Furnham and Bochner (1986: 14) discuss the process of cultural learning rather than the concept of adjustment and state the task is "not to adjust to a new culture but to learn its salient characteristics". To enable learning of new attitudes and cognitive information to be integrated into behavioural transformations it is necessary for people to normalise their experience and acknowledge the cultural process (Winkleman, 1994). Hosts need to think of new arrivals not only as subjects for instruction and accommodation. They are sources of richness and self-discovery as well.

Developing a support system is important in assisting the successful psychological adjustment to the secondary culture (Pedersen, 1995; Anderzén & Arnetz, 1997). Lack of

social support exacerbates culture shock (Furnham & Bochner, 1986; Ward, Bochner & Furnham, 2001; Winkleman, 1994). It is important for individuals encountering a new culture to form support networks to provide feedback, clarify situations, and remove self-doubts to assist in coping with culture shock (Adelman, 1988). These points are relevant not only to those individuals who have moved to a secondary culture but also to individuals who are experiencing culture shock in their familiar environment due to sojourners or migrants. Although it is often easier to initially form support networks with co-nationals, if they are available, to provide support for their cultural identity and values, it is important to form social relationships with members of the host country to “learn more about the culture, to gain practical information, and to develop social skills” (Cross, 1995: 677). A variety of social relationships are necessary to enable the needs of the individual to be met, to prevent isolation, and assist in acculturation. Furnham and Bochner (1986) point out that social support is often best provided at work and that women tend to have more supportive relationships than men do.

Intercultural Communication

Culture and communication are inherently linked (Saville-Troike, 1989; Neuliep, 2000). This leads to controversy in the literature as to whether culture or communication comes first (Johnson, 2003; Fong, 2003). According to Johnson (2003: 191) “the system of language and communication, is the central resource used by human beings to create, maintain, and change culture”. The ability to speak the host country’s language is essential to a person’s ability to function in a secondary culture. One RN spoke to me of a Chinese student wanting to do the competency course who was coming to see her. The student had passed the International English Language Testing System (IELTS) test but Mary was unable to understand her on the telephone. She therefore made an appointment to see the student to let them know that although she had passed the IELTS test and she was willing to pay to get on the course there was no place for her, as the courses were full for the year and her English needed to improve first. Good communication is essential in the work setting for the safety of staff and patients.

Language, proxemics, haptics, and kinesics play a role in communication. As well as these overt means of communicating there are the covert ones – unspoken codes, preconceptions and stereotypes which need to be minimised in the interests of safety, especially with respect to migrant nurses (Brislin & Pedersen, 1976; Neuliep, 2000; Saville-Troike, 1989; Ward, Bochner & Furnham, 2001; Samovar & Porter, 2003). It is also necessary to be aware of the rules of communication, know who to talk to, when to talk, and to ensure one is contextually correct (Saville-Troike, 1989). As people receive communication, they also evaluate and judge it according to their own personal standards, therefore what the person is saying can be interpreted differently from what the speaker intended as others fail to see their point of view. Therefore, everyone can have a different understanding of the same. This can lead to miscommunication, misunderstanding and conflict (Brislin & Pedersen, 1976; Neuliep, 2000; Furnham & Bochner, 1986; Ward, Bochner & Furnham, 2001). There are also discriminatory attitudes towards speech to overcome (Cargile, 2003). Accent is judged and rated and so subsequently is the person (Cargile, 2003). This was illustrated to me when I was shown a communication sent to a group of RNs within one of the hospitals to see if there was support for elocution lessons for RNs from overseas and asking which countries should be targeted. To me this reiterated the ethnocentric attitude of New Zealand nurses. They, as much as migrant nurses need to improve their listening skills and also to verbalise their inability to understand what is being said to the person at the time.

Communication is a process as it is “ongoing, ever-changing, and continuous” (Neuliep, 2000: 7). As well as the above points there also needs to be an awareness of the cultural, environmental, and sociorelational context of communication. A person’s culture teaches them how to communicate, think, interact, and interpret other’s communication. Therefore gestures in one culture can mean something entirely different in another cultural context. All of the above means and modes of communication require learning to assist intercultural communication.

To communicate effectively across cultures Neuliep (2000) talks of the necessity of reducing uncertainty in intercultural communication by being empathetic to other’s ideas

and style of communication. To be able to do this it is necessary to be aware of the “cultural bias of their own behaviour and how the practices of their society differ from those of the host country” (Furnham & Bochner, 1986: 237). The importance of addressing cultural biases and the role they play in communication was highlighted by a comment by a former nursing colleague, “It’s not the language that is the problem. Coming back from London I can’t believe how racist New Zealanders are” (K.E. personal communication, 2 August 2003). Brislin and Pedersen (1976) also mention the impact anxiety has on cross-cultural communication. Past experiences of intercultural communication affect the current situation. For example if a person has had previous experience of miscommunication, they may form a generalisation of difficulty with a culture and will not be as tolerant, or as willing, to take the opportunity to communicate with other people of that culture.

Cultural Distance

The cultural distance between the two cultures also affects the level of distress experienced by the migrant (Ward & Searle, 1991; Ward, Bochner & Furnham, 2001; Sussman, 2000; Berry, 1997a). If a person is moving between places of cultural disparity such as underdeveloped/developed countries, countries of different religious backgrounds, differing class structures, or different political ideologies culture shock will be more pronounced than if they are moving between similar cultures. Mumford’s (1997) study to develop and evaluate a questionnaire to measure culture shock showed a direct relationship between cultural distance and culture shock. The culture shock experienced by people varies according to the similarities and differences between the host culture and the primary culture, and an individual’s personal traits.

Cultures can be categorised into individualistic or collectivistic cultures and awareness of these differences are important when moving through, between, or across cultures (Triandis, 2003; Brett, 2003; Ting-Toomey, 2003). In a collectivistic society “Personality or the individual’s characteristic role in behaviour will not receive the same kind of emphasis or be accorded the same kind of role organising social life that it is given in more individualistic contexts” (Cross & Markus, 1999: 380). Collectivistic cultures focus on the

common good and individualistic cultures give primacy to the individual. Personality is built on culture specific models covering roles, behaviours, and relationships with others, therefore this cultural concept influences self-construal.

In a collectivistic society social relationships are very important. In individualistic culture the systems of meaning - how people think, feel, act, and practices - are more hidden than in a collectivistic society. Individualism stresses “independence, competition, free enterprise and self-discipline” and is seen as a critical element in Western society (Grypma, 1993: 34). Cross and Markus (1999: 380) state that the “qualities and characteristics of being a person are thus fully interdependent with the meanings and practices that characterise particular sociocultural contexts”. In this statement there is no mention of the role of the self in individual interpretability of the social contexts. Collectivistic and individualistic cultures have a different understanding and interpretation of the self.

Cohen (1994: 33) states “individuals are more than their membership of and participation in collectivities, and, second, that collectivities are themselves the products of their individual members”. Ward, Bochner and Furnham (2001: 30) state “Cross cultural relations...can only be tackled when it is explicitly acknowledged that human groups differ in their respective cultural identities, that they have a right to maintain their idiosyncratic features if they so wish”. The greater the cultural distance between two cultures, the more difficult the interaction. The above descriptions of collectivistic and individualistic cultures are very linear. In reality there are differing degrees of both collectivistic and individualistic attributes in cultures.

As evidenced by the above literature review, the majority of the literature on culture shock is situated in psychology. Psychology has provided an explanation and framework for understanding the phenomenon. This psychological approach medicalises the experience by the very categorical cause and effect nature of the various factors, which may impact on the culture shock experience. Care needs to be taken not to view culture shock as a problem or maladjustment but as a natural process. Having identified culture shock and its

effects it is important not to stop there but to follow through with assistance and support for those experiencing culture shock.

Chapter Two

Methodology

Research Topic Identification

Having decided on the research topic and research area the decision was made, in conjunction with my supervisor, to enlist the expertise of a secondary supervisor from the College of Health Sciences (nursing). This was to ensure expert guidance was received from both the anthropology and nursing disciplines to minimise the risk of omissions from my work. Exploring the experiences of non-New Zealand-trained RNs who undertook their training in a country other than New Zealand and commenced work in New Zealand as a RN within the last year required further limitations to ensure the research was specific and realistic. Initial supervision discussions refined the research criteria. The geographical area was limited to Auckland as opposed to New Zealand due to accessibility to participants, financial considerations, and manageability of the study.

Another point of discussion was limiting the participants according to area of origin. There are differing perceptions of foreign depending on the country of origin. RNs originating from English-speaking countries such as England, Australia, Scotland are not seen as truly foreign whereas RNs originating from non-English-speaking countries are. Although the research was prompted into being by comments and observations regarding RNs from Central and Eastern Asia, the study was not limited to participants from these areas for two reasons. Firstly, to prevent further stigmatisation, and secondly, to avoid presumption that RNs originating from countries where English was the first language had no difficulty transitioning to working as RNs in New Zealand. Informal consultation was undertaken with a cross-section of nursing colleagues from various cultural backgrounds to discuss the appropriateness of the research and the interview topics.

Public hospitals within the Auckland area were chosen in preference to private hospitals as all three District Health Boards (DHBs) within the Auckland geographical area have a

familiarisation and orientation programme and similar scope of practice and are the largest employers of RNs. The three DHBs involved are Counties Manukau DHB (CMDHB), WDHB, and ADHB. Conducting research across these three DHBs also minimised the risk of identification of participants. If participants can be identified there is the potential for horizontal violence and/or exclusion by their work colleagues. If the information gathered reflected poorly on the employer the working relationship and the work environment could be affected. A time limit of one year from commencing work in Auckland was decided on through reviewing information in the literature and my own experiences adapting to new environments when travelling and working in other countries.

Position as Researcher

In one respect I am an “insider” as I too am a RN currently working in one of the Auckland public hospitals from which participants were recruited. With regard to this study I am on the periphery as I am a New Zealand-trained RN and have worked in New Zealand public hospitals for many years, and I am also a New Zealander. Denzin and Lincoln (1994: 4) state “research is an interactive process shaped by his or her personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting”. In order to prevent blurring the boundaries between my research study and my nursing employment, I have maintained separation between my work time and my study time by undertaking study on non-working days. I undertook my research independently, and there was no vested influence in my research. As stated in the review of the literature this research came into being from comments made to me in my work environment and from my own observations.

Ethical Considerations

Participants are required to be English language proficient to gain New Zealand registration therefore an interpreter was not deemed necessary for this research. If participants can be identified there is the potential for adverse reaction from colleagues and/or employers as described above. These considerations were also behind the decision to recruit from public hospitals in the Auckland region rather than targeting one hospital. Anonymity has been

maintained by utilising pseudonyms and ensuring any contact with participants occurs outside of the workplace. The methods of recruitment also help to ensure anonymity is maintained. Any perceived identifying factors were discussed with the individual participant and use of the material discussed. Professional and ethical standards as outlined by the Nursing Council of New Zealand (2001b), the New Zealand Nurses Organisation (1997, March), and the Code of ethical conduct Massey University (2003) have been adhered to.

Ethics Approval

Having refined the research topic completion of ethics forms was necessary. This was a circuitous exercise as conflicting information was received from institutional and organisational ethics committees regarding the ethics committees I would need to apply to. Completing documentation for five ethics committees formalised the research process and the direction the research was going to take. Submitting information to five ethical committees/clinical boards was time-consuming but valuable. Accessing information on ethical requirements, forms, and guidelines, for the ethics committees was difficult at times. Mainly in accessing and downloading information from the Health Research Council (HRC) website. Representatives of the research offices, ethics committees, and clinical boards provided invaluable assistance in the ethics approval process.

Massey University Human Ethics Committee (MUHEC) granted primary ethics approval. Prior to submission to MUHEC I checked with a MUHEC representative whether I would also be required to submit to Auckland Ethics Committee (AEC) and was informed I did not need to submit to AEC. Only when I received notification from MUHEC regarding my ethical approval was I informed of the need to apply to AEC. This resulted in considerable lost time. I then prepared for ethical application to the AEC. At the same time I contacted ADHB research development office (RDO) via e-mail regarding ADHB research approval. Halfway through the ADHB RDO process I felt a loss of control regarding my proposed research as I was receiving communications from people I did not know and I felt my proposed research had been exposed to numerous people and the risk of poaching of ideas

was very real to me. There had been no communication to me regarding delegation of my job number to others. This was cleared up with a telephone conversation.

One of the requirements for the AEC was sign off of the Part V. I met with two of the Directors of Nursing (DONs) and explained the research and had e-mail contact with the third DON, and the Acting DON of that organisation due to the DON leaving. The Chief Operating Officers (COOs) of two organisations and the General Manager Human Resources of the third organisation also were informed of the research and signed the Part V. Signing of the Part V gave ethical approval but not permission to undertake the research. Maori Health Services (MHSs) at WDHB was consulted, and the project submitted and accepted by WDHB Maori Health Research Advisory Group. According to the MHS at WDHB there needed to be Maori involvement/consultation in all areas of research which could result in health gains for Maori. The principles of partnership, participation, and protection were maintained throughout the research process by ensuring all points identified on the Information Sheet were adhered to and informed consent obtained. No New Zealand Maori was a participant in the research but Treaty of Waitangi discussions may have resulted as part of the interview process. If this occurred and I was unable to provide information, participants were advised to contact the MHS unit at their work for further information and advice. MHSs at WDHB were also available to provide ongoing support and advice to the researcher. Information on the HRC website as to when Maori consultation was necessary for research contradicted the criteria by AEC that all ethics applications involved Maori consultation. Application to ADHB and AEC needed to be simultaneous. Approval by ADHB was necessary for AEC approval but final sign off by ADHB was not given until notification of approval by AEC had been received. Once AEC approval had been obtained application could be made to the clinical board at CMDHB. WDHB did not require further ethical approval once AEC approval granted and the WDHB clinical board coordinator had received notification of the approval. WDHB required completion of the Research Business Case Application Form to be sent with a copy of the AEC application to the Quality Facilitator.

Participant Recruitment

Once ethics approval had been granted participant recruitment began. Participants were recruited by poster placement in five public hospitals covered by ADHB, WDHB, and CMDHB, and snowballing. Nursing colleagues and nursing friends were aware of my research and so the potential for them to act as an intermediary and inform potential participants in their areas of work of the research also occurred. Posters were hand delivered to wards and Charge Nurses or their representative were asked for permission for poster placement and informed of the nature of the research. On speaking with Charge Nurses or their representatives, the majority of wards had potential participants.

A minimum of 10 and a maximum of 20 participants would be recruited. Due to the number of hospitals participants could be recruited from, a minimum of 10 would provide scope for comparison within a hospital and between hospitals. The maximum was set bearing this point in mind, and also being aware this is a Masters thesis, and also time availability. Due to the fact I am a RN currently employed by one of the three DHBs within the Auckland region, I was aware of the potential for me to influence the outcome of this research by recruiting only participants in my place of work. As I am on site and cover all wards of the hospital, I am known by, and know of, a large number of nursing staff. This knowledge of nursing staff increases my awareness of potential participants within my place of work. When nursing staff approached me and asked if I had spoken to a particular person about taking part in my research my response was that I could not approach staff, they had to contact me of their own free will. I also did not speak about the research with participants from my place of work at work.

As I could not directly approach participants, participants left their contact details either at Massey University or a third person gave them to me. I then telephoned each participant, introduced myself, spoke about the research, and asked if they would be willing to participate. If they agreed I sent them an Information Sheet and a Consent Form with a return envelope to Massey University. If after reading the Information Sheet they were still willing to participate, they returned the signed Consent Form to me at Massey University.

On receipt of the Consent Form I contacted the participant, asked if they had any further questions regarding the research, and arranged a mutually suitable interview time and place. If I did not receive the consent form back I assumed the participant had declined to participate. All interviews took place at the participant's residence. This was decided between the participant, and myself as many were not familiar with Auckland and some utilised public transport. If a participant had not been happy for this to occur the interview would have taken place at either Massey University or an alternative venue mutually agreed upon by the participant and myself. I did not feel the participants workplace was appropriate for two reasons a) the participants anonymity would have been compromised b) the participant may have felt restricted by their work environment and not spoken freely.

Inclusion criteria for participants were non-New Zealand-trained RN within their first year of practice in a public hospital in Auckland, covered by ADHB, WDHB, or CMDHB. First year of practice was the stipulated time frame as after this period of time acculturation may occur and it becomes harder for participants to recall how the transition experience was for them. Although initially exclusion criteria were not set, I became aware through the course of the research that RNs employed by a hospital bureau who fitted my inclusion criteria would be subject to a multitude of other factors potentially affecting their transition experience. The factors included not having a home ward, changing work area every day, having a very limited orientation period – usually one day, not being part of a work team and therefore finding support in the workplace harder to obtain, requiring a longer length of time to build relationships with nursing staff and experiencing relationships of a generally transient nature. By the end of the recruitment period I had not been contacted by any bureau nurses. During the period of recruitment I was contacted by five non-New Zealand-trained-RNs who had been practising in New Zealand between 13 months and 5 years. Although I was very interested to hear what they had to say and it was tempting to include them in the research the length of time they had been practicing in New Zealand was outside my inclusion criteria and I did not have ethical approval to interview them.

Obtaining Data

Participants were interviewed to obtain research data. Interviews were chosen as a means of data collection as I wanted to hear the personal accounts of the participants with minimal bias on my part to enable scope for the interviews to generate the findings. I utilised a semi-structured interview with closed and open-ended questions. As discussed earlier an interview schedule was a requirement for AEC approval. A semi-structured format enabled me to initially narrow my focus and develop six key areas I wanted to find information on – demographics, previous nursing experience, knowledge of New Zealand, recruitment, New Zealand transition experience, and ways of improving the transition experience. A semi-structured interview also assisted in maintaining focus on the topics to be covered. The demographic questions were utilised as an icebreaker to start the interview process, as they are non-threatening and easy to answer. Interview questions were formulated as part of the requirement for AEC approval. The questions were used as a guideline during the interviews with each interview generating data-dependent further questions. In developing the research questions I was aware of the need to ensure the questions were not leading or value-laden, in the sense that I was imposing my perceptions of factors impacting on their transition experience into the interview. The choice of language was important in view of the number of English as a second language participants, and for the reasons above was phrased simply using non-threatening language. On consultation with MHS questions regarding the Treaty of Waitangi were formulated but on further discussion I removed them from the interview schedule as I felt they were leading questions. There was opportunity for the Treaty of Waitangi to be discussed in the differences between ‘here and home’ and what participants knew about New Zealand before coming here. The number of times the Treaty of Waitangi was raised in these questions I would use in the findings instead as this would have more value. Interviews were audiotaped with the consent of the participant. A third person who signed a confidentiality agreement then transcribed the audiotapes.

My own experience as a RN, personal observations in the work environment, and coincidental conversations I had with nursing friends and colleagues also contributed to the data utilised in my research.

Method

Ethnographic research as a method of qualitative research “is based on the belief that knowledge is socially constructed. Those who use this framework acknowledge that both researchers and the people they research have their own values and realities, therefore multiple realities exist” (Holloway & Wheeler, 1996: 1). Geertz (1973: 44) succinctly describes ethnography as observing, recording, and analysing “systematic relationships among diverse phenomena”. I utilised an ethnographic approach to inform my research as this enabled me to obtain data on the participant’s transition experiences as they perceived it and wished to share it. As stated in the introduction having heard comments from various New Zealand RNs regarding non-New Zealand-trained RNs and the difficulties experienced in the workplace I was interested in exploring how non-New Zealand-trained RNs perceived their transition experience. Comments made to me from New Zealand RNs and my observations through the course of this study, and some of my experiences as a RN have also provided data.

Throughout the research process, I undertook to be aware of and explore my own beliefs and attitudes regarding not only the transition experience of non-New Zealand-trained RNs, but also my thoughts and feelings on non-New Zealand-trained RNs as a generic group. This to me was essential to maintain objectivity and enable critical rather than emotive analysis. Johnson & Sargent (1990: 3) state it is important researchers “examine their own unconscious motivation” to enable a critical viewpoint. According to Lazarus and Pappas (cited in Johnson & Sargent, 1990: 33) “understand[ing] the way in which medical science and medical practice take shape, and the way that possibilities for change and improvement are limited and circumscribed” as the aim of critical theory within medical anthropology.

Analysis

A total of 10 participants were recruited for the study. Participants came from two of the three DHBs where posters were displayed. This was coincidental as the onus was on participants to contact me. When placing posters in CMDHB the majority of the Charge

Nurses or co-ordinators said they had a relatively stable workforce and that there was either no one or may be only one or two RNs who fitted the research criteria. Only one person contacted me from CMDHB. However they did not meet the inclusion criteria for this research as they had been working in New Zealand for 4 years.

All except one of the participants had been working as RNs for 6 years or more. The country of origin where participants' nursing training was undertaken, and whether English was their first or second language varied amongst participants. The countries of origin where participants undertook their training were United States (1), Japan (2), India (2), Austria (1), Wales (1), and England (3). Data from interviews with participants was collated and analysed using a General Inductive Approach (Thomas, 2000).

From the participant interviews I was aware of recurring themes emerging. Following completion of the interviews transcripts were read several times to further identify themes and develop categories. From the data six categories were generated. The six categories are: negation of attributes, information efficiency, nursing differentials, nursing similarities, and personal variables. These categories are explained and enlarged in the findings.

Following individual exploration of each of the six categories I then used critical social science to inform my analysis. The Centre for Critical Social Theory (University of Sussex, 2002: 1) states "Critical social theory can be thought of broadly as covering the interactions between the explanatory, the normative and the ideological dimensions of social and political thought". Critical social theory "takes a critical stance towards the social reality that it investigates, by providing grounds for the justification and criticism of the institutions, practices and mentalities that make up that reality" (University of Sussex, 2002: 1). The principles of critical social science underpinned this research. The cultural construction of reality and the historical, political, and economic factors which influence both culture and nursing culture as they pertain to this research were explored.

The interview data was utilised to illustrate the categories generated by placing relevant interview text under the six categories identified. The research findings then emerged from

these categories and were linked back to the research objectives. Quotes from the interviews have not been grammatically corrected as to do so would alter the voice of the participants.

Chapter Three

Findings

Negation of Attributes

Through the interview process I became aware of a recurring theme which participants were voicing regarding the lack of acknowledgement of previous nursing experience by their employer. On analysing the transcripts it became evident that there was another concept being voiced that this extended to, and that was personal knowledge. Personal knowledge is the wisdom the participants have gained through life experiences. The importance of feeling valued by having their experience and knowledge recognized was mentioned by nine of the participants. One participant did not have prior nursing experience.

The frustrating thing is being treated as a newly qualified nurse. I think where I work they have lots of different nationalities, so they make them all start at Level One, which you think to yourself is really great, because you have no responsibility, you are getting paid as a Level Two. But it is actually very frustrating when you have got seven years ICU [Intensive Care Unit] experience and you have got people explaining what propolol is and that you are not getting the interesting cases.

(Deidre)

I felt I had come back ten years and I just felt so undermined. I had got a good job in England and had been in positions where I was managing other staff and managing units and wards, and I had to come back to doing the donkey work, and people talking to you like you haven't got a clue and that was really hard.

(Maria)

They [medical profession] are not interested in listening to you or your autonomy.

(Rachael)

New Zealand really does give you that feeling you are completely an idiot and you are doing the wrong thing.

(Anna)

The negation of experience and personal knowledge has multiple impacts. The most serious impact is the frustration, which is clearly evident in the above quotes. In my practice as a RN I have seen such frustration lead to dissatisfaction with the work place and then to adversely affect ways of relating to colleagues and also nursing care. All participants experienced minimal formal recognition of experiential knowledge.

Another impact mentioned by participants was changes in individual nursing practice to fit in with the current environment, as illustrated in the quotes below. The need to change practice may be genuine and not a result of 'negation of attributes', as staff and patient safety and continuity of care need to be achieved.

You have to do the work the way they want to do, even if you think it is better, the way they did it at home.

(Anna)

I know I ought to change, to the New Zealand set up, whatever cardiac surgery they do rest of the world I have to forget and give my focus on the new practice that they are doing it this way. I am trying to do that so sometimes I get disappointed. Sometimes I feel that I should not have come here. One thing which I have found, they just don't value your experience.

(Rachael)

Things like cardiac arrests in acute areas. Teams would arrive and they were just doing all sorts of things, whereas again we have been basing on European guidelines in the UK [United Kingdom] and I used to think what are we following here? I don't understand what everyone is doing. I used to think; Oh God, you should be doing

that and what are you doing? And everyone used to go; well this is how we do it here.

(Maria)

These three quotes illustrate internal conflict in the participants between the 'new' and the 'old' ways of doing. Having been accustomed to different ways of being and doing in their last work environment, they have become part of a culture where they are immersed in a different work culture and social culture and may not be aware of the historical, political, and economic factors which have helped to form their current work environment. The second stage in the process of culture shock as described on p. 16 is evident in the above quotes.

When entering a new environment where nursing practice is different, changing your nursing practice can feel like you are compromising your own standards of nursing. One may wonder why things are done the way they are and where the practice came from. There is not the history of association with the work environment or knowledge of the inherent nursing culture that one has entered. Guidelines and recommendations on which nursing practice may, or may not be, based may vary from those utilised in one's home country. The position of nursing within the healthcare system and relationship to other health professionals may also be different. All of these factors add to the challenge of nursing in a new environment. These changes and challenges can lead to positive changes in nursing practice for not only the person directly involved but also their colleagues if personal factors permit.

Another aspect, which was mentioned in regard to recognition of experience, was the lack of individual assessment when planning familiarisation and orientation time and programmes. For the participants the length of orientation time and the structure of the orientation depended on the area of work. Specialised areas had increased orientation time, which was also much more structured than the orientation in general areas.

Whoever you are or where ever you have come from, you have got two weeks to sort yourself out and then that is it.

(Gail)

... and you do seem to have to go through this regimented study days thing, there is no individual assessment.

(Deidre)

I don't think anybody ever properly went through the levels in the portfolio. It was assumed that you knew, and that can be quite confusing because you are thinking, do I have to do some work? And I am thinking, well I don't want to do it actually, because here is a Level Two and I am a Level Three and I have achieved all of this and why have I got to prove it all again? I am not proving it all again. I am not doing it. I am thinking you have got my CV [Curriculum Vitae], why have I got to do all this portfolio and spend all my time just to increase my level, when I have been at that level in the UK for the past six years, so I mean forget it. It is making people aware of the levels and what is expected of you within the public system and the educational stuff, the pay.

(Maria)

Recognition of individual nursing experience and personal knowledge is important to minimise frustration and maintain feelings of worth amongst participants. These factors had a strong impact on the transition experience. In relation to nursing staff retention and productivity, it is fundamental that experience and knowledge is recognized.

I did go through a time of thinking I am just going to go back, this is too hard.

(Maria)

Whether the participants had immigrated here permanently and commenced work, or were working and living in Auckland for a short period of time, did not change the participants' need for acknowledgement and appreciation of their experience and personal knowledge.

When moving to a new work environment it does take time to establish yourself and decide where you would like to be positioned in the nursing team. In the previous environment you may have been a preceptor to new staff, a resource person, or shift co-ordinator. These roles and responsibilities need to be reestablished in the new environment.

Economics and power contribute to negation of attributes. The economic aspect is that it is perceived as more economical to employ a Level Two RN than a Level Three RN, and so on up to Level Four. It is also perceived as cost effective to develop and maintain one course specific to the area, which all new staff attend rather than develop and run several courses that cater to individual needs.

Nursing experience is also knowledge. Knowledge is often associated with power and therefore there can be a subconscious aspect of job position protection by ensuring nursing skills and tasks are performed in the ways outlined by the unit/ward. Generalisations are used to judge RNs according to their country of training rather than the individual and their experience, as there is a lot of ignorance regarding nursing practice in other countries. I myself have gained valuable knowledge and insight from participants sharing some aspects of nursing practice in their home country.

Negation of experience within the leveling system does not just occur with non-New Zealand-trained RNs, but also occurs when RNs transfer to another hospital. At the negative end of the spectrum negation of attributes is psychological horizontal violence. It is important that appropriate acknowledgement and remuneration is given to prevent this form of horizontal violence from occurring. The nursing justifications for standardising orientation programmes are safety and consistency of care to ensure public safety. If we open up to exploring new ways of delivering nursing care it would mean critiquing current nursing practice. Immediately defenses come into play as it is viewed negatively as criticism rather than positively as a critique. Critiquing practice takes time, objectivity and analytical skills. An important benefit of critiquing and reflecting on one's nursing practice is that gaps in knowledge and practice would be identified.

Emphasis and credibility is given to evidence based practice (EBP) rather than experiential knowledge. The common centres for EBP utilised in New Zealand are the Joanna Briggs Institute in Adelaide and the Centre for Evidence Based Practice based at the University of Auckland and ADHB. Nursing in New Zealand has previously had limited exposure to RNs from a large number of other cultures. We are geographically isolated with a small population and have had a limited exposure to other ways of doing which leads to an ethnocentric viewpoint in nursing – our way is the right way. Our reality is not necessarily the other person's and, as highlighted in the literature, there needs to be awareness of one's own values and beliefs and the foundations these are built on to understand the cultural aspects of others. Valuing people's knowledge and capabilities gives validity, worth and purpose to what they are doing and assists in maintaining self-confidence.

Information Efficiency

There are two aspects to information efficiency. Firstly, dissemination of information from the start of exploring the options of coming to New Zealand to work, to arrival in the new environment i.e. the whole relocation process. Secondly, communication as an aspect of day to day nursing practice for the participants.

Some participants utilised the DHB and Nursing Council websites and others had direct telephone contact with employers prior to coming to New Zealand. Other sources of information about New Zealand, Auckland, and the New Zealand health care system included nursing journals, guidebooks, and conversing with other people. Four of the participants had previously visited New Zealand and had developed a general overview of the country. One participant came on a working holiday and decided to stay longer so then became registered to work in New Zealand. One participant found out as much information as possible about Auckland, New Zealand, and the New Zealand health care system. The remainder of the participants knew nothing about Auckland, New Zealand, or the New Zealand health care system before coming here.

I can remember looking in the back of the Nursing Times and I got in contact with some of the agencies. And it wasn't until I met one of the agencies in London and they started finding out stuff for me, and I started looking on the Internet and I went to the immigration place in London.

(Maria)

I went into the Internet and I went into New Zealand medical nursing, blah, blah, blah, and then I had this Health Board form in front of me, didn't actually know what it was.

(Anna)

They [hospital] sent me a folder and I went through it and I just thought what is all that.

(Anna)

...actually the hospital sent me a package about the District Health Boards and stuff like that so I had a good idea of [the] unit.

(Louise)

Two participants out of the four whom knew nothing about New Zealand before commencing work thought that in retrospect it might have assisted their transition if they had prepared themselves better before arrival. As discussed in the literature, preparing yourself by learning about the new culture you are going to before leaving your own country can assist in easing the transition to a new culture.

Maybe if I had been a bit more prepared. I perhaps should have found out a bit more about how things work here.

(Gail)

When I think about that now I could have had much more information, it is true. But I have never been away before, and I didn't really expect anything I just went. I had

no idea what I have to do. It would probably make a difference now because I know what it is like. When I first came I couldn't even think about what was important for them. Probably now I would get more information, see what they are like, but I didn't even know what a Nursing Registration looks like, because we don't have it.

(Anna)

The need for information given to participants to be prompt, accurate, and honest was highlighted in a variety of contexts but especially to enable the participants to process their New Zealand registration as quickly as possible and to make well-informed decisions regarding work placement.

The thing is that I came over in February last year and I thought I can start immediately in April. I came over and then Alex told me, which I didn't get when I was at home, that I have to do all of this overseas programme and I have to do this IELTS test to get my registration.

(Anna)

Nursing Council, they take a lot of time.

(Rachael)

If I had known I could have done it back home. They would have given me a bit more information about that. To say, yeah, you need your registration. I send them all my letters and they didn't actually send me back. ...The Nursing Council is very lazy. They didn't send it back and say, 'you know you have to do that and that', they sent it back to me when I was already here. That was a bit slack. Everything was...it was a bit difficult and I was really nearly close to going home after this failed English exam.

(Anna)

I think also the agencies just being honest with you. Here there aren't those senior jobs and there just isn't and they claim that there is, so you come from this here and

actually you are going to be starting down here. They promise you...and I have had many promises made here and that is really. I have just felt disappointed and now I don't pay a lot of attention to it. I know the agencies are trying to get you here. They are trying to recruit you, but this is big in recruitment. People have to give you the reality of the situation because you bring people over and you set the expectation really high that you are going to be doing a job that you were doing in the UK, plus having a better lifestyle and this and this and you get here and you think, gosh I feel like what I was doing when I was a student nurse.

(Maria)

You have to think philosophically really. I don't get too upset about it because I am not here for career advancement, but some of my colleagues that were, were led to believe that they would be treated at the same level that they were in Britain.

(Deidre)

Two out of the three participants who had utilised recruitment agencies did not stay at the job they were recruited for and changed employers. Both of these participants had immigrated to New Zealand with their families and were committed to making New Zealand their home. To assist in the recruitment and retention of RNs it is essential for information to be prompt, accurate, and honest.

I was really struggling and I wasn't happy with where I was and I realised it was a complete mismatch. I had never worked in private and I had never worked in private New Zealand, and I didn't understand the system and a lot of the terms. All the promises of the buddying system, the orientation never happened and then I was left in charge with other agency nurses who didn't know the system.

(Maria)

I did explain to the lady [agency] that I was a bit rusty on ward work so she organised me to have an orientation time. Looking back it just wasn't long enough for me personally. I sort of struggled on 'til about the middle of March and then

realised that it wasn't safe for me, it wasn't safe for my patients, and it wasn't fair on the staff, so then I looked for a more mentored and sheltered work environment.

(Catherine)

Differences in the day-to-day communication within the work environment were identified by participants. Relationships between medical and nursing staff differed for some of the participants between their home country and New Zealand, as was evidenced by their experiences of different ways of communication. Participants viewed having respect for others, and feeling comfortable to say what needs to be said without fear of mistakes or judgements, as important. Cultural and environmental factors influence modes and methods of communication.

I find the way the doctors speak to people is quite different, quite unpleasant. You can't get away with shouting at people in the NHS [National Health Service] anymore.

(Deidre)

Medical staff is very friendly. There is a social system like here in India. In India we respect all doctors. Here it is more friendly, like I never called...that is a cultural thing which happens, in India we never call our elders with their names. We are not supposed to call...one year ahead of me, I will not call his name. But here everybody calls the names. Small cultural difference but other than that the medical staff are very friendly here.

(Rachael)

It is probably a bit difficult for me because of the language as well. It would probably be much more spontaneous back home in my country. I sometimes don't say anything that is stupid because I can't expose myself like I wish to do sometimes. That is probably the problem, could be the problem.

(Anna)

One thing, which was highlighted regarding verbal communication, was that even when English was the first language there could still be difficulty understanding what was being said due to the different accents. As evidenced in one of the quotes below, comprehension difficulties arise due to accents even when English is the first language. This worked both ways as participants had difficulty not only understanding but also being understood in conversation. The literature identifies accent as a factor of a person's speech which is judged and rated (Cargile, 2003). Those participants for whom English was their first language found this helped with their transition.

A lot of people seem to think, at least a lot of people ask me, do you find the language difficult? Because I think that that is a problem for a lot of people who's first language is not English and they automatically assume because you are Asian, that English is not your first language but it is my first language at least, because that is what I speak at home. So it can't be a problem.

(Louise)

One of the great advantages is that basically it is an English speaking country so I didn't have any problems at learning a different language. However it was quite amusing on some of the handovers a nurse would talk about Joe Bloggs being 94% on air, and I was very mystified on what was wrong with his ear, until I realised that they were talking about air. So although it is the same language, I do sometimes have to listen twice and understand the context.

(Catherine)

Even at work, every day people would be going they can't understand what I am saying or I'd say venflon instead of leur and people would go huh?

(Maria)

I think having English as a first language has been very helpful. I see other nurses that I work with who speak other languages as their first language and they definitely have some difficulty. Like taking handover on the phone. A lot of the time they don't

understand certain words and they get frustrated and the other person gets frustrated and...but anyway I think that has been helpful. I think it would be more difficult a transition if I didn't speak English as a first language or I didn't speak it well.

(Hannah)

The quotes illustrate how different accents, names for equipment, ways of speaking and formulating language, have impacted on the communication process for participants. This highlights the point made in the introduction of the importance of learning means and modes of communication to assist intercultural communication.

Amelia discusses not only the difficulty of having to speak and understand English but on top of that having to decipher the different cultural accents that abound. The challenge of working and conversing in a language other than one's first language was highlighted as one of the difficulties for participants.

Because one of the major problems is the different language. In Japan we usually study not in English, everything in Japanese, so I found it very difficult to cope with English language and also here is a multicultural society and even though everyone speaks English but everyone has different accents and just cannot get very well.

(Amelia)

Of course I still have language problem. If I focus on language, yes it is very difficult.

(Samantha)

Leininger and McFarlane (2002: 16) state "Language barriers remain a major and significant factor in becoming an effective care giver for the culturally different". Since communication is a crucial part of nursing it is necessary for non-New Zealand-trained RNs to be competent in the English language to gain New Zealand registration. This is why there is the stipulation of passing an IELTS Level 6.5 or the equivalent. One participant spoke of another nurse, who had been on the competency course with her not getting the

job in a critical area of the hospital due to her inadequate communication skills, as there was too much chance of misinterpretation and there was a reluctance to use the intercom. Miscommunication occurs because there are numerous different ways of both saying and interpreting the same. This stems from individual values, beliefs, and perceptions, which are informed by culture. Even with English as first language speakers the points of reference in communication are not identical due to cultural, environmental, and individual differences such as colloquialisms and slang.

Participants spoke of New Zealand RNs willingness to listen and assist in the transition period. Based on my observations and personal experience I would agree this is initially so. However, as time progresses, and especially if the New Zealand RNs have previously experienced difficulty communicating with RNs with English as a second language, there is a much reduced tolerance of difference. An unwillingness or inability to listen then occurs due to a generalisation being formed regarding the difficulty of communication. Also discussed in the literature is the necessity of language skills as a precondition for effective communication and the ability of a person to function in the secondary culture. Language has a central role in social interaction. Communication not only requires language skills but listening skills on the part of the receiver of the spoken word. To facilitate communication it is important to develop self-awareness to enable communication participants to discover that miscommunication is not just one person's problem.

Information efficiency has a large impact on the retention and recruitment of RNs. There is an expectation by participants that communication will be clear and honest. Two of the participants spoke of the disillusion and disappointment they experienced due to employers leading them to believe senior positions and career advancement were available and comparable with where they came from. When this proved illusionary this impacted on both their transition experience and their decision to stay in New Zealand. False promises lead to non-belief and lack of respect for employers, thereby decreasing the loyalty of employees. The value of RNs and their perceived transferability are factors in the misplacement of participants by agencies in jobs, which did not meet the requirements or skills of the participants. It is necessary for the agencies to ensure their recruiters are in

touch with the day to day reality of the job. Whether economic considerations take precedence over personal considerations is a point to consider as payment is often made only when a person has been recruited by the agency.

Nursing Differentials

One of the aims of this research was to identify some of the differences in nursing practice which participants found between nursing in their home country and nursing in New Zealand. The differences mentioned by the participants are both generalised health system differences, and differences which may be more specific to their area of work, and/or their work environment. As the participants come from diverse backgrounds, both culturally and individually there are a large number of differences mentioned. The differences have been divided into either environmental, nursing practice, or financial differences.

Environmental

This covers the overall arena in which nursing occurs and the social attitudes, organisational culture and historical factors which influence it.

The differences in aspects of nursing cultures which participants experienced when they commenced working here are illustrated below. Physical differences in the work environment such as equipment, technology, and protocols, were mentioned by all of the participants. The different approach to health care delivery by both nursing and medical staff, the variation in work ethic, historical factors, and the level of collegial support were also mentioned. Also the psychological differences participants encounter due to the shift in thinking caused by exposure to the different nursing culture.

All of these aspects mentioned result from the political, economic, cultural and historical factors that have featured in the formulation of the nursing culture in their place of work.

Well it is much more laid back here. Much more...I think a lot of places in England it is still quite regimented on a general ward anyway. You have definitely got set routines and maybe because there are less qualified staff there you kind of...you have to organise yourself better, I think, because you have got more patients to deal with. I find it is quite disorganised here. It is very much... everything is done on an ad hoc basis, where if you think that you should be doing it, do it. Which...that is okay, it probably depends on the kind of person you are. I know what I am doing and I like to know what my routine is for the day. I find it more difficult to do that here. To organise and prioritise things, because generally it is disorganised. It is really nice in some ways because you get all your breaks here, which is never heard of before in England. There is some things to be said, I think about the relaxed atmosphere, but it can make things difficult sometimes.

(Gail)

I do think some of the attitudes and practices and equipment are really out of date. I think the health service is quite under-funded here. The equipment I was used to and when I came here I thought it was really bad. I thought it was like what I had seen 10 years ago when I was a student nurse. Things with basic equipment, proper blood pressure machines, beds that worked and lifting is appalling. ...Lots of things are different. The way things are done is different here and the terms and the terminology and the use of protocols are very different.

(Maria)

Well there is the whole health care system, which is quite different. I don't like generalising too much but I think that overall patients in the hospitals in the States might be a little bit more sicker, more acute in general. We seem to have a lot of patients on the floor that sometimes I can't figure out why they are there. They might have exacerbation of COPD [Chronic Obstructive Airways Disease] or something, and certainly are unwell but sometimes I feel like someone is taking up a hospital bed and someone who is more sick could probably use that bed. And it is expensive and sometimes the doctors go...especially over the weekend when they are not working

and then patients just stay in the hospital from Friday to Monday and nothing really happens over the weekend. The team aren't there so they don't get discharged. They don't get reviewed unless something goes wrong and that to me seems not only expensive, but a little bit impractical.

(Hannah)

I think the set up in New Zealand from my point of view seems to be much better. The breaks situations, the nurses going for their breaks, is very well managed and I appreciate that. It seems to be much more organised and in one sense you are your own practitioner and you are organising your own patients care, so you keep a track of exactly where they are. In the UK I seem to remember that it was more a team effort. I think the system has got quite a lot of advantages for me because you are the responsible one. The buck stops with you although there is teamwork as well because you call on other members of the staff to help you, especially with the heavy patients with moving.

(Catherine)

Cultural differences with regard to ethnic cultural differences were mentioned by participants through examining the role of both the patient and the RN, and healthcare delivery in their country of origin and also in New Zealand. Maria's quote below emphasises the need for non-New Zealand-trained RNs to be informed of culturally appropriate care for Maori and Pacific Island patients preferably before situations arise which may cause offence. It is not only learning about the country which you are moving to that is important to assist in the transition, but also specific information pertinent to the environment you are entering.

Yeah. A lot of cultural difference. Work setting. When you are dealing with a patient it differs. Other than that patient care, everything the same, but when it comes to emotional factors, like small, small things, then it diverts Maori to a European, it differs.

(Rachael)

The other thing, which was quite difficult, was the cultural aspects here in New Zealand. In England and in East London we were very used to ethnic populations of Asian and Punjabi and Bengali patients and you understood to respect their cultural beliefs within nursing, but there I have not nursed Maori or Pacific Island patients and I found that very hard. They were never aggressive but quite difficult people to deal with. Like they would ignore you or the family would get quite upset and you would try and understand what was going on because the only actual input we had was on our orientation about the Maori culture. The Maori culture in practice is completely different.... I think with, not necessarily Maori patients, but with Pacific Island, perhaps Tonga or Samoan patients, and I clearly upset them and I didn't realise and never intended it. But it was just from not working with those types of patients. And real health issues about their weight, and I have never nursed huge patients within cardiac, and it was really difficult to address health issues like stop smoking and don't eat this, this, and this, when they are nearly 200 kgs and they are not interested. There is you going along as this white English nurse, they are not interested. I still find that really hard. Where do you start?

(Maria)

Four participants mentioned the cultural aspects of nursing in New Zealand. The differences of having Maori and Pacific Island patients not only with regard to the nursing care delivery but also with regard to these individuals' attitude to healthcare and personal responsibility for their own health. Three participants identified cultural differences working in Auckland's hospitals to nursing in their home country and also spoke of the need to ensure not only Maori patients received culturally appropriate care, as all patients should receive this care.

One participant spoke of the different role of the doctor and the patient. The patient in Japan delegates responsibility to the professional. The other two participants spoke of the differences of nursing Maori patients from a 'hands on' point of view. No participants spoke of the Treaty of Waitangi. The two participants who spoke of cultural differences and being culturally aware had both previously worked in multicultural areas. One

participant said of her home country "... doesn't have a culture". She felt she had never experienced the cultural aspect of nursing care before and thought the respect shown to Maori patients was very good.

For two of the participants the scope of practice was much larger in New Zealand than in their home country. Obviously this is a major change in nursing practice for those who came to work in New Zealand from this environment. Louise repeated a comment made to her by another RN from India regarding the shift in nursing practice from just following doctor's orders to having to make decisions, which she found very stressful. Louise on the other hand enjoyed the autonomy and the theoretical aspect of nursing here, which she felt, was lacking in India. The theoretical aspect of nursing, the educational input and facility for study was seen to be at a higher level in New Zealand than in their home country by four participants.

The treatment is doctor based and the doctor tells you what to do and that is what you do, but here it is if you are experienced enough and trained enough. Here you can do everything. It is basically you looking after the patients. Of course there are certain limits as to what you do and there are things that the doctors will have to prescribe but generally they leave all the assessments in your hands.

(Louise)

The grading system between staff is slightly different. Which I think in some ways is better here because you can work towards a Level Three or Level Four. You don't have to wait for a job to come up, whereas in Britain it is relatively easy to get to what we call an E grade, Level Two and after that we just have to wait for jobs to get advertised. You have to wait. Here the way...it is much more academically assessed in terms of...so it is all about filling in these reams of books and assessments and study days but no one actually assesses how well you do things, whereas in Britain it is a much more practical assessment. You can have all the exams in the world; you still have to be able to do it. There is much more people who fail practical assessments whereas here you can get quite high up without having the know how,

whether that is people skills or whatever. It is nice that you have got that development option but it doesn't wheedle out people that maybe aren't suitable. People are expected to do more quickly here than in Britain. Certain things that would be advanced practitioner in Britain are expected to do here from the word go.

(Deidre)

Participants spoke of the cultural thinking in their home country regarding the roles of the medical staff, nursing staff and the patient in decision making. These differences in thinking highlight the importance of nursing staff involved in the familiarisation programmes of non-New Zealand-trained RNs, to develop an awareness of other cultures' approaches to aspects of healthcare delivery. Developing such an awareness will assist them to be aware of the day-to-day norms of healthcare delivery in New Zealand. This understanding of New Zealand healthcare delivery can then be shared with non-New Zealand-trained RNs.

In India and Asia, a lot of countries UAE [United Arab Emirates], the public is not really informed. Prior to open-heart surgery they do have a certain amount of knowledge of what is going to happen to them, but it is not like a whole team effort. A lot of the time patients don't want to know those details because they are really afraid of what is going to happen, but here I find the patients very well informed so you don't mind informing them any details regarding the patient treatment and they expect you to do that. That information and communication is also quite different to what I am used to.

(Louise)

I felt lots of patient in this country. I feel very right, very important. Very small thing, but they emphasise their right much more than Japanese people. I felt sometimes it may be good, but sometimes I feel that it is maybe too much because of the environment I came from. And here it is so different. They don't even pay in this country but in Japan, Japanese patients, even though they are paying they are much like humble, but in this country not humble at all. I find it sometimes difficult to

accept these things. It is not always, but sometimes I have found it difficult to deal with some patient. Some of the patients, of course it is their right, but can refuse the treatment or medication if they are not happy about it and for me, cannot believe these sort of things. It is for them that we are trying to give best medication or practice but they simply cannot accept. I don't want to take so many medications, I don't want to have nebuliser what for, and even though we explain they say no.

(Amelia)

About each New Zealand patient very active and Japanese very passive. I think the Japanese want doctor to suggest us what we have to do. We don't want to choose or what we have to do if they need operation. We want doctor to suggest us having an operation, then we say yes please. That is so hard for us to make decision.

(Samantha)

During the interview process I wondered if it would have been beneficial for participants to receive the list of questions prior to the interview to help to stimulate their thinking around the topics. Sometimes it was hard for participants to think on the spot, especially when English was their second language. The trade-off would have been loss of spontaneity.

What is familiar to New Zealand nurses is not necessarily familiar to others. When imparting knowledge in the familiarisation period it is the small day to day things we forget to talk about as we presume they are the same and instead we focus on tangible differences such as protocols. Little differences get overlooked in the orientation because there is the assumption that the RN will know due to being a RN, and also these small things are so familiar to the RNs doing them every day. Also, if the RNs orientating the non-New Zealand-trained RN have not had overseas experience, or even experience working as a RN in another hospital, they may presume that the way they do things is the same everywhere. When I went to England to nurse Primapore dressings were called Mepore, for example, leurs were called Venflons, drugs sometimes had slightly different names, and the role of the RN was different from that in New Zealand. There was much more emphasis on management and ward co-ordination, and medication delivery for the ward, as on the

general wards there were nurse aides who worked alongside the RN doing a lot of the hands-on patient care.

One participant stated she didn't know what Blue 100 was when she commenced work in Auckland. It is essential to know some terms from the start whereas others, for example the dressing names, can be picked up as one goes along. As stated earlier, each hospital has its own nursing culture. I moved between hospitals in the Auckland region and found the culture very different and even the terminology and practice sometimes varied.

The orientation period can be utilised as a time of mutual sharing of knowledge by all concerned. It was the differences rather than the similarities, which stood out for participants in their transition experience. This makes sense as it is identified in the literature that it is difficult to see your own culture, therefore our awareness of the things we do all the time is limited.

Nursing Practice

This section covers hands on nursing care and nursing practice. There is a crossover between the environmental differences and nursing practice as they interlink with one another due to historical and cultural influence on nursing practice. Again, the approach to nursing care delivery was mentioned, this time with regard to what is viewed as appropriate professional behaviour. RNs challenging and questioning medical decisions for the benefit of the patient rather than taking a subservient role was a different experience for two of the participants. Six participants mentioned differences in the models of nursing care utilised e.g. primary or team nursing.

Another thing I felt New Zealand nurses have more responsibility towards the patient than Japanese nursing system. I found that very difficult to cope with problem still. Like House Officer asks us to do something, but very often in my work nurses is against the order. No we not do that. We can say like that, but in Japan we didn't say like that. I thought we like really unprofessional, and if we feel that it is not

suitable or it appropriate towards the patient, we can against strongly, even though they are doctors.

(Amelia)

Here I find one of the differences is that it is very primary nursing. It is very big. You have four patients and you do everything for those four patients. You give them their bath. You make their beds. You give them their medications, and so you spend all of your time with them. And maybe in the States you have more patients and you have Nurse Aides to do a lot of the bathing for you and a lot of the hygiene stuff so that you have more time to administer medications. There is a lot of different levels of nursing [in the United States].

(Hannah)

The rounds are different because here it is so separate, doctors and nurses, they don't work together and back home they have a big round.

(Anna)

Perceptions and experience of legal liability and professional accountability in nursing care varied amongst participants. Levels of autonomy and decision-making and the number of protocols utilised in their area of work were interrelated according to three participants. Within this there were both positive and negative views of the impact the protocols had on nursing care.

Everybody is very big on following protocols here and yet they strictly buy these protocols where in England perhaps you would have a bit more autonomy and you took it on and you liased with whoever and they would say go do A, B, C, and D, and then we will review the patient in 10 minutes, whereas here you strictly have to follow these protocols.

(Maria)

Here for each and everything, you have got a protocol. That is one thing in New Zealand that I appreciate. We never used to have that elaborate protocols for our things.

(Rachael)

The scope of practice of the RN and the ratio of RNs to patients differed from country to country. All of the participants thought New Zealand had a high ratio of RNs to patients and was well staffed. The utilisation of different levels of nurse e.g. enrolled nurse, healthcare assistant, and also ancillary staff varied amongst the countries the participants came from.

I think there is more medical skills that nurses from the States. They listen to a lot of heart sounds and breath sounds and I don't see a lot of that. We have a lot of Nurse Practitioners in the United States.

(Hannah)

First thing I realise that is big difference was the number of nurses working in the wards is very different. I thought here in public hospital they have more nurses than public hospital in Japan, which I worked for. ...Public hospitals in Japan, they only employ Registered Nurses and no health assistant or nursing aide. And whereas here there are a lot of other staff such as nursing aides, orderlies, phlebotomists.

(Amelia)

We don't have runners, you [we] don't have Charge Nurses, we don't have leveling back home. You don't have so much bookwork to prove yourself.

(Anna)

Nursing documentation, specifically care plans and the evaluation of nursing care, were areas that two participants identified as being different. Although they considered the level of documentation as poor, they felt unable to continue to document as well as they had at home, and now documented nursing care according to the current hospital requirements.

Just the way you write it down or whatever. We have care plans at home for documentation. You plan how to do it, write it down and it is much more about care and documentation things. It is very lazy here.

(Anna)

Now I remember the documentation is slightly different. Here in New Zealand people usually just write but in Japan we learned how to write report using SOAP subjective, objective, assess, plan, and we always evaluate patient. Different documentation, but here we seldom make a plan like that, like in your head we are thinking how we can do towards this patient, but it is not documented clearly.

(Amelia)

Financial

Financial differences highlight the participants' perceptions of the utilisation of resources, the business sense of the organisation, and RNs' salaries. Whether participants came from a private, partially public-funded or fully public-funded healthcare system impacted on their perception of financial aspects of healthcare delivery.

In Japan we have to make profit even in public hospital we have to think about the money issue. If we use tape or gauze or whatever, we have to charge to patient.

(Samantha)

Here public hospital, the patients don't need to pay anything and in Japan, even though we have a compulsory insurance, everyone must pay certain amount of money to the Government every month, but still those patients have to pay some of the money at the end to the hospital.

(Amelia)

...so with Japanese health, everybody has health insurance, patient responsibility, health insurance covers 70%, but in New Zealand it is our choice. If we want we can

have health insurance. We know patient is the customer but they have to pay and we have to pay and charge and make profit.

(Samantha)

Four participants spoke of the low level of salaries. They had all made the lifestyle decision to move to New Zealand and accepted that the salaries were low in New Zealand.

Certainly the salary is a little bit lower, but you know that when you come over here and you choose to accept it or not. It is part of living here and that is fine.

(Hannah)

In the US I used to make hell of a lot of money, big money, because they pay per hour, \$34 American dollars they used to pay for me. Here I am getting \$22-23, but my intention was to have a good lifestyle rather than going for money.

(Rachael)

The nursing culture and healthcare system in their country of origin influenced the non-New Zealand-trained RNs perception of the utilisation of resources and level of awareness of the financial costs of the equipment being used.

Much more budget conscious in New Zealand than in Britain, that has been quite interesting. Money is money, save money. To the point of, I think this is a short-term option, we have to come up with two things a month to save money. Cutting up tissues instead of using gauze. It really is quite amazing.

(Deidre)

Another thing about medicine, when patient has been discharged in Japan we return all medicine back to pharmacy and then they recycle, but in New Zealand we donate all drugs to other countries so I think New Zealand is so kind, so very kind and waste money. It's possible to use it again. Suction tubing we dispose every time, every time, but we can use it again, but we don't because there is a risk. This is a very

good way because we don't have to think about making a profit. It is all Government. I think we use so many hospital equipment everyday in New Zealand. Even gauze or tape or bandage or whatever, just easily throw away and dispose of everything. We give Mum a breast pump or bottle all free, but they still ask me, Oh I need another breast pump. Could I? If you need you can buy I think. New Zealand is kind I think. That is my impression.

(Samantha)

In the same manner as national culture, the culture of nursing, (in common with the healthcare system in each other country), is formed through historical, social, political, and economic factors. The Social Security Act 1938 and its subsequent amendments, gave provision for government-subsidised hospital care in New Zealand.

Within the culture of nursing there are institutional variations. The work history of the hospital e.g. specialty unit, tertiary or secondary care provider, and the people previously and currently working in the hospital contribute to the institutional culture. Participants' view of healthcare delivery and nursing care in Auckland public hospitals, in particular resource management, usage, and wastage, was shaped by their experience of private or public hospitals in their own country. The social policies and level of social responsibility for personal health in their country of origin compared to New Zealand also impacted on the participants' perceptions of healthcare delivery, the patient, and nursing care.

Health insurance schemes and private or public funded healthcare, developed either business organisations for profit, or non-profit public service delivery organisations. Those participants who came from privately funded or partially public-funded healthcare systems find poor financial awareness and accountability amongst RNs here and also a higher RN to patient ratio.

The health reforms in the 1990s and the Employment Relations Act 1991 led to deterioration in working conditions for nurses. There was little negotiation between employers and employees' unions and the relationship between employers and employees

became very confrontational which has taken a psychological toll on nurses as well as affecting the work climate. The Employment Contracts Act 2000 has led to an improvement in conditions but they are still below the early 1990s level of remuneration. These differing historical, cultural, political and economic values of countries shape their healthcare system and impact on the participant's perception of our health care system.

Participants noticed the differences more than the similarities. We do not notice that which happens all the time as readily as we do differences or changes. This links in to not being able to see our own culture as we are immersed in it, as described by Sussman (2000) and illustrated by Anna by her comment that her country did not have a culture. The familiar is not easily discernable.

Current hospital culture is politically correct, accountable and seeks accreditation by industrial bodies. Accreditation and accountability impacts on healthcare delivery with particular reference to informed consent, patient rights and protocols. Alongside the legal Acts governing healthcare professionals, the safety and standards in healthcare organisations are expressed through the use of policies and protocols. Given this climate, should a patient be discharged too early and their condition deteriorate the legal and public implications are magnified. Therefore we err on the side of caution and lengthen bed stays in hospital.

Cultural, social and environmental factors influence the role and knowledge of both RNs and patients. In some cultures patients delegate personal responsibility to healthcare professionals due to their knowledge base and cultural expectations of the role of doctors and patients. The institutional and cultural perceptions of hierarchy and authority also contribute to the scope of practice of the healthcare professional and role of the patient. Society and culture set boundaries for the role and scope of practice of the RN, and history assists in influencing the hierarchical position of nurses. Nursing knowledge is not seen as a separate entity but indelibly linked to medicine. Nursing knowledge does have links to the biomedical model but also has its own body of knowledge which, although different, is of equal importance.

Differences in standards of nursing care due to training and cultural differences, the expansion of the scope of practice, the different levels of untrained to trained nursing staff and the ratio of RNs to patients were identified by participants as factors altering nursing care delivery between New Zealand and their country of origin. The personalities of those in charge and in management had a large impact on the ward environment and the support offered to participants. Despite the differences in the work environment and culture participants found nursing tasks remained the same.

From a historical aspect New Zealand is viewed as being a young country so therefore does not have the rich history and long-held traditions of other countries. This relative newness was commented on by one of the participants in relation to the relative ease with which changes could be made in healthcare policies here. English-trained nurses followed the path of the colonisers from England and training in New Zealand has been closely linked to the British training rather than the American. Traditionally nursing had a strong oral history, however, today the written word is more legitimate and knowledge is sometimes lost. Nursing handover and teaching was all passed on orally with or without demonstration to other staff. New Zealand's history has helped to shape the more relaxed attitude to work that participant's found here.

Nursing Similarities

One of the similarities, which was highlighted by all of the participants, was the fact that nursing care was fundamentally the same wherever they had come from and worked previously. Aspects of nursing care identified as the same were patient education, post-surgery care, similarities in equipment and procedures. One participant referred to not only the nursing care as being similar but also the patients being the same wherever you worked. When initially asked what some of the similarities were between working in her home country and working in Auckland, Anna initially identified equipment only but as the conversation progressed also spoke of the similarities in nursing care. Once again that which is familiar is not as easily seen. The perception of the universality of nursing care was highlighted as four participants viewed it as the same worldwide.

I still think the whole public system is still very similar to the National Health Service in England. If you are looking at the system I think it is very similar, and the workings of it and the issues and the politics of it all, definitely very similar. Within nursing, yeah, you are still using the similar type of drugs but they have different names and different brands and you are still doing the same procedures but perhaps in a slightly different way. Certainly the same sort of ethos within nursing, like the care planning, the management of the patients and the running of a ward and team nursing.

(Maria)

I think all the basics, how you make the bed, all of the skills and turning and rolling, all the basic fundamental nursing skills are the same.

(Hannah)

Absolutely the same...it is almost everywhere it is the same. Almost everything though, if you look at it, the monitors, the equipment, everywhere is standard, all over the world. Equipment is the same everywhere but protocols are slightly different.

(Rachael)

The current focus of health care on primary health is occurring in other countries as well as in New Zealand. Primary health focuses on education and health promotion, prevention of and early intervention in disease processes, community health services to assist in effective, efficient healthcare delivery and improving personal responsibility for health. The shift in emphasis from tertiary services to primary health care is necessary not only politically and economically, but also to increase personal responsibility for health.

The similarities in the practice of RNs assist in the transition experience as they provide a fundamental link between members of the nursing profession.

Oh and then there is the whole issue of primary care in public health and stuff like that. We have a lot of the same issues that New Zealand has, where people who live

out in rural areas don't get some kind of healthcare access. There is a big push for primary care being cost effective in the long run and all of this benefit. They are trying to get all this preventative healthcare out there to keep people from coming into the hospital and saving money and... Yeah there is a lot of primary health.

(Hannah)

Network Development/Support Systems

Network development covers internal (work) and external (family and friends) support networks. The support can be ongoing or intermittent. Initial support was an important factor in assisting with the transition experience. All participants spoke of the level of support from their work colleagues. There was a direct correlation between the level of support received and the level of positive feelings regarding the transition experience.

Mary, who is doing the competency programme, and she is quite supportive. Any problems, accommodation, whatever inquiries you had, she would help so I think you could set up everything pretty much before coming here. You could set up your accommodation and everything so that when you come you just don't have to...you are not being stranded. But I don't know about this because of the competency programme. I don't know if I had to go on my own what it would be like. I found that the support was really good.

(Louise)

They [agency] were really good in that they were very good at keeping contact with us. And when we met them in London and we decided to go through with it, David didn't have a job at that time so we were going on my job and they always kept in contact with us. And there was a lot of problems because we couldn't sell our house in England and one thing and another, so we actually came a lot later. And they kept saying they were actually holding the job open and they arranged us accommodation

for two weeks, which was really good and it couldn't have been in a better or nicer place.

(Maria)

I felt that they [the agency] did offer me a reasonable amount of support. However my problem was that I wasn't up to speed with the general ward work.

(Catherine)

They [agency] sort of put me in the right direction. They told me what I needed to do for my own side, all the paperwork and stuff and they were quite good on that front and then once I actually got here they arranged someone to pick me up from the airport and met me. They kept in touch by phone for the first month or so, but I wouldn't say that they were really supportive. I suppose they would have been there if I had wanted them for something. I think it was a case of right we have got you the job and now you are there so get on with it.

(Gail)

Definitely if I look back it was definitely the agency. Although it didn't work out and they misplaced me, the links there were really good. They did help us no end. They were excellent and they really helped us when we first got here. Other new staff, other staff from overseas, you know, even just other English people like I met a really good friend who was German and I still keep in contact with her. She said exactly the same type of things. I think other overseas nurses you kind of migrate to those people that have the same qualms as you have. Definitely the ward I work now, the Charge Nurse definitely kind of helped. Said is there anything we can do to make things a bit easier? Because we did go through a time of thinking we are just going to go back this is too hard. It is the people or the opportunities that you get that help you through that transition.

(Maria)

The level of support from the work environment in the form of familiarisation and orientation within the first few weeks of commencing work tended to indicate the level of ongoing support which could be expected on the ward. A good orientation programme was valuable to the participants as a means of learning about their new work environment and also identifying people who were able to provide support in the work environment.

They assign you to a senior preceptor for the five weeks, by which time you should be able to take care of patients. Even after that there are a lot of people who support you.

(Louise)

I had two weeks orientation with somebody, which was okay. I didn't feel that I needed that two weeks orientation. In fact I am not usually used to working alongside somebody. So after the first week I was more or less on my own and I could go to that person when I needed to, which is good. To have somebody identified as the person who you could go to is very good.

(Gail)

Two participants recruited for particular jobs by agencies initially had negative orientation experiences. Neither of them stayed in these jobs but found other employment in more supportive environments.

I had just arrived in New Zealand. All the promises of the buddying system, the orientation never happened and then I was left in charge with other agency nurses who didn't know the system and this is at a private hospital where the cardiologists and cardiothoracic surgeons asking me stuff that I couldn't answer. I went back and fed this back to them and they took that on board but I said I had to leave and that is when I made contact with AAA and I just thought to go back to into the public system because at least I know that there is always people around.

(Maria)

I did explain to the lady that I was a bit rusty on ward work, so she organised me to have orientation time. Looking back it just wasn't long enough for me personally. It was quite scary because I came into a very busy surgical ward where people were all tubed up and the last time I saw a patient like that was when I was working on Intensive Care. Nursing has evolved a lot since I was last there. I rapidly realised that I needed more mentoring, more support and almost start again at the bottom and work my way up.

(Catherine)

Both participants found different areas of work independently within the public hospital system that was better suited to their experience and offered more support. The second orientation experience was positive for both of them.

I think once I started at hospital I felt I could relax there and learn the technical procedures at a slower pace, rather than be expected to know them and feel that I was letting the side down.

(Catherine)

I made contact myself with the hospital and their normal protocol for all new staff, they do like a six-eight week orientation, and I worked with somebody for six weeks, which was really good, and they just showed you everything and you were never left on your own and all the drugs. All the protocols, all what the doctors did and each step by step, all procedures that you had to go off and help with. All emergency procedures, someone went through everything with you. That was really good. Somebody was always with you and that was much better.

(Maria)

Five participants came with family members and one of these also had friends in Auckland. One participant had friends in Auckland and another had friends in Christchurch. The three remaining participants knew no one in New Zealand prior to coming here. The value of having friends and family in New Zealand, or migrating with friends or family members to

provide support assists in the transition experience and also influenced to some degree why participants chose Auckland over other places in New Zealand. Where established support networks existed they featured strongly in participant's decision on where to live in New Zealand. The potential to develop support networks was also considered when deciding where to live therefore larger cities were chosen.

We couldn't decide where to go. We had a friend in Auckland and somebody in Wellington, so it was a toss up between the two.

(Deidre)

We have got two friends who live out in Albany. They weren't the reason we came to New Zealand, but I think they were probably the reason why we came to Auckland. I think we would have probably still come had we not. It would have made it more difficult because our friends were very good to us.

(Catherine)

I did have two friends here who joined a few months before me who trained with me in India, and work also in ICU even though we don't do similar shifts, but it is a help. It is just the little things that you want to know about, how things work around here. I think anyone would pretty much help you with that. It does make a difference, for sure, if you know somebody. At least they can give you little tips in the beginning, not so much at work but out of work. But then I really feel that I can approach people and ask them about that.

(Louise)

Maria discussed the difficulty in establishing friendships and developing networks here, as there wasn't the same social activity within the work environment she was used to. Going out with work colleagues had previously provided a means of debriefing and developing team cohesion. Other participants also discussed the benefits of developing networks.

I think that was just hard and in general being homesick, so missing our families and just the whole work ethos had completely changed and we didn't realise. We weren't prepared perhaps for the jump backward that we had to take. Now we have and I think the lifestyle that we came here for and the friends that we have made is excellent.

(Maria)

I do get on with the girls at work they are lovely. But that kind of close-knit friendship that perhaps I had in England has just never happened. Outside of work it has, which is really good, but within work, your colleagues, you work with them, you go home and that is it. My Clinical Charge Nurse has been excellent. She generally says how are you doing? How are you getting on? And things I have not been happy with I have been able to say, look I am quite concerned about this and I have raised issues, like safety issues and things like that. I can only ever say that within New Zealand people are really friendly they are really willing to help you. Nobody seems to be out purposely not listening or not pay any attention. They do generally want to help you.

(Maria)

On reflection Maria wondered if having a resource person or network of people who had been through a similar experience and could share information they had found useful when they first arrived would be helpful to assist in coping with the transition experience.

Sometimes you wish. I look back and I think I wish there had been somebody or another person who is like me now that I could go to and say, I am finding all these things really, really difficult what do you think? But at the time there isn't. A resource where you could have a little informal meeting and say, how are you finding things? I have met a lot of Philippine girls at work and they are just leaving and when you talk to them and they say, how have you found things and I say,

initially very hard and it is very different and they are saying exactly the same things. I think it is a career recruitment issue.

(Maria)

Tapping into resources that have been formed by other nurses from the same country was another good source of support and friendship. Through these contacts a good support network has developed amongst the Japanese nurses in Auckland. Another area of support mentioned by all participants was group commonality, therefore participants often migrated towards other nurses who have had or are having a similar experience. Participants often primarily developed networks with their co-nationals here. Cross (1995) identifies the need to establish both relationships with co-nationals if available and also members of the host country to assist acculturation.

There are some Japanese nurses working with me and I have had some information from them before I actually started work. That is really essential to know the system.

(Amelia)

We have some like Japanese magazine and I saw the article about the one Japanese nurse was in AAA Hospital and that is why I contacted her and get information. Because she told me that she found it very difficult to adjust to the new environment in this country. She also didn't know anybody working in a hospital in this country so she wanted to help somebody working in this country, so that was a great help. And also I feel to mention about it because there are so many number of Filipino nurses and Indian nurses working in this country and they usually know each other and they can get lots of exchange information with each other so that they can adapt much, much more quicker than us. We don't know anything about this sort of thing. I feel for overseas nurses it is very important to know and get the information from somebody who knows much better.

(Amelia)

We had the best of it. People were very willing and you went to people and they did try and help you, but it was just struggling your way through the system that you haven't got a clue about. As I say, trying to find people in a similar situation. I made friends with a girl who had just left Auckland and I still keep in contact with her and she had been out from England for nine months, so she was really helpful. She said all the same things and that helped me.

(Maria)

I think it helped me that on the ward there was a couple of people who were also English and English trained and I could go to them and say, is it me or do we do things differently here to what we do at home? I kept thinking, well maybe it is just me. Maybe I am just a bit daft or something. It helps to have that common base to go back to and just check back and say; well this is how we would have done it.

(Gail)

Initially we found it really, really hard to...you end up migrating towards English people. You wanted to make friends and get to know the New Zealand culture but everybody is very established and I think perhaps it was just making friends and trying to not change your ways. 'Cause like I was saying earlier, you can't keep saying, in England we did it like this, because you have come to another country, that is why we came here. You want to fit in. You are trying to fit in but I found that really hard. Not now because we have some excellent friends that are really good friends. English friends as well, but the English friends keep talking in about going back and a lot are travelling. Whereas you are trying to make friends with New Zealanders because you know they are staying.

(Maria)

All participants found the level of support they received from their work colleagues very good. This support was in the form of friendship, knowledge sharing and assistance in the workplace. There were incidental people who were not supportive in some instances but overall the level of support received in the workplace was highly regarded.

I found them [ward staff] very helpful and very supportive.

(Catherine)

Overall I find that Kiwis and New Zealanders are more patient and friendly and polite, and so that has been very helpful when you are in your first year of transition. People are more willing. They don't bite your head off like sometimes they did when we were learning in teaching hospitals in the US. Most people are really quite supportive and then you quickly sort of build up ways of coping with the people who aren't supportive. You kind of ignore them or you don't go to them for help or whatever, but most people have been pretty approachable. We have CNAs [Clinical Nurse Advisors] and CNEs [Clinical Nurse Educators] who are really good to have. You can always go to them and they will help you and that is nice to know. There is different outlets and areas you can go to for help, not just one.

(Hannah)

I had quite a lot of support from Helen [Clinical Nurse Educator]. She is very good. From the start really, she has made it clear that if I have got anything, then I can go to her, so that was a good thing initially. She has been a really good help.

(Gail)

Developing support networks and interests outside of work were equally important in assisting the transition experience.

My other support networks outside of nursing. I think you have to have...if you don't have good coping mechanisms and you don't have other things in your life that are supportive, it is really hard to do a good job as a nurse at work.

(Hannah)

Well I think it is very sociable where I work. There is lots of people, young single people from overseas, so there is always social events going on, so that has helped. You have a small social life right from the word go.

(Deidre)

In the nursing differentials some of the participants mentioned the lack of team spirit. This crosses over into this section as the support and teamwork was lacking in some areas. Consistency of support is important. The personalities of people on the ward affected the ward environment and the level of support received.

I didn't feel supported by anybody. It was quite difficult. I think that I could have had more support from the Charge Nurse. I found it a real hindrance that I just arrived there and the first day was good and it was all very nice and then after that it was as though I didn't exist. It was like, well you are here now, you have just got to get on with it, you are part of the team now. I felt as though if I had had a bit more support and a bit more input from her, things might have been a bit easier. She just didn't acknowledge that I was there after the first day or that I was new and might need a bit of extra help, push me in the right direction. I think as a group, as a team in that ward, they could have been more supportive. They are not very accepting of new people, I don't think. It might be that particular place. I don't know but you spend eight hours a day working with a group of people and it is hard when you are new. You want people to be around, people that you can go to and ask. It is a hell of a lot easier if you feel that you can do that. I didn't feel that for quite a long time, that I could do that.

(Gail)

Both initial and ongoing support was valuable in easing the transition experience. The development of participant's networks iterated the necessity of internal and external support. Adapting to being part of a smaller system, e.g. not so closely tied to the European Union, was challenging for some of the participants as they felt there was not the same strength to guidelines here. When support networks were developed with people from the

same culture, similar cues and experiences were shared to help make sense of aspects of their transition experiences. Kennedy (1994) states forming networks and relationships with people from your own country is a good form of support but can impair socio-cultural adjustment. As identified by Ward and Rana-Deuba (1999) it is necessary to form networks with people from both the primary and the secondary culture to assist with acculturation. Utilising Berry's (1997a) strategies all participants were actively using the concept of integration as they were maintaining aspects of their own culture and still identified with it while also attempting to participate in New Zealand culture through social networks. Certainly good support networks assisted participants through the second and third phases of culture shock, namely the disintegration/culture shock phase and the adjustment/reorientation phase (Pedersen, 1995).

At the beginning I often felt quite anxious and really nervous thinking where is your back up here? What is this based on? It was hard initially but past six months it got easier and I think just from feeling more settled within the place of work and getting to know people and you are just learning more about the way things are done here.

(Maria)

It is not just a different work culture participants have to adjust to, but to a different culture outside of work also. Finding out about the geography of the city, public transport, where the nearest supermarket is, is all necessary. Local knowledge such as this may also need to be imparted if non-New Zealand-trained RNs have no contacts here. The cultural differences e.g. pub culture versus outdoor life mean new ways of developing networks need to be learnt. As family members and friends are not in New Zealand it is necessary for participants to gain other means of support and develop other coping mechanisms. Part of the preparation before coming here could be getting first hand knowledge from someone else that has come from same background and can share his or her experience.

Personal Variables

Another point that became apparent was the uniqueness of each participant's experience and the significant part personality and circumstance play in the transition period. Participants had been prompted by a variety of reasons to come to New Zealand. All the participants had chosen to come to New Zealand to work, although sometimes circumstance played a part in the choice, e.g. their age would not allow them to get into Canada or Australia. For some it was one of many options and circumstance then assisted in the decision to come to New Zealand. For others it was the only place they wanted to migrate to. The level of commitment on its own did not affect the transition experience but the personality of the person did.

My parents live here half of the year in the South Island. They have a little bach down there, and I came to visit them and just liked it so much that I wanted to try living here.

(Hannah)

I wanted to get out of Saudi was the main reason and, I didn't want to go back to work in England. It was just a place that I knew I could come to and it was just a good place to come and work.

(Gail)

The place wasn't really important. I wouldn't have come if I didn't have a job offer. I didn't really want to look for a job. It was just because the unit and the course itself was an attraction and that is what I wanted and that is why I came. Everybody comes with a...it depends on why you come here, and for me it was just a job.

(Louise)

Just only because I heard that the country is good to live, lifestyle, plus I wanted to travel and I look at it as see, actually I decided to live in the US but after that happened with World Trade Centre, that terrorist attack, my spouse was very

uncomfortable and didn't want to live there. Then I thought some other country. It was my brother-in-law who told me that New Zealand is the best place to live and the nursing practice is just coming up so I come to New Zealand and we will try.

(Rachael)

I could choose Canada, or Australia, or New Zealand and I choose New Zealand because here is not a big country and lots of things very similar to Japan.

(Amelia)

I just fell head over heels in love with the place, the culture, the weather, the people, the toilets, the food. So after that we decided we would have to get the children to buy into it because of the age that they were, so last year we came with two of the children and they both said, yeap, go for it.

(Catherine)

Having chosen to come to New Zealand other factors besides having friends in Auckland, as already mentioned, influenced the decision to come to Auckland.

Well, I didn't really choose Auckland. I was initially going to go and work in Christchurch because I have got friends down there. I went through the agency, I didn't apply direct and they kind of suggested to me that Auckland might be a better place to come. I was pushed in that direction by them.

(Gail)

It would be so different from London to like a remote place and we know we needed to make friends and make friends through work and try and settle, otherwise you just think, we are going to go back again. That is how we ended up in Auckland, and I think most of the jobs are available in Auckland.

(Maria)

It is quite straightforward to come from Britain to New Zealand. It is still in the Commonwealth. You don't need to sit the final exams. They recognise your qualifications. But we also did come out with a view to possibly staying.

(Deidre)

The participant's personality was an important factor in how they interpreted their interactions with others and their transition experience. Louise spoke of other RNs having racial issues and identified it as their problem and part of their personality and found they were not interested in finding out about India. An example Louise gave in conversation was the differences in basic nursing care. Indian nurses were still delivering these cares i.e. 2 hourly turns, assistance with eating, and reassurance but were viewed by some other RNs to be doing too much for the patient. The comment was made "They [patient] will expect us to do that now". Certainly these RNs showed no awareness of their values and attitudes and there was no reflective practice in their perceptions of non-New Zealand-trained RNs and their effect on the work environment.

People would say things and you would take it personally because you were a bit like, you don't understand where I come from, and I would constantly get where is your accent from? And you get it anyway and you would have to say, London and everyone would go... and I started getting really fed up with that.

(Maria)

I think how successful you are and how much you learn really comes from you. It depends on how well you can adapt. How driven you are to learn. I think a lot of it really falls back on yourself and not how strong you are but how easily you can see past things and see the big picture and learning opportunities, personal growth, that kind of thing.

(Hannah)

I think it depends on you. How willing you are to adapt. If you come with an idea in your mind of what you want something to be and it doesn't turn out that way, then it would be more difficult, but I didn't come with any plan.

(Louise)

Immigration, migration people coming from overseas. People come with different attitudes and different values from how they have been brought up and people have never ever said anything like, oh you are a whinging pom, or anything like that, and nobody has ever said, but I can imagine if your language wasn't English, what a nightmare. It is difficult coming to a different country and fitting in, let alone if you are a different colour or you spoke differently.

(Maria)

The expectations participants had developed prior to arrival of the work environment, culture and other people were all contributing factors in their transition experiences. Expectations were formed from the information given to them prior to arrival, which was another reason why there is a need for information to be accurate and honest. Failed expectations can lead to disillusionment and pumping up the person's expectations can lead to poor adjustment.

I suppose it depends on what expectations you come out with really. I didn't have particularly strong objectives career wise.

(Deidre)

Just the expectation and the reality of how it is here and just perhaps general stuff like, it is quite difficult to find accommodation and again we were told it was easy.

(Maria)

Coming to Auckland not really knowing anybody. I knew that, I anticipated that but just thought things would be better at work.

(Gail)

Although difficult at times all, except one participant who has just recently commenced work and so is reserving judgement, viewed their transition experience positively. With the increasing number of RNs from overseas being employed to work in Auckland's public hospitals to ameliorate the very real shortage, acknowledgement and understanding by both the nurse and his/her colleagues of the stress and challenges involved in the transition to a new country and work environment is important to promote understanding and cohesion in the workplace.

Chapter Four

Discussion and Conclusion

According to Denzin and Lincoln (1998: 221) “Theory is used to focus the inquiry and give it boundaries for comparison in facilitating the development of the theoretical and conceptual outcomes”. When commencing this research, one of my assumptions was, that there was not enough acknowledgement or understanding of the support required by non-New Zealand-trained RNs migrating to New Zealand when they face stress and culture shock experiences. From the comments made by other RNs, which prompted me to undertake this research, and also comments made to me in the course of the research, I have formed the view that the benefit of RNs understanding participants’ backgrounds and the factors influencing their transition experience through reflective practice is substantial. As identified in the literature participants moving away from their usual support systems, establishing a new life, orientating themselves to a new culture and environment, and forging new relationships all influence the participants’ transition experience. It is awareness of these factors external to the work environment that New Zealand RNs working with non-New Zealand-trained RNs need to be aware of as these impact on acculturation.

Both the participants and the literature highlighted the importance of support systems in the transition experience. Developing a support system is essential as a lack of social support contributes to culture shock (Pedersen, 1995; Anderzén & Arnetz, 1997; Furnham & Bochner, 1986; Ward, Bochner & Furnham, 2001; Winkleman, 1994). Support systems were utilised by participants as a means of providing information about the culture and environment, as people to share experiences with, and physical and psychological support. The majority of participants found the level of support provided by colleagues very good, but acknowledgement and understanding of the cultural differences in the work environment requires improving. Participants did not report any horizontal violence being directed at them.

Culture shock provided the framework for the exploration of the transition experiences of non-New Zealand-trained RNs. It is not only the manifestations of culture shock such as rejection, confusion and anxiety which it is important to develop an awareness of but more importantly, the opportunity for personal growth and development and positive insights that the culture shock experience can provide (Pedersen, 1995; Mantovani, 2000). This correlates to the reflective nature of critical social science and exploring the values and beliefs, which underlie our constructs of reality. Utilising a critical approach enables exploration of and identification of the factors which have contributed to the formation of different cultural ways of being and doing. The six predictors identified on p.18, are useful tools to find out more about the individual and develop an insight into the degree of culture shock likely to be experienced.

Culture shock was not only experienced by participants but is also being experienced by New Zealand RNs due to the shift in position from the cultural majority to the cultural minority in many areas. In the area that prompted this research the acculturating group had become the majority even though they came from a multitude of different cultures. When delivering recruitment posters to the wards one Charge Nurse reported that about 80% of her workforce were overseas nurses (C.G. personal communication, 12 January 2002). One of the challenges created by this situation was the overseas nurses speaking their mother tongue at work, as the English-only speaking nurses felt left out and talked about, therefore a carefully worded memo was developed along the lines of, 'to the clever people who can speak a second language we need to develop a common language therefore English is to be spoken at work' (C.G. personal communication, 12 January 2002).

Focus needs to be given to the impact on RNs already working in New Zealand and their experiences of culture shock due to the large number of overseas nurses coming to work in Auckland's public hospitals and the disequilibrium which has occurred with New Zealand RNs often being the minority within the ward environment. The points listed in the section on managing culture shock such as recognising, identifying, and acknowledging the patterns of adjustment are of equal relevance to New Zealand RNs. Culture shock is viewed as a natural process for those people coming to a new environment, but for New

Zealand RNs in a familiar environment culture shock is often overlooked. There is an adjustment process for New Zealand RNs whether they are in the majority or minority, as presently they are not expecting or thinking of the impact of overseas nurses on both the work environment and themselves. Certainly from the comments made to me and from my observations during the course of this study, there was initially a negative reaction from some RNs working on the ward towards non-New Zealand-trained RNs. As time progressed and acculturation occurred for both the non-New Zealand-trained RN and the New Zealand RN the negative reaction decreased.

The literature on culturally competent care is also relevant to being culturally competent with colleagues. Self-awareness of “how their own cultural origins affect personal beliefs, behaviours, and ways of interacting with people on a professional and personal level” requires development amongst RNs (Hickey, Ouimette & Venegoni, 2000: 255). It is necessary for both the migrant and the host to develop this awareness and understanding in order to minimise the culture shock phase of the transition experience for all concerned. The number of overseas RNs gaining registration in New Zealand substantiates the need to become culturally competent with nursing colleagues.

As evidenced in the analysis Western trained, English-as-first-language speakers also experienced culture shock coming to work in New Zealand. The challenges encountered and differences noted were often similar as for those participants with English as a second language. It was the degree of some of these that varied e.g. communication, negation of attributes.

Prior preparation did impact on the transition experience. Having knowledge of the patterns of adjustment, responses and reactions that characterise culture shock and also prior learning about the secondary culture helped to alleviate the level of culture shock experienced (Berry, 1997a; Churchman & Mitrani, 1997). Prior exposure to other cultures through travel or having previously worked in another culture also decreased the impact of culture shock, as participants were more aware of the processes and phases involved. Prior learning about the secondary culture also minimised unrealistic expectations. The

importance of good, accurate communication between the employer and employee was also an important factor in preventing unrealistic expectations from developing on either side.

Having English as a first language assisted in making the transition experience easier. For those participants for whom English was their second language this provided a further challenge and made the transition that much more difficult. Passing the IELTS test does not always equate with effective communication in the work environment. Understanding of the variations in language, accents, and different ways of communicating is required. Safety is of utmost importance in the work environment and good communication is essential in achieving it. Our culture is reflected in the way we communicate, think and interact. The importance of having an understanding of other cultures and different communication styles is illustrated through out the research.

All participants stated that nursing practice and nursing care was similar in New Zealand to nursing practice and nursing care in their home country. Although some aspects of nursing culture are different in each country due to historical, political, and social factors, there was an overall perception of the constancy of nursing culture worldwide. Having the distinct role of a RN as a reference point and the similarity of nursing practice and nursing care worldwide helped to ameliorate the culture shock experience. The cultural diversity of RNs impacts on the culture of the work environment. Difference needs to be valued rather than marginalised. It is clear that in our changing society bilingual RNs and RNs with different cultural backgrounds are valuable resources whose value must be recognised if we are to ensure access to health services and culturally appropriate care.

Acknowledgment of nursing experience and personal knowledge is paramount to maintaining a healthy, enthusiastic workplace. Having one's experience and personal knowledge negated led to frustration and disillusionment. Negation of attributes is, at times, psychological horizontal violence. The recognition of both previous nursing experience within the leveling system and portfolios of equivalence needs to be addressed. Accurate, individual assessment of the level of nursing practice and nursing knowledge is essential to assist with appropriate recognition of nursing experience.

The findings illustrated the many differences participants identified between nursing in their home country and nursing in Auckland's public hospitals. The differences stood out more than the similarities therefore differences constituted a greater proportion of data. The superficial differences assumed more importance than, and often disguised the underlying similarity. Differences were judged in relation to how that aspect had been in the home country, e.g. equipment, protocols and scope of practice, and found to be either lacking or a positive learning experience. Changing practice to conform to the new environment was challenging at times when participants perceived their way of doing as better. As with any change there needs to be understanding of the process to assist with acculturation. The value of utilising EBP and critiquing practice to facilitate learning from the knowledge and experience of non-New Zealand-trained RNs is important.

Limitations and future directions of this research

Having to formulate interview questions to gain AEC approval I found limited my spontaneity in interviews and at times I felt the interview was a little stilted. This was due to both my background as a RN and consequent perceived professional responsibility to maintain ethical practice by adhering to the questions I had received ethics approval for, and my inexperience as a researcher.

Nurses are not an easy group to recruit as participants. I reached the minimum number of participants as outlined in the methodology through the enthusiasm of nursing colleagues. Developing networks assisted in participant recruitment and iterated the importance of research 'buy in' by key people. Verbal recommendation or physical contact was necessary to develop; interest in the research. Poster recruitment was not enough.

When recruiting participants five non-New Zealand-trained RNs who had been working in Auckland's public hospitals between 15 months and five years contacted me. Due to the length of time they had been practising in New Zealand they were excluded from my research. All of them were disappointed and really wanted to talk to me about their

experiences. This illustrated the potential for this research to be extended to non-New Zealand-trained RNs who have been working in public hospitals for longer than 12 months.

Conclusion

The research illustrates not only the impact of New Zealand RNs on non-New Zealand trained RNs, but also non-New Zealand-trained RNs on New Zealand RNs. Combining the stresses of re-location with adaptation to a new nursing culture means some experience of culture shock is inevitable. All participants did experience culture shock but, all except one who is reserving judgement, viewed the final outcome as positive in spite of misgivings and frustrations en route. Certainly there were differences and challenges in their transition experience, but the personal characteristics of the participant, the supportiveness and attitude of staff, and the effectiveness of local networks assisted in the experience being viewed positively. The positive view of the transition experience by participants does not mean New Zealand RNs can be complacent and not evaluate their impact on the transition experience of non-New Zealand-trained RNs.

If present trends continue more and more New Zealand RNs as well as non-New Zealand-trained RNs will be experiencing culture shock. To improve the recruitment and retention of RNs there needs to be an increase in cultural studies for New Zealand RNs to foster self-awareness and to value and understand differences in other cultures. Awareness of the self and the cultural, historical, economic, and political factors which influence our thinking, judgements, and ways of being increases understanding of cultural differences and diversity and assists in alleviating culture shock. For non-New Zealand-trained RNs there needs to be encouragement to recognise their own culture and instruction in the basis of New Zealand culture and its nursing culture. The experience and knowledge of non-New Zealand-trained RNs also needs to be recognised and acknowledged. Lastly, communication is an essential part of nursing practice and was an area some participants identified as hindering their transition, therefore good communication and mentoring systems need to be established.

Appendix I Information Sheet³

Information Sheet

First year here: A study of non-New Zealand-trained Registered Nurses in their first year of practice in New Zealand.

Introduction.

My name is Amanda Lee. I am a Registered Nurse undertaking my Masters thesis in Anthropology at Massey University (Albany) under the supervision of Dr. Eleanor Rimoldi. I am undertaking a study on the experiences of non-New Zealand-trained Registered Nurses in their first year of practice within public hospitals in the Auckland region.

You are invited to take part in this study of the experiences of non-New Zealand-trained Registered Nurses in their first year of practice in New Zealand. If you are willing to participate please return the consent form within 2 weeks.

About the study.

The aim of the study is to identify the differences and similarities between nursing in New Zealand and overseas, and identify the positive and negative aspects of your experience. Between 10-20 participants will be recruited. As a research participant you will be required to participate in an interview of ¾-1½ hours duration. I would like to audiotape the interviews. The audiotapes will then be transcribed in confidence by a third person who has signed a confidentiality agreement. Once the audiotape has been transcribed a further meeting of approximately ½hours duration to enable you to verify the interview content can be arranged.

The information gained in the interview will be used only for the research study and any publications resulting from it. All information will be kept secure and confidential. On completion of the study data will be securely stored.

³ The Information Sheet, Consent Form and Confidentiality Agreement were printed on Massey University letterhead.

Benefits, risks and safety.

The benefit of the study is an improved, positive transition experience for non-New Zealand-trained Registered Nurses. If you feel unhappy or disturbed following the discussion and would like to talk with someone about it counselling is available. Please contact the Occupational Health Department at your hospital for details of the Employee Assistance Programme.

Participation.

As a participant you have the right:

- To decline to participate
- To refuse to answer any particular question
- To stop the interview at any time
- To withdraw from the study at any time, up until such time as the final draft of the research is completed
- To ask any questions about the study at any time during participation
- To provide information on the understanding that your name will not be used unless you give permission to the researcher. A pseudonym will be utilised if necessary
- To be given access to a summary of the findings of the study when it is concluded

General.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation. If you need to contact either Dr. Eleanor Rimoldi or myself please use the contact details below:

Dr Eleanor Rimoldi
School of Global and Cultural Studies
Massey University (Albany)
Private Bag 102 904
North Shore Mail Centre,
Auckland

Ph (09) 443 9046

Amanda Lee
School of Global and Cultural Studies
Massey University (Albany)
Private Bag 102 904
North Shore Mail Centre,
Auckland

Ph. (09) 443 9700 Ext. 9173/9164

Confidentiality.

No material which could personally identify you will be used in any reports on this study. Data will be kept in a secure, locked file at Massey University both during and on completion of the study. If you would prefer your tape can be returned to you.

Results.

On completion research results will be held as a thesis at Massey University library.

This project has been reviewed and approved by the Massey University Regional Human Ethics Committee, Albany Campus, Protocol MUHEC 02/047. If you have any concerns about the conduct of this research, please contact Associate-Professor Kerry Chamberlain, Chair, Massey University Regional Human Ethics Committee, Albany, telephone 09 443 9799, email K.Chamberlain@massey.ac.nz.

This project has been approved by the Auckland Ethics Committee.

Appendix II Consent Form

Consent form

First year here: A study of non-New Zealand-trained Registered Nurses in their first year of practice in New Zealand.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time, up until such time as the final draft of the research is completed, and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

I agree/do not agree to the interview being audio taped.

I understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:

30/10/02 ver.2

Appendix III Confidentiality Agreement

Confidentiality Agreement

I, in signing this agreement understand any information contained in the audiotapes I transcribe is confidential and therefore will not be discussed by myself with anyone.

Name:

Date:

Signature:

Appendix IV Recruitment Poster



REGISTERED NURSES

DID YOU TRAIN OVERSEAS?
AND
COMMENCE WORK HERE WITHIN
THE LAST YEAR?

I AM A RN COMPLETING A MASTERS DEGREE
AND I WOULD LIKE TO HEAR YOUR
NEW ZEALAND EXPERIENCES.

Please contact Amanda Lee at Massey University
(09) 443 9700 Ext. 9173/9164
if you are willing to participate and
leave your contact details if I am unavailable

(Interview would take approximately ¾-1½ hours of your time)

Appendix V Interview Questions

1. Where did you undertake your nursing training?
2. Had you recently been working as a Registered Nurse before coming here?
For how long?
3. Have you worked in other countries before?
4. What factors featured in your decision to come to New Zealand?
5. What did you know about New Zealand before coming here?
6. What did you know about Auckland before coming here?
7. What did you know about the New Zealand healthcare system?
8. Were you recruited by an agency to come to Auckland?
9. If YES – Was any support obtained by the agency?
10. When did you start working as a Registered Nurse in Auckland?
11. How have you found coming to work here?
12. What are the similarities between working at home and working here?
13. What are the differences between working at home and working here?
14. Are there any factors you can identify which have helped in your transition from
working at home to working here?
15. Are there any factors you can identify which have hindered in your transition from
working at home to working here?
16. Is there any person or group of people who has/have impacted on your Auckland
experience?
17. Overall do you view your transition to working in Auckland positively or
negatively?

18. Is there anything you feel could have improved the transition to working here for you?

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