

**CULTURALLY APPROPRIATE CARE: A
QUALITATIVE EXPLORATION OF
SERVICE-USERS' PERSPECTIVES OF
NURSING CARE**

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ABSTRACT

This research study set out to explore service-users' understanding about what they required in terms of cultural care from nurses. Situated within an interpretive paradigm, the choices made within the methodology were influenced by the writings of Hans-Georg Gadamer around dialogue and understanding. This approach facilitated a newer understanding to explore existing nursing knowledge around culturally appropriate care for a multicultural and diverse society.

Having gained the appropriate ethical approval, participants were recruited from the five main ethnic groups that represented the population of Greater Manchester: White Majority, White Minority, South Asian, African-Caribbean and Chinese/Oriental. Twenty-one participants were interviewed, using a semi-structured approach.

Utilising Attride-Stirling's (2001) Thematic Network analysis, all the transcriptions were analysed to develop Basic, Organising and Global Themes, to systematise the findings and discuss the rich data that emerged.

Unexpectedly, during the interviews participants from the Majority population and the Black, Asian and Minority Ethnic participants expressed similar needs from culturally appropriate nursing care. Specifically, what service users needed from culturally appropriate care was linked to issues around how nurses communicated inter-culturally and the influence of intersectional processes, rather than addressing different, culturally specific needs. The participants stressed the need for nurses to utilise an individualised and non-ethnocentric manner as part of their intercultural communication and congruent interpersonal skills. In order to fulfil this in a fair and compassionate way, nurses would need to develop an openness and genuine desire to engage service users in intercultural communication, and be ready to listen, enable and be curious to learn about their story.

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GLOSSARY

GLOSSARY		
TERM	DEFINITION	NOTES
CULTURAL COMPETENCE	<p>Occurs when the nurse develops the ability to bridge cultural gaps in caring, work with cultural differences and enable clients and families to achieve meaningful and supportive caring (Leininger,1991)</p> <hr/> <p>The ability to maximise sensitivity and minimise insensitivity in the service of culturally diverse communities. This requires knowledge, values and skills but most of these are the basic knowledge and skills that underpin any competency training in numerous care professions. Their successful application in work with diverse people and communities will depend a great deal upon cultural awareness, attitudes and approach of the nurse (O' Hagan, 2001:235)</p> <hr/> <p>A process and an output, which result from the synthesis of knowledge and skills that we acquire during our personal and professional lives and to which we are constantly adding (Papadopoulos, Tilki and Taylor, 1998:10)</p>	<p>Three definitions were provided to show the evolution of this term over a few decades</p>

GLOSSARY cont.

TRANSCULTURAL NURSING	A formal area of study and practice focused on comparative holistic culture, care ,health and illness patterns of people ,with respect to differences and similarities in their cultural values, beliefs, and practices with the goal of providing culturally congruent, sensitive and competent nursing care to people of diverse cultures (Leininger, 1995:4)	
CULTURAL CONGRUENCE	To be culturally congruent related to the nurse’s ability to bridge cultural gaps in caring, work with cultural differences and enable clients and families to achieve meaningful and supportive caring. In being open and ‘sensitive’ to the differences, the nurse’s role is to discover ‘the local (insider) views’ to become an authority on variations in norms and values with that group (Leininger, 1978:36)	
CULTURAL AWARENESS	The degree of awareness we have about our own cultural background and cultural identity. This helps us to understand the	

	importance of our cultural heritage and that of others, and makes us appreciate the dangers of ethnocentricity (Papadopoulos, 2006)	
ETHNOCENTRICITY	A state comparable to racism, where one believes that one's culture or cultural facet is the superior or best culture. Ethnocentrism is judging another culture solely by the values and standards of one's own culture.	
INTERCULTURAL COMMUNICATION	A communicative process involving individuals from reference cultures that are sufficiently different to be <i>perceived</i> as such, with certain personal and/or contextual barriers having to be overcome in order to achieve effective communication (Aneas and Sandin, 2009)	
INTERCULTURAL COMMUNICATION APPREHENSION	The fear or anxiety associated with either real or imaginary, anticipated communication with people from different groups, especially cultural and/or ethnic groups (Wrench et al., 2006)	

ABBREVIATIONS

ABBREVIATIONS		
CAC	Culturally appropriate care	Encompasses all ideas around cultural care philosophies, models or terminology found in nursing
BAME	Black, Asian and Minority Ethnic groups or communities	
SSI	Semi-structured interviews	
TN	Thematic Network	In reference to Attride-Stirling's Thematic Network analysis framework

CHAPTER 1: INTRODUCTION

This research study entitled *Culturally appropriate care: A qualitative exploration of service-users' perspectives of nursing care* was driven by the need to explore culturally appropriate care (CAC) from a service-user¹ or patient perspective. This introductory chapter will provide the rationale and general context within which an exploration of service-users' needs and perspectives regarding this aspect of nursing care has been carried out. It will be followed by the objectives for this research and an explanation of how the chapters in this study have been set out.

1.1: BACKGROUND CONSIDERATIONS OF THIS RESEARCH

This first section will explore the context in setting the scene for this research. In this thesis, the term culturally appropriate care (CAC) has been used to encompass all the different concepts that have emerged or are utilised, from the various cultural care theoretical frameworks within nursing (a more in-depth explanation of these theories will be considered in Chapter 2). This was intentional in that it integrated all the theoretical frameworks, terminologies and expressions I found within the literature that argued for the importance of delivering cultural nursing care as a way of improving service-user experience. As the ultimate aim of all these varying terminologies and concepts of nursing care were similar, I felt that no singular concept or framework could exclusively be said to be more relevant over another. The utilisation of the global term CAC enabled me to consider the breadth of varying terminologies, arguments and perspectives under the subject of the delivery of cultural care by nurses to improve care for a diverse and

¹ The terms 'patient' and 'service user' will be used interchangeably within this thesis. This relates to the varying roles of nurses, from acute care to continuing care roles, as specialist nurses or in public health. The term adopted at any point was influenced by the language from literature being accessed to inform the discussion.

multicultural society (see the Glossary on page xi for common definitions of terminologies and concepts within CAC and this thesis).

1.1.1: AN OVERVIEW OF THE PROVISION OF CAC TO SERVICE USERS

Discussions around the delivery of CAC for service users from a diverse population have been alive within health and social care for a number of decades. Simplistically, CAC relates to the process in which the nurse and other health or social care professionals seek out the cultural context of an individual or community, mainly from a Black, Asian and Minority Ethnic (BAME) background, in order to deliver nursing care (De Chesnay and Anderson, 2008).

Nursing and all health and social care interactions inevitably occur within an overlapping cultural background of social, political, economic and ideological systems. It is arguable, then, developing a greater ability to anticipate and personalise cultural requirements of service users should positively influence the quality of the service (Healey and McKee, 2004). It has also been shown to result in a more positive outcome and heighten service-users' satisfaction with the service (Browne and Smye, 2002; Goode, 2007; Seaton, 2010). Conversely, according to an Australian literature review by Horvat et al. (2014), there was insufficient evidence to link the impact of CAC educational interventions utilising theoretical frameworks with favourable patient outcomes. 'As the most common educational interventions in nurse education continue to be the utilisation of theoretical frameworks of CAC (see section 2.6), Horvat et al.'s work was significant for this research. Ideas from frameworks of cultural care remain one of the main sources of knowledge on which journal articles regarding CAC and improving care for particular service-user groups are based.

At another level, there is a tendency for research and practice knowledge regarding CAC to focus intently on the needs or differences of the BAME communities (Trotter, 2012) and more specifically on issues surrounding the concept of race and ethnicity (Horsti et al., 2014). This is perhaps due to comparative disparities of health outcomes experienced by the BAME communities in the Western world (Greenwood et al., 2016) or a lack of political recognition of changing societal needs, originally set in the 1980s, from the implementation of the Race Relations Act (Black, 2004). It could be argued that this predisposition is also perpetuated by the continued association of the language around discrimination to ethnicity and race by the mass media and politics at large (Taylor and Muir, 2014), and sets apart intersectional issues shared across a population, such as poverty, unemployment, gender or sexuality (Peebles, 2015) from these discussions. Intersectionality, which refers to those coinciding or intersecting shared identities and the experience of interconnected structures of discrimination, can also cause multiple layers of exclusion, and influences the culture an individual adopts or exists within (Yigwana, 2015).

Despite a number of international nursing theories or frameworks (which will be discussed in Chapter 2) and a plethora of literature on the facility of CAC for those from BAME communities, there continues to be expressions of dissatisfaction from service users around its delivery. Research evidence also recognises that a large number of individuals from culturally diverse backgrounds continue to experience poorer health outcomes than those from the majority population² (also see section 2.4 for further discussion regarding these differences). For the past two decades, the main reason cited

² Majority population here refers to the Majority ethnic group people identified with in the UK, who in 2011, made up 80.5% of the population (information from the Office for National Statistics, 2012 (http://www.ons.gov.uk/ons/dcp171776_290558.pdf)

for dissatisfaction related to differences in the ability to access available health services. The word 'access' included the difficulties around communication, language and cultural difference barriers. Institutional racism, where organisations fail to recognise or genuinely acknowledge barriers to accessing culturally and linguistically appropriate services to people of different cultural backgrounds, was another form of access limitation (Shao, 2016; Almutairi et al, 2015; Stevenson and Rao, 2014; Jirwe et al., 2010; Johnstone and Kanitsaki, 2005; Kai et al., 2011; Narayanasamy and White, 2005). Again, these limitations can be applied to the wider population, which includes members of the Majority population or individuals whose cultural identity does not include race and ethnicity.

Reports from as far back as the Black Report (Black et al., 1988) and Acheson (1988) and regular subsequent House of Commons reports considering the inequalities of health (House of Commons Health Committee, 2009; DoH, 2002) continued to express the same problems. Their findings highlighted differences in language, communication and culture have an influence on poorer access to healthcare services and patient satisfaction in the whole population. Napier et al. (2014:1067) emphasised that 'the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide'. Culture, in Napier's research, again, traversed a wider area of intersectional factors, including and beyond race and ethnicity.

1.1.2: THE CULTURAL CONTEXT OF THE UNITED KINGDOM POPULATION

Within health and social care in the United Kingdom (UK), the concept of culture tends to be utilised in two main areas. Other than the focus of this thesis, in the past five years, the word 'culture', especially within the National Health Service (NHS), has been applied within the context of organisational culture. As a response to significant failings in care and an absence of processes to bring these to light by the systems for quality, the Chief

Nursing Officer launched *Compassion in Practice – our culture of compassionate care* (2012). In 2014, to promote continued improvement in NHS organisational culture, another programme, the *Culture Care Barometer* was launched for use by the DoH (2014), as a way of challenging and developing a team approach to patient care.

In this thesis, however, the reference to culture stems from a more individual, person-centred standpoint. Simplistically, the aspect of culture that is relevant to this research is concerned with those conscious or unconscious characteristics that a person identifies with, which may include customs, ways of living, socialised behaviour and social habits, to name a few (in Chapter 2, these aspect of culture will be considered in greater depth). From this point onwards, the word culture will be related to this latter conception of a complex subject.

The conversation around culture within politics and the mass media in the UK and around Europe tends to focus narrowly on elements such as ethnicity, faith groups and migrants (Horsti et al., 2014). Again, this avoids other cultural and intersectional issues that in combination, affect the ability to make effective cultural and lifestyle choices (Stephenson, 2013).

As with most of the industrialised world, since the 1950s the UK has evolved into a multi-ethnic society through migration, significantly from the previously colonised Indian subcontinent and West Indies. More recently, there has been a third wave of economic migrants from countries in and around Europe, such as Poland and Bulgaria³, especially since the Schengen Agreement of free movement between European borders came into force in 1995 (Nanz, 1995). In 2011, the Office for National Statistics stated that 13% of

³ The first wave of this migration from Europe was mainly during and post-World War II in the mid-1940s, with people fleeing persecution and the ravages of war.

the population categorised themselves within a BAME group (ONS, 2011). These main ethnic groups represent and encompass individuals from widely ranging cultures, languages and beliefs.

It is too simplistic, however, to look at changes in culture only from the perspective of changes to the BAME population, as people from all backgrounds adapt, change and evolve socially and culturally through time (Ghosh, 2011). Since the 1950s, the Majority population in the UK has undergone a transformation in the way they see themselves culturally, among others, through a process of formalised legal changes in the country (Black, 2004). At that time, abortion and homosexuality became legal, capital punishment ended and measures were taken to improve the position of women and other minorities, economically, socially and politically. Regional cultures, habits and preferences, such as dialects, had previously been 'taught away' in schools (Trudgill, 1974) and rejected by the wider media. However, these idiosyncrasies developed into something to be proud of, reducing the perpetuation of the idea of cultural homogeneity or monoculturalism of the Majority population (Bassi, 2007; Gunew, 2004). Over a period of five decades, there has been a continued selection and adaptation of choices in customs or everyday practices such as food or festivals, between migrants and the Majority population, which has resulted in a form of 'hybridisation' of cultures (Nederveen-Pieterse, 2006).

All these factors are further complicated within the environment of a globalised world and recent movement of refugees because of conflicts in parts of the world. The idea of globalisation in this thesis is situated within the context of the UK's economic, social, cultural and political interdependence and inter-relationship with the rest of the world. The combination of these events can have an effect and significant influence on the way we choose to live our lives every day, not only economically and socially but also in the

way we perceive ourselves culturally (Hanley, 2011). Using the examples of the pace and power of the information and social technology across the globe, Castells (2010) expressed the profound and unsettling effect of globalisation on the cultural identity of those people who make up the Majority populations of Western Europe and the North Americas. He felt that the abstract principle of individual citizenship valued by these groups has triggered increasing personal challenges around cultural identity and living in the multicultural and multi-ethnic continent it has been forced to become.

Related to this, the evolution, adaptation and changes of culture have been shown to be a challenge for health and social care professions at one level, because of the myriad difference between individuals and groups of people (Bhopal, 2007). At another level, changes in the social structure of society in the past few decades has also had an effect on the expectations of individuals regarding their own health, health professionals and public services (Ipsos-Mori, 2010).

Therefore, for a population as a whole, it could be argued that ideas around what culture and, in this context, what service users need from CAC may be different, not only between those who see themselves as BAME but also within the Majority population. According to Vydelingum (2006), having a narrow perspective of those entitled to CAC could result in poor, unsatisfactory care. It is important to note at this stage, there are very few studies on CAC that consider the different expectations and needs of culturally varied individuals of the Majority population. So, this research study set out to also engage participants from the White Majority population as a way of considering the similarities and differences between ethnic groups rather than a 'everyone should be treated the same' approach, and as a way of eliciting what factors influenced specific differences in patient perceptions of CAC between the Majority and BAME population.

This stance will enhance the originality of this research study and as a way of developing an under-researched area regarding needs of CAC from all sections of a population.

1.1.3: THE IMPORTANCE OF SERVICE-USER PERCEPTION REGARDING APPROPRIATE AND SATISFACTORY NURSING CARE

With cultural changes and expectations of care in society continuing to evolve and change significantly, listening to the patient or service-user voice in garnering information on how to attain satisfactory care becomes a relevant form of evidence in delivering nursing care.

The notion of listening to the service-users' perspectives in health and social care has steadily increased since the 1980s as a significant factor in improving quality of care (Foot and Fitzsimons, 2011). A recent white paper from the DoH, *Culture change in the NHS* (2015), specifies the need for patient-centred perspectives and aims as a way of learning and moving forward from the failings of Mid Staffordshire NHS Foundation Trust and the subsequent Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

If service providers want to contemplate the experience and perceptions of those who access their 'product', then research must first be conducted to genuinely identify the ways and terms in which those patients perceive and evaluate that service (Dixon and Le Grand, 2006; Napier et al., 2014). There also remains a need to ascertain patients' perception of what makes a service satisfactory. They may have a complex set of important and relevant beliefs that cannot be embodied in simple expressions of satisfaction. Turriss (2005) felt that without a deeper understanding of the worldview that informs our reasons and methods in researching service-user perceptions and satisfaction, nurses and researchers will be reacting to a less than robust indicator of success and failing to address the basic issues related to individual experiences of health care.

However, the ways of eliciting the service-users' perspectives regarding their satisfaction and the way it continues to be measured needed to come under some examination for its methodological limitations (Bleich et al., 2009; Hargreaves et al., 2001). The collection of users' evaluations has involved a diverse array of methodologies including in-depth interviews, focus-discussion groups, panels, consultation of voluntary groups, and analyses of complaints and surveys (Blendon et al., 2003). Tucker and Kelley (2000) and Versloot (2012) both stated that types of questions asked or methods of inquiry can act as a form of censorship enforced on patients by giving ambiguous outcomes or limiting the prospect of patients being able to voice their preferences or concerns about different aspects of care. These skewed results can also erroneously reassure professionals into having faith those service users are satisfied with the care provided when it could be otherwise (Crow et al., 2002; Hudak and Wright, 2000).

Black and Jenkinson (2009) and Valderas et al. (2009) felt that there remains a difference in the idea of patient perception and satisfaction perpetuated by bodies such as the NHS and those ideas held or preferred by patients. These writers found that the purpose of satisfaction within a consumerist setting was more related to the improvement of patient compliance and a desire to gauge efficiency accurately in a service sector industry with ever-increasing demands but finite resources. From as early as 1998, Williams et al.'s study and more recently, Smith et al.'s (2009) research, continues to find little consistent empirical evidence to support those assumptions that connect expressions of patient satisfaction to the fulfilment of expectations of a service.

At this time, NHS Choices (<http://www.nhs.uk/pages/home.aspx>), a component of the NHS Constitution, record real experience of patients regarding their care for expressing the personal preferences of satisfactory care. NHS organisations do routinely measure

patient satisfaction in a more positivistic way but overall rarely seek to learn about patients' actual experiences of care (Asadi-Lari et al., 2004). In addition, in terms of research, the 2008-9 NHS Operating Framework took the first step in making patient reported outcomes a mandatory requirement for audit but it did not look at the reasons behind the responses from service users.

King's College (a NHS trust) and The King's Fund (an independent charity that works to improve health and health care in the UK through research and analysis) carried out a study entitled *What matters to patients?* (2011). They found that those involved in the study preferred to be asked about the personal reasons behind their levels of experience or satisfaction and what they wanted to see improved, rather than solely focusing on measuring it by a scale of satisfaction. This may result in a huge array of personal needs but it is necessary to consider these perspectives, given the original reason set out was to learn from them.

Kumas-Tan et al. (2007) expressed concern that the information on which theoretical frameworks were developed, most likely occurred without patient input and were normed on a predominantly White, middle-class, highly educated populations' needs. As such, this has brought me to one part of my motivation to ask service users what they needed from CAC, in order to learn and balance the evidence utilised to inform nursing care.

1.2: RATIONALISING THE FOCUS ON NURSES FOR THIS RESEARCH

Despite a growing interest of CAC emerging from beyond nursing, the focus on my profession in this research was deliberate. Nurses are pivotal in the delivery of satisfactory care from a service-user perspective, as they are the professionals who spend most time with them (Boev, 2012; Turriss, 2005).

If nurses are held as the holder of 'expert' knowledge on aspects of CAC (Johnstone and Kanitsaki, 2005; Seaton, 2010), then a consideration of the contemporary knowledge on aspects of the subject needs to take place. This will ensure that nurses have the opportunity to reconsider how deeply powerful culture is, in shaping the effectiveness of nursing care. To add to this, the nurse leader is the person who decides the practice culture and philosophy of how a clinical area operates, which cascades downward to his or her wider team. As one of the service users' more prominent professional advocates, and the professionals most likely to be the one to spend most time communicating with them, nurses are in a position to ensure they are receiving care that is individualised and effective beyond the medical intervention. In undertaking this study, it was anticipated that the information that emerged would be able to contribute to the present understanding regarding CAC applicable to nursing (and beyond).

1.3: MY MOTIVATION FOR THIS RESEARCH

My interest in the provision of CAC has been one from the beginning of my nursing career. I came to the UK in the 1980s to train as a nurse. My parents themselves, were willing economic immigrants of the diaspora to Malaysia, initiated by the British colonialist agenda. As one of the two first ever BAME students in my School of Nursing at a hospital just outside Glasgow, I began a steep learning curve as to how this friendly and welcoming community categorised themselves and 'Others' (mainly expressed about the English) culturally. I was also constantly asked to label myself (trying to explain that just because I was Malaysian, I was not Malay but Indian confounded many Scots I met).

Any cultural care components in my nursing diploma were sporadically aimed at those people who looked like me and the ethnic grouping I was newly assigned to but I found myself sharing more in common, culturally, with my White Scottish classmates. It was not

considered a particularly important subject, as it was, as a tutor once described, 'a significantly White community'. There were also categories of defined behaviour ('Muslims want this, Indians need this, Jewish people don't....') about these Others. On the other hand, as an outsider, I could easily see the influence of wider, external impacts on the local Majority population, such as unemployment and poverty caused by the devastating closures of the once famous shipyards, on their activities, their health, their culture and their nationalism.

By the time I was progressing my diploma qualification to a degree in Manchester in 1993, transcultural nursing was part of the choice of modules in which I was introduced to the role of sociology and anthropology in understanding people's behaviour culturally. I was, at this stage, introduced to the works of American nurse anthropologist, Madeline Leininger and the ideas around cultural competence.

Again, as the only BAME person on this module, I was particularly interested by the perception held by my cohort when talking about cultural behaviours, which was always outward looking, as opposed to seeing any of the patterns of socialised behaviour in themselves or in their own community. As I remained an outsider of sorts, I continued to notice the differences in the culture within different groupings of the Majority population based on regional or educational attainment, among others, but again, the emphasis continued to be placed on 'Others' and not themselves.

1.4: POSITIONALITY: AN INSIDER/OUTSIDER, INTERSECTIONAL PERSPECTIVE

A number of important reflexive factors had to be made explicit as I progressed through this research. Stronach et al (2007) referred to reflexivity as a practice of critical self-evaluation and a persisting internal dialogue by the researcher, in openly recognising that

their positionality (and the participants' response to this stance) could influence the research process and outcome.

It was inevitable that the multiple characteristics that I consciously or unconsciously identify with, individually or as a whole, would affect and influence this research study. These social and professional positions (from my gender, ethnicity, immigration status, personal journey, political and professional beliefs, my biases, to my emotional responses to participants, amongst others) would reflexively impact on the way I came to a newer understanding of the subject of this research (Bradbury-Jones, 2007). It could be argued that these aspects of myself are also my intersectional characteristics, described by Shields (2008) as those 'mutually constitutive relations among social identities' that influence my perspective of the world. As such, the arguments and debates around this outsider/insider position, intersectionalities and reflexivity in qualitative research was an important factor to deliberate and made explicit during the research journey. According to Berger (2015) and Kacen and Chaitin (2006) these multiple positions of insider or outsider, can affect research in a number of overlapping and unpredictable ways. They have been considered in this next section, by applying them to my understanding of the insider/outsider position and the influence of intersectionalities.

An insider within research refers to those conscious and unconscious social exchanges that occur between the researcher and participants who share a similar ethnic, linguistic, national or religious tradition. This insider status takes on a greater degree of importance when research involves social interaction between a researcher and a participant, who may both imagine that they come from within the same community. According to Ganga and Scott (2006), these forms of insider interviews create a distinct social dynamic, where

similarities and variations between researcher and participant are brought into focus because of overt or imagined shared cultural knowledge.

Framing myself as a possible insider, as a South Asian, British, Hindu, female migrant, there would be no doubt, as I engaged with some of the BAME participants of this study, that there would be some shared experiences, understandings or similarity of experiences that could influence the manner of my interpretation of the research data collected. In the same vein, some potential BAME participants could be more willing to be part of a research study (or be more open to sharing information) due to the perception that I have insight or better understanding about the subject at hand. Alternatively, this could cause potential participants not to fully express certain views, taking the perspective that I may already possess an understanding from their standpoint or may unconsciously not feel comfortable to provide me with information, perhaps from a feeling of possible disclosure to others within 'our' communities.

Equally, being approached by a professional or an academic to answer questions about their ideas around culture (depending on their individual varying perceptions of me), there may be personal experiences in their own lives that limit the way they respond to me. For example, as a possible outsider, it could be argued that the participants from the White Majority group may be less willing to share or want to participate in a study about CAC, as generally, they are not used to seeing or needing to discuss their own culture or discussions around culture are of a sensitive nature. Reflexively, I understood and linked this discomfort or unwillingness to some BAME communities (especially in my experience of living within the Chinese and Oriental communities) regarding 'loss of face', which relates to the personal perception of loss of respect or humiliation. Kwan (2011) and Katyal and King's (2014) research that considers the insider/outsider aspects of

positionality discuss the 'face concerns' processes that could shape research conversations, by being aware of cultural norms such as groups sensitivity to social hierarchy, being vigilant about acceptable public displays of strong emotions and some groups emphasis on conveying group harmony.

Ryan (2015) considers the paradox to being either an insider or an outsider: as in this case, that for researchers from a BAME background, who seem to share identifiable aspects with the participants of their research, can at one level, make each other more aware of each other's' social position. However, this could also result in the researcher and the participants, with those shared aspects to realise that migrant communities are rarely united, and are usually divided by social differences such as class, generation, age, ideas around status and gender. It is felt that these kind of arguments by these and many other writers, around the paradox of positionalities of BAME researchers and participants need to also be a conscious consideration for researchers in the majority population, as otherwise there is an assumption of the homogeneity and social cohesion of this section of the population.

Reflexively, as a nurse lecturer with the responsibility of delivering knowledge and complex understandings regarding culture and CAC to nursing undergraduates, there has been a realisation, through personal experience and professional observation, about the limitations of how nurses translate existing CAC theoretical frameworks into cultural care in practice. Again, moving between the spaces of insider and outsider, these factors have the potential to shape the findings and conclusion of this research study, perhaps through either my previously held biases regarding nurses lack of interest in cultural care or the strong desire to make this research study improve the translation of the theoretical aspects of CAC.

As mentioned, these multiple layers and characteristics of a person's social position, personal experiences, political or professional beliefs used within arguments of insider/outsider positionalities can also be interrelated to discussions around those interconnections of social division discussed within the literature on intersectionality (also discussed in 1.1.1). Within discussions around intersectionality, notions of positionality diverge from the idea of given or fixed groups or classifications of gender, ethnicity and class, and instead pays much more attention to broader social locations and processes of both the participants and the researcher. The seminal work of Crenshaw (1993) for example, utilises arguments around identity politics to illustrate the complex layers of personal identities on the intersectional experiences of violence against women of color⁴. Crenshaw (1993) talks about the elisions of factors merging together to affect or limit the policies put in place to assist women of color in personal experiences of violence, such as battering, domestic violence or rape. The relevance of understanding the ideas put forward from this twenty-four year old American article around women of color, I feel, remains applicable and relevant today. Her deconstruction of the multifaceted layers of social location and personal processes each person finds themselves within illustrates those elisions that two-way processes which impact on research collections and the degree to which information may be shared or otherwise.

Crenshaw's experiences of research and as a scholar in critical race theory found that women of color find themselves caught up within a juncture of social processes or locations such as anti-racism and feminist arguments around gender, resulting in multiple intersectional disadvantages. She found that women of color experience intersectional

⁴ I have utilised the American spelling of color here, to keep in line with Crenshaw's spelling, expressions and arguments.

disadvantage at three levels: structural intersectionality, political intersectionality and representational intersectionality.

At one level, women of color experience structural intersectionality when services put in place to assist them are unable to resolve other factors they live with. These women can face comparatively higher levels of unemployment, may be in poorly paid occupations, lack job skills and are more likely to be burdened by poverty. In some cases, they may also be dependent on their spouse for their immigration status or have no alternatives to childcare responsibilities. Thus, the violence that they experience is only one form of subordination they live with. This argument is equally relevant in the UK today as the Institute of Race Relations (2017) continues to show higher levels of unemployment and the burden of poverty, amongst other factors, being higher in the women within the UK BAME population.

Political intersectionality, in Crenshaw's (1993) perspective encompass the fact that women of color find themselves within at least two subordinated groups that recurrently pursue conflicting political agendas. For example, she expresses that the anti-racist discourse failure to interrogate patriarchy⁵ and the failure of feminism to cross-examine the role of race, color and sexism in ways not always experienced by white women, inevitably result in denying the validity of one discourse over the other.

Crenshaw (1993) also considered representational intersectionality around the lack of positive representation women of color have within wider representations in society, such as music, humour and specifically, as a valid and equal voice in the court of law.

⁵ The failure to interrogate patriarchy is related to persistent stereotyping of especially Black men as being uncontrollably violent. Thus, there is worry that attempts make domestic violence an subject of political action serves to perpetuate and undermine efforts to combat negative beliefs regarding the Black community

Despite some successes, Mercer (2013) argues that despite the growth of sporadic BAME UK based artists, politicians, comedians and intellectuals, arguments around the lack of positive representation in the UK today continues to be a reality for many BAME women, due to the continued perpetuation, stereotyping and negative imagery maintained by the mass media and political rhetoric.

Crenshaw also found that women of color in her research were reluctant to bring charges against their partners partly due to the high levels numbers of Black men being criminalised, criticised and maligned in the USA. In other words, she emphasized the close relationship between stereotyping and the prevalent images of marginalised women, the objectifying of women's bodies and the requirement of women of color to accept misogyny as a way of 'pursuing an antiracist political agenda or the cultural integrity of the Black community'(p.1294). Similarly, the UK based Women's Aid report in 2009, reported that women from BAME communities have very particular reservations about approaching the police related to their concerns about racism in the force.

The importance of Crenshaw's (1993) work clearly shows the multiple insider/outsider locations: social, professional (or others relevant to that individual) in the way potential participants may say, may withhold, or represent themselves or significant others they think they are symbolically connected to. This is an important factor understanding of positionalities of the researcher and participant when carrying out a qualitative research study on communities based on and around ethnicity-based identities. As such, during the duration of this research, I will make explicit my movement and positionality, as I progress through the study.

Having considered the wide-ranging aspects and background to provide a foundation to carry out this research study, two research questions emerged:

Research question 1: What are the factors that characterise CAC for service users?

Research question 2: What components of CAC are of importance from a service-user perspective?

In order to do this, a number of objectives were set for the research study:

- To identify the gap(s) in relation to understanding CAC from a service-user perspective.
- To engage service users to explore experiences, wants, needs and challenges around CAC from a service-user perspective.
- To gain insights from interviews regarding CAC, to add to evolving developments within existing knowledge utilised to facilitate improved service-user satisfaction of nursing care to a diverse and multicultural society.

This research, unusually, also included participants from the Majority population to provide a newer and evolving understanding of CAC. For me, using the patient perspective from representatives from across all of a population was a democratising, fairer and more ethical way of developing a knowledge base. It would also develop my role and my information base as a nurse lecturer and academic. Importantly, the knowledge gained from this research would be able to contribute to the understanding around CAC, which can positively contribute to patient care and satisfaction.

1.5: STRUCTURE OF THIS THESIS

In order to explore this research study effectively, this thesis has been presented in six chapters. In this **Introduction**, I have provided the background discussion to rationalise the research questions and have set the research objectives.

Chapter 2 provides the narrative literature review. Within this, an exploration of the concept of culture relevant to this thesis is deliberated alongside a critique of the existing theoretical frameworks utilised within nursing practice and education. The aims for the study are also set.

Chapter 3 provides the methodology for this research study. Here, a consideration of how my ontological and epistemological position influenced the decisions I made throughout the research process is articulated. It also contains the deliberation around ethics, the method I utilised to collect data, the pilot study and the tool I used to analyse my transcriptions.

Chapter 4 is the findings chapter, where having utilised the framework for transforming the rich data into organised groupings, I unpack the themes that emerged from my data collection.

Chapter 5 is the discussion chapter. Here, having analysed the data, I consider the unifying themes of the research I carried out. I also consider whether my research questions and the objectives I set out with have been achieved. The limitations of this research study are explored. Recommendations and possible areas for further research are also contemplated.

Chapter 6 is my conclusion chapter. In this chapter, the process of my research journey is considered reflexively and the final summing up of this research study is made.

In the final section, the **Reference List** and the **Appendices** for this thesis will follow this. The Appendices, among other required elements, also show my deliberations from a sample transcription, to the processes I undertook to the final development of themes.

CHAPTER 2: CULTURE AND CULTURALLY APPROPRIATE

CARE IN NURSING: A NARRATIVE REVIEW OF THE

LITERATURE

This chapter will provide an exploration of the literature relevant to this research study entitled *Culturally appropriate care: A qualitative exploration of service-users' perspectives of nursing care*. Beginning with a rationalisation of the method used to review the literature, a discussion around the concept of culture has been deliberated, as it influenced the exploration regarding service-users' perceptions of culturally appropriate care (CAC) in rest of this thesis. It is followed by a critique of the theoretical frameworks of CAC in nursing. Having completed this review, the final section of this chapter identifies the potential gap(s), which clarified the aims of this research study.

2.1: CHOOSING A SYSTEMATIC STYLE FOR REVIEWING QUALITATIVE RESEARCH

The holistic approach to nursing care could arguably be seen as a series of interlinked complex actions: these actions being physical, psychological and social in relation to an individual or groups of people, who stand to benefit from these interventions. The literature I accessed would need to provide knowledge about the complexity surrounding the nuanced processes around communication and interpersonal skills between a nurse and a variety of service users. The literature needed to be able to consider the way we demonstrate and express our perceptions of the world, in that it is connected to the complex social systems that surround us. Such perceptions affect how we identify others, and ourselves and, for the purpose of this research, the nurse and service users. The scope of the literature I accessed needed to reflect this and so, it was necessary that the method of review allowed for this flexibility.

As exploring the intricacies around culture and communication involves subjects considered beyond health and social care, there was also a need to consider literature regarding these interactions from a variety of areas: 'grey literature' sources (Jones, 2004). These include studies, areas of professional academia and existing theories and models among others, in order to access information that more often uncovers service-user information and reveals possibilities of the meaning behind the experience individuals face when encountering nurses during illness.

I required a way of qualitatively exploring what was understood regarding this subject and its significance to and for nursing care. In addition, I required an approach to reviewing literature that would allow me to contextualise and inform this research and explore what needed further investigation.

Grant and Booth (2009) refer to 14 different ways of reviewing literature for research. Table 2.1 lists some of these approaches and a summary of my exploration of their suitability for this research. I have only displayed six of the 14 forms of review, as my earlier consideration of some of them found incongruities in their ability to relate to the needs of this research study. For example, although all reviews of literature for research should be systematic, the traditional systematic review style would involve adhering to stricter parameters on the type of research I could use, and this could have limited the type of literature I intended to access. Any method utilising or resulting in quantitative data analysis, such as meta-analyses was also not suitable in this instance. In the same way, the scoping method (required for a preliminary study) and the state-of-the-art review (which would exclude my utilising older literature to see the evolution of the subject) were again, less than appropriate for the intentions of my research. Table 2.1 provides an outline of the forms of review I eventually narrowed down.

TABLE 2.1: TYPES OF LITERATURE REVIEW (ADAPTED FROM GRANT AND BOOTH, 2009)

Type of review	Description (from Grant and Booth, 2009)	Information about searches	Suitability for this research
CRITICAL REVIEW	Aims to demonstrate writer has extensively researched literature and critically evaluated its quality. Goes beyond mere description to include degree of analysis and conceptual innovation. Typically results in hypothesis or model	Seeks to identify most significant items in the field/Typically narrative, perhaps conceptual or chronological	Partly suitable but my review does not require the development of a hypothesis at this point
LITERATURE REVIEW	Generic term: published materials that provide examination of recent or current literature. Can cover wide range of subjects at various levels of completeness and comprehensiveness	At times includes quality assessment of literature but can include grey literature/Typically narrative. Literature analysed may be chronological, conceptual, thematic, etc.	Most suitable
MAPPING REVIEW/SYSTEMATIC MAP	Map out and categorise existing literature from which to commission further reviews and/or primary research by identifying gaps in research literature	No formal quality assessment/May be graphical and tabular	Not suitable as limits scope of literature used
OVERVIEW	Generic term: summary of the (medical) literature that attempts to survey the literature and describe its characteristics	May or may not include quality assessment (depends whether systematic overview or not)	Not suitable as mainly used in reviewing more positivistic medical literature
QUALITATIVE EVIDENCE SYNTHESIS	Method for integrating or comparing the findings from qualitative studies. It looks for 'themes' or 'constructs' that lie in or across individual qualitative studies	Quality assessment typically used to mediate messages not for inclusion or exclusion/ Qualitative, narrative synthesis	Not suitable as I have no requirements at this point to develop any themes
RAPID REVIEW	Assessment of what is already known about a policy or practice issue, by using systematic review methods to search and critically appraise existing research	Time-limited formal quality assessment/ Typically narrative and tabular	Not suitable mainly as I am unsure about what is already known about subject/time limit

Having considered the various review approaches, the concept of the narrative literature review emerged as the one that would most suit my research. It is not without criticism; writers such as Newell and Burnard (2006) have considered the narrative literature review too simple or lacking structure for evidence-based practice research. However, further scrutiny on this approach found writers such as Jones (2004:96) who stated that the use of narrative literature review is a 'democratising factor' for its ability to consider myriad information, from many sources, especially around the significances of illness and its effects on patients and significant others. The narrative literature review approach is mainly utilised as it gives space to the many voices that need to be heard in the context of this research and allows for a concise review of the state of knowledge of this subject and its interconnections. This provided me with the rationale for choosing this approach to review the literature.

The next section will begin with a consideration of the essential components of culture that was relevant to this thesis.

2.2: COMPONENTS OF CULTURE

Culture is man's medium: There is not one aspect of human life
that is not touched and altered by culture.

(Edward T. Hall, 1976:16)

Culture, as a concept remains difficult to define or explain. Eagleton's (1990) study on the subject found that it continues to be one of the most complex words in the English language to define, due to the depth and breadth of its usage. This section of the narrative literature review focused on the aspects of culture that relate to those factors that shape human behaviour and self-identity, which then affect all forms of communication and interpersonal skills, and in the context of this research

intercultural communication. My decision to limit the review to these concepts was because of the focus of this thesis.

The accepted characterisation of culture is dependent on the domain of study it represents. For example, writers from the varying perspectives and branches of subjects, such as anthropology, queer theory, post-colonial studies and, within this thesis, nursing, have developed an assortment of definitions, dependent on their contextual, academic or professional needs. The study of culture around self-identity, human behaviour and intercultural communication most relevant to nursing often concentrates around sociology (Goodman and Ley, 2012; Denny and Earle, 2010), anthropology (Holden and Littlewood, 2015; Dougherty and Tripp-Reimer, 1985) and cross-cultural psychology (Samovar et al., 2014). Therefore, the initial exploration of this concept comprised a combination of literature from these perspectives.

The earliest known definition of culture was the one put forward by anthropologist Edward Tylor in *Primitive Culture* (1871):

...that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.

In 1952, Kroeber and Kluckhohn, in the seminal *Culture: A Critical Review of Concepts and Definitions* discovered more than 164 definitions for this one word in relation to aspects of how people perceive themselves, cultural identity and related behaviour.

The multiple attempts to define culture have shown that these definitions are created and re-created dependent on the political and social context of the time. It affects all aspects of communication and interpersonal skills of groups within society. Within this, cultural self-identity tends to be imagined through notions of inclusion and exclusion

into a familiar group. The core characteristics expressed within the descriptions of all this literature are considered in the next section.

2.2.1: KEY CHARACTERISTICS OF CULTURE

The ideas of culture, despite their various definitions and purposes, all have a number of shared characteristics that add to the inescapability and complexity of the concept. Culture is made apparent through multiple layers of complexity. This complexity is often addressed in terms of 'levels' in some literature and the way they are described varies. A number of writers, such as Hall (1976) and Battle (2012) have considered in a comparable way, the levels at which culture manifests in a person or a group. Hall (1976) described levels of culture as threefold. At one level, tertiary culture occurs when it is recognised and is most obvious as an observable appearance, such as a dress code, dialect or the manner in which people address each other (Avruch, 1998).

At the secondary level, culture is manifested when values are expressed by individuals and in their rationalisations as to why they behave the way they do. The core reasons for a certain person's behaviour will be either unconscious or purposefully hidden; and, despite what they may express, are the intentions for that behaviour, what they would preferably like those reasons to be and the rationalisations for the same behaviour (Spencer-Oatey, 2008). At this secondary level, culture becomes less explicit but is manifested as the underlying rules, such as those of language or the way a common language is spoken. It tends to be known to members of a group but not shared with outsiders.

The final manifestation of culture, the primary level, can be related to basic underlying assumptions (Schein, 1990). Underlying assumptions are an unconscious revelation of culture and it is that which actually determines how individuals or groups perceive,

think and feel about themselves and Others. At this most implicit level, rules are embedded and taken for granted and at times, even unexplainable by even that person or group. It is rarely spoken about, yet known to that entire group.

All the different levels of culture together, influence an individual's behaviour and the interpretations of that same behaviour by others. Hofstede (2001) and Tsai (2007) make an important argument that although certain aspects of culture are overtly visible, their related meanings and reasoning remain invisible: 'their cultural meaning ... lies precisely and only in the way these practices are interpreted by the insiders' (Hofstede, 2001:8). So, a certain behaviour or gesture in one society, which is deemed friendly, may be considered rude in another, as the underlying reason for the action is unknown to those who may find it offensive. In addition, Tajfel (1979) suggested that how we perceive ourselves, express and behave culturally is also influenced by the dimensions of individualism-collectivism within our own group. The idea of individualism-collectivism is the range of feelings, beliefs and behavioural intentions intrinsic within a group, related to the degree of independence or solidarity and expressed degrees of concern for others (Brewer and Chen, 2007).

Ideas around personal or cultural self-identity are interchangeable between being either an individual construct or a social construct. Cultural self-identity reveals itself as an interchangeable collective set of characteristics by which a person is recognisable or known (Hodos, 2010). These may be behavioural or a personal characteristic founded on the notion that it mimics someone else's characteristic. In conversation, the individual cultural construct gives meaning to 'I' or 'me', while social identity supports that meaning and allows a person to speak of the 'we'. This supports the fact that an individual's cultural 'self-identity' is mainly unconscious and constructed by the

context they find themselves in at that time. In other words, our behaviour and expressions of our cultural self are dependent on whom we are with, at that moment. It is sometimes overtly obvious, but mainly subtle. It changes, modifies and adapts over time by being influenced at a personal level, genetically and socially (Clarke, 2008), and externally, through history, politics and by the media (Triandis and Trafimow, 2001). The culture of an individual or group is never a static experience. Your understanding of the personal attributes you hold of yourself in society can be at times accepting or non-accepting of yourself and of Others within your environment. The aspect of cultural self-identity that an individual chooses to identify their self with could be selected interchangeably, among others, from a social, psychological, ethnic, powerful or helpless persona, or through a gender or class label at the same time (Fiske and Taylor, 2013). In addition, individuals and communities, due to the persistence of derogatory labels from external sources and stigma can also, over time, internalise and adopt the negative self-identities assigned to them (Rew et al., 2015; Yap et al., 2014).

However, culture, in whatever form it takes or academic representation it originates from, is never an autonomous whole, uniquely distinctive or idiosyncratic. Culture and cultural self-identity is porous: the diffuse notions of identity (Berry, 2005); the de-territorialised links between members of a group (Papastergiadis, 2013); and the varieties of rules, regulations and norms that guide verbal and non-verbal communication (Carbaugh, 2013) ensure its malleability to the individual person, at a point in time.

2.2.2: THE IMPACT OF CULTURE

In terms of self-identity and communication, culture has two inescapable, distinctive effects. It affords an individual those interdependent beliefs and values that provide him or her, a sense of self and guidelines of everyday behaviour: ranging from survival, to developing a sense of self-worth, belonging and continuity (Wallman, 1992).

Culture also influences the process of enculturation in promoting social cohesion and interaction among a set of groups or sub-groups of its members (Kroeber and Kluckhohn, 1952). Groups that appear overtly similar in terms of language and appearance cannot genuinely be considered monocultural because of the varying subtleties of the culture for each person. As was discussed in Chapter 1 (see section 1.1.2) in any multicultural country, such as the UK, culture cannot only be a feature of Black, Asian and Minority Ethnic (BAME) groups (Cortis, 2003) but the countless differences within the Majority population and groups beyond the limitations of race and ethnicity (Hunt, 2001). As early as 1958, Williams was already expressing the intricacy of the nature of culture within all our everyday lives and stated that 'culture is ordinary': so ordinary, that we do not see it until we are, one way or another, challenged by differences in what we expect and accept as the norm.

2.3: THE CULTURAL 'OTHER'

Everyday political, mass media and historical conversations regarding culture tend to focus on BAME populations and their differences from a unknown collective of 'us', mainly relating such comparisons to the Majority population. Having considered the concepts that influence the diffuse notions of cultural self-identity, this section will look at how this awareness then affects how we consciously and unconsciously perceive those outside our cultural location. Also, the notion of the cultural Other is

explored within this thesis as the perceptions around this concept affected the way individuals distinguished between different forms of cultural identities, needs and associated social activity. Within this, nurses and service users perceiving each other as the cultural Other impacts on the basis of the relationship they will have and the expectations and delivery of CAC. This last point can be also related to the discussions around positionalities (see section 1.4) adopted by both sides (professional and service user) and the degree to information may be shared or withheld.

Anderson (1983) and Piller (2011) stated that the sense of belonging (or otherwise) to a community, has an effect on the way individuals or groups 'culturally' behave, perceive and communicate with each other. This cultural behaviour is part of the Majority population's self-identities and not just BAME populations. They also expressed that the question of difference is emotive: it promotes ideas about 'them' and 'us'; a sense of belonging or otherwise; membership or ostracisation from groups; and how to define 'us' in relation to others, or the Other. From this, we get ideas about communities, sometimes-imagined communities and even ethno-national boundaries.

2.3.1: ORIGINS OF THE CULTURAL 'OTHER'

The notion of the cultural Other comes from an imagined idea of difference, either superior or inferior, to the cultural self-identity or social identities that may represent the norm (Miller, 2008). It is a concept that tends to be considered within some perspectives of continental philosophy and in the social sciences, such as across the classifications of anthropology and sociology. Discussion about the concept can also be found in literature regarding racism (Pon, 2009), gender perceptions (Ghosh, date unknown) and observations regarding disability (O'Hara, 2003), to name a few. The

idea of 'Otherness' is central to the analyses of how Majority and Minority identities are constructed (Zevallos, 2011).

In childhood, identifying with the cultural Other is a natural process of choice, towards those familiar and those our families identify and feel safe with (Turner, 1980). In adulthood, the process of constructing or perpetuating a cultural Other can be amplified by subjective feelings of insecurity, chaos and vulnerability. Berger and Luckmann (1991) stated that as a rule, the negative subjective feelings that are caused by social, economic and political concerns regarding Others coming into a familiar group always result in some form of tension. They stated that in the ensuing struggles acted out by these groups or in the mass media and by politicians, arguments would inevitably be reconstructed around differences in cultural identities. These challenges and arguments that surround cultural self-identity will be made meaningful by a dependence on religious or ideological values, beliefs, myths and narratives, and become framed within a general moral gauge of 'good' or 'evil' (Chen, 2014). Although overall in Western societies the role of religion as a belief has lost its cultural relevancy, it has, over the past few decades, become reimagined as a cultural symbol of identity, which further perpetuates the construction of 'self' and 'Others' (Carbaugh, 2013; Goodwin, 2012; Poynting and Mason, 2007; Kelly, 1955).

2.3.2: EVOLUTION OF THE CONCEPT OF THE CULTURAL 'OTHER' TODAY

With the massive acceleration of globalising trends in the past decade, including changes to economic interdependence and fears around mass migration, nations and national identities have been subject to considerable transformations that affect intercultural communications and behaviour (Young et al., 2007). Gallagher (2014), Meyer (2009) and McIntosh et al. (2004) felt that the construction of the cultural Other

had worsened in the past decade because of manipulation by politicians and a sensationalist media. Society at large looks for targets to vent their worsening frustrations on during times of economic stress. Studies as early as 2003, such as Miles and Brown (2003), the UNHCR (2003) and more recently, the UK 2014 National Social Attitude survey, had noted that it remains commonplace for politicians and the mass media to adopt a more nationalistic stance of intolerance, often to increase electoral popularity or to increase sales of publications through sensationalism.

Some examples of these have become apparent since the UK economic downturn of the past decade. It has become more familiar for politicians across the political spectrum and the media to make unguarded and unsubstantiated comments for their own gain (Okojie, 2013; Mason, 2013; Martin and Stevens, 2013). With this, the negative targeting of some British-born groups who share a variety of extrinsic traits with those undergoing this widely broadcasted negative scrutiny has been emerging, as they report experiences of a newer emerging discrimination previously not seen by them (Masocha, 2015; Thomas, 2013; Wainwright, 2002). Reese and Lewis (2009) and Legault et al. (2009) argued that this rhetoric becomes instrumental in our internalisation of what we see as the truth over a period of time and with it, our internalisation of what makes up the cultural identity of Others and ourselves. They and Meyer (2009) felt that the media and politicians would hardly succeed if the emotions of the common people did not yearn for a cultural enemy, especially in times of social, economic and political crises. Neuliep and McCroskey (1997) and McCroskey (2006) referred to this as 'intercultural communication apprehension', where a fear or anxiety associated with either real or anticipated communication with people from different groups, especially cultural and/or ethnic groups' (McCroskey, 2006:148)

becomes ingrained with a persistent rhetoric from politics and the media. In essence, people who have high levels of intercultural communication apprehension will innately have communication problems stemming from their fear or anxiety and limit communication with those who fit the idea of the Other. Reflexively, it is felt that the obstacles experienced around intercultural communication apprehension can be interconnected to discussions around intersectionalities and positionalities, as they all require a deeper understanding of the social locations and processes individuals, groups or communities (imaginary or real) locate themselves within.

2.3.3: PERCEPTION OF 'SELF' BASED ON WHAT 'OTHERS' THINK OF US

There is another aspect around the idea of 'self' and 'Others' that needs to be explored for this thesis as it affects intercultural perceptions for both nurses and service users. Theoretical frameworks regarding CAC tend to emphasise the importance of communication as a process aimed towards the service user but does not really remind the reader that that social and contextual influence works both ways. Utilising Berger's (2015) ideas around the positioning of a researcher and those personal characteristics that impacts on the research process and participants' reaction to them (see section 1.4), the degree to which the service user responds, in intercultural communication, towards the nurse is dependent on a number of parallel factors discussed in his writings. For example, comparable to researcher participant relationships, the personal characteristics (such as ethnicity, age, sexual orientation, accent, amongst others) and as Crenshaw's (1993) discussions around the elisions of social locations or processes of an individual finds themselves constrained within, may result in the service user be more or less willing to share information with the nurse.

Gudykunst (1995) suggested that we choose, although perhaps not always consciously, whether we want to communicate effectively. In a study of young people in Brixton (London), Howarth (2002) found that our expressions were also likely to be influenced by how we felt we are perceived by Others. Burr et al. (2014) and earlier work by psychologist Kelly (1955) found that in making sense of our experience, we tend to unconsciously employ a number of bi-polar constructs to imagine how the Others might perceive us. For example, in meeting someone we perceive as the Other, we tend to imagine their friendliness (or threat) or the self-sufficiency (or neediness) of that person based on the qualities we think they might possess. This imagination is based on our social and political context. In either situation (friendly versus threat or self-sufficiency versus need), these are all constructs that could be expected to permeate the subsequent interaction with quite different qualities. This is significant within this research as it provides the rationale that the process of intercultural communication needs to be understood beyond the act of the nurse asking questions or speaking to an individual from a BAME background. With communication being a two-way process, there needs to be a wider appreciation that the contact involves interaction between people whose 'cultural perceptions and symbol systems are distinct enough to alter the communication event' (McDaniel et al., 2012).

There also needs to be an appreciation of ethnocentricity within intercultural communication. From one angle, ethnocentrism is a very normal and naturalistic inclination for all of us to fulfil individual and collective needs for 'identity scrutiny, in-group inclusion, and predictability' (Ting-Toomey, 2012:218). However, to be ethnocentric can also mean a person or a society interpreting and evaluating another's behaviour, expressions or acts using their own standard as a moral superior, i.e.

distinguishing between a positive 'us' and a negative 'them'(Piller, 2011). As Martin and Nakayama (2005), Wrench et al. (2006) and Gudykunst and Kim (2002) argued, low level ethnocentrism can be very important for in-group development, nationalistic pride and patriotism but these writers all found that high ethnocentric levels remain innately damaging for intercultural communication. High levels of ethnocentrism within a group can result in unchecked institutional racism being the norm.

2.4: ADOPTING A DEFINITION OF CULTURE FOR THIS THESIS

Having considered the wide-ranging and complex aspects of culture that are relevant to this research, I came to appreciate how embedded all our actions and reactions are cultural in nature. I had realised that culture was constantly evolving, as I reflexively reconsidered how my culture has changed in the past few decades. This was also reflected in the literature from the academic areas that particularly study culture in its many forms. More recent research in Anthropology and Sociology has evolved to 'look both ways' and include multiple perspectives and influences from the emerging global society on how we behave culturally (Kincheloe and McLaren, 2000; Vidich and Lyman, 2000), as opposed to an older 'learning about the exotic other' approach. Taking into account the features, functions, subtle nuances of culture, intercultural communication, intersectionality and positionality I have so far explored, the definition of culture I found most able to encompass the depth and breadth of this study was a more recent medical anthropological characterisation by Helman (2007), who detailed that culture was,

...a set of inherited guidelines (explicit and implicit) which as members of a certain society inform us how to view our world and how to experience it emotionally.

(Helman, 2007)

This idea of culture also determined 'how we behave in it, in relation to others, to our understanding of supernatural forces or gods and to our natural environment' (Helman, 2007:4). It also provides us with the 'symbols, language, art and literature that we transmit to the next generation', as a form of perpetuation of that cultural identity (Helman, 2007:4). I found it incorporated the scope and complexity of social cultural locations, perceptions, behaviours and the multiple cultural identities a person may adopt, making it pertinent to my research question. In addition, this variation of anthropology directs its focus on seeking to understand how humans adapt to diverse environments and how intercultural and intersectional processes work together to shape growth, identity development and behaviour in individuals and groups, rather than an older anthropological characterisation of the 'exotic' other.

Helman's idea of the dynamics of this concept was central to my research as it showed that a person's various understanding of culture remains an important aspect of interpersonal interactions between people. It can mean for nurses that their own perception of what is required when in contact with a service user is different for that person. Awareness of this could be central to effective care delivery for that patient. As Todres et al. (2000) expressed, a nurse who ignores the importance of significant individual factors that characterise the service-user's cultural self-identity could leave the recipient feeling dehumanised.

Helman's definition also alluded to the aspect of human perception that is fallible: people's perception of themselves and Others. Knapp et al. (2014) explained that cultural conditioning, education and personal experience structure all our understanding of the Other people. Consequently, it is possible that a number of nurses listening to one conversation or watching the same event will see and hear

different things. Our perception remains selective as we have a tendency to project our own qualities onto how we see others. This again, can be related to Crenshaw's (1993) discussions of those positional and intersectional elisions of factors that we locate ourselves within (see section 1.4) and out interactions with others. McGee (2000) felt, ultimately, that it is as an appreciation of the service user's personally significant cultural needs that determines whether interventions are regarded as helpful and satisfactory.

2.5: CULTURE IN RELATION TO NURSING

This first section will look at those aspects of UK directives, legislation and codes from regulatory bodies that assert the need for nurses to understand an individual's personal culture and values during the interaction between the professional and the service user.

2.5.1: GUIDELINES FOR NURSES IN RELATION TO CAC

The regulatory body for nurses and midwives in the UK is the Nursing and Midwifery Council (NMC). It stated in its Code of Conduct for professional behaviour and standards (2015) that an appreciation of diversity and culture is an important aspect of delivering care. Specifically, it encourages staff to avoid making assumptions and to recognise diversity and individual choice in their patients (1.1.3 of the Code). It also promotes the use of,

...a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs. (NMC, 2015:2.7.3)

The Department of Health (DoH) also regards the consideration of the service-user's personal culture as an important aspect in the interactions between health

professionals and their clients. Any of the frameworks utilised by the National Health Service (NHS) are required under the Equality Act 2010 to take account of its 'Public Sector Equality Duty', which includes a requirement to work towards eliminating discrimination, harassment and victimisation, promoting equality and fostering good relations between people. Therefore, although the word culture, as within the context of this thesis, has not always been used within the available legislation in the NHS, terminology such as 'diversity' or 'multicultural society' have instead been utilised to refer to the understanding of the differences in service-user needs and perspectives as a significant factor in the delivery of effective care.

The white paper, *Equity and excellence: liberating the NHS* (DoH, 2010) placed more emphasis on improving service-users' experience of health care. Generated by this authoritative guide, the *NHS Patient Experience Framework* (DoH, 2012b) specified the need to ensure respect for patient-centred values, preferences and expressed needs such as cultural issues, dignity, privacy and independence of patients and service users, among other requirements. The *NHS Outcomes Framework* (DoH, 2012c) also made clear that the provision of a 'good experience' of care for service users needed to be a central goal for the NHS. Keeping in mind the discussion around the quality and limitation of feedback discussed in section 1.1.3, for all three of these government directives, this was to be achieved by asking service users for feedback regarding aspects of the care they had received.

At another level, all NHS staff and governmental bodies are expected to commit to ensuring all staff (and students on professional programmes within any UK university) are aware and kept up to date regarding their rights and responsibilities with regards to equal opportunities and diversity, to work towards eliminating discrimination and

reducing inequalities in care. To support this, most NHS trusts and universities offer staff annual online learning programmes, under headings of equality and diversity, equalities legislation, and individual rights and responsibilities we all have in relation to the Equality Act (2010). None of these areas considered in this section utilises the terms race and ethnicity as the exclusive focus on the subject of culture but includes identities such as gender, sexuality and disability identities (among others) that an individual may see themselves as. These codes, regulations and directives are necessary as a way of ensuring that professionals understand the law around equality but do not challenge either long held socialised prejudices or anxieties that could affect nurses' delivery of CAC to a service user.

This national level expectation for understanding and disseminating knowledge of non-discriminatory practices, however, does not regulate or set specific standards by which universities must prepare their health and social care students for a future of caring for a diverse population, in terms of either ethnicity or any other way an individual might identify themselves as culturally different. For example, a study by Bentley et al. (2008) conducted a wide-ranging nationwide review of CAC educational programmes for UK healthcare professionals. They included courses in medicine, nursing, physiotherapy, occupational therapy, speech and language therapy, and pharmacy. Although not specifically clear about nursing per se, this study revealed that overall, only 75% of universities were ensuring some form of educational programme that developed this form of understanding and knowledge about culture was in place. Even in the institutions where CAC education was carried out, the research exposed substantial differences in the content and teaching practices, with some areas solely relying on online equality and diversity training as the only requirement. In their conclusion,

Bentley et al. (2008) felt that CAC education was insufficient to develop students' abilities to care competently for a multicultural and diverse population.

The next section of this chapter will now consider the theoretical frameworks that are available in nursing as a way of improving CAC. There will first be a consideration of this subject at an international level before considering the UK experience.

2.6: THEORETICAL FRAMEWORKS OF CAC IN NURSING

Theoretical frameworks relating to CAC in nursing began emerging in the 1960s (Seaton, 2010). It seems pertinent to begin the discussion on the theories combining culture and nursing with reference to the earliest nursing theory of cultural care by Madeline Leininger (1925-2012) as a foundation. This will be combined with an international perspective of CAC before specifically looking at the UK experience.

2.6.1: THE INFLUENCE AND CONTINUING IMPACT OF MADELINE LEININGER

Leininger has been referred to as the inspiration for many subsequent cultural care theories and her foundational concepts and terminology can be found in the ideas of subsequent models. By 2004, she and those who had been inspired by her theory had been said to contribute to more than 400 scientific studies to the field of cultural care in nursing (Glittenberg, 2004).

An American nurse anthropologist, Leininger was one of the most prolific and influential writers about this subject and has influenced thinking for over 60 years within the United States of America (USA) and internationally (Andrews and Boyle, 1997; Sagar, 2012; Papadopoulos, 2004; Narayanasamy and White, 2005). She felt that people from different cultural backgrounds from the caregiver displayed different behaviours or had different expectations regarding health and illness (Leininger, 1966).

Leininger's model was based on nurses learning about the belief systems of Other cultures and reflected the socio-political era (e.g. the end of segregation and the civil rights movement in the USA) and older Anglo-European learning about the 'exotic' form of the anthropological perspective of culture (Leininger, 1970; Kuper, 1996; Goode, 1994). This knowledge would then be applied to the nursing care of these individuals.

Her Theory of Cultural Care was initially developed and established in 1967, to equip nurses with ways to provide culturally meaningful and supportive care (Leininger, 2002; Kanitsaki, 2003; Leininger and MacFarland, 2002) through assessment, planning, implementation and evaluation of care in diverse situations. The act of nursing intervention was referred to as 'Transcultural Nursing', whose goal was to 'provide culturally congruent, sensitive and competent nursing care' (Leininger, 1995:4). To be 'culturally congruent' related to the nurse's ability to bridge cultural gaps in caring, work with cultural differences and enable clients and families to achieve meaningful and supportive caring. In being open and 'sensitive' to the differences, the nurse's role was to discover 'the local [insider] views' (Leininger, 1978:36) and become an authority on variations in norms and values with that group. This knowledge was then used to make predictions and provide more effective and competent nursing care. The terminology used by Leininger remains pertinent as although practitioners in nursing and other health and social care professions have adopted and adapted these terms to contextualise their practice, they continue to be used in CAC literature.

Her theory was renamed the Culture Care Diversity and Universality model in 1988. Despite the evolution of her ideas to reflect the era, she maintained her convictions regarding her ideas around this theory, its impact on patient care and the need for

nurses to be culturally competent. This was reflected in her final theoretical book with Marilyn MacFarland in 2002 (although she continued to publish around the subject until her death in 2012).

The enduring influence of Leininger is apparent in a number of ways. She founded (in 1973) the Transcultural Nursing Society and the Journal of Transcultural Nursing, both of which continue to flourish. In addition, since 2006 the American Association of Colleges of Nursing (a professional association that works towards establishing the quality standards for nursing education nationally in the USA) recognised cultural competency as a necessity for all Baccalaureate programmes (Calvillo et al., 2009, Seaton, 2010). Their rationale for proposing the integration of cultural competence into nursing education was to support the development of patient-centred care that identified, respected and addressed differences in patients' values, preferences and expressed needs from nursing theories that had emerged.

Other CAC theoretical frameworks, mainly emerging from the USA, include Giger and Davidhizar's (1988) Transcultural Assessment Model, The Purnell Model of Cultural Competence (Purnell, 1991) and Camphina-Bacote's (1999) Culturally Competent Model of Care. Table 2.2 illustrates some of the assumptions, similarities and differences among these theoretical frameworks.

TABLE 2.2 CULTURAL CARE THEORIES (USA) AND BASIC CONCEPTS

Theories, Author, Country	Propositional idea	Assumptions and intercultural skills to develop	Role of the patient/ service user
<p>Cultural Care, Diversity and Universality, Madeline Leininger, USA</p>	<p>Transcultural Nursing: Focusing on both similarities and differences in diverse populations</p>	<p>*Nurses must understand different cultures in order to function effectively *Effective nursing care involving ‘culturally congruent, sensitive and competent nursing care’</p>	<p>*Patients assessed for information so the nurse knows what to do</p>
<p>The Purnell Model of Cultural Competence (1991), Larry D Purnell, USA</p>	<p>Transcultural Diversity and Healthcare: A culturally competent nurse able to provide holistic therapeutic interventions to promote health, prevent illness and disease, prevent injuries and assist to maintain health and restore function</p>	<p>*Nurses and caregivers need both cultural (general and specific) information in order to provide culturally sensitive and culturally competent care *Effective nursing care to be carried out within 12 domains (Ranging from information about diversity to providing respectful culturally competent care)</p>	<p>*Patients as co-participants, influence of culture on actions, awareness of prejudices etc.</p>
<p>Giger and Davidhizar’s (1988) Transcultural Assessment Model, USA</p>	<p>Transcultural nursing: A culturally competent practice field that is client centred and research focused</p>	<p>*Nurses need to work in culturally sensitive environments as each individual (especially with those who are not brought up in the USA (Americans believe they can control nature to meet their needs and thus are more likely to seek health care when needed) is culturally unique but may not seek help and be more fatalistic about illness *Effective nursing care within six cultural phenomena: communication, time, space, social organisation,</p>	<p>*Non-Americans are culturally unique and need to be assessed systematically to be understood within American culture</p>

		environmental control and biological variations. These provide a framework for patient assessment, from which culturally sensitive care can be designed	
Camphina-Bacote's (1998) Culturally Competent Model of Care, USA	Effective cultural competence is achieved with each patient through a process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client/individual, or family or community	*For the nurse, in obtaining cultural knowledge, it remains critical to remember the concept of intra-cultural variation: that there is more variation within cultural groups than across cultural groups. *This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire	*Caregiver/ Nurse patient partnership

2.6.2: THE UTILISATION OF THEORETICAL FRAMEWORKS OF CAC INTERNATIONALLY

Literature utilising Leininger's theory or evolving related concepts continues to be disseminated around the world. Nursing journals have published interpretations of transcultural nursing from the Middle East (Almutairi, 2012; Halligan, 2006); Australia (Omeri, 2006; Davidson et al, 2004); Sweden, Spain and Europe (Plaza Del Pino (2013); Jirwe, 2008); South East Asia (Birks et al., 2009; Lim et al., 2011); Hong Kong (Kaur, 2016)⁶; mainland China (Liu et al., 2006); Korea (Ji-Young et al., 2008); and India (Becker, 2007), to name but a few. Outside the UK, the most significant theoretical framework to emerge, in response to the failures of the cultural competence model of

⁶ I have separated out Hong Kong and mainland China, despite political unification, as this author considers the difference between the cultures of both these geographical locations in her article.

Leininger, was Irihapeti Ramsden's work on Cultural Safety (2002) (the challenges to Leininger's work and rationalisation of this model will be discussed in section 2.6.3.1).

Health and social care professions beyond nursing have also taken on the concept of either transcultural health (used interchangeably with 'cross-cultural care' in some literature) and cultural competence as a way of promoting patient or service-user care, research or education. Examples from medicine (Fox, 2005); social work (Gilligan and Furness, 2005); physiotherapy (Yeowell, 2010; O'Shaughnessy and Tilki, 2007); Speech and Language Therapy (Marshall, 2003); and teaching in schools (Valentine, 2004) are just a few to illustrate its breadth of use. Although the scope of its use varies, the most commonly used terms within these professions continue to be influenced by Leininger's original ideas and aims around 'cultural competence' (see the Glossary for variations in the term by different writers).

2.6.2.1: THE UK EXPERIENCE OF CAC

In the last few decades, there has been consistent interest around issues concerning the provision of transcultural nursing and cultural training for healthcare professionals in the UK, mainly in the area of providing effective CAC for clients from a diverse range of BAME communities.

For the most part, transcultural or cross-cultural nursing is manifested in UK literature based on scholarship, research and education. Compared to the USA, the UK has been a latecomer to ideas around transcultural nursing and CAC. A perusal of the curriculum content of nursing undergraduate programmes in the UK found a number of books and journal articles on the role of ethnicity on health and illness and delivering CAC to BAME groups written by UK authors (McGee, 2013; Holland and Hogg, 2011; Burnard and Gill, 2008; Dutta, 2007; Papadopoulos, 2006, Papadopoulos and Pelezza, 2015;

Narayanasamy, 2002; Serrant-Green, 2001; O'Hagan, 2001; Chady, 2001; Culley and Dyson, 2001; Le Var, 1998). Leininger's work and ideas has also remained present but as Bentley et al. (2008) asserted, there has been little consistency regarding the extent to which it is spread across the board within the education of future health and social care professions. The next section will consider the theoretical frameworks that are more commonly utilised around CAC in the UK.

The most frequently cited UK-based literature or theoretical frameworks are Narayanasamy's ACCESS model (2002) (originally published for mental health nurses in 1998) and Papadopoulos, Tilki and Taylor's (2006) model (originally published 1998). The most recent UK framework is a 2011 adaptation of Papadopoulos, Tilki and Taylor's model, referred to as the Papadopoulos Model for Culturally Competent Compassion. Ramsden's (2002) Model of Cultural Safety, although from New Zealand, has been cited with increasing regularity in the UK (for example, McClimens et al., 2014; De and Richardson, 2007; Gray et al., 2003). Consequently, it will also be considered in the discussion in this section. Table 2.3 shows these three models as a way of showing their underlying foundations, similarities and differences.

TABLE 2.3: THEORETICAL PERSPECTIVES UTILISED IN THE UNITED KINGDOM

Theory, Author, Country of origin	Propositional idea	Assumptions and intercultural skills to develop	Role of the patient/ service user
<p>Irihapeti Ramsden Cultural Safety, 2002, New Zealand</p>	<p>*Cultural safety: an educational process through which all interactions between professional and recipient is bicultural. The need for a critical understanding on the colonial structures that limit equitable health to all</p> <p>*Its strategy is to avert actions that diminish, demean or disempower the cultural identity and wellbeing of an individual</p>	<p>*Care through issues of communication access to the health service. Nurses may be the first health professional people meet, hence the attitude a nurse portrays, if it is one of criticism, blame or assumption, whether expressed knowingly or unknowingly, may make a person feel demeaned and engender feelings of reluctance either to seek health care or to return to a particular health service</p> <p>*The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on their own cultural identity and recognises the impact of the nurse’s culture on their own nursing practice</p>	<p>*Caregiver/ Nurse- patient partnership</p>
<p>The Narayanasamy ACCESS Model, 2002, United Kingdom</p>	<p>*Transcultural nursing can be conceptualised as a strategy of caring which takes into account, with sensitivity and consideration, the individual’s culture, specific values, beliefs and practices</p>	<p>*Care provided through five stages: holistic assessment, communication, cultural negotiation and compromise, establishing respect and rapport, cultural sensitivity and cultural safety</p> <p>*Care provided to include and improve the motivation to be caring, compassionate and beneficial to those in health crisis and need</p>	<p>*Nurse- patient negotiation and compromise</p>

<p style="text-align: center;">The Papadopoulos, Tilki and Taylor Model of Developing Cultural Competence, 2006, United Kingdom</p>	<p>*Transcultural health and nursing: empowering clients to participate in healthcare decisions, by recognising how society constructs and perpetuates power and disadvantage. Promotion of equality and the value of the individual</p>	<p>*Care through a culture generic and culture specific approach: developing from culturally incompetent practice to culturally aware practice, culturally safe practice and culturally competent practice *Care through cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Also, need to address discrimination and disadvantage experienced by people from migrant backgrounds</p>	<p>*Nurse-patient partnership</p>
<p style="text-align: center;">Papadopoulos Model for Culturally Competent Compassion, 2014, United Kingdom</p>	<p>*Empowering clients to participate in healthcare decisions by recognising how society constructs and perpetuates power and disadvantage in a compassionate manner. Promotion of equality and the value of the individual, utilising compassion at the centre of care</p>	<p>*Care deliverance in any healthcare setting should be administered with compassion while ensuring that it is delivered in a culturally competent manner, taking into account the values, culture and health beliefs of the individual</p>	<p>*Nurse-patient partnership</p>

While the ultimate aim of each framework does not differ from any other, these models, together, show the evolution of Leininger’s idea of the delivery of transcultural nursing. For example, all four of these models see culture in the broadest sense, not just linked to ethnicity. Papadopoulos et al. (2006:10), for instance, remind us that ‘all human beings are cultural’, including nurses, which is in direct contrast with Leininger’s affirmation that her 2002 theory of Cultural Care Diversity and Universality ‘was a great breakthrough in caring for the culturally different’.

Culture, for these four frameworks, comes from a more ‘emic’ interpretation or ways of knowing within a culture that, as Ager and Loughry (2004) propose are determined

by local custom, meaning and belief. An 'etic' slant to learning about culture utilises existing theories and worldviews that would have originated from outside the culture being studied, looking inward towards the service user, as with Leininger's approach. Taking into account the discussion in 2.4.3 (regarding the perception of how we may see ourselves dependent on what Others may think of us), with an etic approach, the nurse could remain outside the experience of providing CAC and may not realise their impact on the way the service user is conducting themselves at that point in time.

These four frameworks are also concerned with the impact of authority and establishment of trust as being crucial to the ease at which the communication process takes place. They, unlike Leininger's work, consider the impact of social and organised structures in enabling or inhibiting communication, cultural practices and health lifestyles. As such, they consider the provision of CAC with the practitioner keeping in mind individual differences, as opposed to providing care regardless of individual differences and seeing the Other only as a member of a bigger group. Central to this communication process is the aptitude of the nurse to be reflective, culturally self-aware and have the ability to listen to the patient's narrative in a non-ethnocentric manner.

2.6.2.2: CRITICISMS OF LEININGER AND OTHER CULTURAL CARE FRAMEWORKS

There have been a number of criticisms made against cultural care frameworks and at times, the unquestioning use of Leininger's theoretical frameworks of CAC. The biggest challenge and criticism of Leininger's work came from New Zealand nurse theorist Irihapeti Ramsden. She challenged Leininger's ideas around transcultural nursing and its unquestioning and indiscriminate utilisation as a framework to nurse in New Zealand. This scrutiny of Leininger's work brought about significant changes through

the introduction of the philosophy of cultural safety. Cultural safety is centred on the notion of 'the nurse as a bearer of his or her own culture and attitudes, and who unconsciously and consciously exercises power' (Ramsden, 2002:109). Based around social justice, this concept focuses cultural care on being aware of power, prejudice and attitude rather than on ethnicity and its associated concepts to provide care (Bruni, 1988; Cooney, 1994). This theory arose from Ramsden's indigenous perspective, rather than, as Seaton (2010:10) proposed 'an Anglocentric scholarship'. The theory was needed because of the perceived failure of the theory of transcultural nursing as being ineffective and even dangerous for the Maori people of New Zealand. Ramsden (1990), Cooney (1994) and Coup (1996) felt that the imported American transcultural nursing model ignored and did not provide nurses in New Zealand with strategies to help or assist any service user whose illness behaviours were perpetuated by issues around power, politics, race, racism, religion and power.

Grant and Luxford (2011:17) also referred to the ideas around transcultural nursing perpetuating 'neo-colonial constructs of a white western monoculture', which then limited understanding of cultural self-identity, perception of Others and intercultural communication. Leininger responded to this criticism in 1994 by implying that as they had not been trained to become culturally competent nurses, these writers had failed to grasp the range, emphasis and the practice goals of transcultural nursing. This response to criticism needs to be balanced with the evidence that a number of studies have shown that even for those who possess the USA 'culturally competent nurse' course qualification, patients could be unwittingly stereotyped, homogenised and dehumanised by the lack of knowledge, cultural relativism and well-intentioned

assumptions about certain ethnic groups (Isaacson, 2014; Cummings and Worley, 2009; Schim et al., 2007).

Other criticism levelled against Leininger's work and that of other theoretical frameworks include their tendency to homogenise ethnic groups (McIntosh, 2011; Browne and Varcoe, 2006) and an inference that culture can be reduced to a technical skill for which nurses need to be trained to develop expertise (Kleinman and Benson, 2006; Duffy, 2001). The models utilised in the UK do not limit their use to BAME communities, but the interpretation of theory into the practice environment seems to result in this.

However, it is easy to be critical of nurses in some countries that have utilised Leininger's model wholly without question. Nursing is not recognised as a profession internationally and as such, access to research and academia by nurses remains challenging and deemed unnecessary. For example, in some countries, such as China (Finn and Lee, 1996) and Indonesia (Ibrahim et al., 2009), the actions to improve nursing care by nurses, can be influenced by Western nursing theory, which provides the 'science' for the improvements in care that need to be made.

Another challenge for the effective translation of CAC into practice relates to my previous discussion of intersectionalities in the Introduction (see section 1.1.2).

Literature from Gustafson (2005) and Culley (2006) asserts that nursing usually categorises the cultural Other only by ethnicity. Together with this, ethnicity is used to characterise someone else and almost never assigned to a 'White' person or nurse (Gillborn, 2010). As research on racism, sexism, classism, homophobia and disability has advanced, critics such as Browne and Misra (2003) and Settles (2006) have argued that isolating any one of the intersectional identities, such as ethnicity, for considering

communication and care needs, overlooks the experience of individuals with multiple subordinate identities. Purdie-Vaughns and Eibach (2008) stated that people with multiple subordinate-group identities (e.g. a disabled, minority ethnic woman) do not fit the patterns of their given identity by a more dominant group. Consequently, they can experience disadvantage at many levels in their health or illness experience, and limited intercultural communication with professionals who do not see a person beyond the concept of ethnicity. Again, the four theoretical frameworks utilised in the UK frame culture in the broadest sense of the word, but the interpretation of ideas, in practice, around culture is delivered through a more limiting characterisation.

The final challenge towards theoretical frameworks of CAC relates to the absence of conversations around racism. Transcultural nursing has been criticised for a number of decades for ignoring the effects of unavoidable external influences that affect all our behaviours and unconscious intolerant behaviour towards each other, such as the role of history, politics and the media (Schim et al., 2007; Narayanasamy, 2006; Hagey et al., 2001; Triandis and Trafimow, 2001; Guibernau and Goldblatt, 2000). The criticism also extends into ignoring institutional or personal racism (Narayanasamy and White, 2005; Gustafson, 2005; Coup, 1996) in its ability to develop a demeaning and stigmatising identity for Others. Culley (2006:145) states that 'racism is euphemised, denied or negated' into the literature of nursing and healthcare within a language of equality, tolerance and fairness. This stigmatisation may not just be related to the individual patient's ethnicity or cultural community but be part of a bigger structural unequal relationship built between a dominant health system and a non-dominant person, group or community (Chalmers et al., 2002; Abrums and Leppa, 2001).

This criticism regarding racism is imbalanced in relation to the four frameworks utilised in the UK as they all encourage reflection and self-awareness of ethnocentric ideas as being fundamental to the ability to provide successful CAC. Blame for the lack of consideration of racism should perhaps be placed with those individuals who have chosen to use these frameworks without considering the role of racism within the context of their study. This does illustrate, however, that the utilisation of a theoretical framework does not always influence the nurse in providing CAC in a non-ethnocentric way.

Despite these criticism, UK and European studies continue to show the need for this subject to be taught in nursing education (Taylor et al., 2013; Pahor and Rasmussen, 2009; Hughes and Hood, 2007; Lim et al., 2004). There is also a research collaboration, in its penultimate year, referred to as the 'Intercultural education for nurses' (IENE) project involving six European countries. The project has collaborated in the development of three learning tools, covering culturally competent compassion, culturally competent courage and intercultural communication led by Papadopoulos and Middlesex University. The ultimate aim is to develop a multilingual website, informative guide and a learning platform for nurses (and other health and social care health professionals), with learning materials and tools for developing and improving CAC.

The next section will now concentrate on the UK-based journal articles that have emerged in the past 10 years concerning CAC, to understand the patient perspectives to improve CAC.

2.6.3: PRACTITIONER PERSPECTIVES AND SERVICE-USERS' PERCEPTIONS OF CAC

In order to explore the research questions and achieve the objectives set for this research (see section 1.4) a literature search was carried out within a ten-year period (2006-2016), to elicit the viewpoints of practitioners regarding service-user perspectives regarding CAC. The search was limited to those written by UK nurse practitioners, to gauge the degree to which service-user perspectives were central to or had been taken into account in influencing changes in the delivery of CAC. The search included a wide number of Boolean terms such as 'transcultural nursing', 'culturally appropriate care', 'cultural diversity' and 'culturally competence', with and without the addition of 'patient' or 'service-user perspectives'. Due to the inconsistency in terminology, this ensured that I considered as many variations that journal articles may have used, to inform a greater understanding of what has been written regarding patient or service-user perspectives regarding CAC.

Encompassing the nursing journals or nurses' writing in health and social care journals, in terms of a clear connection to my research question, my searches only revealed seven studies that clearly researched what aspects of CAC were seen as important from the service-user or patient perspective (see Table 2.4 for an overview of these service-user centred studies).

TABLE 2.4: SELECTED STUDIES FROM THE NARRATIVE LITERATURE REVIEW

TITLE	YEAR	AUTHOR/S	JOURNAL
1) The role of the stoma nurse in providing culturally sensitive care for a Chinese child with a prolapsed loop colostomy	2013	Chandler, P.	Gastrointestinal Nursing, 11(1) pp. 18-23
2) The importance of transcultural nursing in cancer care	2012	Lo, Y.	British Journal of Nursing, pp. S32-7
3) A care pathway approach to identifying factors that impact on diagnosis of heart disease in British Pakistani women	2012	Piercy, H., Chowbey, P., Soady, J., Dhoot, P., Willis, L and Salway, S.	Ethnicity and Inequalities in Health and Social Care, 5(3) pp. 78-88
4) Unmet needs and antisocial personality disorder among Black African and Caribbean service users with severe mental illness	2011	Gwaspari, M., Hochhauser, S. and Bruce, M.	Ethnicity and Inequalities in Health and Social Care, 4(1) pp. 38-48
5) Understanding barriers to healthy lifestyles in a Bangladeshi community	2009	Grace, C. R., Begum, S., Subhani, P., Kopelman, P. and Greenhalgh, T.	Journal of Diabetes Nursing, 13(2) pp. 58-66
6) The personalisation of dementia services and existential realities: Understanding Sikh carers caring for an older person with dementia in Wolverhampton	2009	Jutlla, K. and Moreland, N.	Ethnicity and Inequalities in Health and Social Care, 2(4) pp. 10-21
7) The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK	2008	Gilburt, H., Rose, D. and Slade, M.	BMC Health Services Research, 8(1) p. 1

The studies mentioned above were relevant to this research, as they had engaged with the service user to discover needs and perspectives of CAC. These research studies mainly provided a small sample of participants and were focused on understanding just the group of people for whom they were caring.

Grace et al. (2009) for example, interviewed service users with diabetes, to investigate what they understood about their own barriers to adopting a healthier lifestyle within a Bangladeshi community, as a way of improving services for them. Similarly, Lo (2012) considered the importance of transcultural nursing in cancer care by eliciting this information from service users within a hospice. Piercy et al. (2012) utilised focus groups and interviews to reconsider the existing care pathway they were utilising to identify factors that impacted on British Pakistani women being diagnosed with heart disease. Although not in conversation with the service users themselves, Jutlla and Moreland's (2009) exploration of the perspectives of Sikh carers caring for an older person with dementia was also aimed at improving services for the patient from their needs and perspectives.

Chandler (2013), in considering her role as a stoma nurse, felt that she had developed her understanding of CAC due to the interactions with a Chinese boy with a prolapsed loop colostomy and his family. Two mental health related articles were also found. Gwaspari et al. (2011) interviewed service users regarding unmet needs and antisocial personality disorder among Black African and Caribbean individuals with severe mental illness. The second was Gilbert et al.'s (2008) qualitative research regarding service-users' experiences of psychiatric hospital admission in the UK. The practitioners approach here was to disseminate evidence related to the specific groups or individuals with whom they were coming into contact. They were able to express that

the learning from communication made with individuals who differed from the majority of patients they came across, had changed and improved the service delivery to all patients, due to a better understanding of individualised care. This second study was the only one to use participants from the Majority population within its sample.

What was easier to find during the searches was a greater emphasis in practitioner-based literature on a more etic approach, where the articles emphasised shortcomings in the delivery of CAC from the nurse perspective, regarding applied theoretical theory to suggest improvements for care for the BAME group with whom they had practice contact. An example was Berjon-Aparicio's article regarding the lack of cervical screening uptake by Orthodox Jewish women. Here, no Orthodox Jewish women were interviewed for an exploration as to why or how the uptake of the service could be improved (other examples: Bunting, 2016; Hart and Mareno, 2014; Mullay et al., 2011; Vydellingum, 2006).

Some of the literature regarding BAME communities' experiences were part of larger research studies and often related to a public health body's research on physical illness rather than how they would want CAC to be delivered within a service (for example, Ismail and Atkin, 2015; Wilkinson et al., 2014; Smith et al, 2013; Gill et al. 2011; Pattenden et al., 2007; Morgan et al., 2007). These journal articles do refer to the challenges of intercultural communication, ethnocentricity and lack of flexibility as factors in accessing services, but the perspective, again, remains from the practitioner's point of view.

This pattern of writing about what is core to CAC from a nurse's perspective, as opposed to a service user's, is not unique to the UK. For example, in a Swedish study by Jirwe et al. (2010) they gathered data to identify the core components of cultural

competence by interviewing 24 experts (eight nurses, eight researchers and eight lecturers) knowledgeable in multicultural issues, rather than asking service users. In the same year, the Journal of Transcultural Nursing in the USA published the national *Standards of Practice for Culturally Competent Nursing Care* by Lauderdale and Miller (2009). Again, no consultancy or research of service-users' perceptions of CAC was elicited to provide another level of evidence to support their extensive document.

The two countries that put forward the largest amount of practitioner learning from the perspective of their client group were Australia and New Zealand. This could be because there appears to have been a more open national discussion by health and social care professionals regarding Indigenous Australians and the Māori and the degree to which they have much higher levels of ill health and mortality when compared to the non-Indigenous people of these countries (for example, Paradies et al., 2008; King et al., 2009; Anderson et al., 2006). National acknowledgement of the disadvantage suffered by these Indigenous peoples has been associated with both historical colonisation and oppression, which has then been perpetuated by contemporary racism. Arguably, this could perhaps have contributed to the higher rates of practitioners engaging in patient perspectives, compared to the migration history of Others into the UK; however, literature to support my perspective was less easy to find.

2.7: SETTING THE SCENE FOR THIS RESEARCH

Having considered the literature above, there was a lack of qualitative research in exploring CAC from a service-user's perspective, in order to add to nursing knowledge around the subject. In order to explore my research questions, a number of research aims were set. They were:

Aim 1: To develop an understanding of the health service users' previous experiences of CAC.

Aim 2: To develop an understanding of what CAC should be from the perspective of service users.

Aim 3: To understand service-users' views of the influences on the provision of CAC by nurses.

In order to achieve these aims, the next chapter will be the Methodology, which will rationalise the approaches I utilised in order to carry out this research effectively.

CHAPTER 3: METHODOLOGY

This chapter will provide an exploration of my rationale, the progression from the theoretical underpinnings to my methodological approach and my choice of paradigm for this research entitled *Culturally appropriate care: A qualitative exploration of service-users' perspectives of nursing care*. I will also clarify how these choices were inter-linked, affecting my selection of research method, choice of participants, the effect on ethical considerations and congruence of the analysis framework utilised in considering the research questions. It will provide details of the pilot study and information regarding my fieldwork. The final section of this chapter will also detail the processes I engaged in to generate the themes and codes from the transcribed data, in order to analyse the findings of my research.

3.1: ESTABLISHING TRUSTWORTHINESS

As discussed in Chapter 1 and 2, the research questions and the subjective nature of the data placed this study within the area of qualitative research. Qualitative research has been described as a form of 'social inquiry' (Holloway and Wheeler, 2010:3) that focuses on the way people make sense of their lived experiences. I wanted to ensure that my qualitative research did not subordinate the authenticity of the service-user's voice; therefore, the research process required openness in terms of review and the evaluation of its quality and an understanding of the researcher's positionality in relation to the insider/outsider role. I felt these factors influenced the choices I made about how the research questions were explored and clarified before proceeding further along this journey.

Quantitative researchers are bound by the rules of their domain. In contrast, qualitative researchers, whatever their professional backgrounds or preferred paradigms and epistemologies, need to be particularly clear regarding the standards of the quality of their research (Silverman, 2011). This is congruent with the variation and complexity of their questions, the role of the results and the possibility of multiple perspectives in terms of findings (Long and Johnson, 2000).

Similarly, to be able to find a singular suitable judgement of quality for all qualitative research would be challenging. As Rolfe (2006) and Tobin and Begley (2004) expressed, trying to come to a consensus for judging the quality of qualitative research is impossible as the combinations of theory, method and the object of study (intersubjectivity of personal experiences) are too varied to be successfully judged by one standard.

Despite the presence of numerous overlapping concepts such as rigour, credibility and transferability employed to deliberate quality within qualitative research (Harrison and Morton, 2001; Krefting, 1990), I utilised the overarching concept of trustworthiness to express those corresponding concepts of quality that were maintained throughout the duration of this research. In this next section, I will clarify the choices I made and my meaning of trustworthiness as a way of maintaining the authenticity of my research journey.

Establishing the trustworthiness of a study must include a number of strategies made explicit during the whole journey of the study. Trustworthiness, according to Sandelowski (1993:2), is a matter of 'persuasion whereby the scientist is viewed as having made those practices visible and, therefore, auditable'. This broad concept includes ensuring rigour (Rolfe, 2006), credibility (Shenton, 2004) and transferability

(Harrison and Morton, 2001). For me, the concept of trustworthiness and the maintenance of transparency also incorporate issues around ensuring this research was carried out in an ethical manner. (Ethical considerations for this research will be discussed in depth in section 3.6.)

Rigour is the demonstration of the plausibility of a research study (Ryan et al., 2007), shown in this research by making clear the logical connection of the steps taken (Grove et al., 2015). Some writers consider the concept of rigour at a number of levels: rigour of documentation, procedural rigour and evaluative rigour (Kitto et al., 2007). Rigour of documentation was reflected in my research by adopting, wherever possible, an unambiguous and coherent way of presenting the stages of my study, from the introduction through to the conclusion.

Procedural rigour (the transparency shown in utilising appropriate and accurate data collection techniques (Koch, 2006)) was demonstrated by making explicit the choices I had made in each chapter to carry out the different phases of this research. I also ensured the provision of a clear, connected critical and reflexive component to this research by making clear the shifts from my previous understanding of the subject as the research progressed. Another intention in evidencing my reflexive journey was to reduce misinterpretation of the data generated and to give a true voice to the participants' perspectives of CAC (as opposed to just mine), allowing for open acknowledgement of the complex influences between me, my knowledge regarding the subject and the participants who took part in this research.

As mentioned, there was also a need for unambiguity and clarity when it came to the ethical and political aspects of the conduct of the research. In some literature, evaluative rigour is also referred to as ethical rigour (Ryan et al., 2007; Cho and Trent,

2006). In this research, this ranged from the more apparent ethical issues such as confidentiality and anonymity of the participants, to the more subtle but significant awareness of inter-subjective factors that may have affected the conversation between the participants and myself (for example, the positioning of the interviewer, status or gender) throughout the duration of the research study. Issues around consent and ethical practice will be deliberated at many levels within this research, to ensure fairness to the participants of the study and the authenticity of my findings.

Aspects that make up evaluative rigour overlap with the concept of credibility in qualitative research. Credibility refers to the faithfulness of the description to the phenomenon in question (Koch and Harrington, 1998), and to whether the results of a study are well presented and meaningful. In order to demonstrate faithfulness to the participants' views, I returned the transcriptions to the participants to consider their accuracy. I also, in some cases, asked for clarification of some responses (see Appendix 2 and 3 for examples of e-mail correspondence with participants).

Also, in relation to evaluative rigour, I ensured that there were clear explanations throughout the research process regarding the choices I made. For example, the congruence of the Attride-Stirling (2001) Thematic Network (TN) framework I employed to scrutinise the data and show clarity in the conclusions and interpretations I had reached (see section 3.11 and Appendix 1 to 12 showing the process from transcription, organisation of codes, to the final themes).

A final consideration within trustworthiness was the issue of transferability.

Transferability in qualitative research is not related to trying to replicate or apply the whole study to another location. Koch and Harrington (1998) stated that transferability in a qualitative research study is heightened when the findings are meaningful to

individuals outside the research study. For me, in this research, it was connected to how useful the findings would be to the context of the research (nursing, education, research, practice and policy) and those connected to this research (nurses, patients, and other health and social care professionals).

3.2: CLARIFYING CONCEPTS WITHIN MY PHILOSOPHICAL ASSUMPTIONS

At this stage, I needed to explore and understand concepts that would underpin my research. Understanding this would enhance and influence the choices I would make for this research journey in a congruent manner that showed trustworthiness. I recognised I needed to be clear about the context of any research terms used, in order to show consistency throughout the research. The next section will consider how I came to unravel these concepts before considering my philosophical stance for this research.

According to Gray (2009), qualitative research allows for the flexible use of strategies and data collection methods, dependent on not just the research question but also the type of paradigm that the researcher has adopted. Paradigms are simply 'a broad view or perspective of something' (Taylor et al., 2007:5). Weaver and Olson (2006:460) more specifically defined paradigms as 'patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished', clarifying how it affected and guided any research study. I found, however, it was challenging to express which paradigm my research belonged within, without being clear about my ontology, epistemology and methodology for this research. Similarly, Guba (1990) expressed paradigms could only be unquestionable once the inter-linked philosophical characteristics of the ontology, epistemology and methodology of a research study are worked out. Together they

come to create a holistic view of how we view knowledge, how we see ourselves in relation to this knowledge and the methodological stratagems we use to uncover it.

To discover a researcher's ontology is to make clear what makes up their nature of reality (King and Horrocks, 2010). An explanation of my ontology was a way of clarifying my most basic way of knowing, as it would then impact on every research choice I made, from the type of research question I wanted answering, to the way the conclusion would be expressed (Vasilachis de Gialdino, 2009). With this research, my previous experience as a nurse and my interest in the nursing literature on the subject and an understanding of positionalities had instilled a belief that the participants who volunteered for this research would have perceptions that were quite different but equally relevant regarding what constituted CAC. Therefore, as I progressed through this process the chosen paradigm, method or analysis framework would need to reflect and be able to accept the multiple subjective realities I expected to emerge from any data collected.

Crotty (1998:3) defined epistemology as 'the theory of knowledge embedded in the theoretical perspective and thereby in the methodology'. The term epistemology comes from the Greek word 'episteme', meaning knowledge (Merriam-Webster Online, 2015). In research terms, epistemology encompasses our perceived relationship with the knowledge we are researching and whether we are part of that knowledge or if we can remain external to it. Some research authors, such as Crotty (1998) and Trochim (2000), categorised the range and variations of epistemologies (e.g. objectivist, constructivist or subjectivist) within the degree to which meaningful reality exists. As I related and recognised the development of scientific understanding, social structures and truth as social constructions, my epistemological stance was most

closely linked to a constructivist epistemology. Constructivists explain influence through the dynamics of social relationships between individuals (Burr, 2003) and perspectives of research participants are viewed as 'constructed frameworks rather than direct reflections of the real' (Raskin, 2008:16). The adoption of this constructivist epistemology required me to become more self-aware regarding the influences that had so far constructed my understanding of CAC. Related to this, I came to realise that my knowledge of this subject, personally and professionally, would be challenged as I focused on the social construction of perceptions, meanings and interpretations of the participants on the same subject.

Having established my ontology and epistemology, this in turn influenced my choice of methodology. A wide range of methodologies relating to inquiry about the perspective of the participant (or, in this case, service users or patients) emerged (see Figure 3.1). These included case study, ethnography, participant observation, performance ethnography, narrative analysis, hermeneutics, ethnomethodology, phenomenology, grounded theory, participatory action research, historical methods and clinical research (Grbich, 2012; Denzin and Lincoln, 2013; Gray, 2009). All these methodologies varied in their application, dependent on the researcher, the research question and if a philosophical theory had been adopted to provide a form of focus.

Keeping in mind my understanding so far regarding positionalities, my choice of methodology needed to allow me to ask for personal interpretations and listen to the language used to express them, through the questions that I wanted to ask. It also required within it flexibility for participants to express how their perceptions have caused them to behave and interact with their external environment, and to allow me to adapt or revise questions according to what had been said during the analysis.

Attached to this, the chosen methodology needed to allow me to express what I understood or had changed from my pre-study perspective regarding the subject at hand.

There was no doubt, with differing ontologies and epistemologies, my research question could have been explored by any of the previously mentioned methodologies in a number of ways. I needed, however, to acknowledge the movement between my positionality and existing understanding of CAC, and the participants during the process of this research study. I perceived the methodology most congruent with my ontology and epistemology for this research was the circular process of hermeneutics. Simplistically, hermeneutics is defined as the 'art of interpretation' (Dowling, 2004). Within it, the value given to the expressions of participants, using their language and their ideas or semantics of the constituents of that language, provides understanding and knowledge to the research questions without subordinating its value (Byrne, 2001). Hermeneutics will be considered in greater depth in section 3.3.

Having explored my ontology, epistemology and methodology, I began to appreciate the features of the paradigm in which my research was situated. Creswell (2013) asserted that this is an important undertaking each time we venture out on a research study, as our philosophical assumptions may have changed over time, career or goal of study.

There is a perplexing array of different paradigms, sometimes ordered into different categories and used interchangeably by different scholars. Seminal qualitative research authors such as Denzin and Lincoln (2013) and Gray (2009) collated a number of broader paradigms suited to the inquiry of the 'socially situated researcher' (Denzin and Lincoln, 2013:25). In no particular order, Figure 3.1 shows these paradigms in

conjunction with a number of strategies of inquiry and my chosen methodology of hermeneutics. I have organised this figure to express the flexibility of qualitative research in adopting a combination of several frameworks and methodologies within a research design. However, the researcher needs to be able to rationalise clearly the feasibility and legitimacy of adopting their methodology to answer their question, within the paradigm they had selected.

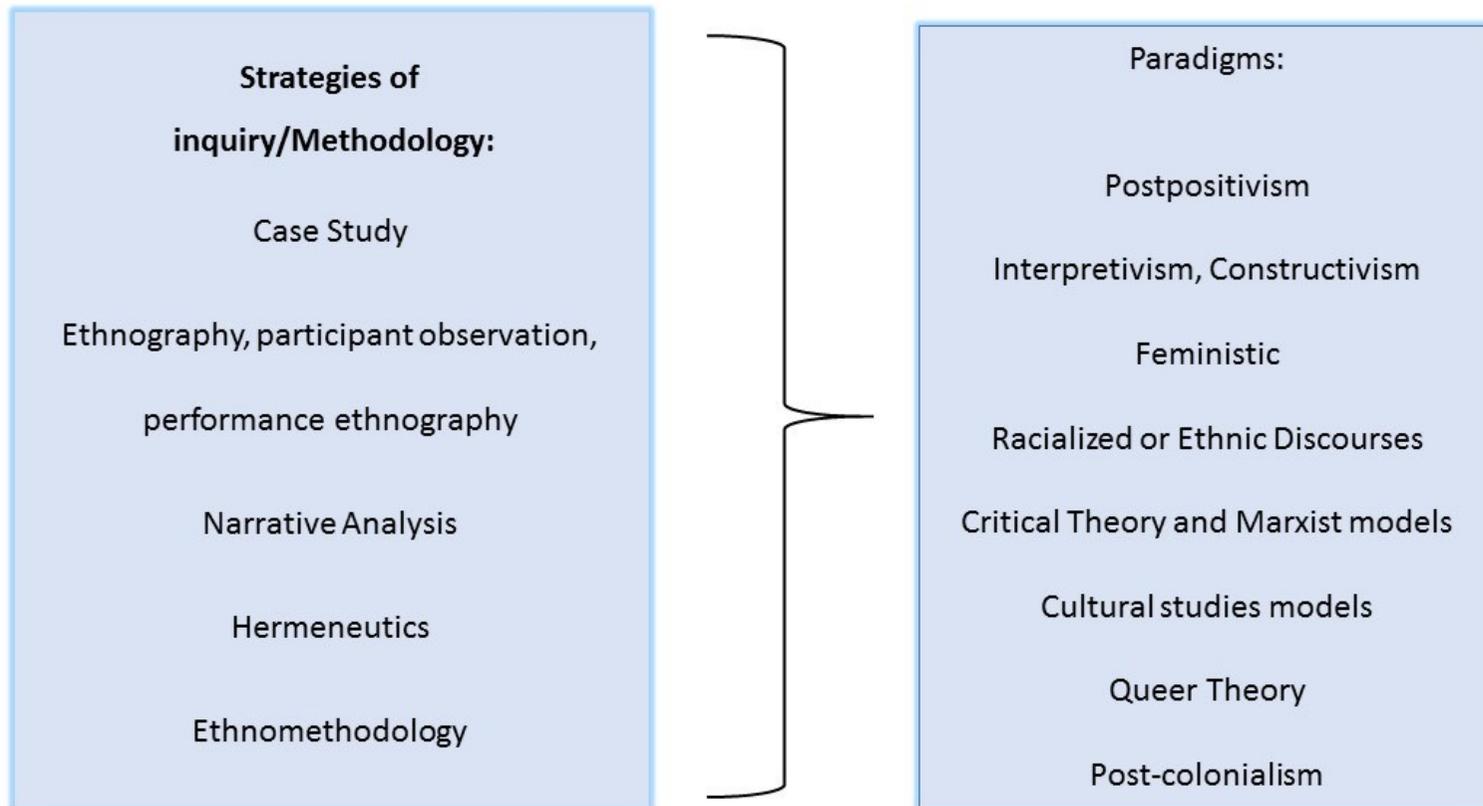


FIGURE 3.1: OVERVIEW OF QUALITATIVE RESEARCH PARADIGMS AND ASSOCIATED METHODOLOGIES

Narrowing down which paradigm was suitable for my research involved considering literature around those listed in Figure 3.1 in light of my research question and its cognisance with my ontology and epistemology. Marxist and feministic paradigms, racialised discourses and queer theory, among others, relate more closely to Denzin and Lincoln's (2013:27) 'materialist-realist' ontology. Those researching within these paradigms explore the impact of the real world that result in individual differences in terms of race, class, gender and sexualities for a person but not beyond. Similarly, a paradigm such as postpositivism, despite the ontology remaining congruent with the idea of multiple realities, situates its philosophy in learning centrally, in the experiences of oppressed persons (Seale et al., 2007). This was only partly congruent with my philosophical assumptions or my aims for the research question.

My ontology, epistemology and choice of hermeneutics as a methodology allowed for the narrowing of choices of paradigm, as searches for congruency through literature searches and examination of other research theses repeatedly brought about similar results. They were centred on the interpretivist paradigm. My choice of paradigm, therefore, was the interpretive paradigm. Influencing my decision was literature by authors such as Kikuchi (2003) who felt participant perspectives in research are social constructions derived from a combination of language, consciousness or shared meanings. Also, Collins (2010:38) linked interpretivism with research that

...is used to group together diverse approaches, including social constructionism, phenomenology and hermeneutics; approaches that reject the objectivist view that meaning resides within the world independently of consciousness.

This paradigm aligned with hermeneutics due to its ontology of multiple realities and its epistemology that allowed the researcher and participants to co-create understandings

and adopt a naturalistic set of methodological procedures (Denzin and Lincoln, 2013). As in the aim of my research, the fundamental objective of the interpretive paradigm is to ascertain the concept of understanding associated to human experience and actions, as expressed and articulated by them through conversation (Fossey et al., 2002).

Interpretive methodologies, such as my choice of hermeneutics, position the understanding and interpretation of participants at the centre of the research. It is steered from an experience-near perspective in that the researcher does not start with concepts determined 'a priori' but rather explores the topic within its context, allowing them to emerge from encounters with participants or the field of work (Creswell, 2013).

3.3: HERMENEUTICS AND THE INTERPRETIVE PARADIGM

Within the interpretive paradigm, the utilisation of hermeneutics as a methodology needed further consideration and deliberation to show its connection to this research. Hermeneutics has been utilised across a number of methodological frameworks of research in various ways, to give priority to the participant's voice. This next section will explore these frameworks to show the rationale of my ultimate choice.

Hermeneutics has its origins in the 17th century, where the method was employed for interpreting and illuminating the Bible and classical literature (Ramberg and Gjesdal, 2005). Collectively, a hermeneutic outlook encompasses a pluralistic viewpoint on a multidimensional and complex reality of the world. In hermeneutics, the experience of gaining new knowledge evolves amid the encounter between the known and unknown or what we have now come to understand and pre-understanding (Goergii-Hemming, 2007; Gustavsson, 2000). According to Byrne (2001), hermeneutics has two suppositions: all of us experience our world through the medium of language; and language provides understanding and knowledge, individually and collectively.

As hermeneutics has no universal principles, it can be applied across different theoretical positions, methodologies and several schools of philosophical thought. According to Dowling (2004), overall the three broad branches of hermeneutic theory with implications for methodology are objective hermeneutics, critical hermeneutics and Gadamerian or philosophical hermeneutics.

Objective hermeneutics is also interchangeably termed descriptive phenomenology and is closely linked to the work of phenomenologist Edmund Husserl (Maggs-Rapport, 2001; Koch and Harrington, 1998). This form of hermeneutics has close links with quantitative research and the positivist paradigm, especially in its strategy for objectivity in phenomenological methods. As such, this form of hermeneutics was discounted for my study.

Critical hermeneutics continues to be linked to the Dutch School of phenomenology, including scholars such as Habermas and Van Manen. In terms of a historical timeline, it remains the most recent school of hermeneutics. Placing analysis of data in a wider social-economic context, it requires the interpretation of issues of power and ideology (Roberge, 2011) as part of its research purpose. The purpose of interpretation here is emancipatory: conventional wisdoms understood by individuals or communities are challenged in order to address potential positional asymmetries for a newer understanding (Butler, 1998). Although this perspective could have made connections to my research, I felt, again, this perspective diverged from my specific ontological and epistemological assumptions in this instance.

The third school of thought in hermeneutics was philosophical hermeneutics. Linked to the work of Hans-Georg Gadamer, understanding is derived from dialogue and language, in that the researcher's pre-conceptions are part of the conversation that takes place in

order to understand the subject at hand. Understanding occurs within a reciprocal relationship of conversation that takes place between the researcher and participant, in order to reach a different, newer understanding. For me, Gadamerian philosophical hermeneutics was most congruent to my ontology and epistemology for this research question.

Gadamer is more often considered a hermeneutic phenomenologist due to his connection with the Frankfurt School of phenomenology; however, for me, his philosophical hermeneutics situates itself beyond this methodological perspective. As Wiercinski (2009:3) expressed, it is 'not a method of interpretation, but an investigation into the nature of understanding, which transcends the concept of method'. It is also important to note that my research is not a philosophical thesis but my ontology and epistemology resonate with Gadamerian philosophical hermeneutics and it has influenced the way I carried out my research positively. This was another way of ensuring the authenticity of the service-users' perspectives in their responses to my research question and its capacity to interrogate my positionalities as the research progressed. With my reflexive journey so far, Gadamer's philosophical hermeneutics remains consistent with regards to interrogating those paradoxical insider/outsider positionalities and the social identities emerging from our intersectionalities. As such, this next section will concentrate on the factors around Gadamerian philosophical hermeneutics that influenced my research process and thinking.

3.4: GADAMERIAN PHILOSOPHICAL HERMENEUTICS

Human being, Gadamer argues, is a being in language. It is through language that the world is opened up for us. We learn to know the world by learning to master a language. Hence we cannot really understand ourselves unless we understand

ourselves as situated in a linguistically mediated, historical culture. Language is our second nature.

(Ramberg and Gjesdal, 2005)

The philosophical hermeneutics of Hans-Georg Gadamer (1900-2002) has its origins in the Heideggerian School of phenomenology. Heidegger was Gadamer's tutor and was instrumental in developing hermeneutic phenomenology as a philosophical methodology that allowed the meaning of 'being-in-the-world' to be uncovered. Gadamer continued the work of Heidegger but it was the evolution and emphasis of Gadamer's philosophical focus on dialogue and language that, for me, was pertinent in influencing this research's processes and decisions.

Gadamer concurred with the Heideggerian perspective that hermeneutics was a way of knowing, thus an ontology; it was about the most fundamental conditions of man's cyclical, evolving understanding of 'being-in-the-world' (Ramberg and Gjesdal, 2005). Yet, the Gadamerian focus was in wanting to uncover the meanings of such a claim within the experience of dialogue and language. He expressed that 'language is the medium in which substantive understanding and agreement take place between two people' (Gadamer, 2013:402). Importantly, in his magnum opus *Truth and Method* (originally published in 1960, I have utilised the reprinted, re-translated version of 2013: xxii) Gadamer asserted that his perspective of hermeneutics was not a methodology of human sciences but a human mode of understanding the totality of 'being-in-the-world'.

3.4.1: GADAMERIAN PHILOSOPHICAL HERMENEUTICS' KEY CONCEPTS OF

UNDERSTANDING

Gadamer began his narrative in *Truth and Method* discounting the ability to discover complete objectivity within human thought, purely armed with the rational procedure of the natural sciences (Lawn, 2006). For him, the process of trying to understand any

subject was focused around language and dialogue, which allowed the process of coming to an understanding (*Verstehen*) and to both perspectives of 'being-in-the-world' (Gill, 2015). In terms of dialogue and language, two overarching aspects that a researcher needed to be conscious of were the key concepts of Gadamerian philosophical hermeneutics and an openness to intersubjective otherness. The deliberation on openness will be discussed in section 3.4.2.

In Part II of *Truth and Method*, Gadamer situated understanding within key interlinked concepts that were central to his form of hermeneutics: horizon, tradition, prejudice and authority. Through dialogue, these notions were prerequisite in appreciating the conditions of understanding, which he claimed made the study of language effective as 'a view of the world' (Gadamer, 2013:458).

Our perspectives of the world, how we see others and ourselves in the world, are our horizon. The horizon, however, does not remain a 'rigid boundary but something that moves with one and invites one to advance further' (Gadamer, 2013:247). Our horizon contains our 'historically effective consciousness' (Gadamer, 2013:312) and prior to an inquiry, our traditions, prejudice and authority make up the conditions of our pre-understanding, like a vantage point. It would be through dialogue with the participants of this study that this previous understanding would come to be heard as an integral aspect in appreciating what they wanted from CAC.

Tradition, the link with our own past, carries with it 'superiority in knowledge and insight' (Gadamer, 2013:279). This superiority connects to the fact that we are always part of what we seek to understand. Therefore, ensuring authenticity to participant responses would need to come from the perspective of those with that lived experience. It can also be related to what has been verbally expressed to us in the past and handed down by

language. This idea was consistent with my ontology and epistemology for this research as the participants' and my previous experiences of CAC would inevitably influence how we both expressed its dimensions during our conversation. It also linked the hermeneutical ideas of language, dialogue and conversation to one aspect of the definition of culture I have utilised for this research: Helman's (2007:4) definition regarding culture, which included it being 'a way of transmitting these guidelines to the next generation by the use of symbols, language, art and ritual' (see section 2.5 for discussion). This tradition and experience equip the researcher and those involved in a conversation with another of Gadamer's necessary conditions of understanding: 'prejudice' (*Vorurteil*).

Prejudice, re-defined by Gadamer in a positive light, revolves around the sources of subjective historical reality of a particular phenomenon. Prejudices 'constitute the initial directedness of our whole ability to experience' (Gadamer, 2013:289). Essential to understanding, no act of a conversation or thought would occur without any pre-conceptions or fore meaning. Conversations, even misunderstanding, develop into a conversational interplay between two people that benefit from the process of reinterpretation and understanding.

The restoration of prejudice as a realistic concept in Gadamerian philosophical hermeneutics allowed me to explore the constant changing course of my perceptions, understanding, deep interest and the unavoidable historical fact of personal lived experience around the subject of this research. To ensure balance, it was equally important for me to be aware of my own prejudices or prejudgments, so that the text or conversations with the participants could present and assert their own truth alongside an openness of my own prejudgements.

Authority, in Gadamerian philosophical hermeneutics, represents forms of self-advocacy about what constitutes facets of the truth to a person. For instance, some forms of authority could influence a person in not using their own reason to arrive at their perception of an event or conversation. Árnason (2000) expressed that the strongest reason yet for committing to understanding participants' perspectives regarding the effects of health and social care interventions is to give respect and be accepting of their self-determinism, thus, in my understanding, authority. Again, I felt this showed the congruence of Gadamerian philosophical hermeneutics with my research.

It could be argued that these hermeneutic concepts as expressed by Gadamer show similarity of ideas around reflexivity and positionality (as discussed in 1.4) as the unconscious and conscious social locations and movement of understanding between the researcher and participants' adjusts and shifts during a conversational dialogue.

An understanding of the fundamental concepts of Gadamerian philosophical hermeneutics provided me the opportunity to look at the participants' perspectives from the conditions of their understanding of the subject, without being nervous of the influence of my own horizon and its tradition, prejudices and authority when interpreting any data. Gadamer, however, also stated that an openness to other perspectives was required in order not to restrict what others were saying, and truly hear their voice.

3.4.2: AN OPENNESS TO OTHERNESS WITHIN DIALOGUE

Hermeneutic experience is verbal in nature

(Gadamer, 2013:460)

Having explained the concepts fundamental to Gadamer's ideas around understanding, this section will now look at how they collectively affect language and dialogue. Dialogue in Gadamerian philosophical hermeneutics requires a number of components: two

participants (the second participant could be a person, text, art, gestures, sign language, among others); an attitude of openness to that other; and that the exchange is orientated towards understanding the subject matter of the encounter (Vessey, 2011).

In understanding the key concepts that are central to a person's horizon, the researcher, then, when engaging in a study, would need to have further insight into a number of factors. New insight does not always result in better understanding of a subject but, as Dowling (2004) explained, a different type of comprehension. The utilisation of Gadamerian philosophical hermeneutics is not about agreement but, as Gadamer stated:

...such a conversation is made no less fruitful by the participants' inability to come to an agreement about the matter, as long as it enables them to become explicitly visible in his being to the other (Gadamer, 1991:37).

Another aspect of Gadamerian philosophical hermeneutics revolves around coming to an understanding, which occurs when the researcher engages in a reciprocal process of interpretation (Spence, 2001). Gadamer expressed that an openness to the other involves recognising that 'I myself must accept things that are against me, even though no one else forces me to' (2013:361). He referred to this openness as 'hermeneutic virtue'.

To maintain this openness and avoid subordinating the participant's understanding, the hermeneutical task was to enter 'into an event of transmission in which past and present are constantly mediated' (Gadamer, 2013:274). Understanding is achieved by our interpretation of responses within a constantly moving circular process and the influence of our positionalities, in which we move from a whole to the individual parts and from the individual parts to the whole through the hermeneutic circle. Gadamer, in describing the hermeneutic circle, stated that 'the true locus of hermeneutics is this in-between' (2013:306). Understanding, however, remains a constantly evolving process. I came to appreciate this process of hermeneutic understanding as a spiral, as understanding does

not remain or return to where it started (see Figure 3.2 for my representation of the hermeneutic process).

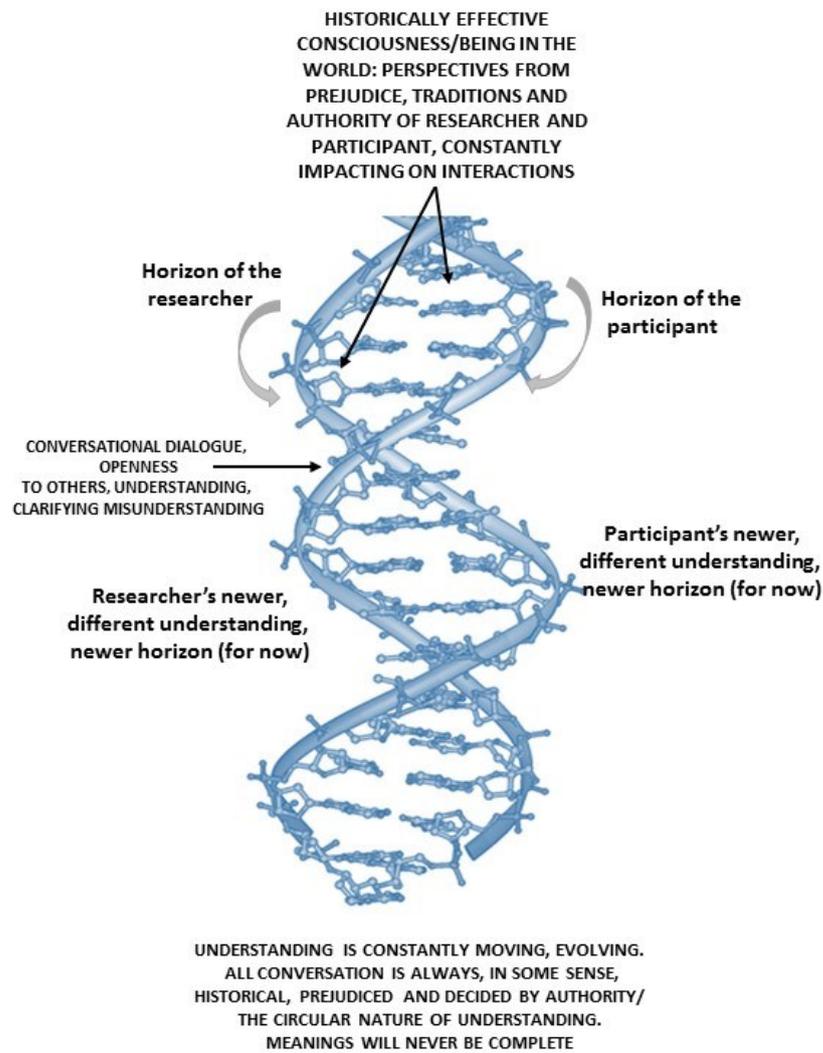


FIGURE 3.2: THE CIRCULARITY OF HERMENEUTIC UNDERSTANDING

The utilisation of Gadamerian philosophical hermeneutics as a way to understand dialogue made me reassess if it had affected my original ontological perspective set out at the beginning of this chapter and my deepening understanding of influence of positionalities. Reflecting on my previous experiences, personally and professionally, my fundamental ontological belief was based around appreciation of the multiple perspectives we can have in how we express ourselves. The ontological basis for Gadamerian philosophical hermeneutics is not at odds with this but I began to have a greater appreciation for the process of interpretation, to reflect the extent of subjectivity or conditions of understanding of the participants' experiences. As expressed by Dahlstrom (2010:410), 'Insisting that the historicity of interpretation applies to the interpreter herself is another way of underscoring that every interpretation is a self-interpretation'. Gadamer's hermeneutic circular progression also made interpretation as trustworthy as possible because it aimed at making explicit its own conditions of interpretation.

3.4.3: GADAMERIAN PHILOSOPHICAL HERMENEUTICS AND NURSING RESEARCH

In nursing research, Gadamerian philosophical hermeneutics research can often be linked to phenomenological methodology. As both these methodologies provide frameworks that allow for the expression of participant knowledge in nursing practice, Dowling (2004) and Cohen and Omery (1994) stated that Gadamerian philosophical hermeneutics and phenomenology have been used interchangeably (for example, Hodges et al., 2001) and sometimes incorrectly (for example, Bergman and Berterö, 2001).

Simplistically, phenomenology focuses on exposing the meanings of the person's lived experience (phenomena) and obtaining commonalities and shared meanings. As

mentioned previously, Gadamerian philosophical hermeneutics differs from phenomenology mainly in its emphasis on language and dialogue, with the assumption that humans experience the world through language and this language is what provides both understanding and knowledge. It is arguable that a hermeneutical study could be phenomenological but for the purpose of this study, in keeping with my philosophical assumptions and my focus on language and dialogue further reinforced the congruence of Gadamerian philosophical hermeneutics with my research.

During my journey of discovery regarding the methodological frameworks that would most suit my research aims, I came across a number of nursing studies influenced by Gadamerian philosophical hermeneutics, which resonated with my philosophical assumptions. A study by Gregory (1994) and literature from writers such as Fleming et al. (2003), Lavery (2003) and MacManus-Holroyd (2007) discussed that within philosophical hermeneutics, the intention of research is not to develop a procedure for understanding, but to clarify the conditions whereby the participants come to their understanding.

Gregory's 1994 study, in particular, stood out in the way her chosen methodology allowed her to express the movement in and out of the hermeneutical circle (discussed in section 3.4.2) when it came to understanding the personal experience of suffering from the patient's perspective, as opposed to the health professional's bio-medical one. By not subordinating the participant's expressions, a significant and different understanding regarding the experience of suffering could be discovered.

3.5: CHOOSING A METHOD FOR CONVERSATIONAL DIALOGUE

So far, the exploration of my philosophical assumptions and choice of paradigm has shown how I came to be influenced by a Gadamerian philosophical hermeneutics methodology to explore my research question. This next section will show how

Gadamerian philosophical hermeneutics influenced my choice to adopt the most suitable method for this research.

Despite having a variety of methods to explore the aims of this research, I felt that the most effective approach in carrying out a conversational dialogue reflecting Gadamerian philosophical hermeneutics seemed to naturally point to interviewing. The next section justifies not only my rationale in choosing this method, but also the factors I needed to consider to reflect the influence of Gadamerian philosophical hermeneutics faithfully during the interviews and subsequent analysis.

Seidman (1991:3), in considering the conversational dialogue of interviews, expressed that:

...at the very heart of what it means to be human is the ability of people to symbolise their experiences through language. To understand human behaviour means to understand the use of language.

Laverty (2003) and Ajjawi and Higgs (2007) both considered that interviewing has very specific functions within Gadamerian philosophical hermeneutics. The conversational relationship provides the basis for discovering reflective shared meanings of an experience (as in the process of hermeneutics, you may return to the participant to clarify aspects of a previous conversation). This allows for the generation of stories of lived experiences (being-in-the-world) from the participant's point-of-view (Cortis, 2004).

Todres (1998:124) deliberated that any method chosen to explore and clarify the back and forth 'shuttlecock movement' of hermeneutic understanding must be able to achieve a number of things. It needs to be able to move us to an area of greater understanding by telling us more about what we have already understood and experienced, and how we live with the subject of inquiry. Reflexively, it also has a function of retaining the

continuity of what is experientially evident and familiar to us and sheds new light on to one's previous ideas, positionality or possibilities regarding the subject of study.

There are various ways of conducting research interviews, ranging from structured and semi-structured to unstructured interviews (Flood, 2010; Standing, 2009). My choice of semi-structured interviews (SSI) was made for a number of reasons. Situated between the controlled environment of structured interviews and, for me, the amorphous area of unstructured interviews, SSI provided a chance to consider CAC in greater breadth and to glean a level of richness from the text that the other two interview methods could not provide. I decided to undertake a pilot study to gauge the degree to which a number of core questions needed to be asked as a way of addressing the participants' pre-research horizon (their traditions, prejudices and authority) and their response in terms of positionalities, to appreciate the context of their understanding around CAC. I also felt SSI allowed participants the flexibility to respond freely to my questions and to recount their understanding of experiences without being constrained by a more rigid set of rules.

Alongside issues around ethics and consent (explored in section 3.7), there were other more subtle positional factors I needed to be aware of during the interview process. All interviews are complex social encounters (Ribbens, 1989) and it was important to remind myself to be aware of those intersectional and positional factors that were considered originally in Section 1.4 (Berger, 2015; Crenshaw, 1993; Mullings, 1999). As Goodyear-Smith and Buetow (2001) stated, this positionality remains an inescapable part of all social relationships. Conscious and unconscious positionalities have the capacity to influence interpersonal relationships by supplying or withholding the means required to fulfil one's own or others' needs and desires. 'Being-in-the-world' has varied meanings, inducing different cultural norms and stereotypes, which sway the opinions and feelings expressed

by both parties. I kept in mind there would be a number of inter-subjective factors. For example, the dynamics of the positionality relationship between the participant and myself can begin from the moment they contacted me; to how they perceived my role or me as a researcher (or as a university lecturer, as stated in the PIS); to the use of their data when completing the research journey. Some inter-subjective factors also crossed multiple cultural boundaries, such as national, ethnic, age, gender, sexual orientation, religion and socio-economic status (Sands et al., 2015).

Miller and Glassner (2004:147) stated that in order for an interview to be truly successful, the interviewer needs to engage the interviewee in a type of active conversation prior to the start of the actual interviewing, to encourage a 'climate of mutual disclosure' and a more ethical, less confrontational, less hierarchical and balanced conversation. This concurs with Gadamerian philosophical hermeneutic ideas around the circularity of hermeneutic conversation, openness and that understanding is not about agreement but making possibly invisible perspectives visible.

Silverman (2004), Miller and Glassner (2004) and Richardson (1990) cautioned all researchers on how they present themselves in relation to the questions being asked. This, they explained, can affect the willingness of the participants to tell their stories. Richardson (1990:25), in particular, explained the pitfalls of the 'cultural story', in that social phenomena were often conveyed 'from the point of view of the ruling interest and the normative order'. However, he also stated that the process of telling a story could empower the participant, as it allowed them the opportunity to challenge popular stereotypes about appropriated cultural behaviours, mainly by resisting the existing narratives about a group of people. I realised that I needed to apply a sense of attentiveness when looking at my role as the interviewer and during the interview, to

attempt to understand the participants' perspectives or as Miller and Glassner (2004:147) expressed, to foster a 'climate of mutual disclosure'. This attentiveness, in my understanding, refers to the reflexive role of being an outsider and an insider within the interview process. I also began to understand that the concept of positionality discussed earlier, traversed not just the interview itself but how I treated the data I generated and the extent to which I was expressing what they wanted to say, as opposed to what I thought was CAC.

By this stage, an emerging challenge for me was the need to ensure there was some form of criticality while considering and writing about the participants' perspectives that would emerge from these interviews. I had to safeguard the authenticity of what emerged by not only being honest regarding my perspectives and those of the participants, but as Haynes (2012) and Alvesson and Sköldböck (2000) conveyed, the need for me to be aware of how the participants and I would be affected by each other during the process of the interview.

This brought me again to the subject of reflexivity. Reflexivity, according to Denzin and Lincoln (2011), forces us to come to terms with the choices made within our research question (ontologically, epistemologically and methodologically) as well as with ourselves and the many identities that we sit within socially, culturally, professionally and historically. In interpretation, Gadamer stated, 'Thus a person who wants to understand must question what lies behind what is said' (2013:378) and saw reflexivity as part of the process of hermeneutical research. For him, reflexivity encourages the emergence of the obscurities of lived experience. However, just stating that I was going to be reflexive felt problematic and insufficient. In addition, the challenge of validation for me involved

having to make the implicit explicit through the value-laden nature of social, cultural and political meanings.

I was aware that I had to put measures in place to ensure the quality of my research; what Rolfe (2006) refers to as the validity, trustworthiness and rigour of my qualitative study. Although already discussed in section 3.1, for the purposes of deliberating ethics, it is important to reiterate that trustworthiness in a research study influenced by Gadamerian philosophical hermeneutics, needs to be established by a clear signposting of the 'research product' (Koch and Harrington, 1998:882) and the plausibility and believability of my negotiation through it. In other words, a reader of my research would be able to follow the ethical stances I adopted, as I moved through my world and that of the participants using a reflexive account of my research. On a personal level, I maintained a reflexive diary (a habit instilled into me as a young staff nurse) to record my thoughts and ideas about my experiences of this research study.

By maintaining a reflexive approach overall, Silverman (2011) expressed that it encourages the qualitative researcher to ask 'why?' to the answers given to the earlier 'what?' questions, and to document the thought process associated with it. Evans and Hallet (2007) also considered the importance of reflexivity as an important dimension in the designing and implementing of their hermeneutic phenomenological research as a way of increasing the credibility of qualitative research. Smith (1998) voiced that there are ethical and methodological benefits in maintaining a reflexive approach during his hermeneutical study on problem drinkers, in that it revealed previously hidden contextual information that would have been missed had he not taken on this idea of reflexivity.

Therefore, for this research, I adopted a number of reflexive ploys to allow my entry into the metaphorical hermeneutic cycle as I needed, from the start, to be able to step back

and be observant regarding the meanings of situations rather than accepting participant's' or my prejudgements and interpretations without question. These reflexive changes emerged as I progressed through this research. In relation to the SSI, I adopted a flexible questioning approach within my interviews, modifying them to suit the participant and their responses (Walker, 2011) (see Appendix 16 for the general guide utilised for interviewing). I have already mentioned that I maintained a personal reflexive journal to make transparent the subjective process on the decisions and analyses of the collected data. Although only a handful responded, I also adopted the concept of 'member-checking' (Rolfe, 2006) by meeting up again with the participants following transcription (for accuracy) and later, during data analysis, as a way of ensuring an increased level of trustworthiness in my interpretation (Dowling, 2008). I felt these actions were in keeping with Gadamerian philosophical hermeneutics, in terms of the openness required to make their views visible and trustworthy, as a review of its quality and ethical approach.

3.6: ETHICAL CONSIDERATIONS FOR THIS RESEARCH AND THE SELECTION OF PARTICIPANTS

This section will outline the ethical considerations for my study and the process of choosing the participants as they were inextricably linked during this part of my research journey.

3.6.1: OVERARCHING ETHICAL CONSIDERATIONS

A consideration of ethics needs to be pondered beyond the process of applying for approval from a research committee. I had come to realise that there was a need for ethical considerations at every stage, from the choice of subject for research to the way the research was carried out and even to the responsibility I had in ensuring the data

collected was treated faithfully. This discussion remains interconnected with my deliberation on trustworthiness in section 3.1, as the transparency shown in the way this research was carried out was part of an ethical approach to conducting research that intended to utilise viewpoints from participants as data.

Denzin and Lincoln (2013) stressed the need, within the diversity of qualitative paradigms and frameworks, for a form of reflexive ethics in order to boost its trustworthiness. This was present in this research in a number of ways: I ensured as much as possible a progressive infusion of ethics through the whole research process and to try to maintain a continuing 'moral dialogue' (Denzin and Lincoln, 2013:170). This was done by engaging in critically conscious effort to challenge and be aware of the social, intellectual and political locations and positionalities of all those participating within this qualitative research.

Cannella and Lincoln (2013) referred to this reflexivity as particularly important as it allowed for those multiple locations and the variation of power orientations within which a diverse population find themselves sitting within.

As originally discussed in 1.4, those aspects of insider/outsider positionality, the multiple, interweaving and intersecting ways in which both, the participants' and my various positionalities and identities are perceived, exposed and negotiated with each other, in this research encounter, remains crucial to the conduct of this research study in an ethical and trustworthy manner.

Merriam et al (2001) stress the need for ethical behaviours when conducting research where inequities around social positions can be framed in terms of power-based relationships between the researcher and the researched. Developing a mutual relationship, and continuing process of negotiating the balance of power and if possible, empowerment of their knowledge allows for a more ethical progression of research.

It required an awareness of the influence of my multiple social, professional and personal locations, from the ability to attract potential participants through to the end of the journey, in concluding the study. The utilisation of Gadamerian Philosophical Hermeneutics, it is felt, will enhance this process as it calls for an examination and re-examination of those pre-judgements and the changes in the horizon of both, a researcher's and participants' perspective.

The need for ethical behaviour in relation to the way I would conduct myself during the interviews in order for this experience to be a conversational dialogue was explored in section 3.5. Now, I will consider how the subject of ethics was also relevant to this research within other aspects fundamental to this research in relation to gaining ethical approval to carry out the research and in the way I selected participants for this research.

3.6.2: SAMPLING AND ETHICAL CONSIDERATIONS IN RECRUITING PARTICIPANTS

In keeping with my philosophical assumptions and reflecting my research question, I was interested in gaining access to a group of people who had been service users of the NHS within the past five years to be the participants. Arguably, the majority of people I come across have access to the NHS but I felt that it would make more sense to ask participants who had recent experience of healthcare provision to reflect current nursing care practices or experiences. Reflexively, having had the personal experience of being a service user and interaction with nurses, I felt this would add to the authenticity of the information collected.

I also felt that the participants needed to reflect the ethnic diversity of the North West, not for the purposes of meeting some sort of positivistic criteria of generalisability but more as a representation of views of the population of the region in the UK in which I reside. Choosing ethnicity as a group can be problematic (McCall, 2005). As a concept,

ethnicity remains subjective, hard to define and self-assigned (Bernard, 2011). My research focus was not about reporting comparative behaviours between ethnic groups to show some form of sample heterogeneity or to provide some measurement of culture. Okazaki and Sue (1995) expressed challenging methodological issues in utilising ethnicity in any form of measurement research. However, according to Bhopal (2007) and Smart et al. (2008) the concept of ethnicity remains the most common way utilised by the government, health institutions, qualitative and quantitative research, and literature to classify and generate health data. Consequently, those who volunteered for this study were not expected to be representative of their ethnic community but conversely, I hoped to explore the limitations of utilising ethnicity as the only measurement of delivering CAC.

I wanted to consider during my analysis, aspects of cultural hybridisation and globalisation (Yankuzo, 2014) on society's idea of culture. In terms of everyday understanding, I felt Azuonye's (1996:760) quote regarding the fluidity of cultural practices was noteworthy:

...apart from some very small tribes in the South American rain forest, every community on earth experiences influences from practically all others. Culture is an immensely dynamic entity. Cultural hybridisation and intermixture is the order of the day. There no longer exists any pure culture, anywhere in the world.

Taking this quotation into account and the discussion in the Introduction, participants from the Majority population were also included in this research study.

According to the Office for National Statistics, within the North West, the five main broad ethnic groups are White English, White Minorities, South Asian, African-Caribbean and Chinese/Oriental communities (ONS, 2013). As a result, I decided that I would try to gain access participants from these groups to my study. This then brought me to the more specific considerations regarding recruiting participants for this study.

3.6.3: GAINING ETHICAL APPROVAL TO RECRUIT PARTICIPANTS

In my position as a lecturer in nursing, one of my ongoing roles includes assisting nursing staff in practice to maintain their mentorship qualification annually. This is an additional post-graduate qualification for nurses to support student nurses achieve their learning in practice. The geographical area I have been linked to for the past ten years, in this role, is one of the most ethnically diverse areas of Greater Manchester. It felt like the most sensible approach to take would be to enlist the help of the array of community nurses I had been in contact with previously, to help me recruit participants onto the study. In order to do this I first needed to apply for ethical approval in line with the Department of Health (DoH) Research Governance Framework, and then local governance approval from the Foundation Trust (NHS body with a local influence) that this geographical area came under.

Whether the research is quantitative or qualitative, the DoH requires that any research involving patients, service users, care professionals or volunteers (or their organs, tissue or data) be reviewed independently to ensure it meets national and international ethical standards (Smajdor, 2009). The Research Governance Framework outlines principles of good governance that apply to all research within the remit of the Secretary of State for Health (Health Research Authority, 2014). This is to ensure that the dignity, rights, safety and well-being of participants are the primary consideration in any research study.

All research applications for the NHS or for areas of social care are required to apply for a Research Ethics Committee (REC) review via the national Integrated Research Application System (IRAS). The role of this ethics committee is to prevent and minimise potential harm to participants. Once approved, further approval at local level, referred to as local governance approval, must be sought.

At this stage, another level of protection for NHS patients, in being accessed by health and social care professionals for the purposes of research, remains necessary to ensure a more local consideration of the feasibility of the impact of the research on the local population. This required a second phase of information provision, including the completion of a 'Research Passport', to ensure my professional and academic credibility to carry out the said research.

Despite criticism from a variety of sources regarding the bureaucracy of these processes (van Teijlingen et al., 2008), the procedure for applying for ethical and local governance approval has been an important exercise in order to protect participants since the Helsinki Declaration in 1964 (Williams, 2008). On reflection, however, although the various forms utilised particularly positivistic research terminology to define questions and requirements, I found it helped me gain greater clarity in my own understanding of the paradigm and philosophical assumptions of this research. It was also particularly useful for clarifying issues around the method of gaining informed consent, recruiting participants and maintaining anonymity and confidentiality. I will now look at these in turn.

As approved by the REC review, research packs were delivered to the district nurses manager who was based at the central health centre; each pack consisted of the Participant Information Sheet (PIS), an example consent form and a return stamped addressed envelope (see Appendices 13, 14 and 15). This manager then oversaw that an administrator sent these documents out to the patients who were being seen by the district nurses or attending nurse-led clinics at this point. This method had been approved by the REC review as one way of ensuring that I as a researcher would not be able to

access any personal information nor influence any potential participant until after they had contacted me to express their interest in the study.

With the assurance that I would not have clinical contact or be able to influence the recruitment of participants for this research, the local Research and Development manager expanded the role of distributing the research packs to the District Nurses, as they went out to see the patients. This was to ensure those participants receiving the information would be capable of being interviewed and could speak basic English (which was a requirement from my original REC approval and for effective interviewing).

In terms of gaining consent, the PIS contained the purpose of the study and my intention regarding the information I received (see Appendix 13). Attached to this was a sample consent form. Any research should, as far as possible, be based on participants' 'freely volunteered informed consent' (Ritchie et al., 2013). This implies an obligation by the researcher to explain fully and meaningfully what the research is about and how the information will be used. In my case, on receiving a positive response, I would contact these participants (according to the method they preferred) and re-explain the intention of the study. Participants needed to be aware of their right to refuse to participate (even during or after the interview) and understand the extent to which anonymity and confidentiality would be maintained.

One of the earlier challenges in recruiting participants related to gaining access to patients from BAME groups. A particular area had a visible South Asian ethnic minority presence (tameside.gov.uk/census2011); however, the nurse manager was quick to comment that not one of their district nurses had any BAME patients on their books. There were a number of possibilities for this. One persistent factor was that on leaving hospital individuals' GPs were still not referring them to District nurses through a

perpetuated false belief that the family networks would care for the person (Badger et al., 1989; Wood and Parham, 1990; Szczepura, 2005). Equally, people from BAME groups have been known to resist referrals or do not consider access to community services as relevant to them. This has been related to a number of issues: nervousness about language and literacy (Campbell et al., 2001); lack of familiarity or limited knowledge of service availability (Szczepura, 2005); and an embarrassment of inviting mainly White health professionals into the home due to strong smells of food or differences in perceived everyday health cultural practices, which may be considered old fashioned or dirty (Mannur, 2010; Rhys-Taylor, 2013).

The lack of any significant responses from BAME participants made me reconsider the way in which I was looking for these groups to interview. After speaking to my Director of Studies, I applied for an amendment within the University ethical approval process I had received for this research, and as I would be accessing participants from nurses operating outside the NHS, the amendment would not need to go to the REC process again.

On receiving approval to go ahead, I accessed the participants through nurses who worked for a number of voluntary sector associations in the same geographical area. In leaving the same pack of information as before, I observed the same principles of anonymity and confidentiality required to access individuals within the NHS, thus continuing the transparent and ethical method for carrying out this research.

Within a fortnight, I managed to get 25 responses. For this research, I interviewed 21 participants (5 White Majority, 4 White Minority, 4 South Asian, 4 African-Caribbean and 4 Chinese). I transcribed the interviews as I completed them and I felt I had enough data after I realised that similar data was beginning to emerge repeatedly. Once I reached this point, I contacted the senders of all subsequent positive responses (either via the district

nurses or through the voluntary sector) to thank them for their interest and apologised that I would not require their help this time.

3.7: PILOT STUDY: INSTIGATING THE HERMENEUTIC CIRCLE

I consider my pilot study here before explaining how I intended to analyse my data, as my experience and understanding of this aspect of research influenced the type of analytical framework I eventually chose to work with.

I carried out a pilot study prior to embarking on the main research for this thesis. A pilot study is an important process as a preparation for a research study to ensure its feasibility or as a trial run in preparation of a future project (Polit et al., 2001). By doing this, shortcomings of the approach, such as an ineffective research method or deviations from a protocol that might need to be employed, would hopefully surface prior to the actual study (van Teijlingen and Hundley, 2001).

This exercise achieved a number of things in this research. In relation to conducting the interviews, I felt it allowed me to get a more reflexive and clearer picture of the focus of my study, with Gadamerian philosophical hermeneutics and the questions I could ask or needed to ask. It would, I hoped, allay my underlying nervousness about running out of questions and looking incompetent during the process. I also felt it would increase my confidence in developing a reciprocal, reflexive interviewing technique on this topic.

My appreciation of a reflexive hermeneutical process of questioning was strengthened as I became familiar with the range of questions that might be asked. For example, I became more comfortable with conversations that involved grappling with the semantics of the word culture with the White English participants. In addition, by reflecting on what I initially deemed a less successful pilot interview, I identified ways I felt would allow me to

engage the participants of my main study in a smoother, constructive shared conversation. This was important, as although I would be interviewing volunteer participants, I felt it came with a degree of responsibility to 'use' their time effectively. The pilot study gave a degree of structure and an ongoing process of interpretation with regards to the type of data that might emerge during the main research interviews. This gave an indication as to the form of framework I would need to utilise during the analysis. Mainly, I found this exercise gave me a practical sense of the area within which this subject of CAC was situated, in order to reach a new understanding within a particular context.

Taking into account that I needed a more experiential understanding of this process, sampling seemed less of an issue at this pilot stage. However, I wanted the pilot to try and mirror the participants from the ethnic group I intended to interview in my main study. I carried out six interviews with colleagues (either fellow lecturers or administrative staff), three of whom described their ethnicity as White English, one White Minority, one African-Caribbean and one South Asian. I was unable to recruit someone from a Chinese background within the Faculty to participate in the study. Again, to reflect my main research all my pilot participants were currently service users or had been within the past five years.

I approached colleagues at work via e-mail, asking if they would be interested in being interviewed by me for this research. I provided a basic explanation about my study and that I would record it. I stressed that it would be a confidential process and would be carried out privately in my office or wherever they were comfortable. All the colleagues who participated chose to be interviewed in my private office.

At that time, I felt my first interview was unsuccessful. It only lasted 25 minutes; this alarmed me as some other doctoral level studies that shared similarities with my research described interviews of up to 90 minutes. I also found it difficult to write anything down at this point, as I felt it would take away from the flow of the conversation. I learnt that if I wrote a word in relation to the thought I was having, I was able to recollect my thought after the interview to enhance the memory of my trail of thought at that point. To reflect my understanding of Gadamerian philosophical hermeneutics, I began by asking questions about their previous experiences of CAC within nursing. This was to glean information about their traditions, prejudices and ideas of authority before I asked questions about what they perceived CAC should be. So, initial questioning generally included topics of conversation such as their perception of the word culture and their personal experiences of cultural activities, during their childhood and now, to contextualise our conversation. This was followed by a more focused questioning and dialogue regarding their expectations of cultural care.

It was while transcribing this first interview and writing notes in my personal reflexive diary a few days later that I found I had thought-provoking information that gave me more ideas about what to ask and how. My first interview was far from the failure I had imagined. My colleague was equally nervous and some of the responses (my incorrect prejudgement that my colleagues thought just like me) took me aback. I also found the conversation that followed after I said, 'I don't think I have any more questions for you' elicited interesting comments regarding the subject itself and my interviewing abilities. These were recorded as I had forgotten to turn off my recording device.

The subsequent interviews all lasted just over 30 minutes. As I was inevitably interpreting some responses provided in relation to what I had asked, subsequent interview questions

were adapted or changed to suit the style of conversation occurring between the two of us and to refine my conversational questioning technique. I appreciated I was interviewing people I have known for some years and the 'warming up' process would probably take longer with the participants of my main research. In addition, as I would be in the participants' environment (at their home or at the local clinic) I too would have adjustments to make to ensure their ease.

In terms of transcribing, I used a variety of methods to find out which one suited me most. I utilised both typing the taped interviews verbatim and dictation software called the 'Word Dragon' voice recognition system. Verbatim transcription denotes a word-for-word reproduction of verbal data, where the written words are an exact replication of the audio-recorded interview (Poland, 1995). With the dictation software, I listened to the taped audio using a two-way headphone system, which then typed out what I said into the attached mouthpiece. Both approaches required me to re-listen to the interviews for accuracy but I felt that the dictation software was the most efficient method to utilise during the main research phase as the number and length of interviews I carried out would increase. Despite my choice, I found whichever method I used required equal attention to detail, so the choice I made would not have a negative effect on the transcribing process.

However, Maclean et al. (2004) stated that the way in which interview content is both heard and perceived plays a key role in both the form and accuracy of transcription.

Taking into account the ethos of Gadamerian philosophical hermeneutics, I had to ensure that what I had transcribed was not only accurate but any interpretation remained congruent to the theoretical underpinnings of this specific investigation. I chose at this point not to analyse my pilot study, as this was a feasibility exercise in preparation for my

actual study; however, I made notes regarding my changing ideas in my personal reflexive journal. I also felt that it would affect issues around confidentiality as those colleagues could have easily been identified through some of the information they shared.

Overall, this pilot study allayed the bigger fears I had before I started this journey. This pilot also gave me a number of refinements for my actual study. In terms of the interview process, it allowed me to reframe, clarify, reorder and revise questions that I had planned to ask. By this point, I had a guide of questions, which were core to all participants, but flexible enough to adapt to the course of the participants' conversation. I became more comfortable, according to the Gadamerian philosophical hermeneutics perspective, that any disagreements of ideas, any new pathways and directions that occurred during the participants' interviews could only be a bonus, adding to the richness for my analysis and allowing me to flexibly explore new unanticipated areas. I felt it also made me a more effective listener as the influence of Gadamerian philosophical hermeneutics allowed for space where there was a lack of consensus in ideas and the safe space to discuss those differences.

In order to get authentic data from those receiving care that is deemed cultural, I needed to understand myself and then put myself aside so I could really hear what patients think CAC is. An awareness of concepts around horizons developed, from the Gadamerian philosophical hermeneutics tradition; authority; and prejudice helped me become aware of my conditions for understanding. The plan was when I came to re-understand what CAC is for these participants, my horizon would not just be dominated by my previous beliefs but a fusion of what I have heard, listened to and learnt from those I interviewed with my previous knowledge.

I came to realise that I was already entering the hermeneutic circle and the start of the interpretation process. This ongoing process of this circularity of understanding (Kezar, 2000) was initiated as a result of understanding unexpected information that surfaced from engaging in the practical activity of conducting the pilot study.

3.8: INTERVIEWING THE PARTICIPANTS

This section will provide details of my fieldwork. I interviewed 21 participants (see Appendix 17 for some demographics of the participants). They were interviewed either in their homes, at various community centres they attended or at the University, in my office. All over 18 years of age, I interviewed five participants from the White Majority population, four from White Minorities, four Chinese, four African-Caribbean and four South Asian, both male and female.

All the participants resided in what was considered to be in the top three deprived areas of the North West (Manchester City Council, 2010). As discussed in section 3.5, dependent on the unconscious perception of each participant regarding me (and vice versa), I needed to be aware of issues around positionality and subjectivity with the participants, and I had pondered, as an outsider, if this would impact the conversational dialogue I envisaged would take place. As Breen (2007) expressed, negotiating the insider/outsider dichotomy in any qualitative research remains intrinsic to all social relationships that impact upon the ease and comfort required for a conversational dialogue to occur during the interview.

Wherever the participants came from, I knew I needed to be careful about the language I used as some of the participants may have been unable to express responses to my questions within the language framework of CAC that I had become immersed within. I was reminded of Gadamer's ideas of misunderstanding to gain understanding.

Interpretive hermeneutics remains one of the methodologies that writers such as Carel (2012) felt could be utilised to overcome this type of imbalance and redress multiple perspectives of the illness experience for those who may be perceived as less articulate by professionals. With an awareness of the philosophy of Gadamer (2013), I felt it would be valuable, to try at least, to limit this negative effect on this research. The acknowledgement of the basis of our understanding, our truth, is contextual to our history and tradition. Perhaps their (and my own) perspectives hold prejudices that colour individual perspectives but as Gadamer(2013) continually states in his works, 'all human understanding is ultimately, interpretation'.

To record the interviews, I continued with the process of verbatim transcribing as per the method I adopted during the pilot. I found the Dragon Voice recognition system particularly useful for the longer interviews, as it halved the time required to transcribe. It still did not reduce the need for checking and re-checking what I was hearing from the digital voice recorder, for the purpose of accuracy. However, this did have a benefit in that I became more immersed in the data and what the participants had said at the interview, enabling me to take notes in relation to the thoughts I was having (see example of the notes on sample transcription in Appendix 1). I also found that listening to the recorded interviews allowed me to re-imagine the actual interview and to appreciate the non-verbal communication, the sections that the participants were stressing to me (Vandermause and Fleming, 2011).

The other factor that I remained aware of was that I had to ensure that what I had transcribed was not only accurate but remained congruent to the theoretical underpinnings of this research study. I adopted a number of strategies during this time to safeguard this. Firstly, in keeping with the reflexive strategies I referred to earlier in

section 3.5, I e-mailed some of my transcripts to the participants, among others, to check for accuracy. For some of the participants with no access to a private computer, I printed my transcripts and went to see them again (by arrangement). Also, I felt this opportunity to meet some of the participants again to generate a newer understanding of our previous conversation and how it would be interpreted, was being true to Gadamerian philosophical hermeneutics. Although not everyone responded to the e-mails, those that were returned expressed their satisfaction at the accuracy of the transcriptions. A handful of participants (five participants) even responded with 'another thought', which I found useful when analysing my data at a later stage to ensure my newer horizon regarding CAC kept evolving.

Reflecting my constructivist epistemology, returning to the participants, in one form or another, felt like a type of co-construction of the information we were both trying to comprehend, as we engaged in a hermeneutic circle of coming to a newer understanding. Gadamer (2013) expressed his philosophical hermeneutics as a practice of co-creation between the researcher and participant, where the very construction of meaning transpired through a circle of readings, reflexive writing and interpretations. According to Lavery (2003), the coming together of the researcher and participant has the ability to progress the experience being studied, through a combination of imagination, the hermeneutic circle and attention to the semantics of dialogue.

As in the pilot, during the interviews I combined the process of audiotaping the interviews and taking a few notes at the same time. Fasick (2001) felt that the use of written notes taken during an interview is more effective than the exclusive use of voice recordings that are subsequently transcribed verbatim. Before the interview, I explained to the participant that I would take notes but I wanted to make sure that it did not affect the

flow of the interview. Again, I noted the odd word, gesture or intonation in my notes as they were speaking (to trigger what I was thinking at a later point or to enable a deeper consideration of meaning related to what had been said for the purpose of interpretation). This was a useful exercise as these words helped me be more reflexive, as I could not help but link what was being said to some knowledge or experience I had.

As soon after the interview as possible, I wrote more notes to ensure that my ideas about the interview remained fresh and any thoughts I had about a particular interview were not muddled up with another one I would carry out soon after. I also made notes in my personal reflexive journal. Researchers should review their field notes and expand on their initial impressions of the interaction with more considered comments and perceptions (Myers and Newman, 2007). These reflections and early stage, perhaps naive, interpretations included other issues raised by the participant, their demeanour during the interview and other socio-cultural factors, which may have affected how the interview progressed. These interpretations were beginning to hold together through a blending of the transcriptions and their context, the participants, myself and my own perspectives.

3.9: CHOOSING A FRAMEWORK FOR ANALYSIS CONGRUENT WITH GADAMERIAN

PHILOSOPHICAL HERMENEUTICS

An exploration of the approach employed to analyse my data will now be considered. Graneheim and Lundman (2004) stated that the utilisation of an appropriate framework for analysis adds robustness to the chosen paradigm, methodology, influencing philosophy and overall, to the study itself. Taking into account that Gadamerian philosophical hermeneutics has no specific method or framework specified for analysis, I felt the choice of the most suitable framework was important to continue to ensure the

faithfulness of what had been expressed by the participants. Thus, it was imperative that the data I scrutinised was explored in a congruent way, to reflect my adoption of Gadamerian philosophical hermeneutics and to yield trustworthy and meaningful findings.

The decision on how I chose to analyse the data collected from my interviews needed to be based upon more than common choices made by nurses and social science researchers within Gadamerian philosophical hermeneutics studies. Grbich (2013) asserted that a framework's suitability to the philosophical assumptions of the research needs to be considered as this adds to the trustworthiness of the whole process of analysis and the final discussion; in this case, the philosophical assumptions of Gadamerian philosophical hermeneutics.

There are a number of techniques available to analyse interpretive qualitative data, to reflect the diverse, complex and nuanced approaches within this paradigm (Holloway and Todres, 2003). In keeping with the interpretive paradigm, the most prevalent techniques utilised within nursing and social science research (Braun and Clarke, 2006) were content analysis and thematic analysis, in a number of variations (Vaismoradi et al., 2013).

Content analysis and thematic analysis share a similar purpose of analytically examining smaller units of content of transcribed, descriptive material from participant perspectives prior to analyses (Sparker, 2005). Their popularity is also related to their ability to identify 'thematizing meanings' from the collected data. Their benefits include flexibility (Boyatzis, 1998) in the different types of methods applied to collect data and their ability to provide a rich and detailed account of data (Roulston, 2001), despite the use of a framework.

Content analysis is a descriptive approach to codifying data and its interpretation allows for the quantitative count of the codes, if required (Morgan, 1993). It also allows qualitative data to be analysed and is suitable for simple reporting of common issues on subjects with little previous research (Grbich, 2013; Green and Thorogood, 2004). An exemplar of a thesis influenced by Gadamer's hermeneutic philosophy is Koch's (1993) study utilising content analysis concerning listening to the voices of older patients. This research study was carried out to establish literature around a lack of information regarding patient voices in the needs of elderly patients.

I intended that the data collected would provide not only a description but also a degree of interpretation of what the participants' explanations meant and how they made sense of their personal experiences in their descriptions. As supported by Marks and Yardley (2004), I was conscious that utilising content analysis would remove the hermeneutic meanings of the stories the participants were sharing. Because of this awareness and reflecting my philosophical assumptions of Gadamerian philosophical hermeneutics, content analysis was not suitable in this instance.

In comparison, thematic analysis frameworks provide a much more qualitative, detailed, and nuanced account of data (Vaismoradi et al., 2013; Braun and Clarke, 2006). They are also flexible research frameworks, which allow for searching and identification of common threads that extend across either entire interviews or whole sets of interviews (DeSantis and Noel-Ugarriza, 2000). Braun and Clarke (2006) asserted it was *the* foundational method for any qualitative analysis. Boyatzis (1998) explained that thematic analysis is not only a suitable method for identifying, analysing and reporting patterns within data, it also helps with interpreting some of the rich data that emerges. The themes that emerged from a study by Stewart et al. (2015) on psychiatric patients'

perceptions of nursing staff (using Braun and Clarke's (2006) thematic analysis framework) showed the flexibility of this approach as compared to contents analysis. A range of thematic analysis frameworks are utilised within interpretive research, though they are poorly explicated at times (Braun and Clarke, 2006). Attride-Stirling (2001) expressed that it remains vital that researchers are able to show the path of analysis through their data and the assumptions that informed their analysis. This is to allow effective evaluation of the study so it can be compared to others on the same topic and ensure other researchers are able to carry out future research without impediment. For me, this would also add to the trustworthiness of this research.

Ontologically and epistemologically speaking, I did not intend to focus on the motivation or individual feelings of responses given by those I had already interviewed. I was more interested in studying those factors or contexts their responses were derived from. This would be in keeping with Gadamerian philosophical hermeneutics, in that I was not developing a procedure for understanding but trying to clarify the conditions for understanding. In addition, in keeping with the interpretivist paradigm, meaning and experience were more an evolving expression of social, political and cultural interactions than a static state within individuals (Dowling, 2007). My analysis framework required within it an explicit way of showing these interactions in individuals and all those I had interviewed.

Thematic analysis, in its many forms, identifies patterns in a number of ways: inductively or theoretically. Within a theoretic thematic analysis, a 'top-down' approach is used, with the researcher's area of interest leading the way in a detailed analysis of some aspect of the data (Boyatzis, 1998).

In terms of themes, the selection of framework needed to be able to cope with a number of factors. Themes capture significant information that emerges from within the data, in relation to the research question (Clarke and Kitzinger, 2004). The choice of framework needed to be able to cope with a flexible approach to determining prevalence of themes and sub-themes, as I wanted to analyse the social, cultural and political context of the responses. Also in relation to themes, the framework chosen for this research needed to reflect the move from description of the data organised to interpretation of latent meaning. As Patton (1990) stated, this allows for an attempt to hypothesise the significance of patterns and their wide-ranging meaning and implication, in relation to the question asked. The two most popular thematic analysis frameworks utilised in nursing research that would be congruent to Gadamerian philosophical hermeneutics are Braun and Clarke's (2006) 6-phase guide to doing thematic analysis and Attride-Stirling's (2001) Thematic Networks (TN).

I scrutinised a number of research studies that had utilised these two frameworks to work out which of these would be more suitable for my research and would be true to my philosophical assumptions and support the requirements of my study. Utilising Braun and Clarke's (2006) framework for analysis was Trajkovski et al.'s (2012) research on neonatal nurses' perspectives of family-centred care and Sharma et al.'s (2010) study regarding clinical users' perspective on telemonitoring of patients with long-term conditions. I also considered another three studies: Ashton's (2007) research on how to evaluate a peace education project in children within war-torn countries (for UNICEF), Othman's (2009) thesis on educational experiences and cultural factors in the learner's attitudes prior to entering University and Heckles' (2011) thesis on eliciting narratives to understand beliefs and practice on the development of multi-agency work in children's centres. All three of

these latter studies employed Attride-Stirling's (2001) TN framework. These studies clearly, diagrammatically illustrated the connections and the ways individuals made sense of their experience, and the way larger social circumstances influenced those personal meanings. I was also able to see the connection in these studies to my philosophical assumptions and Gadamerian philosophical hermeneutics that all understanding was interpreted within a hermeneutic circle of the key concepts central to seeking truth: those of historicity, tradition, prejudice, authority and horizon.

Although both these frameworks are suitable for Gadamerian philosophical hermeneutics and my research question, I felt the framework that I finally found most congruent with my ontology, epistemology and methodology was Attride-Stirling's (2001) Thematic Networks (TN) framework for qualitative research.

It was clear TN would be able to support the ongoing reflexive dialogue that would enhance the trustworthiness this research required. The TN framework also would be able to diagrammatically show how the codes and themes emerged, which I felt would add to the transparency of the study, as a reader would be able to follow the sequences, inter-connections and progression made by my data by looking at the Thematic Networks. In addition, with regards to the studies I had perused, I preferred the way in which TN's web-like illustrations expressed diagrammatically the interconnected links between the codes that emerged for discussion; they were in line with my way of learning and understanding.

3.10: ATTRIDE-STIRLINGS' THEMATIC NETWORK (TN) FRAMEWORK FOR ANALYSIS

According to Attride-Stirling (2001: 387), the ideas around the TN were originally developed on the principles of philosopher Stephen Toulmin's 1958 Argumentation theory. According to Shook (2005), the Toulmin Model of Argumentation consisted of an

illustration encompassing six connected components used for analysing arguments, predominantly in the areas of rhetoric and communication. As mentioned in the previous section (section 3.9). TN has been used beyond this philosophy within successful research studies.

TN produces interconnected diagrams⁷ that summarise the main themes constituting a piece of text (see Appendices 6 to 12). For me, the utilisation of these unifying networks allowed for the themes to be presented in a non-hierarchical, hermeneutic way and in a fluid and flexible system, which appealed to my way of learning and made sense of a large amount of data.

A Thematic Network begins with working out what the Basic Themes are and working to a final (or more than one) Global Theme. Having gathered the emerging Basic Themes, they are then categorised according to the basic story they were telling. These become the Organising Themes. Developing networks involves moving forward and backward within the data to ensure connections between the basic and unifying themes. Organising Themes need to be reconsidered in light of their Basic Themes, and are brought together to demonstrate a single conclusion or super-ordinate theme. This then becomes the Global Theme. Table 3.1 shows the stages of analysis to be applied once the data has been transcribed.

Attride-Stirling asserted that this framework was a technique that assisted in breaking up texts and finding within it 'explicit rationalisations and their implicit signification' (2001:388) and was not there to find the beginning or end of rationalisations. For me, this was particularly pertinent to the process of the Gadamerian philosophical hermeneutic

⁷ Attride-Stirling refers to her networks as 'web-like' networks but due the large amount of data that was generated for the Basic Themes, I utilised the interconnected diagrams for my data to be understood clearly.

circle as it reflected Gadamer's expression regarding understanding and that of horizons, that 'meanings are never complete' (2013:274).

TABLE 3.1: ATTRIDE-STIRLING'S (2001) STAGES OF ANALYSIS ACCORDING TO THE TN FRAMEWORK

<p><u>ANALYSIS STAGE A:</u> REDUCTION OR BREAKDOWN OF TEXT</p>	<p>Step 1. Code Material</p>	<p>(a) Devise a coding framework (b) Dissect text into text segments using the coding framework</p>
	<p>Step 2. Identify Themes</p>	<p>(a) Abstract themes from coded text segments (b) Refine themes</p>
	<p>Step 3. Construct Thematic Networks</p>	<p>(a) Arrange themes (b) Select Basic Themes (c) Rearrange into Organising Themes (d) Deduce Global Theme(s) (e) Illustrate as Thematic Network(s) (f) Verify and refine the network(s)</p>
<p><u>ANALYSIS STAGE B:</u> EXPLORATION OF TEXT</p>	<p>Step 4. Describe and Explore Thematic Networks</p>	<p>(a) Describe the network (b) Explore the network</p>
	<p>Step 5. Summarise Thematic Networks</p>	
<p><u>ANALYSIS STAGE C:</u> INTEGRATION OF EXPLORATION</p>	<p>Step 6. Interpret Patterns</p>	

3.11: THE APPLICATION OF TN TO THIS RESEARCH

The utilisation of this framework did not occur as a linear process, as the emergence of certain Basic and Organising codes instigated thoughts or a newer understanding of a certain aspect of the data. This then resulted in me returning to the transcriptions to either reconsider if other participants had expressed similar thoughts; a process that related to stages articulated in the earlier part of this framework. For me, this overlapped with Cohen et al.'s (2000:72) description of the analysis process in hermeneutical research, stating that the goal of analysis is a 'thick description that accurately captures and communicates the meaning of lived experience for the informants being studied'.

As I began the process of transcribing and rereading the transcripts, I kept in mind what Gadamer (2013) had expressed regarding how we come to understand. Understanding for him occurs at a number of levels. It could transpire at a practical or intellectual level (perhaps when experiencing an 'Aha, that's it!' moment). It may triggered a cognitive understanding (for example, understanding of previous behaviour through self-awareness) or prompt a semantic understanding (for instance, the interpretation of previously unintelligible literature becoming clearer). I also keeps in mind the openness he encourages to facilitate new understanding. Similarly, Tigert (2012) explained that this openness requires an attitude of 'giving oneself over to the game' to allow an engagement with the dialogue so that new perspectives around CAC emerge.

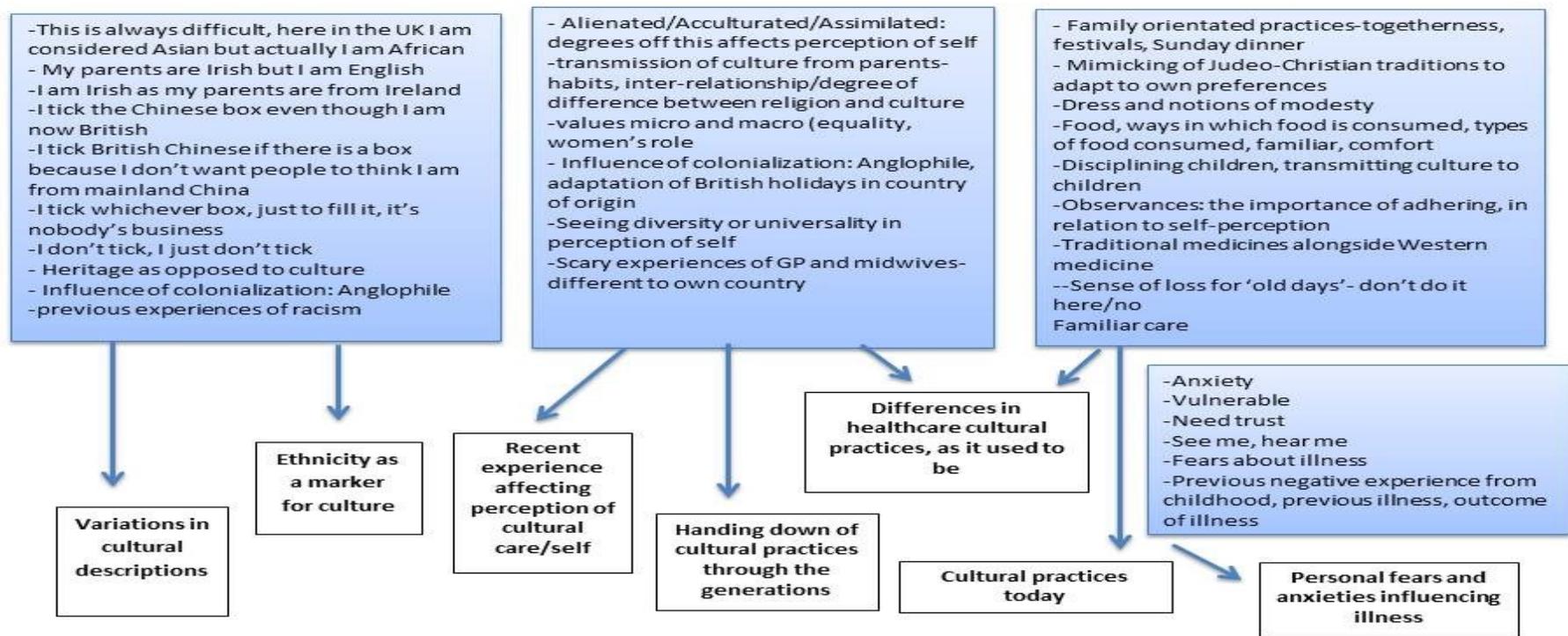
In keeping with TN, my first role in developing a Thematic Network was to reduce or breakdown the text available. Keeping in mind my research questions and the Gadamerian philosophical hermeneutics' influence on this research, I started to note down recurrent words, specific topics and text segments that appeared as a theme within my text by highlighting the printed transcriptions (see Figure 3.3 for the first stage of

finding codes for specific words and Figure 3.5 for the first stage of discovering emerging themes from text segments for coding). These codes emerged when I spent time rereading sections of all interviews, sometimes looking at responses to similar questions across the board, to elicit the uniqueness, variation or similarities in personal responses. With each transcription, I returned to the audio recording of the interviews to re-imagine the interview, to ensure I had noticed their emphasis or emotion behind some responses, as opposed to my understanding on the subject. Any queries or clarifications required were redirected to the participants by e-mail (which had been agreed during the original interview). This was not an attempt at trying to find rational, consistent answers, for like me, the participants exist with myriad incongruities between the different aspects of their lives (Benner, 2001). It was more, as Gadamer articulated, to look into the conditions of their understanding of CAC (see Appendix 1 for an anonymised sample of a transcription with notes and highlighted codes and Appendix 2 for subsequent e-mail contact for clarifications from the same participant).

Identifying the codes was not a linear process but a hermeneutic experience, as it involved moving back and forth between transcriptions and discovering unexpected topics even when I felt I had already managed to get as much as possible from the transcriptions. Sometimes, when considering a response from one participant, a thought would be triggered in me, to look if there was a similar response in other participants' views. I gathered a combination of repetitive words and some text segments as codes. Once I collated them from all the interview responses, I then separated them into a number of groups that reflected clusters of similarity (see Appendix 7 to 9 for the structured Basic Themes of coding developed from Figure 3.3 and 3.4 and 5).

As patterns emerged, I grouped the 'codes' of responses into Basic Themes, which I found separable by what the participants perceived themselves to be, to want for themselves or needed from those caring for them, in terms of CAC. This process refined the text segments and helped me to gather the codes to develop 16 Basic Themes.

For the next stage, seven Organising Themes were identified, described and connected to groups of Basic Themes, before the final stage of TN analysis (See Figures 3.5, 3.6 and 3.7 for transition from Basic Themes to Organising themes).



Thematic Network/Global Theme 1: The person behind the illness/Emergence of Basic Themes

FIGURE 3.5: EMERGENCE OF BASIC TO ORGANISING THEMES FOR THEMATIC NETWORK 1

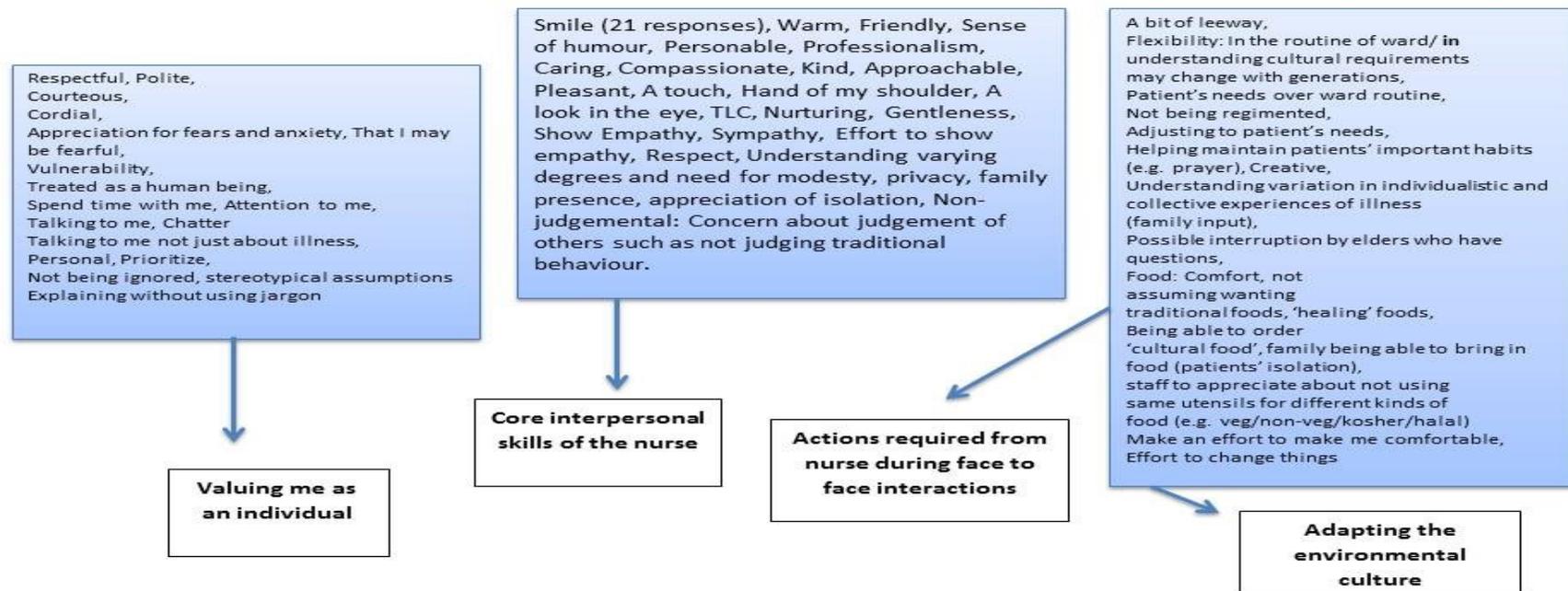
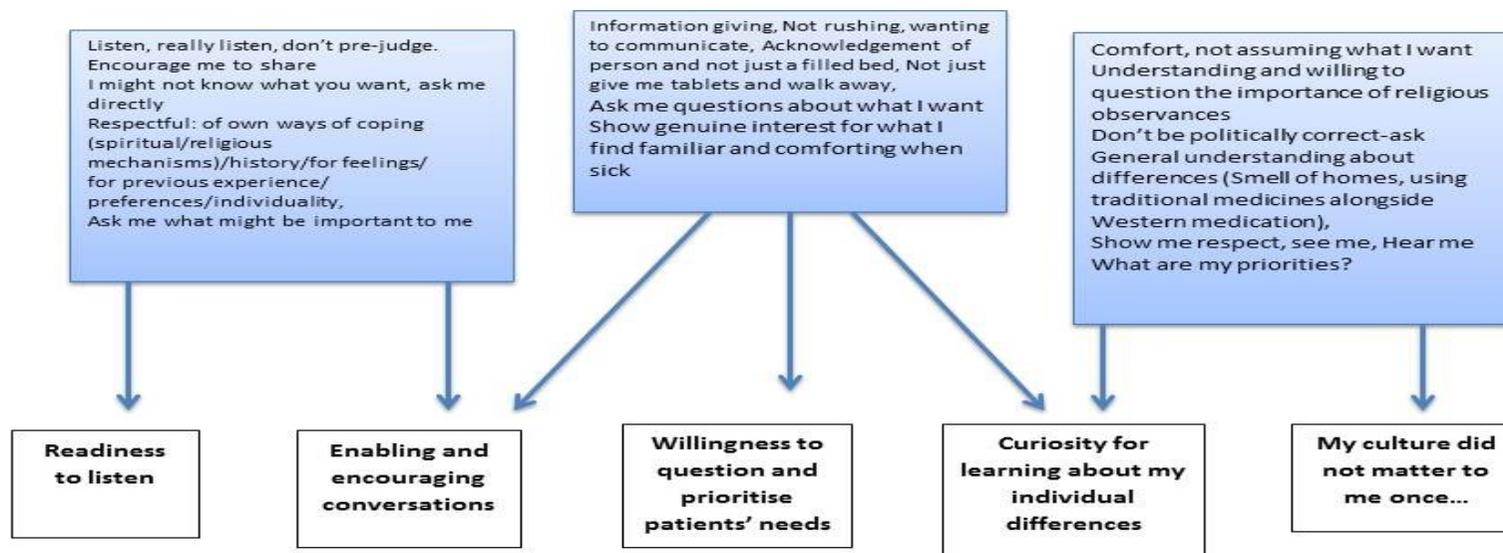


FIGURE 3.6: EMERGENCE OF BASIC TO ORGANISING THEMES FOR THEMATIC NETWORK 2



Thematic Network/Global Theme 3: Enlarging the domain of possibilities/Emergence of Basic Themes

FIGURE 3.7: EMERGENCE OF BASIC TO ORGANISING THEMES FOR THEMATIC NETWORK 3

Finally, from this process and reflecting on my research question, I identified three Global Themes, which were, as per Attride-Stirling, expressed as metaphors. The Global Themes were: 'The person behind the illness', 'Seeking a balance' and 'Enlarging the domain of possibilities', illustrated in Figures 3.5, 3.6 and 3.7, will be discussed in detail in the Findings chapter.

In summation, this chapter has considered the decisions I made based upon my philosophical assumptions, my paradigm and the methodology I adopted to answer my research questions. By adopting an interpretive paradigm, and being influenced by Gadamerian philosophical hermeneutic to consider how patients perceive CAC, this chapter has set the foundation for the following Findings chapter. This chapter has also explained the process and framework I utilised to analyse my data. Having done this, the next chapter will develop, discuss and analyse the findings of this research. Reflecting TN, the next chapter will explore, in detail, the findings of this research under the three Global Themes.

CHAPTER 4: FINDINGS

This chapter will present the findings of this research entitled *Culturally appropriate care: A qualitative exploration of service-users' perspectives of nursing care*. These findings were organised from the data of 21 semi-structured interviews of participants from the five ethnic groups (Majority and Minority) of Greater Manchester (see Appendix 17 for anonymising table with some demographic information of those interviewed). As discussed in Chapter 3, my method of organising and categorising my codes for analysis was informed by Attride-Stirling's (2001) Thematic Networks framework (TN). I retained her intended aim of the tool: 'to explore the understanding of an issue or the signification of an idea' (2001:387). The over-arching influence of this process, however, was my understanding of Gadamer's philosophical hermeneutics. As such, its influence on my findings and subsequent discussion also affected the way that TN was utilised and any divergences from the TN tool have been justified and clarified as the chapter progresses.

4.1: THE GLOBAL THEMES/THEMATIC NETWORKS

Three Global Themes, which are represented together in Figure 4.1, emerged from the analysis of the data from this research study. At times, the abbreviations for Global Themes or Thematic Networks have been used synonymously to express the 'core, principal metaphor that encapsulated the main points in the text' (Attride-Stirling, 2001:393), as they represented the main assertions from the issues that arose from the Organising themes and Basic Themes. The Global Themes were:

- The person behind the illness (Thematic Network 1)
- Seeking a balance (Thematic Network 2)
- Enlarging the domain of possibilities (Thematic Network 3)

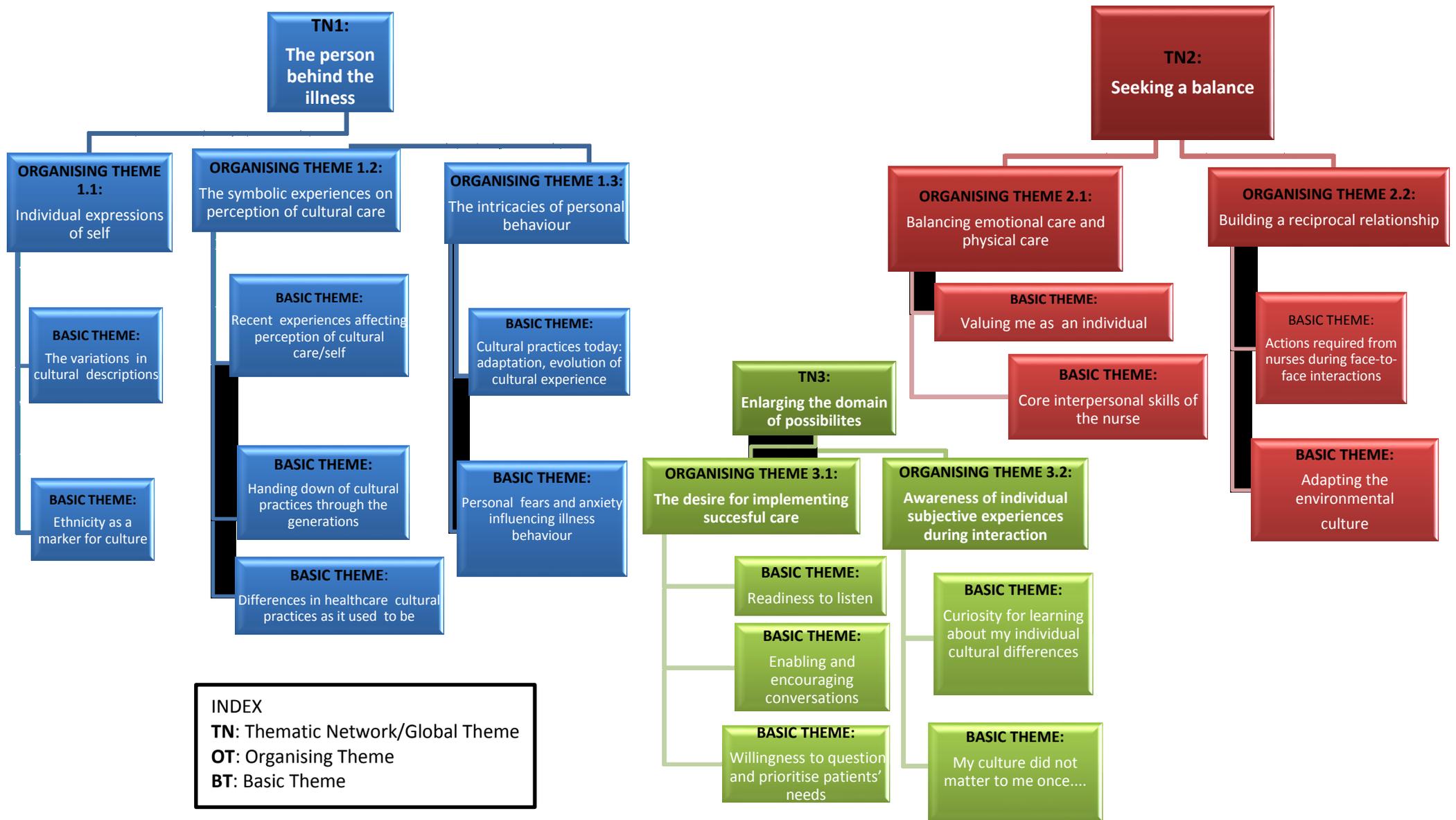


FIGURE 4.1: THE GLOBAL THEMES

The processes around communication and interpersonal behaviour that occurs between a service user and a nurse interlinked these three Global Themes. In this chapter, these Global Themes have been described in turn, sequentially, along with their Organising Theme's and Basic Theme's (TN1, TN2 and then TN3). In the following sections, each Global Theme will be described separately for ease of reference and clarity, to illustrate the emergence of the networks. This linear approach departs from Attride-Stirling's (2001) TN description; however, I felt that this approach would assist the reader in being able to anchor my interpretations and increase trustworthiness on the summary provided by the network. Similar adaptations, to explore and understand the main issue or the meaning of an idea, have also been utilised in research studies by Marshall and Goldbart (2008) and Skovdal et al. (2009).

4.2: GLOBAL THEME: TN1/ THE PERSON BEHIND THE ILLNESS

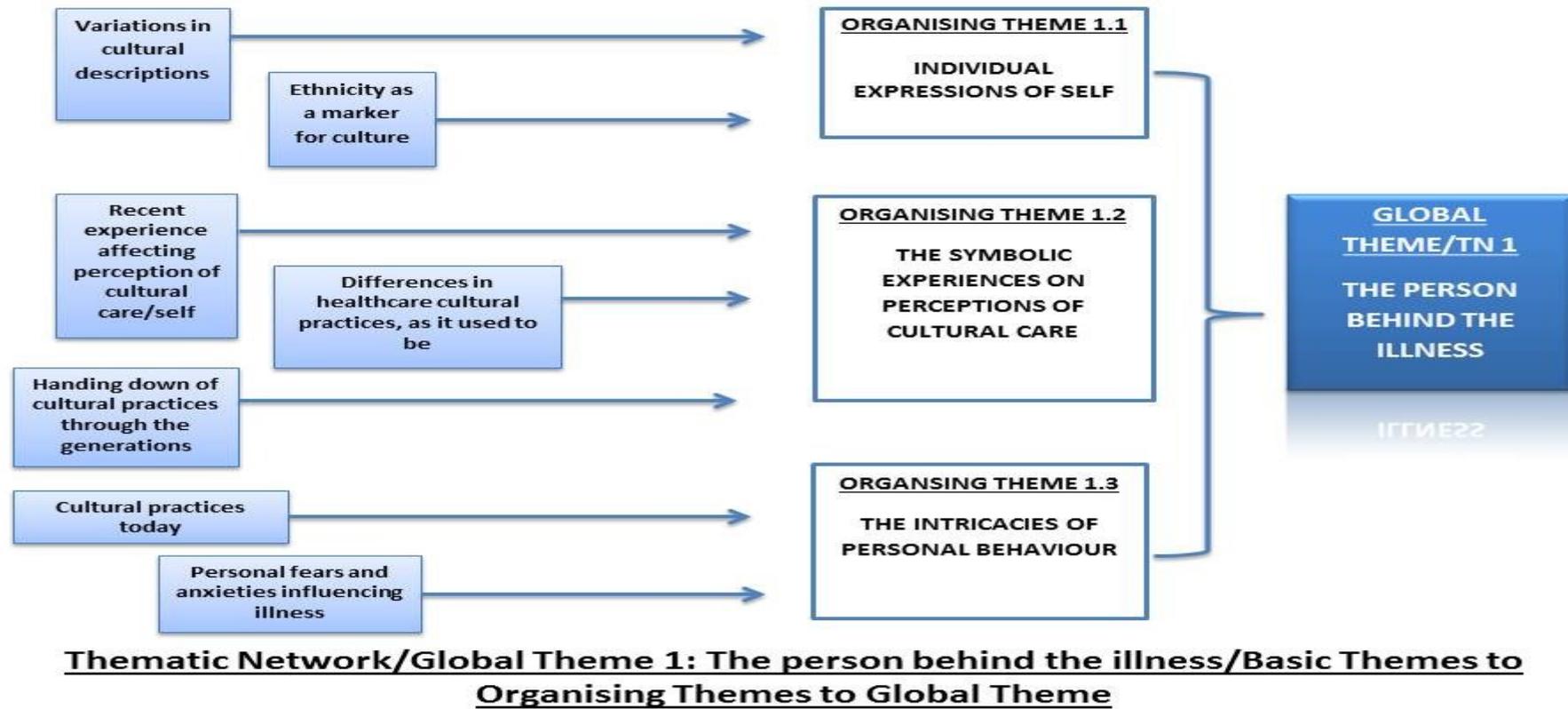


FIGURE 4.2: TN1/THE PERSON BEHIND THE ILLNESS

As Figures 4.1 and 4.2 indicate, the core metaphor utilised to describe the first Thematic Network was 'The person behind the illness'. This Global Theme emerged from those responses that conveyed personal descriptions and perceptions of culture and the congruence of their self-description in comparison to the ethnic descriptions or labels they are provided with for official purposes. The three Organising Themes and associated Basic Themes, which made up this Thematic Network, are considered individually in the next section. At this stage of the analysis, the ethnic group and gender of the participants has been mentioned alongside their quote. The inclusion of these aspects of the participants' characteristics was to consider, at the discussion stage in the next chapter, the possible impact on the responses regarding CAC to the questions from the interviews.

4.2.1: ORGANISING THEME 1.1⁸/ INDIVIDUAL EXPRESSIONS OF SELF

The two Basic Themes with similar responses that made up this first Organising Theme were 'The variations in cultural descriptions' and 'Ethnicity as a marker for culture'. These two Basic Themes were related to what the participants were expressing about themselves in terms of defining themselves culturally.

4.2.1.1: BASIC THEME/ THE VARIATIONS IN CULTURAL DESCRIPTIONS

In relation to describing themselves within the boundaries of culture, individual expressions, even from those participants who would appear similar to the outside world, were diverse and varied in their characteristics.

⁸ The number 1.1 here relates to the number allocated within Figure 4.1 and Figure 4.2. All Organising Themes have been allocated a number, in relation to their Global Theme/Thematic Network. These numbers will also be relevant in Chapter 5, where the discussion is related to the Global and Organising Themes that emerged in this chapter.

The following responses show the variations in spoken language when the participants expressed their ideas around the subject of defining culture. Some participants talked about religion and culture in the same context. There were inter-related connections made between concepts such as religion, tradition and their link to culture but often most participants were unable to delineate the specific differences. An example came from this participant:

G⁹: *Can the same religion have different cultures?*

AC17¹⁰ (African-Caribbean female): *Yes, yes, dependent on which part of the world you are coming from, depending on your upbringing, depending on what class you are, comes into it but I don't use status but people around me do.*

Correspondingly, another participant who is a Muslim stated when asked to define what she thought her culture consisted of:

SA9 (South Asian female): *I think, I don't know, uhm...cultural, it doesn't really matter to me because perhaps it is about language, maybe dress and that sort of thing but to me...uhm...its connected but the religious aspect is more important, it's about the afterlife, it's a faith, I'd adhere more to that than I would to a cultural trait.*

Another participant from a West Indian background related one aspect of her culture to the way she and those she identified as her community practised their faith:

AC19 (African-Caribbean female): *Culture means the thing that we believe in and, you know...it defines us, as a group, you know, it ... you know, we have a culture of going to Church,...and praising God in the way that we like to, the way we like to do it. Yeah!*

⁹ G denotes myself, the principal investigator.

¹⁰ Please refer to the guide within Appendix 17 for detailed clarification of the anonymising labels used as reference to the different participants within quotes.

However, not all participants used this wider sense of community identity to define culture. A UK born Chinese participant was more generic in her explanation regarding culture. She described it as a personal and intrinsic condition within which we all exist:

CO15 (Chinese female): *I think culture is something very deep inside ourselves, that we do something, without consciously, actively thinking about it, without planning, you just do it, really like, automatically, or you make a decision, very easily, and culture in my opinion, is something that you do here, related to your value base.*

Another Chinese participant, who was born in Hong Kong but had been a UK citizen for 10 years said:

CO16 (Chinese male): *Culture means my heritage, or generally the heritage of that race, it involves a lot of religion, tradition, it involves a lot of environmental changes or the environment that they live in, including language food, everything there, so, it is quite a big thing.*

For some participants, the degree to which the inter-relationship between religion and the culture of their daily lives was evident. In fact, both the participants from an Orthodox Jewish background stated they did not see a difference between the two. As this participant stated:

WM2 (White Minority male): *For Orthodox Jews, there is no word for religion in the Hebrew. So, what other people would call religion we call culture anyway. So, all the dietary laws, the food and menus, the cuisine, has developed from the biblical commandments ... So it's very hard for Jews, to disassociate religion from culture.*

Participants from the Majority population generally took longer to describe their culture, unlike when it came to stating their ethnicity. They explained concepts around their own cultural activity by comparing themselves to what they saw as cultural in other

communities. Here are two examples of White English participants who described their cultural dimensions by comparing them to their perceptions of other cultures:

WE9 (White English female): *Well, it was only me and my two sisters. My friend was a Black girl who used to have a different sort of culture than we did. Because we were close friends, she would invite me to her house, maybe they would go to a church meeting or something like that and I used to wonder what it would be like to go ... we didn't have anything cultural like that.*

WE10 (White English female): *Uhm ... Something relating to the people that is different to other territories, other areas, so, perhaps, I am a Scouser by birth and I feel that my culture is different from those of Manchester.*

The word 'heritage' was used a number of times to describe culture (as did C016, who was Chinese, quoted on page 113). These two White English participants also felt that the word 'heritage' was a better description to describe their culture, as they felt there was no reason to utilise the word culture for themselves, to stand apart or to be identified:

WE10 (White English female): *Ehm...I suppose my culture is the heritage and what I have been brought up.*

WE21 (White English female): *Every Sunday we used to go visit my grandparents, so that was sort of a tradition or heritage ... which I now do with the children.*

One participant expressed how adherence to religious and cultural fulfilments did cause problems for those who had to be hospitalised in local institutions, where he felt the staff had little appreciation of this integral link between their everyday life and dedication to their culture. The following quote from him illustrated the point of misunderstanding his community's religious and cultural habits.

WM2 (White Minority male): *I have spoken to a lot of psychiatric Jewish patients who have said, "I have felt worse since I have been brought in here than when I was admitted. It is making me feel worse" ... there is nowhere for them to pray.*

There are no proper books for them to read. There is just general literature but there is no specific Jewish literature, that kind of thing, to study from or to pray with because that is what we do at all times...We don't play snooker, we don't play board games, we don't do this, we don't always watch television or listen to the radio. They say, "you were just being difficult, you are not cooperating", they are, it is written down they are uncooperative.

The responses from all the participants, regardless of ethnicity, regarding individual expressions of self were revealing. The myriad concepts utilised to define their own horizon (culture as religion, culture as dress, culture as food or culture as geographical location among others) were inseparable and overlapping dimensions of their understanding of what made up their perspective of culture.

4.2.1.2: BASIC THEME/ ETHNICITY AS A MARKER FOR CULTURE

This Basic Theme emerged from a cluster of responses around the link between the participants' ethnic identification for official purposes and their personal perceptions of the same compared to the culture they practised.

A number of participants felt strongly about being labelled. One participant stated:

AC18 (African-Caribbean female): *There has been times when I haven't ticked anything because I think, I am who I am, you don't need to put me in a box, there have been times where I have ticked and purposely ticked Other (Laughs) ... and so sometimes I tick or don't...so, I have ticked any old box, here you go, I have ticked a box because you want me to.*

Another participant felt similarly:

SA6 (South Asian male): *I don't tick, I don't tick it. I don't see why I should... It's nobody's business as far as I am concerned.*

Another African-Caribbean participant expressed the difference between how she was labelled and perceived by people around her, as opposed to whom she felt she was.

AC17 (African-Caribbean female): *This is always tricky. In this country, well, back home in Mauritius, I see myself as African because Mauritius is part of Africa, but here in the UK, people say I am Asian and as there is no African Asian box...I sometimes tick Other though not always, it depends on how I feel.*

Two participants of the same ethnic origin had different feelings about how they expressed their ethnicity and showed the inadequacy of these labels due to personal circumstances. This participant stated:

CO16 (Chinese female): *I tick the Chinese box even though I am now British by nationality.*

On the other hand, another participant from the same Black, Asian and Minority Ethnic (BAME) group stated:

CO15 (Chinese male): *I tick British Chinese, or say so in the Other area if there is no box. People might think I am from China but I am from Hong Kong.*

These official labels were not universally understood or agreed upon by the BAME participants. For example, one of the participants did not realise that her ethnic group had been recognised as such in the UK since 1985.

WM3 (White Minority female): *We are not an ethnic minority; we need to be redefined as an ethnic minority and not as a religion.*

Comparatively, the other Orthodox Jewish participant found the labelling representatively beneficial:

WM2 (White Minority male): *...but I now tick White Minority as Jews have a distinct separate culture, well, Orthodox Jews anyway.*

All five of the White English participants did not hesitate for a moment in expressing their ethnicity when asked.

The use of ethnicity as a label for defining cultural identity remains problematic and this will be considered further in the context of these findings in the Discussion (Chapter 5).

The descriptions contained within these two Basic Themes were able to convey the uniqueness of self-expressions of culture and yet stand apart as an Organising Theme.

4.2.2: ORGANISING THEME 1.2/ THE SYMBOLIC EXPERIENCE OF CULTURE

The symbolic experience of culture that made up this Organising Theme referred to those responses from the participants, where they attributed their own meaning to a personal experience from their past, not just within healthcare, which they felt impacted on how they perceived or wanted to experience cultural care.

The three Basic Themes that emerged from this Organising Theme were 'Recent experiences affecting perception of cultural care or self' and 'Handing of cultural practices through the generations' and 'Differences in healthcare cultural practices'. Not all responses in this section pertained specifically to cultural nursing care; however, our discussions during the interviews were not linear and moved back and forth between the nurses' expectations and how they came to have their perceptions; as such, they are pertinent to this theme.

4.2.2.1: BASIC THEME/ RECENT EXPERIENCES AFFECTING PERCEPTION OF CULTURAL CARE OR SELF.

Some of the participants spoke about recent experiences, not just in relation to their own experiences but also significant others, which affected their own behaviour and how they 'behaved' with health professionals. There were both negative and positive responses. On the negative side, these participants stated:

***CO16** (Chinese male): So that they are not judging what we are doing, let's say, recent experiences, for example my wife gave birth, we have in our culture,*

...uhm... some food, some traditional foods that will make the mom, ...the new mother... feel better and we try to help them to recover but because those foods may be a bit smelly...uhm...well, maybe not smelly but a different smell quite strong... So, the midwife, she kept mentioning it ... I am a bit nervous when they are coming to our house for the next baby.

SA5 (South Asian male): *We used to bring food in for Mum, because that's what, the only thing she would eat ... but we shouldn't have to and you become aware that they kind of look at you in a different way, for example, we eat with our hands, Indian food is not appropriate for a knife and fork. They were kind of looking at us as though we were weirdoes! I am not looking forward to that again.*

This participant explained about how the less than satisfactory experience at the hands of a number of health professionals during a personal trauma had made her very anxious about future hospitalisations:

CO14 (Chinese female): *When I was in xxxxx, they just don't care about your feelings, they just say, "Just Wait!" Before I going to the consultation room, because two years ago I had a miscarriage, and I was waiting to go in the scan and I already knew I am missing this baby and I already depressed...and when I go in I was crying and they just don't care about your feeling. "Okay! Lie down and I will do the test for you" and then I continually crying and they just don't care, they say, "it's fine, everything is fine". You can see the face is like aaa....blank, just blank. I was very nervous about going to hospital again.*

However, the same participant, at a later stage was able to have a more positive experience in a local hospital.

CO14 (Chinese female): *... because I went to check about my breast because I found a little something and then I went to do the scan, because I nearly never do it because I'm quite nervous ... but even the support worker and the nurses are very good, they say to me "don't need to be nervous, it is very common to find it and we will support you".*

4.2.2.2: BASIC THEME/ HANDING DOWN OF CULTURAL PRACTICES THROUGH THE GENERATIONS

As mentioned, this Basic Theme was not specifically related to the participants' perceptions of cultural care but impacted on how their earlier cultural life experiences, whether they were migrants to the UK or not, affected their expectations of CAC during an illness experience. These two participants stated:

CO15 (*Chinese female*): ...say for example we value family, the input of family, especially when we are ill, everybody cooks food that is making you better...I still believe in that, I think one of my priorities is that I saw, value, our shared family when ill, not just me, but members of my family, I have a role.

WM4 (*White Minority female*): the big thing in Poland, when you are ill or in hospital, is having your family, family visits, family bringing food, taking care of you, really, so when you are abroad, this would be really hard.

Overall, the participants from all five ethnic groups associated a number of cultural values and norms from their childhood that they related with comfort (food, family, gentleness of people around them, prayer) during illness, which they then felt would improve their experience of being ill now.

4.2.2.3: BASIC THEME/ DIFFERENCES IN HEALTHCARE CULTURE

The norms of healthcare practices previously experienced (at times during pre-migration to the UK) were used as a comparison to understand and express CAC. This participant expressed what had been her anxiety about her maternity experiences:

WM4 (*White Minority female*): When mums in Poland become pregnant, they want to go for scans every week, to check that everything is okay, and while you are in here, in England, you only have three scans or less. They expect more really and get very scared that they think English doctors don't care. So, they go to the

private Polish clinics that exists in England and pay to have scans so they are double checking that everything is okay.

This participant went on to consider how, despite this difference in care, she found the treatment of women in the maternity system in the UK more compassionate and professional.

A British born Somalian participant expressed a commonly held cultural viewpoint of her own community:

***AC20** (African-Caribbean female): Somalians have this thing here, that healthcare here is not as good as it is in Germany,...and you hear that a lot, as due to migration, we have lots of relatives there, who were also asylum seekers from the 70s...they say, the English healthcare system doesn't work as well, you need to go to Germany but I think and I don't agree...but... it's about how you communicate, if you don't communicate properly which sometimes they don't, it may take a longer time for you to get diagnosed.*

The dialogue from all the participants regarding experiences or persistence of commonly held views and its impact on a present-day outlook on CAC, including ideas around cultural traits or practice, remained an integral part of their bigger perceptions around their expectations of CAC.

4.2.3: ORGANISING THEME 1.3/ THE INTRICACIES OF PERSONAL BEHAVIOUR

This Organising Theme emerged from a consideration of the changes in behaviours and adaptation of cultural practices learnt from childhood, which may have affected the participants' present-day outlook in terms of expectations of CAC. One of the Basic Themes concentrated more around the fluidity of cultural experiences and was entitled the 'Cultural practices today: adaptation and the evolution of cultural experiences'. The second Basic Theme was based on other emotional factors, which the participants

expressed as outside cultural experience but would still influence their expectations of CAC (cultural or otherwise). It was referred to as 'Personal fears and anxiety influencing illness behaviour'.

4.2.3.1: BASIC THEME/ CULTURAL PRACTICES TODAY: ADAPTATION AND THE EVOLUTION OF CULTURAL EXPERIENCES

The majority of participants discussed their changing culture and how this had adapted over time. For example, some of the participants from BAME groups, who were not Christian, alluded to the mirroring of celebrations of the Judeo-Christian traditions of this country, adapting it to their own cultural preferences. An example was provided by this participant:

CO13 (Chinese female): *Yes, we always celebrate Christmas, not in a Christian way but we are cooking the turkey but [laughing] always have to have rice! I have to have rice, it makes me feel better.*

One participant expressed the way in which she adopted the hijab, despite it not being compulsory in her community, as more of a personal convention rather than a necessity:

AC20 (African-Caribbean female): *Like wearing a headscarf, like, I wear it but my sister doesn't, actually that's a weird one, I wear it because I have become used to it and I expect a nurse to help me cover it if I couldn't but I don't wear it for a religious reason.*

A Chinese participant talked about differences of acceptable gender related cultural behaviour between her and her parents' generation.

CO13 (Chinese female): *The case is ... traditional Chinese, they have different regulation, uhm... Because I am female, in traditional Chinese, the female musts pay loyalty to her husband...ultimately, the son is right and you are wrong...I say to him now that you have a wife, you will have to take responsibility, but he's not as traditional as his parents because he is brought up here.*

A British born participant of African-Caribbean descent mentioned how even language expressions and communication regarding her community had changed from her mother's generation:

***AC19** (African-Caribbean female): You know, I wonder if it's something that you might get from older generations, just because you know, my mum, she stills uses the term 'coloured'...Yeah, I cringe but it must be a generational thing but I would not expect it from a nurse now, I would be very upset.*

This Basic Theme showed how the practice of culture was not a static experience but a fluid entity of changes and evolvement of what an individual believed previously or as a way of preserving one's own identity as a form of self-preservation.

4.2.3.2: BASIC THEME/ PERSONAL FEARS AND ANXIETIES INFLUENCING ILLNESS BEHAVIOUR

Unlike the previous Basic Theme, responses here were related to participants' emotions or feelings about having to be hospitalised, experiencing illness or having contact with nurses and other health professionals. They expressed emotions that could be seen beyond the confines of culture and were mainly related to the anxieties of uncertainty. These expressions were found across all participants' responses. For example, these participants expressed these thoughts:

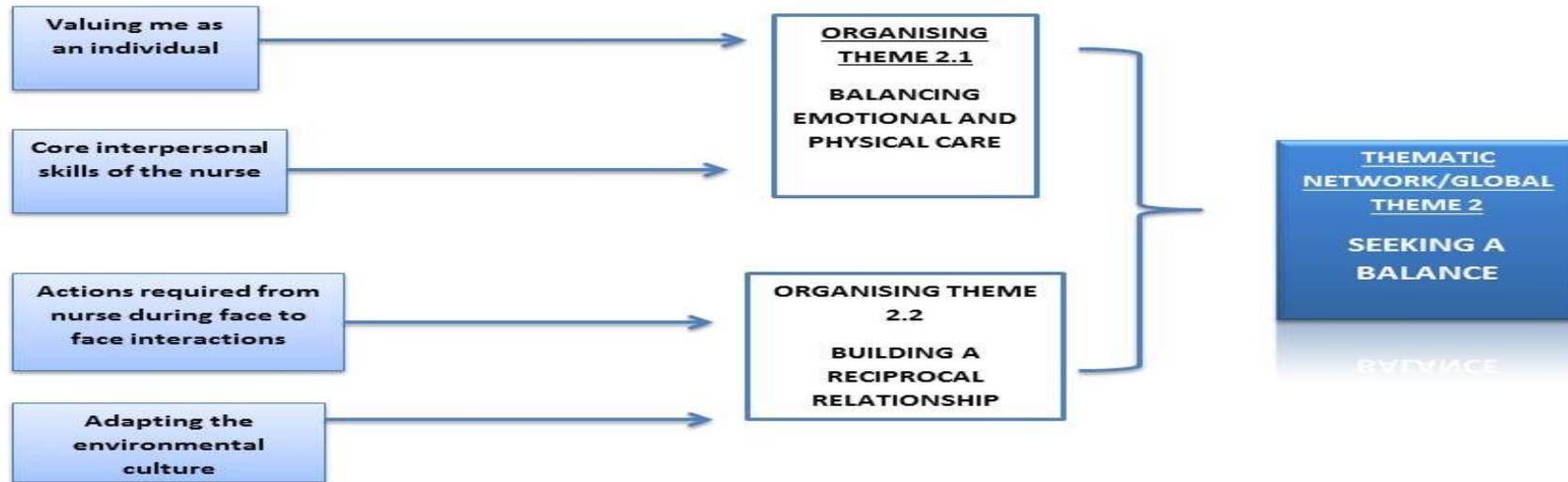
***SA7** (South Asian female): Although I have been sick and been to the doctors recently, if I was to go into hospital, it would be the first time I will be absolutely scared, about what's going on... I would really feel uncomfortable in that kind of environment, because I don't know what's going to happen.*

***WM4** (White Minority female): Although my English was good enough, I thought the doctor used language that I didn't understand. When my son was born, he was not very well and the doctor drew a picture for me and said this and this and that*

very quickly and I didn't really understand and I was very scared I was missing something. I am always scared I am missing something.

This Basic Theme showed that there were individual incidents that the participants had that they described as being beyond cultural experiences, practice or expectations, which could influence their expectations of CAC.

4.3: GLOBAL THEME: TN2/SEEKING A BALANCE



Thematic Network/Global Theme 2: Seeking a Balance/Basic Themes to Organising Themes to Global Theme

FIGURE 4.3: TN2/ SEEKING A BALANCE

This Global Theme related to those responses from the participants regarding their holistic requirements from nurses in order for CAC to be effective. This network reflected a more outward looking (as opposed to the more intra-personal perspective of the previous network) perceptions and expectations of the nurse. Two Organising Themes emerged: 'Balancing emotional and physical care' and 'Building a reciprocal relationship'.

4.3.1: ORGANISING THEME 2.1/ BALANCING EMOTIONAL AND PHYSICAL CARE

This Organising Theme emerged from those responses where the participants considered the importance of emotional and psychosocial support as equally important as the daily medically orientated care they would receive from the nurse. The participants expressed ideas around how unique the role of the nurse was, combining the importance of the science and art of nursing care, which included psychological, social and spiritual components. These responses were grouped into two Basic Themes: 'Valuing me as an individual' and 'Core interpersonal skills of the nurse'.

4.3.1.1: BASIC THEME/ VALUING ME AS AN INDIVIDUAL

The need to acknowledge the cultural individuality and uniqueness of each person was expressed by all the participants, irrespective of their ethnicity. This included discovering those values, beliefs and environments that reflected their expectations of nursing care. It was conveyed in a number of ways, such as how the interaction would make them feel while ill and conversations that would make the participants feel that they were not just another admission. For example, both these participants stated:

CO15 (Chinese female): *For them to genuinely put my health and my well-being as their first priority, at least, make me feel that it is...*

AC19 (African-Caribbean female): *You know when you go in these days, the nurses don't have time to talk to you because they are so busy but at least when they come over to you, take that time, to have a few words, just to value the person you are with and who you are. You know, acknowledge the person that is there, not just as a bed or a number, you know, but as a person.*

The acknowledgement of their individuality by the nurse was considered by all the participants as being an important factor in improving their overall experience of being a patient.

4.3.1.2: BASIC THEME/CORE INTERPERSONAL SKILLS OF THE NURSE

The responses to questions about the important features of CAC included what all the participants, irrespective of their ethnicity, saw as good and ineffective aspects of non-verbal communication. They indicated this aspect of the nurse's persona was equally important and an indicator of whether the nurse was genuinely interested in caring for them holistically. For example, this participant said:

CO16 (Chinese male): *I think that is the main part for the patient. It is caring and the explanation.*

This following comment by this participant, who was the only person in her family to reside in the UK, stated:

WM4 (White Minority female): *For me it is the heart, the nurse having the big heart, understanding that these people are alone in here, without family, they expect people to be around them but they are not. They are probably lonely...I know nurses are very busy, for the patient to know that you have time for them, and really taking care of them, and not really just being at work.*

This feeling of positivity and an interested persona from the nurse was important to this participant who needed to attend hospital for a series of treatments:

WE12 (*White English female*): *Uhm, chatter, open, you know.... I went to get a drink of water, you know and needed some water and had to fill the jug of water, she would say to me, "Oh, give it here, I'll get it for you", she was friendly, chatty, err... It made my day more bearable and for the all future treatments I have to go in for. If they are positive to me, about me, it makes me feel positive about my treatments.*

Conveying positive body language and interpersonal skills was also deemed equally significant to conversations for these two participants:

AC18 (*African-Caribbean female*): *I think that would come down, a lot to, body language, tone, facial expression, attentiveness, and also how much they were trying to communicate with me, erm, if I am ill and not really giving much away.*

CO15 (*Chinese female*): *I think that the nurse needs to be friendly, approachable, understand me, communicate with me really quite closely, and properly, good body language.*

The participants talked about the relationship between themselves and the nurses being based on factors such as trust, honesty, being present and respect. They felt that a relationship based on these values would act as important support and a buffer for their experience of illness.

4.3.2: ORGANISING THEME 2.2/ BUILDING A RECIPROCAL RELATIONSHIP

This next Organising Theme takes those aspects considered in the previous theme of 'Balancing emotional and physical care' and concentrates on how they need to be manifested or made apparent, in ways that benefitted both the nurse and the patient. In seeing the cultural person behind the patient, the participants expressed they wanted a more give-and-take relationship with the nurse. For them, being able to exchange

information and be able to relay those values that mattered to them was expressed as being part of CAC and being mutually beneficial. They felt that the nurse would show this by encouraging conversations, listening courteously and showing patience. This Organising Theme has two Basic Themes: 'Actions required from the nurse during face-to-face interactions' and 'Adapting the environmental culture'.

4.3.2.1: BASIC THEME/ ACTIONS REQUIRED FROM NURSES DURING FACE-TO-FACE INTERACTIONS

In this Basic Theme, the role of the patient moves from a passive, answering questions role to one of assisting the nurse or being involved within the interaction. Here, communication to provide CAC becomes a two-way process of information sharing, to share empowering information for mutual benefit.

WE21 (*White English female*): *I would want her to ask and know my history; I want her to know the medication I am on but apart from that... I would want her to be knowledgeable as to why I was in there, so, what treatment I would need or those kinds of things or whatever but equally I would want her to be kind, and respectful, fair and compassionate and hear what I have to say with interest.*

AC19 (*African-Caribbean*): *But at least when they come over to you, take that time, to have a few words, to really hear, just to value the person you are with and who you are. You know, acknowledge the person that is there, not just as a bed or a number, you know, but as a person, you and, andreally, that's it, you just want to feel taken care of, not just give you the right medical care but share information, you know and to be looked after in the appropriate manner!*

Regardless of their ethnicity, this type of response was apparent in all the participants' responses and that the reciprocity of this mutual communication helped with the reduction of anxiety or uncertainty of being ill.

4.3.2.2: BASIC THEME/ ADAPTING THE ENVIRONMENTAL CULTURE

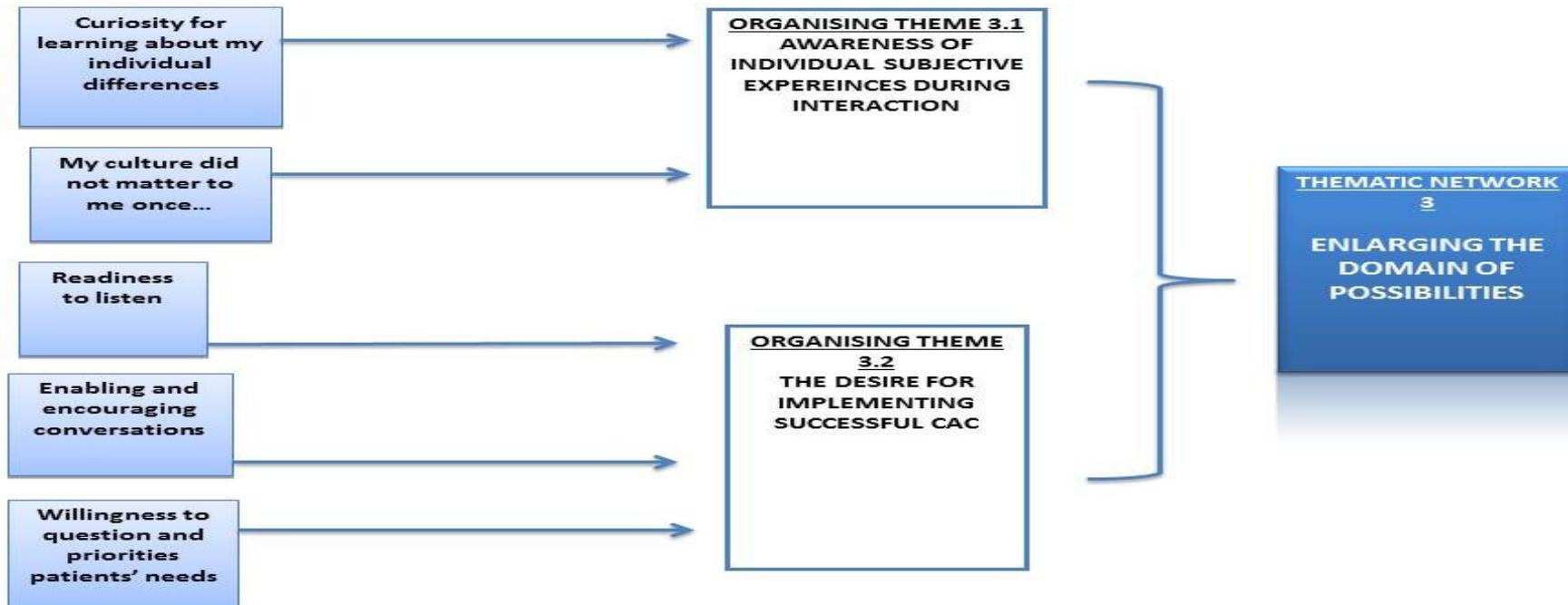
A number of participants expressed the need for flexibility, within reason, of the rules and regulations that a ward's daily routines were set by. The flexibility shown personalised the experience and it was less stressful for the patient's emotional and psychological state while being ill.

***WE9** (White English female): I know they have to work to a routine but when somebody is ill, you need your family more than regular visiting hours so, but then again, maybe a little bit more leeway. They never asked me that but allowed it for an Asian lady, who seemed to want some quiet. She would roll her eyes at me when her relatives arrived. But no one asked me and I felt I could not ask. If a person is really upset, I would like to say to a nurse, could you arrange for someone to come and see me. I need them now, more so than three to four, you know, visiting hours.*

***CO15** (Chinese female): ...as I was saying, I live on my own. A lot of time, you are on your own. The visiting hours are very limited...well, I totally understand because I am a nurse,...but...you cannot have too many visitors on the ward but I think I would like somebody to be with me, like a friend or family to come and see me quite closely, quite regularly, to be alone in the hospital can be quite lonely and depressing.*

All participants mentioned flexibility from rigid rules as a way of improving their experience and a way of conveying a personalised touch in terms of CAC, within the uncertainty of illness. For this group of participants, this Organising Theme brought to the fore the degree to which nurses needed to pay equal attention to the emotional aspects of the experience of illness and the medical reason for coming into contact with the nurse.

4.4: GLOBAL THEME: TN3/ ENLARGING THE DOMAIN OF POSSIBILITIES



Thematic Network/Global Theme 3: Enlarging the domain of possibilities/BT to OT to GT

FIGURE 4.4: TN3/ENLARGING THE DOMAIN OF POSSIBILITIES

This Global Theme represented the deconstruction of the attitudes related to the various aspects of verbal and interpersonal responses that would need to take place between the participant and the nurse, which in the opinion of the participants would then facilitate hearing the patient's perception of CAC. They were connected by the aspects of conversation and interpersonal communication that the participants said the nurse needed to be willing to engage in to explore those details, and the aspects not obvious visually that would enhance the delivery of culturally appropriate care (CAC).

Two Organising Themes emerged from the Global Theme: 'Awareness of individual subjective experiences during interaction' and 'The desire for implementing successful care'.

4.4.1: ORGANISING THEME 3.1/ AWARENESS OF INDIVIDUAL SUBJECTIVE EXPERIENCES DURING INTERACTION

This Organising Theme related to the responses from the participants regarding individual interactions that would provide the nurse with significant information about the individuality of the patient's values and norms to be able to pick up those aspects of CAC that are relevant to an individual patient. The two Basic Themes were 'Curiosity to learn about my individual cultural differences' and 'My culture did not matter to me once...'

4.4.1.1: BASIC THEME/ CURIOSITY TO LEARN ABOUT MY INDIVIDUAL CULTURAL DIFFERENCES

This Basic Theme reflected the participants' responses that wanted the nurses to be more inquisitive about individual cultural needs, without succumbing to ethnic stereotyping of any group (BAME or Majority population). A number of participants related this to their

experiences of being provided meals in hospital. For example, this Pakistani participant stated:

SA8 (South Asian female): *And also, I think, I am a British Muslim, so, my needs are different to say, my mum. So, as a British Muslim, that I too like my fish and chips as much as she likes her fish and chips and generally, and I can't eat spicy foods, just don't assume that's all I eat.*

Similarly, this West Indian participant expressed:

AC18 (African-Caribbean female): *Oh...Let me think. This isn't related to me being a person of Caribbean descent, more about being treated as a person...I would want her to ask me about what I could eat or not, would like to eat or don't eat, is there a reason or whatever, as I don't have any control over that, as I have it brought to me and not make assumptions because of my ethnic group. I would want her to ask me do I eat dairy, wheat that sort of thing, as I can't! Do I like even...it would be nice to be asked.*

This participant expressed that her parents, despite speaking basic English, would not express personal and religious observances, such as dietary restrictions (they are Hindu vegetarians) unless asked:

SA7 (South Asian male): *And when they have lived in a country where they get nothing and so, they are thankful for what they get here, so, might just nod and not say anything.*

A similar sentiment was also mirrored by a White English participant about her mother:

WE12 (White English female): *You know, she is 88. She won't say anything, because she remembers the lack of anything during the war and times when you just got on with it. If you don't ask, she won't tell you. She told me she ate cauliflower cheese the other day, as the nurse just fed her without asking what she would like. She hates cauliflower but didn't want to offend the nurse!*

One participant felt that the stereotypical assumptions made about the social status of her community left her struggling to access healthcare services:

WM3 (*White Minority female*): *Actually it's not anti-Semitic to have a clinic on that day but it is difficult for me to travel on the afternoon of the Sabbath but they never asked. And I had to go to xxxx but it would have cost me over £200 by taxis and I don't drive anymore, so my friend had to take me. I think they assumed because I was Jewish and live in what is considered to be a wealthy area, I would be able to afford this.*

4.4.1.2: BASIC THEME/ MY CULTURE DID NOT MATTER TO ME ONCE...

From across all ethnic groupings, this Basic Theme had the highest number of similar responses from all the participants by far. The responses alluded to more basic, authentic expressions of positive respectful behaviour that, for both these participants, allowed for the re-imagination of how CAC might be perceived:

SA8 (*South Asian female*): *I know I can't have everything but if they make an effort to show they tried to understand, I would feel they respected me, it would be ok.*

WE12 (*White English female*): *As long as they are polite, courteous, and they show some respect, you know, respect for feelings or whatever, yeah, that's it really.*

More than half the participants expressed their understanding of the variety and number of patients that were being cared for by the nurses and alluded to present-day staffing levels and its impact on their ability to spend individual time with the patient. However, they felt despite this there needed to be a fundamental ethos or specific emotions conveyed regarding respect, trusting their understanding of illness and a sensitive, non-judgmental persona when interacting with the ill person. This, they related, would make them feel valued and encourage the conversation to be reciprocal and therapeutic.

4.4.2: ORGANISING THEME 3.2/THE DESIRE FOR IMPLEMENTING SUCCESSFUL CARE

This Organising Theme had three Basic Themes: 'Readiness to listen, 'Enabling and encouraging conversations' and 'Willingness to question and prioritise patients' needs'. These Basic Themes related to the different characteristics around the attitude taken by the nurse to enhance CAC. They were more about an inclusive attitude of the nurse towards being interested about CAC and wanting to discover information from the patients, which they then felt would improve individualistic specific cultural questioning to improve CAC.

4.4.2.1: BASIC THEME/ READINESS TO LISTEN

These two participants conveyed the need for the nurse to spend time to genuinely listen to them, with interest and without rushing.

***WE21** (White English female): By listening to you, when they are respecting what you are saying, by kindness really, just even a smile, which even if your first language isn't English, people understand the smile. To feel that you are receiving, the correct treatment, if you require treatment and you are being treated as a human being. So, not being ignored or that.*

***WE10** (White English female): Talking to me, understanding my condition, listening and understanding that I may be fearful,...uhm..., just talking to me, not just being regimental, passing by my bed and passing me tablets. Stop and talk to me, have a conversation with me, about anything. Don't just give me my tablets and walk away I am not a freak, just another person.*

Regardless of ethnicity, all the participants wanted a nurse who showed interest in what they had to say and that their opinion mattered too, rather than just being a passive participant within this situation.

4.4.2.2: BASIC THEME/ ENABLING AND ENCOURAGING CONVERSATIONS

The participants, whatever their ethnicity, found that they felt more satisfied with care when given time to explain their condition within their understanding and also being given the time to clarify those issues important to them, as these next responses show:

***WE9** (White English female): You know, when my husband was really poorly, and he was at home, we had to have nurses coming in everyday, you know. And, it was nice that they could spend just a little bit of time with him, speaking, not only about his illness or treatment but also about other kinds of conversation, encouraging him to talk about his fears, about the future, rather than medical all the time, so, it puts the patient at ease.*

***WM3** (White Minority female): And I turned up and the nurse was lovely and he asked me if I had any other illness and I said no, and he was lovely and took his time. I was surprised that he didn't just ask me about the mole and encouraged me to describe my symptoms, in my words and having been in xxxx for some time, I was used to the doctors there, who were efficient but brusque.*

The effect of a sensitive approach to mutually fulfilling conversations affected the participants' psychological state in a positive way.

4.4.2.3: BASIC THEME/ WILLINGNESS TO QUESTION AND PRIORITISE PATIENTS' NEEDS

This Basic Theme reflected those responses that implied the need for the nurse to be able to ask questions and not assume their preferences or priorities. Some participants stated that when they had encountered a nurse or other health professionals, topics that the nurse may have perceived as more sensitive were often avoided or assumptions were made. Both these participants, for example, had previously expressed that people often avoided questioning them, as they were afraid of offending by asking questions that the nurse may have deemed as sensitive or irrelevant to the delivery of nursing care:

AC17 (African-Caribbean female): *Firstly, I would like them to feel comfortable, because nothing is worse than when...they are feeling edgy and that they are not going to be themselves. Ask me, ask me about me, so, make themselves comfortable, I am human and feel free to ask any questions that is relevant to improve my care. Don't go down some politically correct sensitivity road and make assumptions about me, based on stereotypes.*

SA7 (South Asian female): *It would be nice to be asked about what, what I would want or, how I would like to be cared for, in the sense rather than just kind assuming, yes, because they might already assume, assume that I am Asian, especially in Manchester, that I might be Muslim because that's what usually tends to happen.*

Focusing on the willingness to question, one participant suggested that if the nurses had questioned him about his daily routine and recorded it as important, his experience in hospital would have been more satisfactory. For him, as for some other participants, there were equally pressing daily priorities that needed to be fulfilled in spite of being physically ill:

WM2 (White Minority male): *The information the nurse needs to have, is that when you have a patient of a particular Minority, or even Majority community, ask them 'what do they need?'... If they had asked me and shared this as equally important information with the rest of the nurses, they would know I need to pray in the morning for 40 minutes, every morning. I don't mind working around their routine but I kept having to explain again and again for the whole period I was there.*

These three Basic Themes reflected the type of reciprocal conversations that the participants preferred to be engaged in, in addition to those questions that would help with treating their condition.

4.5: SUMMARY

The results from the data from the interviews of these 21 participants have provided three Global Themes or Thematic Networks that emerged from the utilisation of Attride-Stirlings' (2001) TN's. Overall, the main findings converged around the adoption of an open, non-judgmental attitude through which the nurse would be able to uncover the multifaceted nature of their service users by utilising a range of communication skills. They would also need to embrace courage and creativity in delivering safe and CAC to all their service users, without being constrained by personal limiting ideas about their patients.

Having completed this process, the next chapter will discuss these findings, keeping in mind the influence of Gadamerian philosophical hermeneutics on this research.

CHAPTER 5: DISCUSSION

This chapter will provide a discussion of the findings of this research study entitled *Culturally appropriate care: A qualitative exploration of service-users' perspectives of nursing care*. It will also provide, in light of the findings and discussion, the limitations of this research and future recommendations.

5.1: INTRODUCTION

At the end of the narrative literature review in Chapter 2, a gap in the research around the understanding of culturally appropriate care (CAC), specifically from a service-user's perspective was identified. A dissonance was found within the literature in that it focused on the practitioner's perspective of what CAC should be for the service user, rather than the service-user's perspective and expectations of it. As a result, this research set out to explore and to understand the characteristics of CAC from a service-user's perspective.

With the influence of Gadamerian philosophical hermeneutics on this research in mind, three aims were put in place in section 2.7, to explore the research questions, through dialogue, to come to a newer understanding:

Aim 1: To develop an understanding of the health service users' previous experiences of CAC.

Aim 2: To develop an understanding of what CAC should be from the perspective of service users.

Aim 3: To understand service-users' views of the influences on the provision of CAC by nurses.

The consideration of CAC and its associated constructs such as ethnicity (in this case, multi-ethnicity and the inclusion of the Majority population within research on cultural

preferences) and multiple personal ideas around nursing was always going to result in providing the generation of complex (and at times chaotic) but rich data. Together with this, the discussion that developed from the analysis cut across the themes that emerged in Chapter 4. As such, in order to organise the discussion clearly in a consistent and structured manner, the aims stated above are utilised in this chapter as the main headings. In the discussion below, reference is also made to the Thematic Networks and Organising Themes that emerged from the analysis of the data in Chapter 4, to clearly connect the findings from the dialogues with the participants to the deliberations in this chapter (see Figure 4.1).

5.2: TO UNDERSTAND HEALTH SERVICE USERS' PREVIOUS EXPERIENCES OF CAC

The first aim was focused around exploring the previous experiences of the participants as a way of contextualising their present horizon around CAC. This allowed for the exploration of the participants' conditions of understanding regarding the subject.

5.2.1: INEFFECTIVE INTERCULTURAL COMMUNICATION

All the participants expressed that the shortcomings of some of their previous experiences of CAC from nurses were based around a failure in understanding the nuances around intercultural communication. It remains arguable that all conversations are a two-way value-laden process, as we are unable to converse without expressing ourselves, unconsciously or otherwise, without the voice of our own social, political and relative locations that have come together to make us respond in a particular way. The nurse, however, as the professional responsible for ensuring empathetic and sympathetic care, was found on a number of occasions not to be aware of this. For example, a Chinese participant had expressed the lack of empathy and sympathy shown during an ultrasound scan to determine whether she was miscarrying her baby. This also became apparent

during the interviews with the participants from the White English population, who expressed the same fundamental needs from their interactions with the nurse as the other four groups of participants from Black, Asian and Minority Ethnic (BAME) groups, at whom the frameworks and literature around CAC tend to be aimed **[see Thematic Network 1]**.

Gadamer (2004) articulated that our listening, reactions and understanding are reflexively shaped by factors such as the historical, social, political narratives of an individual and its connections with cultural meanings or symbols for that person. This finding was also easily linked to Bhui and Bhugra's (2004) assertions that any acts of speech between health professionals and service users, which may otherwise have been a straightforward interaction, always traversed inherent psychosocial aspects of the individual, expressed through languages, behaviours and expressions of distress. This influenced, then, the unconscious and conscious interpersonal skills displayed by the individual. Over the past few decades, literature from writers such as Tesone (1996) and more recently, Kravchenko (2010) and Altrov (2013) have continued to clarify that even for people who share the same mother tongue as the health professionals, misinterpretation can still occur due to differences in the symbolic experience of illness or the semantics of the language itself.

5.2.2: INCONGRUENT INTERPERSONAL SKILLS

All the participants conveyed that their previous experiences with nurses would have been improved had the nurse demonstrated congruent interpersonal body language alongside verbal communication, which was seen as important in reassuring them when they were ill. For example, all 21 participants expressed the need for the nurse to smile and convey a feeling of respect when caring or speaking to them. They talked about how

the nurses had not, at times, conveyed emotions or expressions that were linked to reassurance, reducing anxiety, genuine interest and a positive, non-judgemental willingness to 'wanting to' care for the participant. When asked how they would instinctively know if a nurse cared for them, all the participants expressed non-verbal factors such as an 'attitude'; a positive, relaxed body language; and a reassuring tone of voice, which would intuitively convey this to them **[see Thematic Network 3]**. Bach's (2004) research on the relationship between psychology and nursing care also found these characteristics highly valued by service users. Bach and Grant (2009), Greenberg (2007) and Benner (2001) all stated that service users were more satisfied with care when they met nurses who conveyed a genuine interest and acceptance of them.

All the participants within their responses stated that they had been able to tell how acceptable (or otherwise) they were from the facial expressions or body language of healthcare professionals, despite conversing in a non-judgemental way. A number of South Asian and African-Caribbean participants had experienced incongruent non-verbal expressions despite positive verbal expressions, which they linked to the concepts of respect and other reassuring gestures such as displaying warmth, being friendly, appropriate humour, being professional, showing care, empathy and sympathy among others **[see Thematic Network 3]**. De Cremer (2002) and Greenberg (2007) linked the feeling of being respected to feeling included and others wanting that individual to be included in the social contact that was taking place at that point. Elwyn et al. (2013) and Nordgren and Fridlund (2001) associated the effect of this feeling of respect to a form of self-determination and ethical behaviour, where because of their illness, decisions could be and often had been made for them, without their involvement.

5.2.3: PRIORITY OF CLINICAL CARE OVER EMOTIONAL SUPPORT

Although there was an appreciation for the carrying out of the daily routines and clinical observations, nearly all participants stated that in their experience, some nurses did not encourage conversation or make eye contact when carrying out daily routines that they felt nurses seemed to prioritise as more important. As part of their responses in relation to considering the fundamental abilities that a nurse should possess, all the participants placed significant value on the expertise around emotional care over the 'higher' clinical or technical skills the nurse possessed, whatever the outcome of their illness or reason for contact [see **Thematic Network 2**]. According to Legg (2011), providing good psychosocial care with effective intercultural communication comes down to good communication skills, both verbal and non-verbal. Similarly, Ellis et al. (2006) stated nurses play a unique role in emotional support, as they are able to initiate the dialogue in order to understand how individual service users are experiencing their illness or need support psychologically, socially and spiritually.

However, we all understand culture within the structures, strategies, anticipations and guidelines of our own society. As in Gadamer's philosophical hermeneutics cycle, coming to a new understanding helps us comprehend and convey various emotions in our everyday life and when ill, as we compare it to our own horizon (Miyamoto et al., 2010). As expressed in **Organising Theme 1.3**, being closed to reactions, expressions or unusual behaviour, which may be normal for the service user but strange to the nurse, could add to an already fraught emotional experience of being ill. Failure to appreciate varying emotional experiences of illness could not only be construed as being insensitive, but damaging to the interaction itself (McCulloch, 2015). Within this, Reimer-Kirkham (2000) stated that for nurses to limit healthcare experiences of their service users only to the

Other culture of that person, would be to exclude the extent to which their story were 'rendered voiceless, not taken seriously, silenced, peripheralised, homogenised, ignored and dehumanised' (Reimer-Kirkham, 2000:352). It would result in ignoring factors that had a significant role in their emotional experience as service users, in that moment. This also applies to the nurse applying his or her own dimensions of understanding illness (or continued need for contact) to those who are not only overtly the Other but those who appear similar or familiar, as these would result in stereotypical assumptions being made as to what was personally required by the service user (Phillips, 2007). Within this research, this was reinforced clearly in the comparable responses and needs expressed between the Majority and BAME groups.

5.2.4: LACK OF RECIPROCITY IN DIALOGUE

As was expressed in **Thematic Network 3**, all the participants were clear about how they had experienced a feeling of reassurance during contact with the nurse when they engaged the participant in a reciprocal conversation and was able to convey a genuine interest on a number of issues related to CAC. Again, the similarity of responses between the White English group and the BAME group was noteworthy.

The participants' needs around reciprocity also included wanting their version of the illness story heard. They felt that the conversations taking place between themselves and the nurse sometimes lacked a genuine attentiveness to the participant's ideation of their story. Charon (2006) has written widely regarding the skills required to observe the service-user's story during any conversation, calling the process one of 'narrative humility'. Within this, she and writers such as DasGupta (2008) or Tervalon and Murray-Garcia (1998) (who interchangeably use the term 'cultural humility') refer to the need for

a reciprocal process of partnership between the health professional with the service user during all contact.

Russell and Timmons (2009) expressed that as nurses, in hearing their story and choosing to look at the person behind the service user, we are being given the opportunity and privilege of hearing the specific experience through another's eyes, gaining an understanding and creating an influential encounter that has therapeutic benefits to the service user and to improving satisfaction with the service. Similarly, in Toombs' phenomenological study (2013), service-user stories held meaning, and by relaying their experiences of living with illness, they were afforded an opportunity to make sense of all that was happening. Elwyn et al. (2013) expressed that providing a space for a story to be relayed promoted a sharing of temporal and spatial boundaries, encouraging bonding and contextual understanding of the situation at hand.

DasGupta (2008:981) also felt that nurses should develop their abilities on treating the service-user's story as 'dynamic entities that we can approach and engage with, while simultaneously remaining open to their ambiguity and contradiction'. Mirroring Gadamer's viewpoint of clarifying misunderstanding through dialogue to come to a better understanding, acknowledging this 'strangeness' could encourage nurses to keep their horizons of understanding open to new possibilities (Gadamer, 2013). DasGupta's work also encouraged the professional to engage in a process of self-awareness in relation to our perception of the story being told and preconceived expectations of that person. This could thereby encourage the nurse to keep an open mind and not pre-empt what was about to be expressed, and actively and genuinely listen to what was being said. By the health professional acknowledging a socially more commanding position, engaging in the

art of narrative humility, according to Hunter and Hunter (2006) and Arthur (1995), could also address the hierarchical discrepancies that a clinical relationship can bring about.

5.2.5: ASSUMPTIONS OF SERVICE-USER NEEDS

The participants, from mainly the BAME groups but also a White English participant had expressed that, at times, the nurses had already made a judgement about their needs based on either their religion or their ethnicity [see **Thematic Network 1, specifically Organising Theme 1.3**]. For example, two of the South Asian participants expressed that, in their experience, a number of nurses had assumed that they had no choice about wearing their hijabs and had not realised that both these participants had made a choice to wear them. The stereotyping of groups of people, due to overt and different cultural practices has been shown to inhibit intercultural communication (Kim, 2004). Charon (2006) felt that appreciating and understanding the nuances of intercultural communication, including the role of authority or hierarchy in the judgement of others would encourage the nurse to refocus on the story of the particular service user they are interacting with, despite having had encounters with similar service users, illnesses or having had a similar experience themselves. As Gladwell (2005) suggested, it could also encourage recognising and considering the potential dehumanising harm of 'spur-of-the-moment' judgements and first impressions of other people. Writers such as Chandler (2014), Shapiro (2011) and Toombs (2013) expressed that conversations with service users, with awareness of narrative humility facilitated the examination of the complexities between that individual story and their own wider cultural context.

Again, traversing across all the ethnic groups, the participants had stated that in some of their previous experiences, nurses had not shown an interest or a willingness to ask questions in order to reveal certain preferences or cultural needs that were important to

them [see **Organising Theme 3.1**]. Questions around personal cultural preferences were restricted purely to dietary needs or being asked about their religion (which in turn, again solicited questions mainly about diet). The participants stated that the conversations had been limited to them answering questions regarding their medical admission at that point only. A willingness to question the myriad beliefs and possibilities of ill health can be related to the concept of cultural desire. Originally mentioned in Table 2.2 (within the explanation of the core concepts of Camphina-Bacote's (1998) theoretical frameworks), this concept places the motivation of the healthcare professionals to 'want to' engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters against being 'made to' or 'having to' provide CAC (Camphina-Bacote, 2002). Camphina-Bacote felt it was ineffective for the nurse to simply say that they respected service-users' values and beliefs or go through the motions of assuming that CAC had been provided because a number of predetermined questions had been asked or they had read a book stating that was how a particular ethnic group behaved. Having originally utilised Leininger's theoretical (1989) concepts around cultural competence, Camphina-Bacote noticed that her own immigrant community was not benefitting positively from the cultural competence movement in the USA. In 2002, she expressed that what she thought was lacking within this movement yet central to cultural nursing care was the nurses' real incentive or desire to deliver care that was culturally responsive to that service user. This could be linked to Ramsden's (2002) work around the unconsciously colonialist agenda around providing CAC to Others and in appreciating that the delivery of CAC requires the nurse to really understand issues of authority and status. Concepts around cultural desire included an attitude of openness and flexibility with Others, to be tolerant of differences and appreciate similarities, and to be prepared to engage in a life-long learning process from Others as cultural informants. This attitude of

cultural desire is also inextricably connected to the previous concept of narrative humility (Charon, 2006; Juarez et al., 2006; Tervalon and Murray-Garcia, 1998) in that wanting to adopt a 'humility'-based intersubjective stance of the Other, in relation to learning about their personal cultural identity, could be one form of expressing cultural desire [see **Organising Theme 3.2**].

Within the presumptions and assumptions held by the nurses, two of the White English participants had expressed that they felt they were unable to ask for what they perceived as preferential treatment that service users from the BAME background had been offered in the name of CAC. Burman (2003) has argued that the narrowing of cultural needs specifically to Other communities has excluded groups of people who have equally pressing needs from service provision.

5.2.6: IGNORING INTERSECTIONAL NEEDS

The emphasis of CAC on the Other, and mainly BAME communities that appear different at face value ignored two things in relation to a more equal allowance of personal preferences. As was expressed in **Organising Theme 3.2**, the participants across all five ethnic groups were concerned that issues that cut across distinct or specific cultural or religious labels rather than intersectional concerns, such as poverty, poor housing and loss of personal income, were seen as less relevant to the nurses. For example, one Chinese participant was more concerned with her isolation from her family in hospital, rather than any personal cultural observances she may practice at home. Collins (1998) and Powell-Sears (2012) both stated that instead of only scrutinising ethnicity, gender, class or race as typical social hierarchies, considerations around intersectionality would also allow for the examination of how all these concepts reciprocally may create one another and provide a more satisfactory CAC. This could be related to the fact that we all

hold multiple social locations, which interweave with one another to form our exclusive health experiences, observations and needs. As was made clear within **Organising Theme 1.3** and as Powell-Sears (2012) stressed, our culture, at any one time, remains a product of a combination of our multiple social locations, which may be relevant to our illness experience and expressions of our personal behaviour.

At another level, as was made apparent in **Organising Theme 2.2**, not extending CAC to the White Majority population could result in a less individual approach to nursing and ignoring preferences that are equally important to their illness journey or reason for contact with the nurse. The semantics of the word culture could result in nurses ignoring the personal preferences of those who are part of the White Majority population, ignoring personal or distinct cultural practices that a person may value. This was particularly glaring when a White English participant expressed her desire for her family to spend time with her outside visiting times, during three weeks of enforced bed-rest. She expressed that this luxury had been afforded to the South Asian service user in the same hospital room but not to her. It was equally disconcerting to learn that another participant from the White English group, who also had prolonged hospitalisations, had also felt unable to request some services extended to the BAME service users cared for alongside them. Examples such as relaxed visiting times for relatives or a specific dietary preference were given, but as they were not from a BAME group, they felt that they were not entitled to special requests. The response to this, had the request been made to the nurse is unknown. It could be argued, however, the belief that dispensations made on behalf of cultural needs is limited to and only for individuals from the BAME communities persists. This framing could result in nursing care being complicit in not promoting equality and fairness in terms of person-centred care.

It is arguable that these were forms of ethnocentricity in themselves, by the assumption that an individual from a White Majority background would not have, need or be offered the same if it would improve their illness journey in some way. The BAME participants in particular expressed that the nurses lack of awareness regarding their own ethnocentric views, despite claiming to carry out CAC, remained a fundamental issue from which stereotyping and inequalities arose [**Thematic Network 1**]. As Papadopoulos et al. (2004) stated, ideas around CAC should be instrumental in challenging ethnocentric beliefs, practices and unwitting prejudice towards service users from all backgrounds.

5.2.7: IGNORING THE UNIQUENESS OF THE SERVICE-USER'S CULTURAL IDENTITY

All the participants felt that in their experience, nurses had made generalised assumptions regarding them, their illness, their preferences or their needs, based on previous service users the nurses had already encountered. This pre-judgemental behaviour can be associated to Gadamer's (2004) ideas around the hermeneutic circle, where we come into a conversation or dialogue with another person with a horizon already influenced by history and traditions (see 3.4.2 for discussion regarding the hermeneutic circle and horizons). These assumptions were not just related to factors around ethnicity or race, but also the illness or reason for contact with the nurse. As much as they felt it was important to note some group characteristics, the participants felt that in order for CAC to be effective from the perspective of all the participants, the nurse must understand the intricacies and complexities of how each person is culturally unique [**Thematic Network 1**].

This brought to mind that during the interviewing stage of this research, our conversations began by enquiring about the participants' ideas around what they considered culture or a cultural activity to be, to gauge the similarities and differences in

both our horizons. The metaphor of horizon was employed by Gadamer (2004) to refer to a range of cultural, historical and linguistic preconceptions about our perspective of the world. Due to the possibility of different understandings regarding the word culture, it was important for both the participant and myself to ensure we had some appreciation of each other's perspective. In our conversations, the beginning and end of all our horizons were unclear and fluid, as were all our histories, which had changed over time and were dependent on whom we were having the conversation with at that point. As in the case of this research, an appreciation of this complexity needed to be respected, and as expressed by Van Quaquebeke et al. (2007), the emotions behind the understanding of individuality needed to move beyond tolerance to respect.

As the findings demonstrated in **Thematic Network 1**, the participants' language and conscious verbalisation and imagination of culture as a concept brought about a collection of ideas and expressions that showed similarity and fluidity for this concept between and within all the ethnic groups. There was a variety of combinations of concepts utilised to define all the participants' perspectives of culture. They encompassed expressions from culture as religion, culture as dress and culture as food, to limitations of imposed identities by others: all inseparable and overlapping dimensions of their horizon of what makes up their culture. Besides the information of how different ethnic groups or religious groups may experience their culture, this notion of similarity or of overlapping cultural perspectives tends to be underplayed within the interpretation of the literature around CAC, with emphasis on difference, specifically apart from the way the Majority populations' lives are supposedly lived.

The parameters of cultural self-identity were fluid and changeable, despite the overt similarity within their specific ethnic group or religion. In this research, two BAME female

participants found that the nurses, during a previous conversations during hospitalisation, found it difficult to perceive that the practice of wearing a hijab could be a way, for some women, of affirming their cultural identity rather than it being an enforced religious act [see Organising Theme 1.3]. For example, in relation to those participants who talked about certain aspects of dress or modesty as part of their personal representations of culture, a study by Wagner et al. (2012) looked at the attitudes of health professionals towards Muslim women. They found that their attitudes drastically changed to the negative when the women who wore a hijab were part of a BAME background. Razack (2004) found that adoption of what is considered overtly religious accoutrements (such as the standard wig for Orthodox Jewish women, hijab or niqab for Muslim women) has been known to be done unconsciously as a means of positive self-affirmation and opposing pervasive discrimination. This study also found that in the face of more recent negative stereotypical portrayals of religious minorities, one participant expressed that she had adopted wearing the hijab as a way of expressing her cultural identity, as Razack (2004) identified, in ways that exaggerated her group belonging and difference from broader society.

According to Kim and Sherman (2007) there are differences between those aspects of ourselves that we allow, or manifest when with others, changing spontaneously between the private, public or collective self. The extent to which these interchangeable expressions are dependent upon the concept of the self, at that moment, in relation to the other person being made contact with varies, because it involves sharing one's own thoughts and ideas, which may be perceived as different or difficult for the other person to grasp (Fiske et al., 2002). The unconscious choices made at that point have specific consequences for social behaviour, perceived acceptance by others and the degree to

which we share information or expressions of distress when ill (Becker et al. 2004; Triandis, 1989)

The discussion regarding cultural self-identity so far has mainly highlighted responses from the participants who are more overtly and may seem obviously conservative within their BAME groups. What this did not show was the personal preferences of participants from their same groups. Neither did it show that they might be from the Majority population, who may share equally conservative opinions about their daily practices and decorum, which may not have been obvious by just looking at them. An example of this comparison could be made from an example given by an African-Caribbean participant. During the interview she referred to her preference for tight jeans as a lack of modesty, declaring that her definition of this concept was partly related to the norms and values expected of the women within the Somalian community in her area [**Organising Theme 1.1**]. Syed et al. (2005) stated that for some women living in Islamic societies, there may be an emotional aspect and unspoken pressures related to the concept of modesty. Comparatively, some White British undergraduates in a study by Gregg et al. (2008) expressed modesty within a range of expressions such as, 'not boastful', 'humble' and 'shy' to express the same concept. This alluded again to the ideas around cultural behaviour, in that the external, obvious cultural traits of an individual can only be discerned by considering the underlying parts of individual culture, such as beliefs, values, motivations, world views, gender roles, etiquette, social or familial rules, importance of time, concepts of self and many more. These patterns of thought underlie the behaviours that can physically be seen in an individual.

5.2.8: THE CULTURE-LESS MAJORITY POPULATION

It was mentioned in Section 1.1.2 that the originality factor of this study was the inclusion of participants from the White Majority population as part of this research study because research has either tended to group them outside or distinctly. As articulated in the findings in **Thematic Network 1**, all the participants from the White English group found it more challenging to express their culture, see themselves as cultural people or see themselves apart from people assigned to their bigger ethnic grouping. The five White English participants found that in their case, the nurse did not ask them about their religion, ethnicity or questions related to personal values and beliefs. Yet, this study also found that they provided different responses to the same questions about the dimensions of their culture. According to Okley (1996), members of any Majority population can struggle to 'see' their own culture, unless framed within the frame of reference of what Other cultural groups do. This could partly be the experience of living in an environment where your cultural values, norms and practices remain as the standard, and are therefore invisible, requiring neither explanation nor justification (Nagel, 1994), and within which Others stand out. Comparable to the variations in individual cultural practices or similarities to daily activities of BAME communities, the literature around CAC nursing care very rarely considers the needs of the different cultural groups in the White Majority population as requiring questioning or attention. This monocultural approach, which sees the Majority population as one group in itself can have a detrimental impact on nursing care. The terms 'White English' or 'Majority population' (like 'Asian' or 'Muslim') can imply similar monocultural assumptions about this group as a whole.

This idea of the 'sameness' of the Majority population and the differences of the Other are also played out and perpetuated by politics and the mass media. Writers such as Ademola and Okunola (2013) and even earlier, Paletz and Lipinski (1994) stated that the

mass media continues to be central in conveying ideas from political culture that generate a sense of 'nationhood'. Perhaps this is an attempt to bring together a disparate group of people (in this case, the Majority population) and as a way of pointing out the Other. As Ramsden (2002) and Sue (2004) asserted, however, 'Whiteness' and ethnocentric monoculturalism are influential and entrenched worldview determinants that can be harmful to Minority groups, gender and other types of marginalised groups in society. Equally, it is also felt that this prevailing perspective of similarity and resemblance can be detrimental to individuals and groups within and beyond the confines of ethnic classification, as the concept itself can be invisible and may operate outside the level of conscious awareness, and consequently becomes ignored. Among other reasons and central to nursing care, this has an implication for equality and fairness, such as access to health and social care services for those individuals struggling with intersectional inequalities that affect their health (Viruell-Fuentes et al., 2012). As **Thematic Network 1** showed, despite the certainty with which some of the White English and BAME participants' expressed themselves as either a distinct religious or ethnic culture, there remained obvious differences in the idiosyncrasies between the participants from the same ethnic or sub-ethnic groupings. However, there was overall similarity in their needs from the nurse in terms of CAC.

These variations in responses from all the participants regarding their cultural self-identity could be attributed to a number of different reasons but Ewing (1990), an anthropologist, suggested that all of us provide evolving and differing accounts of our culture and ourselves, dependent on the context of the inquiry at hand. This again, was relatable to the idea of culture or cultural activity being a semiotic process, and those meaning-making symbols that are utilised for different contexts change constantly. Illness

or chronic disability brought with it, as the participants reflected in their own experiences, a certain vulnerability. The variation of needs by all the participants showed the nurses required an appreciation of the unique lived experience of vulnerability in individual service users [**Organising Theme 1.2**]. Spiers (2000) felt that nurses needed to understand the concept of vulnerability at two levels. At one level an individual, in experiencing ill health or needing long-term continuing care, could be considered vulnerable, at an externally evaluated risk. It could be also be argued that a service user not experiencing a positive relationship with the nurse could make them more vulnerable. Pertinent to this section of the discussion is the idea of vulnerability as a unique experiential state. Within this context, vulnerability becomes a psycho-social-cultural experience due to the experience of exposure to harm to an individual's integrity.

Within the intricacies that make up an individual's cultural self-identity, there is the possibility that the cultural self-descriptions of all the participants could be influenced by how they see themselves in relation to others or the history of that community. The 'Other' here does not just apply to those with obvious differences, such as ethnicity, but includes everybody [**Thematic Network 3**]. For example, two African-Caribbean participants were adamant in not having their ethnicity used as a way of labelling their cultural selves despite the nurses framing questions within these limits. As discussed in Chapter 2, those from Western cultures may see individuality and independence as important in their identity (Markus and Kitayama, 1991) and those influenced by a more Eastern perspective possibly saw themselves as more interdependent and influenced by their social connections and surroundings (Kim and Ho, 2007).

Literature by Markus and Kitayama (1991), Rothbaum et al. (2000) and Miller (2002) has emphasised this polarity as a way of understanding cultural self-expressions, specifically

in migrant communities. However, they have rarely considered either variation of this in Majority populations or the adaptation or assimilation of culture in migrant communities. Kagitcibasi (2005) felt that the more prominent use of the Western-Eastern separation was probably due to the influence of Western psychological theory and practice that has traditionally stressed the importance of individual independence as necessary and a more simplistic way to explain cultural self-expression. Not having awareness or an appreciation of either perspective could result in an ethnocentric approach to care, which some of the participants expressed in their unease and sense of being undervalued or in some cases marginalised.

It was also important to consider the participants' responses (and unconsciously, mine to theirs) regarding culture and cultural self-identity during the interview, taking into account the many aspects that make up others' perceptions of my identities or social locations: South Asian, Indian, Hindu, professional and female. Within this research, at the end of the interview a number of participants expressed having prior anxiety at being interviewed by someone whose religious or ethnic identity was not clear by name. One participant, in particular, having been a victim of continued religious persecution by another religious community, had ensured prior to consenting, that I was not a member of this group. This inquiry had also impacted on the first few minutes of the interview before we found common ground in our conversation. She expressed during the interview that her community's cultural identity and how much information she would share with me was very much based around this ongoing religious harassment. Some frameworks and literature around CAC concentrate on or are interpreted as paying attention to those etic aspects that make up the service-user's culture. This can be discovered by a one-way process of asking questions. Rarely do they consider the role of

our socialised understandings on the dynamics of the actual interactions or the representation of the nurse itself, and that the information given could be enhanced or limited by how the nurse approaches the two-way conversation.

I found that keeping in mind Gadamerian philosophical hermeneutic perspectives around the circularity of understanding in any conversation brought me to a newer understanding of the interaction between a nurse and a participant. A person's cultural self-identity and subsequent engagement in any conversation may be based on the interaction between three aspects of awareness by both participants. Firstly, on each individual's position in relation to the institution (e.g. hospital/clinic) or their place within the social structure (e.g. service user/female/elderly). Next, the social position in which either person taking part in that speech event sees themselves (someone in a position to give help/someone in a position where help is needed). Finally, the interpersonal identity of the individual person the individual communicated with (positive/negative, genuine/disinterested, confident/scared) can also influence this contact.

Piller (2011) and Cousins (1989) found that people express cultural conceptions of self differently, dependent on the social motivation of that individual or group at that point. These different conceptions of self are dependent inwardly on personal, historical factors that shape our different identities (Baumeister, 1986), depending on the variety of social situations we find ourselves in. Outwardly, issues, such as apprehension, fear of offence or being labelled racist, and language differences compound this self-expression. Even assumptions of how those listening to us may perhaps stereotype us or their unconscious use of unaccountable language (Frank and Goldstein, 2011), such as dismissing the service-user's fears, or displaying negative interpersonal behaviours during the said conversation (Jandt, 2001) affects this self-expression. As discussed, these forms of

knowledge are rarely conveyed in CAC frameworks or literature as being significant and yet, according to the participants, are central to effective intercultural communication for all service users, as the unconscious impact of the questioning nurse, and what and whom she or he may represent could influence the information relayed for nursing care.

5.2.9: THE EVOLUTION OF CULTURAL IDENTITY BASED ON PAST EXPERIENCES

One other aspect that emerged from the interviews concerned three participants from the African-Caribbean and South Asian groups who shared a number of stories related to previous experiences of racism. When analysing the transcriptions, it was found that these participants placed little importance on whether they would respond to questions about their culture or ethnicity in official forms [see **Organising Theme 1.1**]. This brought about a clearer appreciation that a person's self-identity, within culture and ethnicity, could be related to the individual participant's history in relation to their experiences of racism or other forms of discrimination. Again, Gadamer's (2004) explanation of our hermeneutic circularity of understanding was made clear by this realisation (see 3.4 for discussion on this). Although this may not be the case for everyone, Tizard and Phoenix (1995) in a study about the identities of some people from mixed-race backgrounds, felt that at times the experience of racism can actually help individuals in being much clearer about the dimensions within which they would prefer to be acknowledged. Hornsey (2008) and Yoo and Lee (2005) also have both found that some who have had negative discriminatory experiences in relation to their culture or ethnicity could develop a stronger cultural self-identity as a consequence.

The participants across all ethnic groups expressed in relation to previous experiences and wanting their individuality appreciated, felt that the nurse also needed to be aware of the impact of wider political experiences on the peculiarities individuals preferred

around cultural self-identity. For example, as the quotes show within **Thematic Network 1**, one Chinese participant made a distinction about wanting to be identified separately from the people of mainland China; this is not uncommon due to its political history with Britain and China. Brewer (1999) found soon after Britain 'handed back' Hong Kong to China in 1997, issues around ethnic and national identity had emerged due to the differences in cultural attitudes, habits and politics. She argued that the Hong Kong population, who have always had exposure to cultures and social behaviours from around the world, have struggled to come to terms with a new government who remains cautious about culture from the 'outside world'. As Leonard (2010) expressed in a similar vein, in their view, the people of mainland China are often more likely to be seen as the Other, than any White expatriate who may live in Hong Kong. Similar expressions from other participants from all the ethnic groups touched on the impact of historical or recent wider political changes on the identities of their conscious and unconscious cultural self.

Coming to understand the previous experiences of service users regarding CAC was an important aspect of understanding the horizon of the participants, especially when it came to exploring what they felt should make up those varying aspects of nurses roles. Their previous experiences as service users allowed them to be able to contextualise their priorities in terms of CAC and this is discussed in the next section.

5.3: TO DEVELOP AN UNDERSTANDING OF WHAT CAC SHOULD BE FROM THE PERSPECTIVE OF SERVICE USERS

Having explored their previous experiences, the second aim of this research study was an exploration of the aspects that service users felt would need to be part of CAC and how they would enhance their experience if they were ill or required continued contact with a nurse. The participants expressed requirements regarding CAC relating to the overall

attitude of the nurse, in relation to seeing the importance of a person-centred approach rather than needing a culturally specific interaction, unique to a specific group or community.

5.3.1: AN APPRECIATION OF THE INDIVIDUALITY OF CULTURAL SELF-IDENTITY

The aspect of CAC that all the participants perceived as essential was for the nurses to try to uncover, through verbal interactions and an ongoing interest in acquiring knowledge about other communities' customs and beliefs, a non-judgemental, intra-personal perspective of all service users and their complex expressions of behaviour. These behaviours could be cultural or otherwise, as all aspects of these factors made up aspects of their cultural self-identity. For instance, there was a realisation early on in this study that for some of the participants, the reasons or need for the word 'culture' as a form of expressing their self-identity and validation among and from others were more obvious. These justifications of ideas around cultural differences were most apparent for those individuals or groups that followed a more formalised religion, while existing within a progressively secular society. In keeping with these findings, MacFarlane (2012) identified that this was a common concern for those who were more religious within the Majority population or the BAME groups, as they tended to have trouble in expressing or maintaining a less clear division between culture and religion. This could partly be related to a constantly nuanced relationship they have had to negotiate between balancing the protection of their identity rights and the limits imposed by others (such as public institutions, schools, legislature and negative media reporting) to their right to express the same. The participants felt an appreciation of the varying ideas that service users may have improves nursing delivery of CAC.

5.3.2: CAC CENTRED AROUND RESPECTFUL HUMAN VALUES

Again, it is important to note at this stage in the discussion that the participants from across all ethnic groups of this study expressed an unexpected similarity in their responses regarding what they wanted from CAC: it seemed that CAC was centred on basic respectful human values rather than around stereotypical cultural markers or nursing action. Underlying all the responses was the willingness of the nurse to engage in effective communication alongside congruent interpersonal skills. All the participants expressed this idea, as they articulated that each meeting or conversation that took place between them and the nurse was a value-orientated encounter that would affect the effectiveness of care.

5.3.3: RECIPROCAL INTERCULTURAL COMMUNICATION

Another fundamental requirement for all the participants was for the nurse to engage in reciprocal conversations, benefitting both parties. In seeing the person behind the service user as a core characteristic of CAC [see **Organising Theme 2.2**], the participants expressed that they wanted a more give-and-take relationship during any conversations with nurses. This idea was no less important to those who spoke English well than for those for whom it was a second language or felt less proficient. For them, being able to exchange information and express what mattered to them was conveyed as being mutually beneficial. They felt that the nurse would show this by encouraging conversations, listening courteously and showing patience during conversations that may be affected by anxieties [**Organising Theme 3.1**]. Trede and Flowers (2014) found that respectful listening and engaging in conversation beyond the cause of illness provided the service user an opportunity to tell their stories and feel encouraged to share their worries, expectations and hopes, all factors they found to play a role in the outcome of

the illness. McQueen (2000) described this reciprocity by comparing the directive approach of 'caring for' to combining it with 'caring about' a person.

All the participants expressed that the role of the nurse should include providing information, the reduction of anxiety and reassurance at a time of stress for them **[Thematic Network 2]**. However, despite this, a number of studies have shown that nursing activities and documentation tends to be profoundly dominated by a more biomedical perspective or that significant aspects of nurses' responses to information gleaned from admitting service users were facilitated by a pharmacological response to almost every functional deficit (Tovey and Adams, 2003; Irving et al., 2004). Tovey and Adams's (2003) analysis of nursing documentation found a dominance of the medicalised techniques in the treatment of the patient rather than any information or inferences to the human contact that had been made.

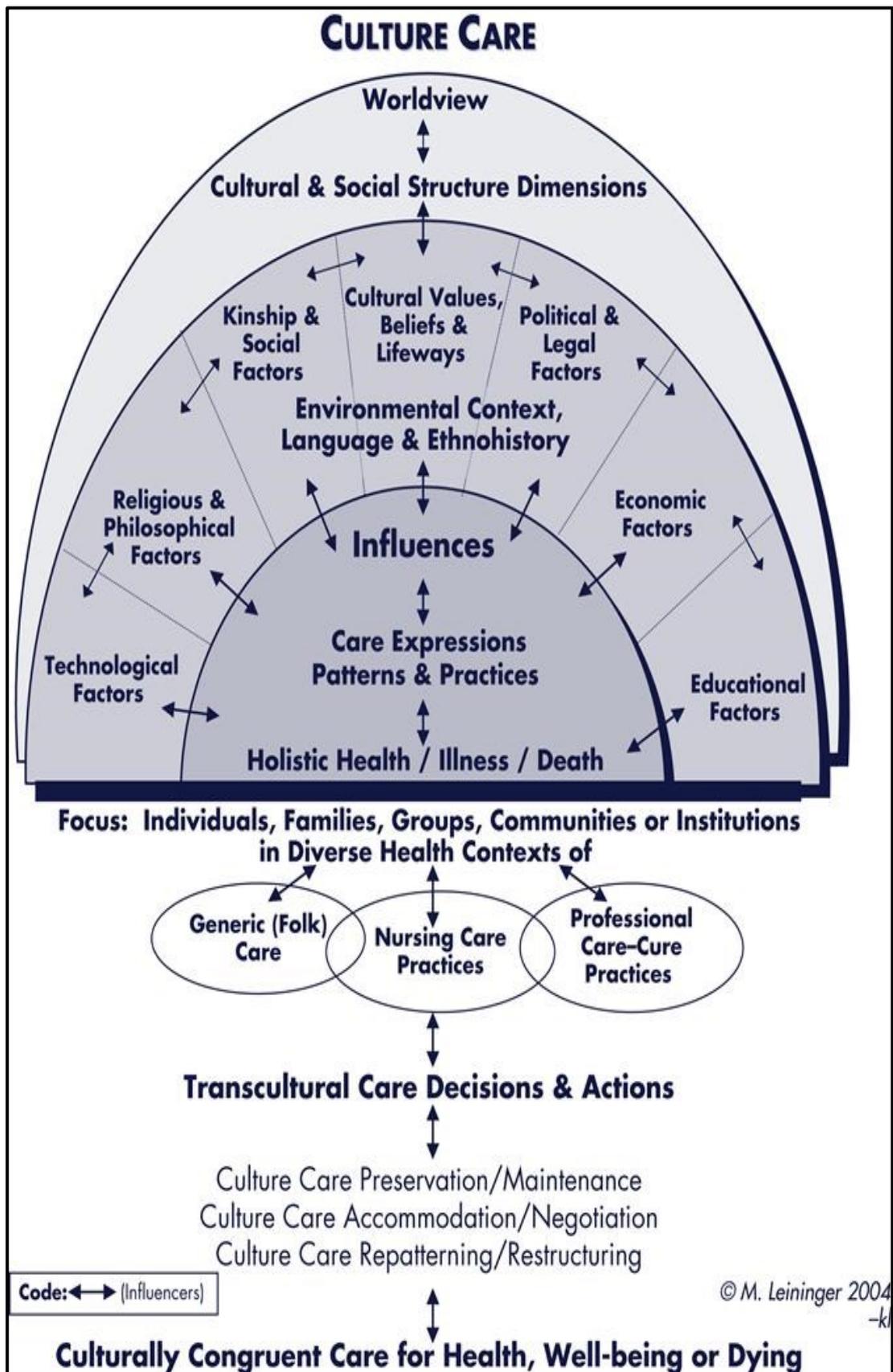
It could be argued that in relation to the balance of conversations we have with our service users, the larger feature of the information we gather tends to be seen as favourable to the nurse 'to do the job', rather than a mutual conversation, for mutual benefit.

Admission and nursing care frameworks such as the commonly utilised Roper, Logan and Tierney's (1996) Activities of Daily Living for example, could have the potential to develop a mutually helpful means to develop a reciprocal relationship and to gain information that would allow the nurse to advocate on service users' behalf in certain circumstances (Hyde et al., 2006). However, frameworks such as the ADLs and in relation to this thesis, Leininger's Sunrise Model (1991) (see Figure 5.1) with sections that actually show the inter-relationship between the factors that impact on a person's cultural identity, have instead been utilised as a checklist of questions to complete an admissions procedure. This style of interpretation stifles the reciprocity of conversation required to convey

reassurance and comfort, with nurses completing an assessment utilising a ward admission form that has only limited space for the sub-headings pre-set by the framework.

Kreps and Kunimoto (1994) felt that mutually beneficial communication remained the primary means by which the symbolic aspects of illness could be expressed. In attending to specific service-user needs, the nurse's abilities, skills and attributes could arguably bring about their reciprocal contribution to the development of a more empathic relationship.

FIGURE 5.1: LEININGER'S SUNRISE MODEL (1991)



One participant, from an Orthodox Jewish background had expressed how her interactions with a specialist nurse were positive in her being less anxious and developing a trusting relationship [**Organising Theme 3.1**]. Raudonis (1995) and Mottram (2009) both indicated the need for this mutually beneficial reciprocity is essential in reducing the emotional impact of the illness experience for the service user. Both these studies emphasised the importance of emotional care over the physical care that was required and an increase in service-user satisfaction. Thorne and Robinson (1988:782) also found that this reciprocity in the nurse-service-user relationship brought about a 'necessary satisfying component' for both parties. Attree's (2000) study regarding the service-user's perspective of 'good care' found that a two-way open exchange of communication was seen as one of the most important characteristics of building a satisfactory reciprocal relationship.

5.3.4: APPRECIATING THE IMPACT OF THE ILLNESS EXPERIENCE BEYOND THE SERVICE USER

As the analysis in **Thematic Network 2** showed, reciprocity, for the participants of this study, was not limited to communication with the service user alone. Petrie and Weinman (2006) and Yates (1999) found that service users perceived care to be more effective when the nurse also paid attention to the impact of illness on families and in some cases, their community. This was particularly important for those service users who came from more collectivist communities (not exclusively) where some aspects of their reality were determined by a collective sense of self-identity (Hofstede, 2001). In this case, the participants expressed the need for the nurse to understand the contexts where there were differences in relation to values and attitudes compared to the more accepted starting point and that of a more inclusive experience of social living (discussed in section 5.2).

Despite these seemingly persistent 'collective-individualistic' ideas about communities, it was important to note that a number of participants from the White English group (usually considered more within the individualistic paradigm) also expressed the need for the nurse to include their relatives or significant others in playing a bigger part in helping them feel better [**Organising Theme 2.2**]. Together with this, there were also BAME participants who originate more from the collective traditions, who expressed distinct personal ideas of self. In addition, there was a feeling that this sentiment of collectivism increased when there was a perceived (real or otherwise) threat to a group's cultural identity. This was expressed by some participants who were Muslim or from an Orthodox Jewish group, be they from a more individualistic or collectivist community; this is apparent in studies and reports in relation to increasing anti-Semitic, anti-Muslim or anti-immigration intolerance (Lebor, 2014; Leong, 2007; McLaren and Johnson, 2007). Within this, an understanding of cultural behaviours and self-identity expressed by the service user needed to take into account their openness to being reciprocal in a conversation was also influenced by present-day positive and negative experiences in their lives and the symbol the nurse may unconsciously represent (Booth, 2015).

During the narrative literature review for this study (see Chapter 2), the importance of effective communication was emphasised in all cultural care frameworks. For example, Leininger's Sunrise Model (1991) diagrammatically provided the facets that can contribute in making up the cultural identity of the multifaceted person (see Figure 5.1). The nurse then utilises the model, to ask the service user questions around these factors, to improve the understanding and delivery of cultural care. As **Thematic Network 1** showed, the individual expressions of the cultural self were different even between those who may have a collective identity, either through ethnicity or through religion.

5.3.5: LISTENING TO THE SERVICE-USER'S STORY

Taking this into account, another factor that the participants felt was important within CAC (and the factor that seems to be underplayed in these frameworks) is the complexity of what really constitutes intercultural communication and through this, the art of really listening to their story. DasGupta (2008) stated that 'traditional cultural competency training' mirrored a more biomedical style of learning and teaching, which is externally focused, principally concerned with becoming proficient about the Other, rather than examining the internalised prejudices, fears or identifications we inevitably hold about our service users, whatever their background. Isaacson (2014) found three common themes in a US study of final year student nurses who had already attended training to become culturally competent and deemed themselves as such. What emerged was these nurses defined culture, cultural definitions and experiences of health and illness only through their own lens (in the case of this study, a dominant White American domain) during their 'immersion' period of living with a Native American community. Isaacson went on to explain that once these students had embarked on a learning journey of self-awareness and reflection (through analysis of daily diary keeping), they were able to better understand the intricacies of intercultural communication and be less ethnocentric.

The emergence of the Thematic Networks from the data and the discussion in Chapter 5 signposted the complex role of the nurse in hearing and supporting those who are physically ill or need continued support due to a chronic condition. The role of the nurse in delivering any nursing care needed to be supported with the appropriate emotional and social support during stressful times in the service-user's life. By not engaging the patient in reciprocal conversation and really listening to their individuality, the required support is less likely to be effective. The participants in this research referred to

emotional and social support using expressions such as comfort and kindness, and at times, referred to a previous and familiar experience they identified with (for example, in prayer or in familiar food) as a way of dealing with illness. There was an expectation that besides caring for their presenting illness, the nurse would be part of the equation that provided this emotional and social support. Taylor et al. (2007) found that this emotional and social support had the capability to lessen psychological distress and promote psychological adjustment in stressful circumstances.

Harter et al. (2005) expressed that personal narratives are a fundamental way of giving meaning to experience when people are ill. Jagosh et al. (2011) and Robertson (2005) expressed the multilevel impact of storytelling including the ability to bond with the service user, validation of marginalised groups, a form of catharsis for the service user and a means of resisting oppression among others. Not a recent idea, the importance of listening to the service-user's perspective was apparent in examples from Kitwood's (1997) seminal work on person-centred dementia care, Williams and Grant's (1998) research on making the implicit ideas of the patient explicit and Clarke et al.'s (2003) study on how to utilise patient stories in engaging pre-registration student nurses. The more recent person-centred nursing literature, such as McCormack et al.'s (2011), advocates patient stories as a way of uncovering what made a particular individual unique and what connects them to others.

5.3.6: AWARENESS OF HOW ETHNOCENTRICITY CAN DEHUMANISE DELIVERY OF NURSING CARE

The ability to be aware of ethnocentric beliefs and values was also expressed as a need by all participants. An example of this was found in the responses of a Chinese participant [see Organising Theme 1.2]. He expressed what he felt as anxiety and embarrassment as

the Health visitor who visited his new baby and wife the year before, repeatedly commented on the smell of traditional herbs that had been prepared to help the new mother recover and assist her to produce breast milk for the baby. This participant stated that he was particularly anxious about future visits from any Health Visitor when future babies arrived. Scollon et al. (2012) and McIntosh et al. (2004) found that health professionals needed to be aware of a number of intersubjective issues when communicating with any service user, of any culture. They expressed the need for the nurse to really listen to their service user, while being aware of issues around authority, hierarchy, status, subordination and appreciating the symbolic and contextual impact of the conversation to the outcome of the meeting for it to be successfully heard. All communication encounters dynamically move between these areas in one conversation, as symbols and contexts of communication represent different things to those involved in the conversation (Samovar et al., 2014). However, taking into account all conversations involve more than one person, a nurse's exercise of authority, at times, could also work in the service-user's favour where a conversation is stilted due to the participants' previous experiences. Reciprocal conversations, as Lindgren (2000) stated need to be productive and mutual, with the understanding that both sides bring their own histories with them.

Interestingly, all of the Chinese participants and some of the South Asian BAME participants in this study expressed anxieties around not wanting to be judged by the nurse or other health professionals regarding the smell of either their traditional foods (South Asian and Chinese) or traditional (mainly Chinese) medicine [**Thematic Network 3**]. This type of reaction used to surprise me. For example, during my time as a specialist nurse a new service user from a BAME group expressed her relief on seeing me at the door for the first time. She stated (related to the fact I appeared outwardly, to be from

the same ethnic group as her), 'Oh, well, at least I don't have to worry about my house smelling of curry, I was so nervous about who was coming to my house'.

Low (2005), Classen (1993) and Synnott (1991) have all written about the concept of smell as a socio-cultural phenomenon, related to myriad meanings and symbolic values by different cultures. Related to these responses, the sense of smell is used to express ideas of 'oneness' and 'otherness' and ideas around acceptability or otherwise. Thus, within this perspective, the description of different olfactory characteristics to different races and different social groups is a universal trait, one that contains certain empirical basis, for body odours can differ among ethnic groups due in part to genetic factors and to food consumed. Low (2005), however, also expressed that those communities who feel self-conscious about these labels may be concerned about judgements based on one's past experience or expectations and being worried about stereotyping or being labelled as 'dirty'. Again, a nurse, aware of how his or her behaviour can come across as judgemental concerning their reaction to differences, can affect the sense of reassurance between the nurse and service user.

The starting point of reducing ethnocentricity and intercultural communication apprehension is the development of self-awareness in the nurse (Neuliep, 2015). A consideration of self-awareness 'crucially contributes towards one's understanding of the nature and construction of their cultural identity' (Papadopoulos, 2004:10). It is felt that the examination of self-identity in the nurse can only affect positively the reduction of ethnocentricity and intercultural communication apprehension. Not unique to these theoretical frameworks, the nurse engaging in self-awareness as a way of improving CAC is also apparent in Leininger's writings from 1995 onwards and in all of the UK frameworks or guidebooks discussed in Chapter 2 (O'Hagan, 2001; Holland and Hogg,

originally 2001; Narayanasamy, 2002 and all Papadopoulos' writing from 1998 to the present).

Despite evidence for the need to approach education around improving the delivery of CAC, there has been little use of self-awareness techniques as an added aspect of improving the delivery of CAC to service users. Perhaps the wider top-down influence from statutory strategies regarding diversity and equality has been seen as solution enough for improving care. For example, diversity and equality training that is now compulsory for all NHS staff consists of the utilisation of online courses that concentrate on the law around equality and diversity. However, these online exercises do not take into account that completing a tool about being fair to Others could add to intercultural communication apprehension as those participating can feel they are being judged, instead of a more time consuming safe space to deliberate the origins of all our learnt prejudices. There is also the possibility that this exercise, without a space for discussion, is continuing to view CAC as special care.

Engaging in self-awareness, however, can be an uncomfortable exercise for anyone, as it requires people to be honest about previous errors, their ethnocentricities and personally held prejudices. Nurses with a lack of self-awareness about their own ethnocentric views or paternalistic attitudes can immediately stifle the communication process from being a mutually beneficial experience (Pearce and Pickard, 2010). In addition, the belief that by just working in a multi-ethnic environment can develop the affective constructs such as cultural sensitivity, competence and desire could fail to manifest, if the management support for such an environment is absent (Reimer-Kirkham, 2000).

A general philosophy that facilitates the process of developing self-awareness, encouraging cultural desire and appreciating narrative humility is critical reflection (Smith, 2013; Schön, 1991; Johns, 2004). Briscoe (2013:563) stated that

...critical reflection creates a vehicle that is able to transport the learner from embedded ideas to a more considered opinion, but this may be uncomfortable and painful at times.

This is because the process of critical reflection lays bare those long held underlying assumptions, the dominance or pervasiveness of ideologies that effect practices and the recognition of personal limitations and prejudices (Iedema et al., 2006; Williams and Grant, 1998; Mezirow, 1990), which can surprise and be challenging to self-identity.

Despite the responsibility of reducing ethnocentricity, developing cultural desire and developing narrative humility is in the hands of the individual; there needs to be a supportive, strong, safe environment and leadership for it to be effective in terms of patient care (Briscoe, 2013). Within this, there needs to be awareness that critical reflection as a process can result in a greater suppressed self-determined 'prejudice regulation' if it not facilitated or managed effectively and done just as a 'tick-box' activity (Legault and Ducharme, 2009). It results in nurses providing socially desirable or politically correct responses so as not to appear biased or prejudiced without any real critical reflection (Stockē, 2007; Lalwani et al., 2009). For the past three decades, writers such as Khan (1982), Jacks (1993), Duffy (2001) and Jirwe et al. (2010) have found that nurses, nurse educators, and health and social care professionals often avoid any form of analyses that challenge the dominance of Western political and cultural systems. Encouraging a safe atmosphere to reflect on the origins of our prejudices, which are

present in everyone's behaviour, in a critical way provides a more neutral starting place for all nurses.

5.3.7: AWARENESS BY THE NURSE OF THE ROLE OF INTERSUBJECTIVE VALUES ON INTERCULTURAL COMMUNICATION

During the interviews, especially in **Thematic Network 3**, participants in all groups expressed how awareness of unconscious behaviours that displayed or exerted authority hierarchy and other intersubjective values such as the status of the nurse over the service user had a significant role in making the service user feel comfortable and respected.

Cross-cultural psychology literature (Bochner, 2013; Oyserman and Destin, 2010) has emphasised that these intersubjective values behind aspects such as authority, hierarchy, status, subordination and equality among others, are the more influential factor in determining cultural self-identity than previously imagined, on both sides of the conversation. Their work emphasised that intercultural contact between the professional and service user can affect the communication and behaviour of both parties due to the interaction being a heavily differing value-oriented encounter. Again, like the subject of ethnocentricity discussed in 5.3.6, the need for the nurse to be self-aware of these factors in communication requires honest, critical reflection from the nurse.

5.3.8: NON-JUDGMENTAL APPROACH TO DIFFERENCES

For the participants, the issue of being non-judgemental or making overall assumptions was a significant factor at many levels. Within **Thematic Network 1**, a number of participants from across all five ethnic groups voiced their concern over how nurses, in their previous experiences, had unconsciously stereotyped or assumed their needs (or lack of need) by outward appearances or regional accents. The BAME participants in particular expressed the homogenisation of their overall culture and the application of a

Judeo-Christian framework to their quite different way of practising their faith. Inevitably, living in the West, everyday language and questioning of religions or cultural practices has a tendency to be related to a familiar Judeo-Christian framework to make sense of its workings; for example, referring to the Bhagavad Gita (the main Hindu holy scriptures) as the Hindu 'bible', despite these sacred texts being incomparable.

For nurses who have only had exposure to those who practice religion within a Judeo-Christian context and operate in a mainly secular environment, the challenges of appreciating the intensity of adherence to some people's daily religious observances could be an unfamiliar or unknown process (Clarke, 2006). The comparison made may be inevitable (as in Gadamer's explanations of how we come to understand hermeneutically) as we learn to understand and rationalise newer ideas by comparing them to our own context of understanding. However, some of the participants expressed a lack of appreciation of the different ways of worship and faithfulness in carrying out prayers daily, perceiving them as odd and at times, obsessive.

Research by Pirutinski et al. (2009) and Huppert et al. (2007) found distinct challenges faced by individuals who encountered psychiatric service teams, who were unfamiliar with Orthodox Judaism or other highly organised beliefs. They stated that some health and social care professionals found it difficult to distinguish normative practices regarding the complexity and detailed scope of adherence that individuals or different groups choose to live by. For instance, the practice of the concept of 'scrupulosity' focuses on adherence to Judaism's detailed religious laws such as dietary restrictions (e.g., not mixing milk and meat); studying correctly; regular, repetitive prayer throughout the day (Greenberg and Shefler, 2002); and the act of prayer being accompanied by chanting and swaying. Those unfamiliar with Orthodox Judaism or similar adherences could

misinterpret this scrupulosity and the custom in which it is practised. Within psychiatric domains, observing these unfamiliar, repetitive habits might lead to an incorrect diagnosis of obsessive-compulsive disorder (Huppert et al., 2007). All the participants reiterated that (as discussed in section 2.3) during their contact with the nurse, conversations needed to pay attention to the individual constructs of culture, which gave meaning to 'I' or 'me' as opposed to the social identity that supports meaning and allows others to speak of them as a 'we'.

5.3.9: LIMITATION OF THE CONCEPT OF ETHNICITY IN IDENTIFYING CULTURAL IDENTITY OR NEEDS

As was found in **Organising Theme 1.1**, another essential aspect of CAC that the participants felt the nurse needed to be aware of was related to the limitations of ethnicity in expressing how people see themselves or act culturally. As highlighted in section 3.6.2, ethnicity as a grouping could be a limiting definition of a set of people. It remains a useful tool especially in epidemiological studies (Bhopal, 2007; Smaje, 1995) as one variable used to define populations for public health studies. The uses of ethnicity in both the characteristics of populations and their experience of disease have been easy to describe, and the literature on ethnicity and health continues to grow (Comstock et al., 2004).

A number of the participants talked about the advantage of being recognised within an ethnic group. The participants from an Orthodox Jewish background alluded positively to the fact that being a White Minority was not just recognition of their different culture and identity but also this was then recognised as one marker for health disparity within their group (Mor and Oberle, 2008). For example, it was through epidemiological studies that it was discovered Ashkenazi Jewish women (Jews of European origin) carried a higher

chance than the rest of the population of developing breast cancer due to a mutation of the BRAC1 and BRAC2 gene (Rubinstein, 2004).

The term White Minority has not always been a distinct ethnic and cultural group.

Evidence from writers such as De Bono (1996), Bradby (1995) and Anthias and Yuval-Davis (1992) found that the conceptualisation of ethnicity as the primary social identification of minorities had resulted in an invisibility for groups that became superficially subsumed into a supposedly homogeneous White category. This was despite the similar experiences of discrimination and disadvantage of these groups with non-White BAME groups. The usefulness of ethnicity as a label needs to be balanced with a reduction of stereotyping. Other than the participants from the Chinese group in this research, all the other BAME participants expressed that their cultural needs had been measured against their ethnicity, without questions to ascertain their preferences [**Organising Theme 1.1**]. For example, in the UK today there are at least eight groups of Orthodox Jews, ranging from Modern to the Ultra-Orthodox with varying cultural practices (Kraemer, 2007). Anand and Lahiri (2009) also stated that historically, evidence from studies on ethnicity have shown a lack of clarity about the research purpose and also that ethnocentricity can affect the interpretation and use of data (Strickland, 2002; Cain and Kington, 2003) from these studies. This questioning highlights again the fundamental problems with utilising ethnicity as the significant marker within any type of service-user interaction or health research.

The argument that assumptions, stereotypes or lack of need made about service users based on their ethnicity, either the Majority population or BAME communities, could result in a limiting or even harmful delivery of care to the service user is not a new argument (Nazroo et al., 2009). For example, a participant expressed the issue of not

being referred to the community services for care at home, under the assumption that she would have family who would take care of her [**Thematic Network 1**]. This aspect has continued to be expressed by researchers such as Phillips and Taylor (2012) and Naidoo et al. (2006). This stereotype was an issue I had to face when trying to recruit participants from the BAME groups via the District Nurses. Although one of the areas I had tried to recruit from had a high rate of South Asian service users, not one of them was under the care of any home-visit community services.

Having expressed the participant's perspective of the core features of CAC and the process by which they could be translated into practice, the participants also felt that there were barriers that could impact on the success and failure of these aspects being a reality.

5.4: TO UNDERSTAND HEALTH SERVICE USERS' VIEWS OF THE INFLUENCES ON THE PROVISION OF CAC BY NURSES

The third aim of this research set out to explore what the participants felt were obstacles to receiving CAC based on their perspective and needs. The exploration of this perspective benefitted this research in identifying the challenges and possible solutions based on more than my personal and professional prejudgements of this subject. The participants expressed aspects they feel are interlinked societal influences that unconsciously inhibit CAC from being successful.

5.4.1: THE IMPACT OF NEGATIVE STEREOTYPING OF THE CULTURAL 'OTHER' BY EXTERNAL FORCES AND CHANGES TO UK SOCIETY

According to the BAME participants, the first impediment in successful CAC involved ideas around the perpetuation of the cultural Other. They were sometimes anxious, but mainly baffled, that requesting specific CAC was considered special or extra, as opposed to care

delivered in different ways, given most of them were born and have grown up in the UK [see **Thematic Network 3**]. As highlighted in Chapter 2, the creation of self-identity and the Other can be a way of defining ideas around superiority and inferiority. Unrelenting negative political and media driven rhetoric about culture or multiculturalism has been shown to influence societal perspective of newer Others (such as refugees and asylum seekers) but, with it, also of long established migrants who may share externally obvious characteristics with these newer groups (O'Neill, 2011; Kinvall, 2004; Ryan et al., 2009). Kinvall argued,

Superior are those on the inside (of the religion or nation) who represent purity, order, truth, beauty, good, and right (order), while those on the outside are affected by pollution, falsity, ugliness, bad, and wrong (chaos). (2004:763)

One example of this could be illustrated by literature from demographers and theoretical globalists in the 1990s who were already predicting changes in immigration patterns to compensate for the lower reproduction levels in the West and the need for foreign workers to maintain the accepted levels of affluence (Brislin and Yoshida, 1994; Duffy, 2001). Unexpected mass migration due to ongoing conflicts seen more recently and the emergence of alternative super-global economies have resulted in unexpected major transformations of economic instability, global political powers and arguments regarding nationalistic boundaries. These changes have challenged our socially constructed ways of knowing our prejudices, our own cultural identities and ourselves (Heise and MacKinnon, 2010; Thane, 2010).

As expressed within **Organising Theme 1.2**, a White Minority participant voiced that within some parts of his community, the accelerated changes in society at large was making some members of his religiously conservative community choose to becoming

more isolated, in order not to lose their cultural identity. The attitude, encouragement and promotion of wanting to effectively carry out CAC in a reciprocal way needs to be played out against a background of present day unpredicted, escalating societal changes, which affect the way we see ourselves and Others.

As Kinvall (2004) and Papastergiadis (2013) deliberated, the effects of globalisation can challenge the more subtle cultural definitions of who we are and where we come from. According to O'Neill (2011) and Manners and Whitman (2000), for those who live in the more developed parts of the world, it has become commonplace for people to feel intensified levels of insecurity as the life they once led is being disputed and changed at the same time. As national cultural identities become eroded in an increasingly plural society, it has been argued by these authors that a number of factors related to globalisation have increased the gap between those who have reaped the benefits of the global market and those who have been left behind. In addition, capitalistic and democratising forces of the free market threatens the more traditional and understood structures of power, privilege, employment and status. These insecurities can lead to the further marginalisation of those already perceived as Others who are resident in the country, on top of the 'newcomers' (Kunst and Sam, 2013; Atherton, 2013).

The globalisation of economics and politics has also been felt among ordinary citizens, including nurses, as known culture and ideas around self-identity are challenged and events elsewhere (real or imagined) are becoming increasingly localised. Duffy (2001) provided an example of this challenge to identity. She referred to the simplicity with which some Americans had dismissed national health care as un-American, but were unable to see the endemic ethnocentrism on which that idea was based (Duffy, 2001:490). Another example could be the situation in which Western Europeans have

struggled with the need for new workers to maintain their professions or industries while, at the same time, attempting to avoid the threat of cultural change by immigrants. These examples point to a more unyielding attitude in societies that feels the need to safeguard themselves from the newer 'third world' and their not quite 21st century ideas; again, a factor perpetuated by the mass media and not repudiated by many politicians. This, as expressed by some participants, impacted on how those already in the Other category were perceived in the delivery of CAC as receiving extra or special nursing care

[Organising Theme 2.1].

Page (2009) stated that the subject of immigration, migration and refugees remains highly salient in the conversation on Others as over the past 15 years it has become one of the most commonly chosen most important issues of concern by the British public. The one factor that influenced the 'Brexit' campaign over other arguments was focused around often misconstrued ideas and worries of migration (Preston, 2016). Over a decade previously, Abrams and Houston (2005) in a British Societal Attitudes survey item found that the typical survey respondent overestimated 'non-Western' migrants as 25% of the UK population, when the full (Western and non-Western) foreign-born population was actually only about 11%. The pervasiveness of this type of misrepresentation was apparent in a survey of almost 8,000 children (aged 10 to 16) across England, which found that negative attitudes towards migrants and Muslims were widespread among school pupils (Buchanan, 2015). The data, based on questionnaires sent to more than 60 schools across the UK by the charity Show Racism the Red Card (2015) between 2012 and 2014, found there was a serious overestimation by schoolchildren regarding levels of migration to the UK and 60% of children questioned believed the idea that asylum seekers and immigrants were 'stealing our jobs'. Blinder (2014:8), however, also found that neither

studies, politicians, publications nor the mass media attempted to clarify information or rather 'misinformation' that the public continue to hold regarding these subjects.

5.4.2: LACK OF INTEREST BY THE NURSE IN UNCOVERING THE CULTURALLY UNIQUE SERVICE USER

As deliberated in the discussion of Aim 2 (see section 5.3.1), one of the overarching ideas expressed by the participants from across all BAME groups was the feeling that the nurse was genuinely interested in finding out about those idiosyncrasies that make a person culturally unique. This may be a challenging situation given the strongly held ideas around those who continue to be associated with Other groups, due to overt similarities seen in individuals. As **Thematic Network 3** showed, they felt it would be important to the fundamental success of delivering CAC. In relation to encouraging the enthusiasm to carry out CAC, as Camphina-Bacote (2008) argued, constructs such as cultural desire need to must be 'caught' rather than just 'taught'. That is, the need for an educational process that develops ideas around a positively situated sensitivity, appreciation and natural curiosity to hear the cultural aspects that are important to a service user at that time during their illness and health journey. Together, it could be argued that the larger issue of successfully implementing any CAC framework could lie within encouraging cultural desire and developing cultural humility to carry out effective CAC.

5.4.3: INTERCULTURAL COMMUNICATION APPREHENSION

Another factor that the participants of this study felt would influence the success or failure of CAC was related to sensitivities surrounding conversations around culture in Western societies. All the participants from the BAME groups expressed that nurses needed to be less anxious and be interested in questioning aspects of their culture that may be deemed sensitive, as a way of improving their illness experience [**Organising**

Theme 3.1]. For example, two of the South Asian participants expressed that nurses had adopted an oversensitive politically correct stance, avoided questioning and made assumptions about their needs, which then made the provision of CAC for them ineffective.

This avoidance and anxiety of questioning could be connected to the previous discussion in section 5.2.9 regarding changes to cultural identities. As nurses, like their communities, become increasingly unsure about identities around their own and Other communities', differences and sensitivities in cultural practices (inflated into pronounced dissimilarities by the mass media) cannot but have an impact on anxieties held around ease of intercultural communication.

As discussed in section 2.4.2, this overly sensitive political correctness is referred to as intercultural communication apprehension where real or anticipated communication with people from different groups, especially cultural and/or ethnic groups, results in avoidance or stereotyping. Here, this apprehension can be related to another level of Gadamer's (2004) prejudgements that has been added to a person's horizon, which impacts on conversations between the nurse and service user. These fears and anxieties could also be related either to personal fears of appearing offensive or discriminatory, perpetuated by the mass media (Hong et al., 2004) or to ethnocentricity (Wrench et al., 2006).

To be politically correct was originally a commitment to fairness, for those who had been openly marginalised in society by a historical, political and social structure (Malone, 2002). Over the years, a more tacit, less patronising principle of how to behave during intercultural communication (such as, interactions among people of different races, genders, religions, disability and other potentially charged social identity groups) has

become the verbalised accepted norm. This has, in the UK occurred in tandem with anti-discriminatory policy (such as the Equality Act, 2010).

According to van Boven (2000), the pressure to appear politically correct can have important consequences for the way people conduct intercultural communication. Despite private doubts, in order not to appear racist, sexist or culturally insensitive, a person (or community) could adopt a more defensive but socially acceptable reaction to what has come to be perceived as socially charged incidences. Van Boven argued that this pressure could lead to 'pluralistic ignorance': a situation in which a majority of group members may privately reject a norm, but incorrectly assume that most others accept it, and therefore go along with it (Prentice, 2007). The participants from the BAME groups expressed that this apprehension had reduced the ability of nurses to really listen or hear them due to long-term held ethnocentricities and stereotyping prejudices **[Organising Theme 3.2]**.

Another issue with the ideas perpetuated around intercultural communication apprehension was that, as a reaction to not wanting to be perceived as racist or discriminatory, the nurse feels unable to challenge any behaviours of the service user, even if it is harmful to them (Jeffreys, 2015; Hopton, 1995) or unlawful (Hamilton, 1996). Consequently, in some societies that have had more exposure to the notions of political correctness and the development of anti-discriminatory legislation there is an experience of people feeling judged and fearful of being blamed for potentially sensitive subjects (Ely et al., 2006). Individuals from both sides worry about how Others view them as representatives of their social identity groups. They also feel inhibited and afraid to address even the most banal issues directly, such as questions about the correct pronunciation of the other person's name or culture. As a consequence, without really

listening to service-user's stories, private conclusions are drawn based on stereotypes, previous judgements, ideas perpetuated by the media, among others, then unconfirmed, these assumptions become immutable (Marques, 2011; Morgan et al., 2007; Repper and Perkins, 2003) and part of the information we use to care for those who need our care. Some participants in this study alluded to this 'attitude' when they felt that nurses would rather make assumptions or stereotype their cultural needs than ask for their preferences and needs. This was pertinent in the experience of a South Asian Hindu vegetarian participant; the nurses assumed he was Muslim and provided him with a halal diet that contained beef, without even asking him his preferences **[Organising Theme 3.2]**.

In an attempt to understand the dynamics the participants felt impacted on the success or failures of implementing CAC, I enquired from all the participants how the nurse would know about their specific (cultural or otherwise) needs and the response was persistently simple: 'Ask me what I want or need' **[Organising Theme 3.1]**. Central to challenging the insecurities surrounding the negative interpretation of political correctness or intercultural communication apprehension was the art of effective questioning and listening. The assessment process at admission, despite having to pay attention to the immediate reasons for hospitalisation, needed to take into account their associated anxieties, their ideas of support and the factors beyond that illness that defined how they saw themselves at that point.

Intercultural communication apprehension, because of ethnocentricity, can occur due to nurses (and society as a whole) from dominant cultures viewing those from Other cultures as 'out-groups' (Gudykunst and Kim, 2002), although both these concepts are no less common in Minority populations (Hooghe et al., 2006). The lack of self-awareness regarding these unconscious attitudes could result in CAC not being translated into

reality. The awareness of these attitudes and personally held values of a communication encounter was expressed as an important factor in translating CAC for all the participants, even those participants from the White English group, who felt distinctly different due to their upbringing outside Manchester or significant regional accents. Although the importance of intercultural communication is emphasised in the theoretical frameworks, features that are external social and political influences, that effect nurses' unconscious and conscious behaviour, thwart understanding regarding the depth and complexity of the process. As discussed in Chapter 2 (see section 2.4), in the past decade the less than responsible use and semantics associated with the words linked to culture and the rhetoric being engaged by politicians and media will have unconsciously influenced the worldview of this society. This notion could further compound CAC as being considered as special or 'extra' care, for Others.

Intercultural communication apprehension and ethnocentricity is, however, never a one-way process. Intercultural communication apprehension from the perspective of the service user also has an impact on the success of CAC being successful. Service users themselves, as unique individuals with unique horizons, bring with them their socialised or learnt apprehension to sharing their needs with the nurse [**Organising Theme 1.3**]. As Taylor et al. (2007) stressed individuals from a more collectivist community, whatever their ethnicity may not be as willing to share their needs or problems with the nurse. This may be because the person normally, within their community context, avoids bringing their personal problems to the attention of others or seeking support because of the perception that such an act can weaken the harmony of their bigger social group.

5.4.4: THE IMPACT OF REDUCED STAFFING NUMBERS ON INDIVIDUALISED CARE

Another issue that participants from all the five ethnic groups referred to was the reduced staffing numbers as a factor in the core characteristics of CAC not being transformed into practice [**Organising Theme 3.2**]. There were numerous comments and excuses provided by the participants across all groups regarding the impact of a reduced number of qualified staff in being able to communicate effectively or carry out CAC. The impression that there were reduced nursing levels on the ward, which then made the nurses turn to task-orientated working and pay more attention to the more medically orientated needs of the service user was commented on by the participants. This idea was evident in Currie et al.'s (2005) literature review on the combination of reduced nursing staffing levels, the quality of care and reduced service-users' satisfaction. The link between the reduction in numbers of health professionals and the subsequent focusing on the illness or disease, rather than the person experiencing the illness, is not a new grievance within health and social care. Often more prominent in medical literature (Charon, 2006; Kuczweski, 2007), it has been a subject of regular scrutiny within the context of nursing (Beuthin, 2014; Molzahn et al., 2012; Galvin and Todres, 2009). If the impact of reduced staffing levels influences everyday care, then it is arguable that those nurses who perceive CAC as special or extra are less likely to want to hear the service-user's story, may see it as just another task to tick off or, as expressed by the participants, narrowed to special diets or preferred prayer times. Some literature has investigated complaints and expressions of dissatisfaction with services. Such studies show frequent changes to policies, mission statements or practice models that perpetuate the provision of sound health care that can be achieved only through prompt diagnosis, speedy, effective treatment and an uneventful, full recovery, has continued to be problematic for service users (Phair and Good, 1989; Turner and Kelly, 2002). Added to this, the

increasingly technological and specialised focus of care has been found to have an effect on reducing the human dimensions of illness (Todres et al., 2007); ignoring the cultural aspects that make up every service-user's psyche has resulted in what Cowling (2000) has described as the 'clinicalisation' of the human experience.

Within **Organising Theme 1.2**, participants spoke about ideas around comfort and the familiar as one aspect of satisfaction in receiving effective nursing care. Kolcaba (1995) expressed eloquently the ideas around the satisfaction and comfort derived from nursing by relating it to art: 'Art is created for an audience...the nature of the quality of art is determined by its audience' (Kolcaba, 1995:287). For nursing in particular, studies over two decades have shown that the pressures of constant changes to strategy by the government, deficits in qualified staff ratios and increasing litigation-defensive bureaucracy have had their effect on the art and ensuring comfort for service users by nurses (Langley et al., 2009; Cunningham et al., 2012; Rafferty, 2006; McKenna, 1995). The participants' responses reflected also the limited way that some nurses in these studies engaged with the emotional and cultural aspects of illness during nursing care delivery (Galvin and Todres, 2009; Kowalski et al., 2010; Heaslip and Board, 2012).

5.5: A REFLEXIVE RESEARCH JOURNEY

The last six years have been interspersed with periods of apprehension, of great introspection, increased confidence, exciting discoveries induced by the process of producing a thesis and an evolution of my personally held ideas around CAC.

Methodologically, the discovery of the ideas from Gadamerian philosophical hermeneutics and its relatability to this research was not a straightforward one with a journey of fits and starts but ultimate confidence in its connection to this research. Its relationship and connection to understanding the theoretical debate around

intersectionality and the insider/outsider positioning, such as the writings of Crenshaw (1993) provided a wider picture of the complex social, political and professional locations (amongst others) that we position ourselves at any one given time, was significant. As in the whole process and my conversations with the participants, my epistemology and ontology influenced my choice of methodology, the analysis process and the interpretation of the transcriptions. This is in keeping with the continual process around understanding of Gadamer's philosophical hermeneutics. Within this, a realisation that the process of hermeneutics, for different aspects of this research, started at different points and moved in both a clockwise and anticlockwise direction and that it never returned to where I had begun the journey became apparent. Being part of this hermeneutic understanding involved a reappraisal of my personally held knowledge of emerging data and discoveries never considered before, in terms of CAC. Gadamerian philosophical hermeneutics provided me with the methodological freedom to return to the participants when new thoughts and ideas emerged from the transcriptions. This allowed a real effort to represent the authenticity of the participants' perspectives and research in as ethical a way as possible. It also gave me the liberty to research a subject that would accept the discovery of newer understandings but not require an ultimate answer to my research question. This was pertinent as in the methodology chapter (see section 3.2) I had stated that the over-arching influence of this exploration would need to reflect my ontology and be able to accept the multiple subjective realities that I expected to emerge from the data I had collected.

From the outset of this research study (see section 1.1.2), I felt that one of the strengths and originality of this study, often researched sparsely or separately from research around care issues for the BAME population, has been the inclusion of the Majority

population as an ethnic group. It would have been inevitable that my early experiences as a migrant to the UK in the mid-1980s and observation of the varieties of cultural needs in the Majority population around me influenced my worldview. It also introduced me to the ideas of intersectional inequalities and positionality (such as gender, ethnicity, immigration status, poverty and unemployment), all which could play a crucial role in the culture of a patient and our interactions during the research process. This research has partly backed up that worldview but also that the conditions of understanding, as set out by Gadamerian philosophical hermeneutics, have to be expressed by those needing individualistic CAC, as the participants of this research have articulated.

Utilising this newer and an original understanding for this type of research, I have come to appreciate that the application of cultural care theories and frameworks needs to be expanded to all service users, whatever their ethnic background. Taking into account that nurses in the UK are themselves a multicultural group (Winkelman-Gleed, 2006), CAC for all service users has the ability to promote, in education and in practice, the capacity of the nurse to see culture beyond the limitations of ethnicity (and race). It has to include other aspects of an individual person's external influences that may affect the way they have to or choose to live their daily lives. As highlighted in Chapter 2, Goodhart (2013) felt that the continued persistence by the media and in politics regarding 'discrimination presumption' based on race and ethnicity has lost its usefulness, due to changes in the face of British multicultural society. In terms of equality, to provide person-centred CAC is to provide individualised care for all. I also strongly feel, taking in the context of our present day social and political locations, nurses might be more willing to engage in CAC if it was aimed at the population as a whole, and not just to the Other. The exclusion of the group you are a member of within the equation of CAC can cause resentment and again,

promote ideas around CAC being special or only for the Other. Arguably, CAC for all could have the ability to influence beliefs based on ethnocentrism.

5.6: LIMITATIONS OF THIS RESEARCH STUDY

With hindsight, there were a number of methodological and analytical limitations that emerged while carrying out this research study. I acknowledge that this study could have been implemented utilising a number of methods and even without the influence of Gadamerian philosophical hermeneutics, but this approach had resonated the most with my epistemology and ontology. However, to ensure that it was the service-user's voice and experience that was being expressed, I would have no hesitation in utilising one-to-one semi-structured interviews again. I feel that the influence of Gadamerian philosophical hermeneutics gave me the courage to be more open to the uniqueness of the participants' responses. However, this is tempered with the knowledge that different researchers, with different horizons may have interpreted the data another way.

Added to this, the participants' and my positionality may have unconsciously influenced the conversation we were engaging in and their responses to me. Similarly, their structural, political and representational intersectionalities that they were situated in (see section 1.4 for discussion on this) may have again been the dominant factor in how they responded to me during our conversational dialogue. For example, there may have been potential participants from the White Majority population who may have hesitated to participate in a study regarding cultural care due to existing intercultural communication apprehension.

Also related to the participants, a further limitation of the study was the impact of the geographical location of the participants. The area in which the participants were located in is considered one of the most deprived areas in England. The participants came from a

wide range of backgrounds, professionally and in relation to their income group but accessed similar services in this area. It would also be beneficial to know, in future research, if these findings would be altered if carried out in another, perhaps more affluent, area of the North West of England. Again, this would not be to provide comparison to this study but more of a process of learning about the 'conditions of understanding' regarding what a wider range of service users want from CAC.

The information disseminated about the study in form of the Participant Information Sheet (PIS) during the recruitment of participants was only available in English. Despite this being the recruitment strategy, it is with the acknowledgement that this in itself would have limited the participants of this study in terms of enhancing knowledge as to what service users need from CAC. Perhaps there will be members of any community who do not speak English, who may not have paid attention or felt comfortable to respond to the call for participants for this study. It could be claimed these population groups, who may have had different experiences and perspectives from the English-speaking participants, may be more vulnerable. Their opinions might benefit nursing knowledge as the idea of 'experience' has many meanings, given the myriad cultural and intersectional possibilities within which we all exist. Again, this is a possible area for future research.

5.7: RECOMMENDATIONS

In this section, I have provided a summary of my recommendations. These recommendations focus upon a number of sections around contributing to change in the knowledge base in CAC, developments within undergraduate nursing education and student nurses, and recommendations for future research. They also include those actions I have already put in place as a consequence of my newer understanding of CAC. These recommendations and actions have emerged through a better, evolving,

hermeneutic understanding regarding the perceptions and needs of CAC from a service-user's perspective. A summary of these actions are also in Table 5.1

5.7.1: DEVELOPMENTS WITHIN UNDERGRADUATE NURSING EDUCATION

I will challenge and encourage my immediate and other associated teams to develop and evolve the ideas of cultural care from a more monocultural approach with ideas that promote the utilisation of stereotypical cultural attributes of service users to a more person-centred, inclusive strategy in delivering the nursing or other healthcare curriculums. For example, I was successful in receiving a £4,000 grant from my University, to carry out a two-day cultural study day with the team I work alongside on a daily basis. The basis of the application was to engage the team with the findings of this study and to develop strategies for reducing ethnocentricity, increasing cultural self-awareness and evolving the way the subject of CAC is communicated. Post this project, two focus groups and a number of interviews will be carried out to evaluate and learn from this project. Findings will be disseminated via international conferences and publication of findings in appropriate journals.

Within my role as a nurse lecturer and with responsibility for introducing concepts around CAC to student nurses across their three years, I will continue engaging the student nurses (and other health and social care students) in connecting the delivery of CAC for all service users, beyond the limitations of ethnicity and race. In these sessions, the student will engage in a number of sessions and group work on the challenges and intricacies of intercultural communication, intercultural communication apprehension and ethnocentricity. Utilising my newer understanding of positionality, intersectionality and a greater understanding around the insider/outsider stances in all interaction, I will provide

my students with a newer understanding and strategies on how to question and challenge apprehension in intercultural communication through reciprocal conversations.

I will also continue to collaborate with my colleagues beyond nursing, to stimulate debate and research within the Faculty of Health and Social Care and the Department of Education by sharing the findings of my research formally and informally. By highlighting my findings, this will contribute towards disseminating my research to a wider group of health and social care undergraduate and postgraduate students and develop a newer understanding around ethnocentricity and intercultural communication apprehension, in order to improve care for service users. For example, I have just met with the Programme lead from the Science ,Engineering and Engineering educational degree, to consider rolling out the project that I am about to embark with my own team. Collaborations such as these can result in the emergence of research and this would allow for further engagement, which will contribute to the existing knowledge base on CAC.

5.7.2: RECOMMENDATIONS FOR FUTURE RESEARCH AND IMPACT ON HEALTH AND SOCIAL CARE POLICY

The paucity of qualitative, service-user perspective research within CAC was made apparent during the narrative literature review. At one level, I will engage and work as a lead to encourage others to participate in collaborative research within this subject matter. With this kind of activity, I intend to disseminate knowledge in a way that stimulates change within policy, research, teaching and practice.

As of April, 2016, Greater Manchester has now control of its own public funding for health and social care. A report of my thesis was sent to the Executive Lead for the 'Strategy and System Development at Greater Manchester Health and Social Care Partnership', in order to share the findings of this study. He has agreed to have a meeting

with me in August, 2017, where I will have the chance of convincing him regarding this subject and to influence policy.

At present, I am working in collaboration with a nurse academic at the Department of Public Health Nursing, Faculty of Health Sciences at Gazi University, in Turkey. We are in the process of collating data from student nurses, from both our universities, regarding 'Intercultural sensitivity of nursing students'.

As I have done for the past six years, I will continue to present my findings in nursing and other health and social care conferences and posters (see Appendix 9 for examples of papers, posters and public lectures already completed).

By engaging in scholarly activity, locally, nationally and at an international level, I plan to publish and share my research findings in high and low impact international conferences and widely read journals (I have 2 articles from this research being reviewed at present). Dissemination of this research for a wider nursing audience will allow nursing staff in practice, and other academics in other fields, to draw on these findings. This type of dissemination could have the potential to evolve and improve policies that focus on meeting service-user needs and satisfaction. In June 2017, I will present my findings at the annual international conference (European Transcultural Nursing Association) in Odense, in Denmark. With the originality shown by engaging the White Majority population, sharing this information with other health and social care professionals, who are also interested in CAC, has the potential to develop additional understanding and for further collaboration.

I intend to continue to engage with the University's Department of Knowledge and Enterprise, to disseminate and share findings of this research with multi-disciplinary

teams in practice, as an effective way of providing CAC for all. As I have been doing prior to submission of this research study, I will maintain my engagement with the multi-professional health and social care staff through enterprise, to develop their understanding and ability to improve the delivery of CAC.

Having utilised Gadamer's philosophical hermeneutics as the influence in this study, my intention is to continue to engage with research and teaching around the subject of CAC with an openness required to really see, hear and listen to service-users' perceptions and needs. My intention is to be part of the community that contributes to changes and the evolving knowledge base regarding CAC.

5.8: SUMMARY

This chapter has now discussed those aspects of CAC that participants felt were priorities, having based it on previous experiences of being a service user and what they perceived to be the barriers for its transformation at the bedside. These characteristics emerged by adopting a methodology that was influenced by Gadamerian philosophical hermeneutics and analysing the data using Attride-Stirling's (2001) Thematic Networks.

In the final chapter, I will bring together the different stages of this research study.

TABLE 5.1: RECOMMENDATIONS AND DISSEMINATION

	IN PROGRESS	FUTURE DEVELOPMENTS	OUTPUTS
LOCAL/EDUCATIONAL INTERVENTIONS	<p><u>Undergraduate student nurses</u>: connecting the delivery of CAC for all service users, beyond the limitations of ethnicity and race.</p> <p><u>Department of Nursing academics</u>: 2 day team project in challenging ethnocentricity and language utilised in curriculum to increase fairness and equality</p>	<p>Undergraduate health and social care students, learning on an interprofessional basis</p> <p>Ethical approval being sought to evaluate effectiveness of 2 days project with team</p> <p>Liaising with Programme Lead from Science, Technology and Engineering education academics to run 2 day project (similar to one run with Department of Nursing)</p> <p>To carry out research within the voluntary/third sector, to hermeneutically develop a deeper understanding regarding the impact of intersectionality on cultural life</p>	<div style="border: 1px solid black; padding: 10px;"> <p>PAPERS, in both high impact journals and widely read journals (see example in Appendix)</p> <p>CONFERENCES, both international and national, networking, collaborating and hermeneutically evolving understanding regarding</p> </div>
NATIONAL/INFLUENCING POLICY	Influence the Devolution Manchester process by meeting with the Strategic Director for Health and Social Care Reform.	Working with relevant stakeholders to influence processes within Devolution Manchester.	

INTERNATIONAL DISSEMINATION	<p>Collaboration with University of Gazi, Turkey on mixed method research study entitled 'Intercultural sensitivity of nursing students'</p> <p>Book Chapter with Reimer-Kirkham (Trinity Western University, Canada): 'Working with diversity – an overview of diversity in contemporary society and the effect of this on healthcare situations', in 'Spirituality in Healthcare: Quality and Performance' (edited by Fiona Timmins and Wilfred McSherry).</p>	<p>Report on findings from local projects at international conferences, such as NETNEP 2018 in Banff, Canada/ Nurse Congress 2018 in Spain</p>	As above
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CHAPTER 6: CONCLUSION

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

Maya Angelou

6.1: INTRODUCTION

In this final chapter, I have summed up the exploration of this research entitled *Culturally appropriate care: A qualitative exploration of service-users' perspectives of nursing care*.

This study set out to explore the importance and the characteristics of culturally appropriate care (CAC) from a service-user or patient perspective, in order to be ultimately able to improve the delivery of nursing care to them. In Chapter 2, the narrative literature review found a paucity of literature that guided and informed nurses regarding CAC from a patient perspective. By combining the unusual choice of recruiting participants from all ethnic groups (Majority and Minority) with the influence of Gadamerian philosophical hermeneutics and the utilisation of semi-structured interviews (as set out in Chapter 3), I gained rich data towards exploring both research questions. Once the findings were organised (Chapter 4), the following discussion chapter, utilising the aims of the research, was able to hermeneutically explore past experiences, present needs of CAC and clarify what the participants saw as the issues that would limit the success of it being delivered by nurses. In the next section, in keeping with the philosophy that influenced this research, I will bring together and conclude my research journey.

6.2: CLOSING THIS STAGE OF THE HERMENEUTIC SPIRAL

Prior to providing the specifics of the participants' requirements from nurses in terms of CAC, a thought provoking finding of the study to consider is that the individual cultural needs of the participants from the Majority population and BAME communities showed very little difference, even though they are often portrayed as being very different from each other. This inclusive and original approach to research in CAC is in keeping with the provision of equal and fair care to all service users. In addition, what they preferred concentrated mainly around how nurses communicated with them. Their needs were not based on their ethnicity, religion or communities' different practices but on nurses' ability to engage service users in respectful intercultural communication. This respectful intercultural communication reconnects to ideas explored in section 2.3 around the nurse paying more attention to the individual cultural construct, which gives meaning to the 'I' or 'me', rather than the social identity construct that supports meaning whereby an individual service user is referred to as 'we'. The skills needed as to how the nurse was able to encourage effective intercultural communication with them could have easily been linked to the literature discussed in Chapter 1 (see section 1.4) and Chapter 3 (see section 3.8) that considered the insider/outsider roles, the elisions of intersectionalities and those issues of authority, class and gender, among others, between the interviewer and the research participant.

The participants of this research study were clear in their requirements regarding the delivery of CAC from a nurse who was caring for them. First and foremost was acknowledgement of their individuality. They required the nurse to treat them as individuals, not as a representative of a bigger ethnic group. This individuality required the nurse to behave personally and professionally in a non-ethnocentric way. This

outlook, the participants felt, would encourage respect, kindness and a willingness to question individual differences, without assuming cultural behaviours that may have assigned by or stereotyped by wider society. This, they felt, did not mean that the nurse should ignore learning about the cultural or religious behaviours of those he or she cares for, but he or she should practice nursing in a space that allows this awareness to sit alongside consciousness of the individual subjective experiences each patient may have.

The participants wanted the nurse to realise that their behaviours, needs and wants were not always caused by their culture, although it may be expressed in ways that are typical within the norms of the participant's specific understanding. Again, the basic need from the nurse here was to combine an interest in communicating with the service user, while preserving their individuality.

Throughout all the interviews, the participants in this study felt that the actions taken by nurses to treat them as individual cultural beings plays a larger part in supporting them during an illness episode or continued ongoing contact than their technical or scientific knowledge base as a nurse.

Exploring what the participants of this research study want from CAC arguably has resulted in uncovering aspects that are commonly advocated verbally and theoretically in nursing care or education: individual or person-centred care. What this research has also made clear is that fundamental to this idea being successful is the genuine interest and desire of the nurse in wanting to do so. In this research, the desire to implement successful care was expressed within the nurse's readiness to listen, to enable and encourage conversations and a curiosity or willingness to question service users about their experience.

The theories that support nursing knowledge must maintain their pace with the history, patterns and changes of the society it claims to care for. As such, in keeping with the Equality Act (2010) in the UK, the practices of anti-discriminatory legislation and cultural care frameworks that are presently in use, the provision of CAC must include all service users, of all ethnicities, be they Majority or Minority, and other groups that choose to identify themselves collectively in the name of fairness.

6.3: CONCLUSION

This research has found that culture is not a concept that can be limited to extrinsic visible differences in individuals because it grounds everything that we see and do. It has to be delivered by nurse educators and practised as a fundamental idea that has the ability to open up a holistic way of thinking about delivering individualistic care and I return to the personal feeling that every decision we make is ultimately cultural. As the participants expressed, the nurse needs to be able to see patterns of human behaviour beyond racial, ethnic, religious or social groupings. The nurse must be able to 'see' groupings culture in age, generation, disability, body image or varying types of mental illness. Within this, they also need to maintain flexibility by appreciating the construct of subcultures. Assessing cultural needs should not be extra or for 'special people'. It is not successful just by learning about Other Minority groups' needs in terms of diet or prayer. It needs to be based on fairness and compassion for all patients, as we all have certain wants, needs and preferences during an illness experience.

The delivery of CAC, to the satisfaction of the patient cannot be carried out by the cultural care theoretical framework alone. To use the language of Camphina-Bacote (2002), in order to 'catch' cultural desire, there needs to be an evolution in the approaches utilised to ensure non-discriminatory care. The existence of legislation and online diversity

training packages that inform individuals of the law around equality only play one part of ensuring CAC is perceived as a necessary aspect of all care. Education, research, practice and policy needs to promote equality and those concepts that support CAC as a fundamental approach to improving service-user satisfaction in the care they receive. Most of all, as this thesis has shown, what patients want from CAC is a compassionate, respectful nurse who is interested in them as an individual.

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APPENDICES

APPENDIX 1: SAMPLE OF ANONYMISED TRANSCRIPTION FROM SA7

SA7

Transcribed 14/7/14, re-checked 22/11/14

Re-explanation of the study given, Consent form signed.

G: Ok, xxxx, when you get an official form and it asks you for your ethnicity, what do you tick?

SA7: Uhm.....Asian or Indian...yeah, either I suppose. I don't always bother with that bit

G: Tell me something that you and your family did, when you were a child, that you did every year, uh, that you think is a cultural practice, whatever you define as culture as? Or...something that you did every month, or ...something that you did together? It was just the pattern for your family...

SA7: I think that the only thing that we did, probably every year that my community did...weddings! Every summer, we used to go to different peoples'....loads of weddings

G: Uhuh!

SA7:... and its was every summer

G: Yeah, wedding season!

SA7: Yeah, and every Saturday (sighs)...I wanted to go into town but couldn't, because we had to go to a wedding. And, I can remember, all of us, Mum and Dad would say to us, to all of us, because we hated going, they would always say to us, we would be back early but early. But early always meant 3 or 4 o'clock and we would leave the house at 1000, always. That was one of things we would do...yet, every year, every year, yeah, every year we would do that all the time. And I think that my Mum and Dad, especially my Dad, was quite involved, you know, in the community, so, when there was a wedding...he would always have to go .We...there was no other, kinda , choice about it....yeah.

G: Did you like, you know, uhm....was it an excuse to get dressed up? Was it fun?

1

identity flexible

- fluid

- Not really impacting on personal identity

the horizon

Focussing on subject are we both talking about same thing?

Symbolic experience of culture

→ experience with community younger self identity

own cultural identity (other teenagers)

Evolution from parents conception of culture

changing her idea around culture

SA7: I suppose...but I didn't like it, because, uhm, because I used to find it really boring....uhm, and my Mum and my Dad used to say, you can keep your Mum company ..uhm, but when we were there, it was like, Mum would obviously find people to talk to, of course and I would be the one who didn't have anybody to talk to. There would be people there I knew...I could talk to, like relatives, you know, distant relatives, actually I'm not sure they were relatives but you know, relatives and family friends (G: Aunties and Uncles!) Yes! (Laughs)...yeah, so, those kind of things happen even now, so I didn't like it, so, it was the same thing but yeah, we, I used to get dressed up, but I used to, but when my mum used to go to India she used to buy me saris or a kind of suit, uhm, and they were, I never used to like them. Because me and my Mum, we've got, we've got very different tastes (Laughs!) and her idea of nice and my idea of nice is massively, completely different. So, I didn't really feel that comfortable either. And, when you were young, you are at the stage, do you wear a sari? Do you wear a suit? Because, when you're young, you wear a suit, don't you? When you are older, you start wearing saris and I suppose, when I think about those kind of things, and sometimes even now, because when my Mum goes to India, I get nervous, and some that she gets nervous as well, she won't buy me loads, just in case I don't like it.

similar experience to me

different ideas of dress

evolution of acceptable dress

But this year when they went, she bought three or four saris, and she was a bit nervous. She didn't think I would like it. When she came here, she was very surprised because they were pretty nice then I thought to myself, "have I turned !! into my Mum?" (Laughs). You know what I mean? But in terms of, wearing, wearing, I think it just used to feel like, like, I had to go there instead of a wanted to be there, so over the years I have stopped going. Mum and Dad say I should go, they say, that's why nobody knows you. But now I think, I don't want to go because I don't know anybody. I only want to go when I know somebody, so I can really enjoy it. Now, I've been to so few weddings, but each one of them I have really enjoyed uhm, so, I feel it has changed, really changed my attitude to weddings because it was very much the attitude, you had to go! Whereas, now, my Mum and Dad ask me, before I did not have a choice. I suppose now I

evolution/ adaptation

adaptation/ change in culture

evolution

don't live at home any more, and they will ask me if I want to go to the wedding. Well, if I know them now I say yes, but if I don't I don't go.

G: that's brilliant, thank you. Is there anything you did as a child, that you do now, like a cultural habit perhaps, but you did as a kid and now you continue to do that, for example, do you observe anything? Or, you know.....

SA7: Uhm.....in a cultural way, do you mean?

G: Uhm, yeah, I suppose, in any way, anything you define as cultural. Something that your parents did, now that you did as a child and continue to do now.

SA7: Hm, I was thinking about cooking (G: yeah!) When I was younger, I learnt to cook very early, uhm, chapatis especially, it's the only thing that I know how to make properly now (laughs!) And, now, this is going to sound really bad,.... When I was younger I learned to make chapatis, actually this is making me think about the weddings, I think I knew how to make chapatis when I was in primary school, I knew how to make it when I was very, very young. My mom and dad used to work shifts, so my mum would do shifts and she normally did 2 to 10 or six till two. There would be one part of the day, which chapatis would need to be made, food would need to be made that would fall upon me because → Gender roles I was the only girl. I have two brothers one older one younger, so when my mum was at work I would make the chapatis, and some food, so that someone sort of thing, there was a period of time when I didn't do it, you know, for a long time. Because I didn't need to. Because, you got bored of doing it every day, for five people, but now, I find it's one, one of those things, I am really glad I learnt to do because now I know how to do it. → Reflexive That's now one of the things I would continue to do, uhm..., in terms of cooking, I still wouldn't feel comfortable cooking for my mum and dad, because I don't think my cooking is that good, uhm, also because now I have got my sister-in-law, she's such a good cook, so, again, I wouldn't really feel comfortable. In terms of experience, they have got much more experience, I really wouldn't feel comfortable. The only thing I can make is chapatis. So that's one off the, I don't know if I've answer the question (G: no it does, it does) So there!.

G: Uhm, okay, right, imagine you are in hospital (SA7:OK) God forbid, and you are being cared for. Is there, I'm going to ask you this question in a number of ways okay? Okay, so, is there any cultural thing that you know, that a nurse did know about you, in order to care for you effectively?

SA7: Well, one of the things I always think about is food because I don't eat beef, uhm, it's bizarre because I have just been to a wedding and there was a vegetarian option, and a meat option. I do eat meat, but the only meat option was beef, so I opted for the vegetarian. So, someone asked me if I would like to try some and I said no. I mean, it's a religious thing, but I'm not that religious, it doesn't be like it's a religious thing, more like a.... observance. And now, because for my whole life I have never eaten it like, I feel there is no point in doing it, so in terms of that, so anything that I can think off in terms of food, in terms of that kind of cultural, cultural thing, that is the main one.

familiar

different ideas regarding culture. observance from religion

G: okay, okay. Anything else?

reduced/blurring lines between religion + culture

SA7: Uhhmm..no, don't think so...

G: Okay, ignoring the cultural bit, let me ask you the same question, this time without the word culture in it. If you were in hospital, what things, what information would a nurse need from you, to care for you?

SA7: Okay, hmmm, gosh, (laughs) I don't actually know because I've never been in hospital, only to the GP.

G: Imagine what you think it might be? Or do you think it might be pretty much straightforward?

SA7: Uhm, when I think about caring I suppose I'm just thinking about personal preferences. You would have a general idea of how to care for people but that doesn't take into account what individual people would want and is. And I suppose, it would be nice to be asked about what, what I would want or, how I would like to be cared for, in the sense rather than just kind assuming, yes,

individuality Asking? is

complexity of culture

reciprocity

stereotyping
ICA, not asking questions

because they might already assume, assume that I am Asian, especially in Manchester, that I might be Muslim because that's what usually tends to happen. It has happened a few times. Erm...and then take it from there. As I'm not, so they might just assume I am. Now that is something that they would need to be aware of, because that is what might happen or if I'm not Muslim, they assume I must be vegetarian, that's the other thing I get often is I must be vegetarian, so yeah, yeah, I suppose just making sure that you are asking

ICA, gear, not asking questions

IP Skills
G: How would you, want that nurse to be, with things that's related to you, as a person, what you want that nurse to be? How would that nurse, he or she, have to be in order to make this horrible experience better?

SA7: I suppose trust, you need to be able to rely on that person, although I have seen my GP before, because if I was in hospital, it would be the first time, I probably will be absolutely scared, about what's going on. I wouldn't really feel comfortable in that kind of environment, erm...so I need somebody or I can rely on and somebody I can trust to make it better, to listen to me, to be understanding and to take into account, what and who I am.... Yeah, they need to be, what is that word?...yeah, personable, personable type of person. When I mean caring, I mean being able to trust somebody, I mean that kind of persona that they are caring kind of person, that does take into account other people's needs other than... yes, take into account

illness experience vulnerability

really listening to me / individual

IP Skills

G: That's great, but what would convey that? You have no results, no diagnosis. Unsure what will be the outcome? How would they convey those emotions? How would that come over?

SA7: I'm not sure...

G: I am stood next to you, how would you want me to be with you, at a very close and personal level?

SA7: Kinda..., Friendly, comforting, I suppose. Yes, definitely, that would definitely be one of them. Being friendly and understanding what makes me kind of feel much better, kind of, probably not too serious, well, I think that

IP Skills IP Skills

listening

core IP skills

(comfort what I understand it to be

would make it kind of much worse because you kind of feel Kinder, if somebody doesn't have a sense of humour, it would ^{put} me at ease anyway.

G: Yup, brilliant, thank you.

Would it change
G: now, I watch it imagine you're at home, and you have broken your leg and you have a little wound on the heel and the nurses got to come to the house (SA7:Yeah) to care for you. They are in your space now. How would you like that nurse to be, other than knowledgeable. What sort of way should baby behaving, in order to get across to you, that the care, and they are effective?

SA7: HmMMMMM...

G: it's your space now...

SA7: I suppose it still would ^{IPS} probably be the same as before, I would still prefer it if they were still personable, smiling... erm, even though they are coming into my space, I would probably still feel vulnerable and I need someone to look after me, so those kind of qualities, I would still prefer, yeah, that sort of thing. *reassurance comfort*

G: How would they find out if you're okay?

SA7: I think you know, they would just need to have just need to, to ask, ask the *Ask!!* questions. I think when people go round the houses, and don't really ask you tell you what they want to say. I would prefer that they would direct, because there is less space for ambiguity and you don't understand what's going on. So, *honesty* probably be direct ask..yeah.

G: Great, I want you to imagine that you are abroad in a country that you don't speak the language and neither do they. So, you are unfortunately in hospital, they are getting an interpreter but you would have to wait for that, again, how does that nurse have to come across to you, to show, that he or she, is working in your best interest?

Again!
SA7: That's a good question. And again, I think I think one of the most important things is smile. It always helps when you go abroad and you don't understand what's going on and if somebody smiles and is with you, then you are most

likely to feel, well, I am most likely to feel... safer. Yeah, Yeah, if I didn't understand what they were saying and people were quite stern, then it would make me feel worse because I didn't know what was going on. Whereas, who was the, erm, with you, maybe 'with you' most of the time, I suppose you could still be talking in a different language but in a calm sort of way and voice. That would definitely make me feel better, it's kind of the like I suppose, er,... Is it, interpersonal skills (G: Yeah) yeah...interpersonal skills, non-verbal skills, yeah, you can still do those ones that will kindly make you feel much more, much more comfortable.

Handwritten notes:
 - "safer" circled, with "comfort" written above it.
 - "you could" underlined, with an arrow pointing to "appropriate communication with congruent IPS".
 - "interpersonal skills, non-verbal skills, yeah," underlined.
 - "comfortable" circled, with "associate with familiar" written next to it.

G: when I started asking you these questions or first asked you to be part of the study, did you kind of think of anything about what you had experienced, or others around you?

SA7: Yeah, I was thinking about my parents actually...

G: Ok, I know you can't speak for them but imagine they needed to attend either a clinic or hospital. I know you can't speak for them, what do you think might be important to them if they were ill or in hospital? So, in terms of the nurses caring for them, because you can't be there all the time. What would convince you that they was in good hands?

SA7: well, my Dad was in hospital recently. His English is okay but not as good as my Mum's. So, I think, my Dad would pick up on certain things but probably not say anything. When he was in hospital I remember thinking that my Mum was going with him, but all I can think about was I must get somebody else to go with them so that they can interpret what they saying. Because when I spoke to my Mum she said the doctor said this and the doctor said that, but then I kept thinking, are you sure? I would have spoken to somebody else who went with them, uhm, who are like, kind of relatives, and I had to go to them to clarify, if what my mum said was right, that they had got the proper kind of help and that my mum interpreted things the right way. The thing is, when somebody is there to help you, they are okay with it, they are just grateful for what they are getting, for the help that they are getting. So for me, if there were nurses caring

Handwritten notes:
 - "cultural ways of sharing info" written above the start of the paragraph.
 - "simplicity of language" written next to "probably not say anything".
 - "ensuring understanding" written next to "so that they can interpret".
 - "ensuring understanding" written next to "I would have spoken to somebody else".
 - "generational experience" written at the bottom right of the paragraph.

for him, therefore my Dad, erm, they would probably have to work on the non-verbal kind of skills, to be reassuring, just being there, they may not really need to say very much. It is there was somebody could speak Gujarati or even Hindi, actually, you were really need to have those as well, just to really explain to my Mum and Dad in simple language, rather than just get into the technical... (G: yeah, yeah)... because they can understand basic English and my Mum can understand a little bit more. My Dad can probably understand a lot more than he chooses to speak. Probably, he would probably pick up on a lot but not say anything. It's kind of being simple, being straightforward.

→ IPS
 → effort to care.
 not all communities are willing to share!
 ? socialisation
 ? collective communities

G: Do you think that that would be different from anybody else, even if they spoke the language?

SA7: No, I don't think so, you can always pick up how a person is with you, can't you?

G: Do you think generations behave differently?

IPS, awareness of attitude, wanting to care, interest in camp

SA7: (laughs): yeah, yeah, you know, now that you said it, I think I agree with you. And when they have lived abroad where they get nothing and so, they are thankful for what they get her. Yeah!

G: Great, that was great, thank you!

generational may not express needs need to bring it out of them

APPENDIX 2: SAMPLE OF E-MAIL CONTACT POST-INTERVIEW WITH SA7, TO CLARIFY EMERGING THOUGHTS/IDEAS

essentially more important than physical comfort if you know you can get physically comfortable by yourself. I think when I'm ill I want to feel safe that everything's going to be ok in the end – so I guess emotional comfort is more important to me and I suppose that's what I'd want from a nurse more than physical comfort. So yes, emotional comfort is more important than physical comfort.

security

- 3) Give me an example or a story where you feel that the nurse is showing or could show how they value you or your experience as a patient

I think being in a hospital setting and having a nurse make you feel like you're a person rather than a patient that needs to be seen to and then sent home. I remember being in hospital with my partner who was taken by ambulance. I was concerned about what was going on – even though I wasn't the one that was ill. The nurse who was treating us was nice. I think that's the best way to explain it – she was nice. She spoke to us in a normal way and although we were in A&E there wasn't a feeling of worry and she was friendly. I remember thinking that I didn't want her to leave when her shift had finished. I don't know if she made me or my partner feel valued but she made me feel safe and I guess that could be a part of feeling valued. I wasn't the patient in this situation but I still felt comfortable in her presence and if I was a patient then that's what I would want.

IRS

Balance of care given versus commitment in emotional vs scientific care

*able to convey interest, knowledge, reassurance
Culture really secondary*

Wed 07/01/2015 12:30

Email from and to **SAT**

RE: More questions for my research study

Hi Guy,

Email sent as transcription: felt like more emphasis on emotional / spiritual over the physical

Not sure if the info below makes sense but if it doesn't then please let me know and I'll try and clarify what I mean

1) How important is emotional or spiritual comfort to you when you are ill?

The degree to which skills to nurse is put across

I think emotional comfort is more important because when I feel ill I want to feel safe. By having someone there that I feel I can trust and I feel safe with is important. I think feeling that I can trust someone is part of emotional comfort for me. In terms of spiritual comfort, I'm not sure about how important this is to me. I am spiritual/religious to a certain extent but not to a large extent so maybe this doesn't play a part as much as emotional comfort and wanting to feel safe.

Effective communication versus skills base

Comfort / again emphasis of what they may normally hand out to them, areas of comfort

2) Is emotional or spiritual comfort more important than the physical comfort that the nurse is able to give?

I think this depends on what type of illness that I have. But then again, emotional comfort may help me feel better about my physical discomfort. I think emotional comfort is

APPENDIX 3: THREE SAMPLES OF E-MAIL CONTACT WITH PARTICIPANTS (POST-INTERVIEW), TO CLARIFY EMERGING THOUGHTS/IDEAS (CA17, CO13, CO15)

Gayatri Nambiar-Greenwood

CO13

Sent: 12 January 2015 00:01
To: Gayatri Nambiar-Greenwood
Subject: Re: reminder PhD interview

Hi Gay,

Hope you are well. I am sorry for the late reply. I hope it won't be late for your dissertation.

Please kindly see my reply as below.

How do you want the nurse to behave towards you?

Helpful, informative and respectful - as I have a broken leg, I will have a lot of issue need to assist by nurse.. I hope they can being helpful and don't feel I am troublesome.. Also, I know they will have a lot of work to do.. So, if I can do it by myself.. Then, I will go for it. Therefore, the nurse should be informative so that I can ask and sort out by myself. Polite is must.. But respectful is also important because no one want to stay in hospital... *Cultural traits*

What behavior would you like to have so that staying in hospital isn't so bad?

Respectful and caring - it likes the relationship within the family. If the nurse can let the patient feeling like that.. The patient won't be afraid staying in hospital and they

On 19 Dec 2014, at 08:46, Gayatri Nambiar-Greenwood wrote:

Hi, Just checking if you got my e-mail
Guy

From: Gayatri Nambiar-Greenwood
Sent: 16 November 2014 15:31
Subject: PhD interview

Hi
I hope you are well.
I am now analyzing all my interviews and am sending out e-mails to all those i interviewed for some clarification on some of the questions i asked.

Can you e-mail me back an answer to this question(it doesnt have to be pages long!)

You are admitted to hospital because you have a broken leg.
You will need help to get around, wash and go to the toilet.How do you want the nurse to behave towards you, so that you feel cared for in a positive way? What behaviour would you like that nurse to have so that staying in hospital isn't so bad?

Please can you e-mail me back the answer when you get a chance.

Thank you,
Guy

Gayatri Nambiar-Greenwood

CO15

From: Lisa Mok <lisa.mok@walyin.org.uk>
Sent: 12 January 2015 18:02
To: Gayatri Nambiar-Greenwood
Subject: RE: More questions for my research study

Hi, [redacted]

To answer your questions:

1) How important is emotional or spiritual comfort to you when you are ill?

Very important. I think it is especially important when I am terminally ill, or having some kind of long term illness. I can imagine I will need very regular emotional comfort as well as spiritual comfort to me.

2) Is emotional or spiritual comfort more important than the physical comfort that the nurse is able to give?

No, I think it is equally important.

Importance of a balance

3) Give me an example or a story where you feel that the nurse is showing or could show how they value you or your experience as a patient

I had experience of visiting an A & E Department after I cut my finger badly and the bleeding did not stop no matter I tried all methods. I did not wait for too long (around an hour). A nurse came to me, inspected my wound and put dressing on my finger and the bleeding stopped soon after that. Throughout the process, the nurse was very patient and did not rush and was very confident. I felt nice in the whole process although I knew that it was a minor accident only.

IPS (communication skills) / not particularly

Hope the above were fine, please let me know if you have further questions la.

cultural in nature -
just general
'nurses'

Thank you.

From: Gayatri Nambiar-Greenwood <mailto:G.Nambiar-Greenwood@mmu.ac.uk>

Sent: 05 January 2015 10:00

[redacted]

[redacted]

Subject: More questions for my research study

Hello to all of you,
Happy New Year!

So, I have started analysing the transcriptions of the interviews I did with you and I am now looking for recurrent themes that is emerging from my research interviews.

You mention (maybe not in these words) the importance of the nurse valuing you, your experience as a patient or as a person, having empathy for your experience.

1) How important is emotional or spiritual comfort to you when you are ill?

2) Is emotional or spiritual comfort more important than the physical comfort that the nurse is able to give?

CO15

Gayatri Nambiar-Greenwood

AC17

From: [Redacted]
Sent: 06 January 2015 18:42
To: Gayatri Nambiar-Greenwood
Subject: Re: More questions for my research study

Hi there

Please find my answers below for the questions you have asked:

1. It would mean a lot to me if I was ill to have emotional or spiritual support. I believe that this type of support does not require a lot of effort as they say 'it doesn't cost to smile'. Medications and ailments may provide help in healing the medical condition. However it can be very upsetting or anxiety provoking if anyone was diagnosed with any form illness. Hence providing emotional and support, I believe, would reduce that anxiety and spiritual support would help me to accept the situation.

2. All three are important to me as I believe in holistic approach when it comes to caring. There's only so much physical comfort the nurse or medical team would be able to make arrangements for. Providing emotional or spiritual comfort enhances the care delivery and provides with a sense that the person caring for you truly cares.

3. I recently had to do some investigations re: suspected breast lumps.

When I went for my check up, I was informed that there was only male doctors available. Although I have seen male doctors before regarding minor illnesses I felt a little bit uncomfortable about my check up. The female nurse who was with me recognised that this could be an issue. She provided the available options:

1. Waiting for at least 2 months for a lady doctor.
2. Carry on with procedure by the male doctor and she reassured that she will be present in the room and reassured that my dignity would be maintained.

Balance / Reciprocal Communication.

I decided to go for the second option purely because the nurse was so good in providing emotional support and showed understanding in my dilemma which meant a lot to me. I didn't feel that she trivialised my concern. On the contrary she helped me in feeling at ease with my beliefs. The nurse also ensured that I was made to feel comfortable throughout the investigation procedure.

My culture seemed less important because she understood such good communication.

(afterwards I did question myself as to what difference would it have made being a male or female doctor... I guess I was upset and anxious about the whole situation at the time)

anxiety, not culture (perhaps reacting in a way congruent to culture)

..... Hope the above is ok.
Please let me know if you need anything else Guy xxx

~~Big hugs~~

~~xxx~~

~~sent from my iPhone~~

> On 5 Jan 2015, at 14:09, "Gayatri Nambiar-Greenwood" <[Redacted]@mmu.ac.uk> wrote:

APPENDIX 4: NRES ETHICAL APPROVAL FOR RESEARCH STUDY



**Health Research Authority
National Research Ethics Service**

NRES Committee North West - Cheshire

HRA NRES Centre North West
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Tel: 0161 625 7816
Fax: 0161 625 7299

19 February 2013

Mrs Gayatri Nambiar-Greenwood (G.Nambiar-Greenwood@mmu.ac.uk)¹¹
Senior Lecturer in Nursing
Manchester Metropolitan University
Department of Nursing,
Faculty of Health Psychology and Social Care
Elizabeth Gaskell Campus
Hathersage Road
M13 0JA

Dear Mrs Nambiar-Greenwood

Study title:	How does cultural awareness in nurse education translate into cultural humility in clinical practice?
REC reference:	13/NW/0034
Protocol number:	-
IRAS project ID:	93777

Thank you for your email of 25 January 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

¹¹ Note that from the point the study began to the final submission, although the project remained the same, in a form hermeneutic development, the title of the study evolved, to express the aims and objectives of my study. The Ethics committee was informed of these changes during the annual reports.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites: The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see 'Conditions of the favourable opinion' below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ('R&D approval') should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ('participant identification centre'), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

13/NW/0034	Please quote this number on all correspondence
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Mr Jonathan Deans Chair

Email:nrescommittee.northwest-cheshire@nhs.net

Enclosures: 'After ethical review – guidance for researchers'

APPENDIX 5: PARTICIPANT INFORMATION SHEET FOR PARTICIPANTS



PARTICIPANT INFORMATION SHEET

WHAT DO PATIENTS WANT FROM OF CULTURALLY APPROPRIATE CARE?¹²

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Purpose of the study?

I am a nurse lecturer at Manchester Metropolitan University and a PhD student. My study's title is 'What do patients want from of culturally appropriate care?' In order to be able to answer this question, I am interested how patients from different ethnic backgrounds understand the phrase 'meeting their cultural needs' and explore what it means to them.

For my research, I would like to interview people who attend health centres or are cared for by the District Nurses at home, from different ethnic backgrounds. I would like to hear the stories of your experiences, to understand how people from different communities experience and about this subject.

The information given in your interview will be used to help improve the education and training of nursing students at the University where I teach. It is hope that this could improve the care that student nurses provide when they are with patients.

Why have I been invited to participate?

You are being invited to participate in this study as your experience as a recent patient may help me gain information that will help my study. The District Nurse who is caring, or has cared for you recently has decided on your suitability for this study.

Do I have to take part?

It is up to you to decide whether to take part or not. If you do decide to take part or just want more information before deciding, you can respond to me by signing the reply slip attached to this information sheet and putting it in the stamped address envelope provided. Only when I receive this reply slip will I contact you (I will not have any of your personal details prior to this). At this point, I will be able to provide you with a further explanation and be able to answer your questions answered in private.

If you then agree, I will ask you to sign a consent form. This consent form allows me to carry out the interview that I would like you to be part of and also ensures that I do it this with confidentiality and professionally.

¹² Note that from the point the study began to the final submission, although the project remained the same, in a form hermeneutic development, the title of the study evolved, to express the aims and objectives of my study. The Ethics committee was informed of these changes during the annual reports

Even if you decide to take part at the beginning, you are still free to withdraw at any time and without giving a reason. If you already have been interviewed by this point, I will still be able to use the information you have given me but I can delete it if you wish.

What will happen to me if I take part?

If you do decide to take part I will carry out a taped in-depth interview with you, in private, at a place and time that is convenient for you. The interview will take at least an hour but a maximum of 90 minutes. I will use a digital voice recorder to tape the interview. The conversation will be subsequently downloaded onto a secure university computer which is password controlled. Only I will have access to your file.

If, during the interview, you feel either unhappy to carry on or are upset about our discussion, I will stop the interview immediately. I will inform the Manager of the District Nurses about this, as a precaution, to ensure your well-being.

I can interview you at the health centre (in a private room) or, if you prefer, at your home. If you drive to the health centre, I am able to give you 30p for every mile that you drive and your car parking expenses. I will also be able to cover the expenses of any public transport that you use to come to the interviews

What are the possible benefits of taking part?

The benefit of taking part in this study will be a better understanding of the way the subject of cultural awareness is taught in university and in practice, to student nurses. I will also be able to share this information with the nursing staff to help them develop care they provide.

Will what I say in this study be kept confidential?

All information collected from you will only be heard by me. All names and identifiable data will be changed to maintain your confidentiality, privacy and anonymity. I will have to abide by the rules set out by this health trust and also in accordance with the University's policy on Academic Integrity. As I will be using a digital voice recorder, any of our interactions will be erased as soon as my study is completed.

What should I do if I want to take part?

If you choose to take part, I will go through the consent form with you, which you and I will be required to sign. After that, I will negotiate with you as to what time, day and place you would like me to interview you.

What will happen to the results of the research study?

The results of my research will be written up as part of my PhD studies. I will use some of the information in order to either present at conferences or publish articles in peer-reviewed journals. At all times your confidentiality, privacy and anonymity will be maintained

Who is organising and funding the research?

Although I am a senior lecturer in nursing, this study is part of the part-time PhD within the Department of Nursing at Manchester Metropolitan University. They have also funded my study.

Who has reviewed the study?

This study has gained ethical approval from the North West-Cheshire Research Ethics Committee (12/EM/0486).

Contact for Further Information

My supervisors for this study are Professor Carol Haigh (c.haigh@mmu.ac.uk/ 0161 247 5914) and Dr. Gill Yeowell (g.yeowell@mmu.ac.uk/ 0161 247 2961). Any concerns regarding the way this study is being carried out should be referred to them. You may also write to them at The Faculty of Health, Social Care and Psychology, Elizabeth Gaskell Campus, Manchester Metropolitan University, Manchester, M13 0JA.

If you have any concerns about the way in which the study has been conducted or would like some independent advice, you can contact the Chair of the University Research Ethics Committee on ethics@mmu.ac.uk/ 0161 247 6213. You may also write to her at the Department of Research and Knowledge Exchange, Ormond Building, Manchester Metropolitan University, Manchester, M15 6BX.

Thank you

Thank you for taking the time to read the information sheet.

Gayatri Nambiar-Greenwood,
Senior Lecturer in Nursing,
Department of Nursing,
Faculty of Health, Psychology and Social Care,
Manchester Metropolitan University,
Hathersage Road,
Manchester M13 0JA
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CONSENT FORM

WHAT DO PATIENTS WANT FROM OF CULTURALLY APPROPRIATE CARE?

Researcher:

Mrs. Gayatri Nambiar-Greenwood,
Senior Lecturer in Nursing,
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Faculty of Health, Psychology and Social Care,
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Please initial box

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

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

3. I agree to take part in the above study.

Tick the appropriate box below

¹³ Note that from the point the study began to the final submission, although the project remained the same, in a form hermeneutic development, the title of the study evolved, to express the aims and objectives of my study. The Ethics committee was informed of these changes during the annual reports

Please tick box

- | | Yes | No |
|--|--------------------------|--------------------------|
| 4. I agree to the interview being audio recorded | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I understand that anonymised quotes may be used in publications | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. I agree that my data gathered in this study is stored in a secure university password controlled hard drive until the end of the researcher study period. | <input type="checkbox"/> | <input type="checkbox"/> |

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

I understand that data collected during the study may be looked at by regulatory authorities and relevant persons, where it is relevant to taking part in this research. I give permissions for these individuals to have access to this information.

APPENDIX 7: INTERVIEW GENERAL TOPIC GUIDE

Questions general guide asked to establish participant's horizon of cultural understanding and experience

- What do you define as culture? Describe something you would call a cultural activity you would engage in?
- If you were required to tick a box in an official form that asked for your ethnicity, which box would you tick? Why (yes/no)?
- Tell me about an (cultural) activity that you and your family did as you were growing up? Do you do this with your children now (yes/no)? What do you do now with your family/these days instead?

Questions asked to establish what makes up components of CAC for the participants

- Imagine you are in hospital, and there is a nurse coming towards you to take care of you. What sort of information (cultural information) should she/he have (what should she/he ask you) in order to take care of you? What about those things you don't think are cultural?
- If they came into your house, say a district nurse, would there be anything in particular (cultural/general) that you would expect from that nurse?
- How would you know that the nurse was interested in your health and well-being (culturally/general)? What would their behaviour convey to you that they were caring for you?
- If you went abroad, to a country whose language you don't speak and you end up in hospital, how would you know/be able to tell that the nurse at your side really cared for your well-being?
- How would your nurse find out about your personal/cultural preferences?

APPENDIX 8: PARTICIPANT ANONYMISING TABLE

ETHNIC GROUP	ANONYMISING LABEL	GENDER	PROFESSION/FORM OF EMPLOYMENT	PLACE OF INTERVIEW	SOURCE FROM WHERE PACKS WERE PICKED UP
Orthodox Jewish/ White Minority	WM2	Male	Academic	Participant's home	European Migrant Welfare Association
Orthodox Jewish/ White Minority	WM3	Female	Academic	Participant's home	European Migrant Welfare Association
Polish/ White Minority	WM4	Female	Volunteer at Welfare Association	Interview in private room at Welfare Centre	European Migrant Welfare Association
Slovakian/ White Minority	WM1	Female	Professional Interpreter	Interview in private room at Welfare Centre	European Migrant Welfare Association
Chinese	CO15	Female	Manager	Interview in private room at Chinese Welfare Association	Chinese Welfare Association
Chinese	CO13	Female	Receptionist	Interview in private room at Chinese Welfare Association	Chinese Welfare Association
Chinese	CO14	Female	Clerk	Interview in private room at Chinese Welfare Association	Chinese Welfare Association
Chinese	CO16	Male	Youth Worker	Interview in private room at Chinese Welfare Association	Chinese Welfare Association

African-Caribbean	AC20	Female	Unemployed/ Volunteer	Interview in private room at Welfare Centre	Community Centre
African-Caribbean	AC19	Female	Foster Mother	Participant's home	Community Centre
African-Caribbean	AC18	Female	Manager for voluntary service	Interview in private room at Welfare Centre	Community Centre
African-Caribbean	AF17	Female	Pharmacist	Interview in my office	Community Centre
South Asian	SA16	Male	Retired/Volunteer/ ex-nurse	Interview in private room at Welfare Centre	Community Centre
South Asian	SA8	Female	Volunteer/female imam	Interview in private room at Welfare Centre	Pakistani Community Centre
South Asian	SA7	Female	Academic	Interview in my office	Indian Association
South Asian	SA5	Male	IT technician	Interview in my office	Indian Association
White English	WE11	Female	Unemployed/service user of voluntary service	Interview in private room at Welfare Centre	Community Centre
White English	WE10	Female	Manager/ex-nurse	Interview in my office	Community Centre
White English	WE12	Female	Receptionist at community centre	Interview in my office	Community Centre
White English	WE9	Female	TEFL voluntary teacher	Interview in private room at Welfare Centre	Community Centre
White English	WE21	Female	Mental health nurse/Midwife	Interview in my office	Community Centre

APPENDIX 9: PRESENTATIONS AND PAPERS (RELATED TO THE RESEARCH STUDY) FROM

2010 TO 2016.

During the period of my research study (December 2010 to December 2016) I was involved in a number of conferences and one publication. This section shows those activities generated from my research journey, as I developed my reflexive understanding for the different aspects that informed it.

July 2011: 'Is culturally competent care only for 'Other' patients?', *Research Institute for Health & Social Change Annual Conference*, Manchester Metropolitan University 2011 Annual Conference, Thursday 30th June and Friday 1st July 2011.

September 2011: 'The determination of culturally competent care: Whose culture? Whose agenda?' *NET2011 International Networking for Education in Healthcare Conference*. Churchill College, University of Cambridge.

September 2011: 'Understanding the cultural me to comprehend the cultural you: Introducing cultural diversity through self-awareness.' *NET2011 International Networking for Education in Healthcare Conference*, Churchill College, University of Cambridge.

October 2011: 'Cultural Incompetency – The measurement of cultural needs for all within a reductionist context.' *37th Annual Conference of The Transcultural Nursing Society*, 'Exploring the World of Transcultural Nursing: Coming Together to Transform Health Care', Las Vegas, USA.

August 2012: 'Limitations of cultural diversity education without instilling cultural self-awareness and humility.' *Sigma Theta Tau (Honor Society of Nursing) 22nd International Conference*, Cardiff, Wales.

September 2012: 'Tell me your story: Situating research questions regarding cultural humility within patient experience.' *NET2012 International Networking for Education in Healthcare Conference*, Churchill College, University of Cambridge.

September 2012: 'From sympathy to empathy: Developing a predisposition for humanized care delivery for individuals with Learning Disabilities with interprofessional seminars.' *NET2012 International Networking for Education in Healthcare Conference*, Churchill College, University of Cambridge.

May 2013: 'Understanding epistemic injustice as a way of providing culturally appropriate care.' *RCN International Research Conference*, University of Glasgow, May 2014.

July 2013: 'Utilizing the philosophy of Humanized Care in developing non-discriminatory health practices.' *Research Institute of Health and Social Care 2013 Conference*, Manchester Metropolitan University.

June 2014: 'A humanized approach for de- and re-constructing pre-conceived notions of the 'adult' patient in a pre-registration nursing degree.' *NETNEP 2014, 4th International Nurse Education Conference Noordwijkerhout, Holland*, June 2014.

December 2014: The need for cultural humility within current healthcare debates concerning the wearing of religious attire by healthcare staff: Nambiar-Greenwood, G. and Timmins, F. *Nurse Education Today*, 35(3) pp.421-422.

February 2015: 'The delivery of effective cultural care for health and social care clients: the micro and macro challenges.' Public lecture at Trinity College, Dublin, Ireland on the 19th of February 2015.

February 2015: 'The influence of Gadamer in acknowledging the patient's perspective as evidence for delivering Culturally Appropriate Care.' Royal College of Surgeons Department of Nursing, Dublin, Ireland, 17th of February, 2015.

July 2015: 'Considering the difference between extant knowledge and patients' perspective regarding culturally appropriate care.' Annual conference for the Research Institute of Health and Social Care, Manchester Metropolitan University, 2nd July 2015.

September 2015: What is the real meaning of culturally appropriate care? *Nursing in Practice*, 85 pp.30-31 (see attached article at end of this section).

November 2015: Editor's choice: Nambiar-Greenwood, G. and Timmins, F. (2014) 'The need for cultural humility within current healthcare debates concerning the wearing of religious attire by health care staff.' *Nurse Education Today* 35(3) pp. 421-422. 'Editor's Choice' article November 2015 (see attached editorial at end of this section).

March 2016: RCN International Nursing Research Conference, Edinburgh 2016. Symposium paper: Patient perspective regarding Culturally Appropriate Care.

June 2016: 'Research on Culture: Promoting Individuality at the bedside.' Research Institute of Health & Social Change High Summer conference, MMU.

July 2016: 'What do we know about what service users want from Culturally Appropriate Care?' IENE 4 One-day Conference: Promoting Culturally Competent and Compassionate Leadership for Nurses and Other Health Professionals, Middlesex University, London.

September 2016: 'What do service users want from Culturally Appropriate Care?: An exploration influenced by Gadamerian Philosophical Hermeneutics.' NET2016

International Networking for Education in Healthcare Conference, Churchill College,
University of Cambridge.

March 2017: 'Trustworthiness: A hermeneutic qualitative research journey', Royal College
of Nursing Research Conference, Oxford.

June 2017: 'In the name of fairness: Interconnecting cultural care and intersectionality',
European Transcultural Nursing Association annual international conference, Odense,
Denmark.

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What is the real meaning of culturally appropriate care?

Nurses need to be culturally self aware in order to appreciate that all of us are culturally shaped, therefore every patient should have a cultural assessment

Culture affects everything and every choice we make every day. It not only relates to cultural differences but also the dress, food and celebrations of a certain community. There needs to be a rethink of what constitutes care that is cultural as the effects of globalisation and worldwide economic changes

affect us even further. To consider this issue, this article has adopted the term culturally appropriate care (CAC).

CAC, in this context, incorporates all of the cultural theoretical terminology that is used to deliver individualised care.

American nurse theorist and nurse anthropologist Madeleine Leininger in the late 1950s created the term 'cultural competence' and the concept of 'transcultural nursing'. Championed by nurses internationally, subsequent cultural theorists developed a variety of terminology that uses culture to indicate a particular need or approach taken to deliver nursing care.

The NHS Constitution and the Nursing Midwifery Council also reinforce the need to consider the culture of a patient, as part of effective individualised care delivery.

"The healthcare professional and the patient, both being products of their own culture, bring with them into a professional relationship, pre-conceptions"

The extensive nursing literature on cultural care agrees with these important fundamentals: there needs to be effective, sensitive, non-discriminatory communication, the positioning of the understanding of health from the patients' experience, values or perspective, and a professional open to the creative application of services.

"A desire to care for any patient is conveyed by non-verbal behaviour and actions"

LIMITATIONS AND CHALLENGES OF PROVIDING EFFECTIVE CAC

It could be argued that the provision of CAC has a tendency to be seen as ensuring the provision of diet, prayer space, pamphlets in different languages and mainly, delivery of 'extra' care to those who appear different.

CAC is more than just identifying the needs of patients, it requires those needs to be user-centred and have the ability to adapt continuously to respond to either changing needs or the impact of differing life histories and events of all patients.

This is challenging because although health professionals are aware of the individualities of patients they are often constrained when caring for individuals in an unpredictable environment with a perceived lack of time.

The biggest challenge for the delivery of fair CAC is the motivation of the professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters: not just that they "have to".

At a subconscious level, we naturally categorise people into different groups, hierarchies and levels of acceptances, and so as members of wider society, it can be challenging for health and social

"As professionals, we need to be able to see to the bigger picture and not rely on lay-definitions and generalised assumptions of those we will be caring for"

person they care for; by acknowledging that we are all made up of powerful personal experiences of learned, shared and transmitted values, beliefs and norms. This guides our thinking and decisions in familiar ways, once we recognise this we are more likely to understand that difference is a result of an alternate set of equally powerful shared values.

CAC should also be seen as the provision of humanised care.² The healthcare professional and the patient, both being products of their own culture, bring with them into a professional relationship, pre-conceptions of what is right or wrong.

The cultural norms of the professional must encompass codes of conduct, the law and other confines within which they need to operate. It is not, however, about complete acceptance of practices that may be considered harmful to a patient, but is about an appreciation and compassion for the perspectives the patient has developed.

PROMOTING EQUAL CULTURAL CARE

There needs to be a re-adjustment of the presumption of discrimination made by the government and powerful bodies concentrating on arguments around the confines of race and ethnicity. As per the Equality Act set in 2010, there also needs to be a wider focus on people of all backgrounds in the UK.

There needs to be a clear and honest discussion around how our professional values affect our personal values in a non-confrontational and accusing environment. Professional values are the guiding beliefs and principles that influence work behaviour. Therefore, another way to instil cultural desire is to include the professional within the cultural equation.

By looking and discovering their cultural self-awareness, the professional will be able to recognise and articulate their own cultural values and principles, while understanding how these may differ in other communities. It also allows the identification of personal strengths or limitations and for the professional to note the impact of normal personal emotions or prejudices and the impact this may have on others.

A desire to care for any patient is conveyed by non-verbal behaviour and actions. Together with the tone of language expressed in non-judgemental communication, nurses are more likely to be successful in encouraging patients to share information. As professionals, we need to be able to see to the bigger picture and not rely on lay-definitions and generalised assumptions of those we will be caring for, be it personally or professionally. There are serious implications for health and social care professionals and more significantly, patients, if CAC is not seen.

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care professionals not to adopt the same attitude, despite the regulation of trying to provide non-discriminatory care to all patients.

WHAT REALLY SHOULD CAC CONSIST OF?

In 2012, the Nursing & Midwifery Council and the General Medical Council released a joint statement on professional values, responding to recent high profile failures, (although this was not the sole responsibility of the nurses and doctors who were there at the time).

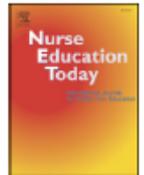
The joint statement was a reminder to staff about what constituted professional values and about treating people as individuals and respecting their dignity. It doesn't, however, pay attention to how much our personal values affect how we act professionally.

Firstly, CAC is for all communities: this includes not just the ethnic minorities of a country but also the ethnic majority.

An individual's cultural identity is complex and multi-layered, it is sometimes overtly obvious but mainly it is subtle and unconscious. It changes, modifies and adapts over time by the external influences of history, politics and the media. It can also be subtly different between individuals in the same family, or visibly similar groups, communities or professions who identify themselves as a group.

Providing CAC is not about making an assumption about personal preferences or by pandering to the media-driven myth of political correctness, which makes people nervous about asking 'culture' questions in case they offend. It involves, at one level, asking questions about personal preferences from individuals rather than making assumptions.

CAC is also about the professional realising that they are equally a product of their own culture as much as the culturally different



Editorial

The need for cultural humility within current healthcare debates concerning the wearing of religious attire by health care staff



Internationally nursing is shunning its religious heritage and is firmly established as a secular occupation (Paley, 2008). This distancing parallels post-enlightenment attitudes towards religion in the West. Globally there are limited discussions and debate in contemporary nursing literature on the subject of religion and religiosity with an emphasis instead on spirituality and spiritual care delivery. At the same time clients' spiritual needs in many areas of the health care setting internationally are often unmet (RCN, 2010; Hermann, 2007) and while health care workers interventions are common they often lack the necessary training and knowledge (McSherry and Jamieson, 2011).

However a new manifestation of health care's limited understanding in this field is the recent public criticism of health care colleagues' religious attire. Female Islamic health professionals have come under intense scrutiny insofar as wearing the *Niqab* is thought to represent a "barrier to good communication between health care professionals and patients" (Gallagher, 2013). Although deemed a "professional" rather than "political" issue, views about personal treatment "by a doctor wearing a veil" (Express, 2013), without seeing "the face of the doctor or nurse" (Gallagher, 2013) are receiving high level political attention. The *Niqab* attracts criticism internationally (Bremer, 2012), resulting in France, for example, applying a national ban on these among school children. However the rationale for recent specific focus on the health care profession (as opposed to any other public sphere) in such a public way is unclear.

Of particular concern in this matter is the nursing discourse on the matter (NursingTimes.net, 2013). A recent poll latter determined that a "ban on full face veils [was] backed by nine out of 10 nurses". Providing a platform for discussing this issue also facilitated a negative dialogue to occur with comments such as:

"Black (masked) sacks should not be masquerading as health care professionals."

"Whether, visiting, living or working in a country shouldn't people [sic] still be expected to obey the rules and laws both written and unwritten of that country and not stick rigidly to those of their own at any price?"

[NursingTimes.net (2013)]

We hold the position that this approach might serve to further alienate cultural groups. This political, historical and media-driven discourse encourages the concept of culture to be seen within a reductionist ethnicity and race dialogue, paying attention only to what are the obvious accoutrements of difference such as dress. This consigns those who

do not fit into the dominant culture within the dynamic of the *other*. The [veil wearing] *other* [as a presumed homogenous group] are perceived not to comply with societal norms. Certainly online dialogue (NursingTimes.net, 2013) supports this perception. The latter reflects calls for conformity to maintain the social fabric of society thus controlling acceptable and unacceptable behaviours (Kelly and Toyne, 2009). Although largely confined to Britain, responses could be seen to reflect the voice of the profession internationally, as there is often internal consistency among the nursing profession internationally, who could be seen to speak with one voice. Media involvement places the issue on an international level and as is common the reporting of multicultural issues unexpectedly marginalises victims (Manning, 2011).

At the same time arguments against wearing the *Niqab* appear to be unfounded. The suggestion that patients lose out on key aspects of communication if they "cannot see their [health care workers'] face" seems not only lacking in empirical evidence, but also basing on a western approach to non-verbal communication. Clearly the world is being seen through a specific cultural lens, which fails to consider the wide variation in human communication behaviour (Burnard and Gill, 2008). The media and political rhetoric echo a failing multiculturalism that could serve to affect the public's attitude. This is unethical in terms of the potential negative effect not only on marginalised groups but also on the health professions as a whole.

A *Niqab* clearly restricts lip reading possibilities of hearing impaired patients however this is equally true of operating theatre situations, where all staffs' mouth and nose are covered. Facial disfigurement or paralysis could also leave a health care worker similarly challenged (in terms of mouth movement). While facial expressions can certainly enhance (or otherwise) a verbal message there is no definitive information that confirms that eyes *only* non-verbal support is restrictive. Indeed modern healthcare increasingly relies on technology that calls for verbal or written information as a replacement for person to person contact. It seems conspicuous that an emerging dominant discourse about communication in health care concerns anecdotal worries about the [potential] behaviour of a small minority (Gallagher, 2013) rather than addressing more widespread challenges to effective communication evidenced perennially in patient complaints and feedback internationally (Aylott, 2011; Wheeler, 2010).

We contend that the argument against veils is insubstantial and occurs in the context of media and politically motivated bias and a limited understanding of peoples' spiritual needs.

Rational evidence based discussions for veil use or non-use should take place in an environment of mutual respect, rather than being played out in the public media. While client safety is paramount, there ought to be sensitivity to cultural, religious or spiritual needs and a suitable solution arrived at in a mutually satisfying way. Policy requirements ought to

be value neutral and aimed at promoting quality patient care, so restrictions that apply are universal and apply to all staff not just to one religious group. What is required is receptivity towards learning and understanding the complexity of the concept of culture termed *cultural humility* (Tervalon and Murray-Garcia, 1998). This provides for self-reflection rather than focusing on the *other* and serves to redress potential power imbalances to develop mutually beneficial solutions (Tervalon and Murray-Garcia, 1998).

The arising issues centre firstly on the negative portrayal of the matter evident within the media. There appears to be a lack of sensitivity to or awareness of women's religious needs or obligations with *all or none* thinking evident – it has to be a “ban” without dialogue with relevant parties or consideration of particular contexts. Secondly its management in media and political circles reflects the tendency to project onto the “other” rather than accepting that any health care worker may choose to display religious preference on their body [jewellery, tattoos, adornments etc.]. Thirdly, the argument lacks substantial evidence.

Thus it may be concluded that the claim, while logical is overly influenced by underpinning values that (a) fail to recognize the important contribution of religious expression in any society, (b) fail to comprehensively consider the evidence contributing to the debate, (c) are contextually bound and lack culturally humility and (c) are possibly overtly influenced by political agendas that favour an intolerant approach. We need, as Ross (2008 p. 2797) suggests, a wider consideration of the consequences of national guiding policies to support a “multi-faith [community] ... in a religiously diverse society”. Clearly local policy requirements that address attire from a multicultural and practice perspective are required and it might serve the profession better if the nursing media had a more balanced and evidence based approach when entering into a global public debate.

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