

Research papers

The cultural lived experience of internationally recruited nurses: a phenomenological study

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ABSTRACT

The aim of the study was to investigate the cultural experiences of internationally recruited nurses (IRNs) in the UK within the Trent region. This study examined the cultural adaptation process, both from a personal and a nursing perspective. The paper is based on interviews with 12 nurses – seven female and five male. A phenomenological approach was adopted using a semi-structured interview technique. For the purpose of this study culture has been categorised as either ‘primary’ or ‘secondary’ culture. The findings demonstrated that how the nurses perceived their own culture influenced their adaptation

process significantly. The data clearly showed how the IRNs felt deskilled and devalued. Significant cultural issues were identified which had an influence on their experience. This included the preparation in their country of origin, the quality of the induction programmes in the UK, language issues and life outside work, all of which were seen as having a distinct effect on the adaptation process.

Keywords: adaptation, international recruited nurses, phenomenological study, primary culture, secondary culture

Introduction

In recent years, there has been a global practice of recruiting nurses from other countries, also practised by the UK. There is considerable evidence that a shortage of nursing staff exists in the UK. *The NHS Plan* set targets to increase the nursing workforce by 20 000 nurses by 2004 (Department of Health, 2000). Part of this strategy includes recruiting from abroad, and as a result the numbers of internationally recruited nurses are increasing in the UK. According to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC, 2001), 8003 nurses from overseas were admitted to the register between 2000 and 2001, and this trend is continuing.

It should be noted that the person who migrates encounters a new culture, a process sometimes called acculturation. This is a ‘process by which newcomers to a group, work to make sense of the surroundings and come to acquire the kind of knowledge which

would enable them to produce conduct which allowed established members of that group to recognize them as competent’ (Bond and Bond, 1994 (citing Dingwall, 1977) pp. 12–13). The ‘new’ knowledge relates to the host culture, and therefore one would argue that culture would have an influence on the adaptation of nurses to their respective new country of residence and work.

Literature review

Although some scholars have written anecdotally about the experiences of overseas nurses, there is little actual research linked to how nurses adapt culturally. For example, Daniel *et al* (2001) have investigated the expectations and experiences of Filipino nurses recruited

to work in the UK. The research explored the Filipino nurses' expectations and their experiences of new roles within UK nursing. Adjusting to the new environment proved stressful. Allan and Larsen (2003) explored the motivations and experiences of internationally recruited nurses. Alexis and Vydellingum (2004) also conducted a study that aimed to explore, describe and develop a greater understanding of the experiences of black and minority ethnic nurses working in the NHS in the south of England. It also revealed that internationally recruited nurses (IRNs) were having some difficulties adapting to the new environment. Such studies are important in that they provide significant insights into this issue. One specific issue appears to be the lack of support for the cultural transition of the nurses. Yi and Jezewski (2000) conducted a study in the US to investigate how Korean nurses adjust to US hospital settings. The findings of that research clearly demonstrated that culture influenced the adaptation process of the nurses.

A number of hospitals in the UK have devised adaptation programmes for IRNs, but these do not always include a cultural component. The Royal College of Nursing (2002) recommends that employers provide a general induction programme into UK life and culture. With that background in mind the aim of this study was to investigate the cultural experiences of IRNs in the UK Trent region. This study examined the cultural adaptation process, from both a personal perspective and the nursing context.

Objectives

Objectives of the study were:

- to explore how the cultural backgrounds of internationally recruited nurses affect their adjustment process
- to investigate the acculturation process the nurses undertake to adapt to new culture from a personal and nursing perspective
- to identify the support mechanisms that are in place to assist with the transition.

Ethical issues

Ethical approval was obtained from the Local Research Ethics Committee. Permission to conduct the research was also obtained from the head of nursing and the coordinator of the international recruited nurses for the NHS trust involved in the study. To maintain confidentiality and the anonymity of the participants, the initial invitation letters to join the study were sent to the co-ordinator for IRNs, who sent them

to the nurses concerned. The letters were accompanied by an information sheet, which explained the purpose, the nature of the study, time commitment, confidentiality, anonymity and participants' right not to participate in the research. Telephone numbers of the researchers were included in the letter so that those nurses who wished to be interviewed could phone the researchers voluntarily. It was envisaged that the interview might remind some of the participants of the difficulties they had encountered, and therefore the interviewees had the potential to be traumatised. The following measures were taken. On the day of the interview the nurses were asked again if they were still happy to talk about their experiences. While interviewing, nurses were observed and if they looked uncomfortable the interview was discontinued. Information on how to contact professional advice was available.

Sample and data collection

As part of the main study, 24 letters were sent to nurses from three hospitals in one county within the Trent region in the UK. For the purpose of this study, IRNs are those trained outside the UK, who were either recruited by an agency or hospital or had come independently to the UK seeking jobs. Twelve nurses (seven female and five male) volunteered to participate while two nurses declined to participate because they did not want to be reminded of the experiences they had had.

A phenomenological approach (Colaizzi, 1978) was adopted in this research (see Box 1). Phenomenology is a way of thinking about what life experiences are like for individuals (Powers and Knapp, 1990). Therefore, this approach was useful in eliciting the nurses' lived cultural experience during their transition. Lived experiences consist of everyday experiences of an individual in the context of normal pursuits and focus on 'what is real and true' to that individual (Fain, 2004). Using a semi-structured approach, nurses were interviewed at a time and place convenient to them, between September and October 2003. Two researchers conducted all the interviews independently and all interviews were tape recorded. Participants chose where to be interviewed. Interviews with seven participants took place in an office in the school of nursing and five interviews were carried out in nurses' own homes. The choice of venue of the interview was important, to allow free discussions, thereby enhancing the credibility of the data. The length of the interview varied from 45 to 90 minutes. An interview guide was used (see Box 2)

Interview questions were developed and piloted in two pilot interviews. The main focus of the interviews

Box 1 Colaizzi's phenomenological steps

- 1 Description of the phenomenon of interest to the researcher
- 2 Collection of the subject's descriptions of the phenomenon
- 3 Reading all the subject's descriptions of the phenomenon
- 4 Returning the original transcripts and extracting significant statements
- 5 Trying to spell out the meaning of each significant statement
- 6 Organising the aggregate formalised meanings into clusters of themes
- 7 Writing an exhaustive description
- 8 Returning to the subjects for validation of the description
- 9 If new data are revealed during the validations, incorporating them into an exhaustive description

Source: Colaizzi PF (1978) Psychological research as phenomenologists view it. In: Valle R and King M (eds) *Existential Phenomenological Alternatives for Psychology*. New York: Oxford University Press, pp. 48–71.

Box 2 Interview guide

- 1 Which country do you come from?
- 2 How long have you been here?
- 3 How were you recruited to come and work in England?
- 4 Can you describe what preparation you had for moving to England?
- 5 Tell me your story about your experiences.
- 6 How was your first week's experience in the UK?
- 7 Has it changed? In what way?
- 8 Can you please describe your experiences at work?
- 9 Can you please describe any aspect of your cultural background that has influenced your adaptation personally and professionally?
- 10 Are there any suggestions that your recruitment agency could have made to improve your transition from one country/culture to another?

was nurses' cultural experiences when moving to the UK, but general questions were asked at the beginning of the interviews to establish rapport. Nurses described how they had been prepared in their own country and about their current experiences. Field notes were written and were read out to participants at the end of the interview to confirm that what was written reflected what had been said.

Data analysis

Data were analysed as soon as the interviews had taken place and were transcribed verbatim. First, transcripts and field notes were read repeatedly in order to

acquire a feeling for them, thus making sense of how participants described their experiences. Colaizzi (1978) recommends that the data in the transcript should be validated by being taken back to participants. It proved difficult to make second appointments for nurses to verify the data. Therefore field notes were used to supplement the tape recordings. The researchers wrote down the main points, checking and confirming with participants soon after the interview. The next stage involved extracting significant statements. The analysis also included establishing the frequency of response of each statement and noting which participants made them, to show if the statements applied widely among the participants rather than applying to one particular nurse.

The meaning of significant statements was then interpreted – this was referred to as 'formulating meaning'. To enhance credibility of the data, two colleagues (a doctor and a nurse) familiar with the phenomenon approach were asked to analyse the transcript too. Recurring themes in each interview were compared with subsequent interviews to create major themes and subthemes (see Table 1). A discussion took place between the coders, and no differences of themes were detected.

Findings

Participants were from Mauritius, the Philippines, India, and Nigeria and all spoke English as a second language. Some were single and some married with children. Experience in nursing ranged from 3 to 12 years and their length of stay in the UK ranged from 9 months to 2 years. The mode of recruitment was either through an agency or hospital or through a friend.

Data collected were organised into themes. Each theme will now be discussed and illustrated with supporting representative quotations.

Table 1 Themes and subthemes

Themes	Subthemes
Conceptualisation of the culture	Primary and secondary culture
The influence of primary culture on nurses' adaptation process	Language
The influence of secondary culture on nurses' adaptation process	Home country nurse training
Less paperwork at home	
Support mechanisms for the IRNs	General support <ul style="list-style-type: none"> • preparation • accommodation • induction • support in the wards • life outside the working area

Conceptualisation of the culture

The IRNs perceived and described the culture in two ways:

- the '*primary*' culture refers to the way IRNs were socialised in families, for example in terms of communication such as language and how to show respect to someone
- '*secondary*' culture refers to the way nurses were socialised in their professional life. This referred more to how nurses were trained or educated as nurses in their home country.

'I would view culture as my traditions and customs. But here I would also think of how I have been trained as a nurse. This has an influence on how I adapt here.' (Hospital C: male Mauritius – IRN 2)

Combining these two types of cultural influence affected how nurses adapted themselves personally and professionally.

The influence of primary culture on IRNs' adaptation process

Some nurses foresaw some potential problems regarding their primary culture.

'Nursing is nursing but I was not sure about the general life in England.' (Hospital C: male Mauritius – IRN 3)

Nurses were not sure how they would adapt generally; for example, some brought their own food with them.

Language

Although all the IRNs we interviewed spoke English, some experienced communication problems. The problem arose when patients and 'host-country' nurses used colloquial English and spoke fast:

'It was not to understand English but to understand the way they speak. It was fast. I could not answer the phone because you have to understand it for one to answer. But later you become used to the way they speak.' (Hospital B: female Mauritius – IRN 2)

The accent was also a problem for some nurses. The IRNs could not understand the host nurses' and patients' accent and equally, they could not understand some IRNs' accents. As one nurse stated:

'Sometimes you had to repeat yourself so many times for others to understand. Some staff regard you as if you do not know anything and you are stupid.' (Hospital A: male Mauritius – IRN 3)

One of the nurses from Mauritius found understanding easier while working in the operating department. This was mainly because the names of the surgical instruments and procedures were on the whole universal. He felt he could anticipate what the surgeon needed, and also eye contact above the surgeon's theatre facemask indicated what the other staff members needed.

'When the surgeon is asking for something, I may not be gathering what he is talking about but I know which instrument because of the experience.' (Hospital C: male Mauritius – IRN 5)

Otherwise it would have been difficult for the nurse to understand.

Influence of secondary culture on the IRNs' adaptation

Home country nurse training

All participants pointed out that their home nursing training equipped them with a range of skills:

'At home once you do the training, you do all sort of things for example, and any qualified nurse can give intravenous infusion drugs.' (Hospital A: female Nigeria – IRN 5)

'In India if you are a registered nurse you can do anything.' (Hospital B: female India – IRN 1)

'When one graduates you do everything. Here you have to undergo certain training. You are not allowed. Anyway it is quite amusing.' (Hospital A: male Philippines – IRN 4)

IRNs' initial perceptions were that the nursing learned in their countries would not change even though they were migrating to another country. One nurse echoed other nurses:

'Nursing is nursing, it does not change. One gives a bed pan to a patient, it will never change.' (Hospital C: female Mauritius – IRN 3)

In other words, nurses expected that the skills they acquired in their country would still be utilised in the UK. However, the IRNs did not utilise all their skills, at times even feeling that they were not trusted to carry out certain procedures.

'Sometimes, if you have for example a dressing to remove, or something like that, simple things, 'no I will do it' as if they don't want you to touch the patient. They are not confident with you ...' (Hospital C: female Mauritius – IRN 1)

There was also confusion as to which tasks they were allowed to perform in various wards; a nurse who was also carrying out 'agency work' in different wards in the same hospital noted this.

Some nurses carried out tasks without questioning because they needed to fit into the system and did not want to appear 'difficult'.

'I had started my induction in Recovery. It was difficult because in the first week, I had a mentor who was younger than me and according to me I have been working for 12 years as a nurse. So I know a lot of things. So many things, that you are not allowed to do here. I think I have more experience than she has [mentor] and so many things she was teaching me I already knew but I had to listen to her. Be very patient and act as a student.' (Hospital C: female Mauritius – IRN 1)

However, some nurses acknowledged that some skills were new to them, ranging from sophisticated skills like peg feeding and using dynamap to basic skills like bed baths and cleaning patients after passing faeces.

'Like the dynamap – I have never seen it before. If they want to work effectively they should explain.' (Hospital C: female Nigeria – IRN 4)

In terms of basic skills one nurse stated:

'When patients are dirty for example they pass stools, either relatives or the domestic cleaners clean the patients. We are not allowed to do it. We never did the cleaning of stools and things. Other nurses might have done it but I have never done anything like that. I came up here, I did not mind doing it because it was just like cleaning a baby.' (Hospital B: female India – IRN1)

Some interviewees came from a society where caring for a family member was a strong cultural norm. The family there will provide the basic care for the patients. Therefore it was strange for this nurse to perform basic tasks. A nurse from Mauritius also expressed herself thus:

'The first time I came on the ward, I asked a lady would you like to have a bath? She asked me, a bath? I am going to have a wash. I said it is the same thing. She said no. A bath you are going in a tub. I said all right I am making a mistake here. I felt stupid. I asked her. How would you like to do it? She said give me the bowl I will show you. I gave her the bowl. She put the soap immediately in the bowl of water. Putting the towel in it and she was starting. Can you do my back please? Then I started to observe how they do it on the ward. I mean the auxiliary nurses.' (Hospital C: female Mauritius – IRN 2)

Although these basic tasks are learned during their training, they are often not practised in their home countries. Therefore these nurses were trying to relearn these basic skills.

Less paperwork at home

Almost all nurses interviewed mentioned that the degree of paperwork was overwhelming, and that it far outweighed the amount of paperwork they would be involved with at home. This is something they had not expected when they were initially recruited, and they felt strongly that it needed to be addressed in some way so that they were more prepared before coming to the UK. The paperwork made them anxious most of the time.

Support mechanisms for the IRNs

There was general support from 'host' nurses and other healthcare workers. Nurses praised the international co-ordinators for supporting them generally:

'... [name of the co-ordinator of IRNs] was very good and supportive. She kept on asking me how my children were at home. That was nice of her. I miss my children.' (Hospital C: female Nigeria – IRN 4)

Some nurses appreciated that on the day they arrived, they found other IRN nurses waiting for them to welcome them. This was greatly appreciated.

Areas of cultural support mentioned by participants are outlined below.

Preparation

The initial preparation in the home country was quite mixed. It was seen by some IRNs as vague and it had not really prepared them for travelling thousands of miles. As one of the female nurses said:

‘Well the only thing I did was to get all my certificates ready – nursing and school certificate and all my papers like work permit, marriage certificate and birth certificate. I did not know what to expect in terms of weather and my work. It was not a big preparation. It was a bit stressful.’ (Hospital C: female Mauritius – IRN 1)

‘It is cold here. I came in November, my relatives told me about the weather. They [the recruiting hospital] sent me information about how we are going to be inducted for where I was going to work.’ (Hospital A: male Mauritius – IRN 2)

The IRNs felt that more information could have been given about cultural issues in the UK. However, a Filipino nurse expressed satisfaction with the preparation in terms of culture of the UK:

‘In Philippines we have to go to a British Embassy, get the necessary documents, like working permit, the NMC [Nursing and Midwifery Council] papers and there are papers you read about England. You are not allowed to go out without a seminar. Some of the things covered are cultural, for example foods eaten in England.’ (Hospital A: male Philippines – IRN 4)

Accommodation

Some IRNs were offered accommodation in the student nurses’ residence for three months. This was appreciated as it made their adaptation to the country a lot easier but some did not like to be accommodated in nurses’ residences.

‘Somebody who has been a family woman before, coming to cope in such accommodation is hard. In Africa you take a lot of time cooking. You use this and that. Some people will want to use the kitchen at the same time. So you have to time yourself when no one will be in the kitchen when you can find time to cook everything.’ (Hospital C: female Nigeria – IRN 5)

‘It is difficult when you are alone and in the nurses’ home, you have to give up for the kitchen, queue for the bathroom. So this was difficult for the first week.’ (Hospital C: male Mauritius – IRN 1)

Induction

‘Culture is not discussed on our induction days. It is just the way you start work. Giving you lectures on fire alarms

and so on. It is good, don’t get me wrong but it would have been more nice if someone says explain yourself in term of culture and then discuss how could adapt here.’ (Hospital C: male Mauritius – IRN 5)

This is a representative quote of how some nurses felt about the induction. The induction was often quite ‘generic’ in the sense that they shared their induction with nurses who were relocating from other sites in the UK.

‘It was a general induction for the whole staff who had applied to work in this hospital for induction programme. It does not deal with cultural needs. But it was good to know what is going on and to meet other people.’ (Hospital A: male Mauritius – IRN 6)

Support in the wards

For some nurses in the study, the ability to adapt culturally was sustained through the support from other nurses.

‘First thing I would say is that I had a chance to be in a ward where everybody now I can say is my family. I have got somebody I can talk to and also some took me out for a meal. Which was nice of them. They sometimes talk about UK life.’ (Hospital C: male Mauritius – IRN 2)

‘Some patients or nurses use English which I cannot understand. For example, “duck”, “spending a penny”. One of the healthcare support worker explained what it means.’ (Hospital A: male Mauritius – IRN 1)

It was evident that informal support from other staff was valuable. However, there was still a feeling of needing more support.

Life outside the working area

The first week of their arrival in UK was seen as the most problematic. At first, there was a sense of euphoria when they were just arrived, as one of the male nurses stated:

‘It was nice when we were coming to a new country. The first week I can say I was enjoying. Everything was new. The first week was not bad. You just enjoy life but after that you have to go through realities, courage, patience, you need to be strong in a certain way.’ (Hospital C: male Mauritius – IRN 3)

Other examples extended and repeated this theme of self-reliance:

‘I am a religious person, but when I came, I did not know where the church is. No one showed me. I just thought anyway that is a personal matter.’ (Hospital B: female India – IRN 1)

‘Adaptation of course means, one need to adapt to the life in this country. You need to adapt to everything in the area. You have to get used to the money currency. Because you have the tendency to compare the prices, the value of things whether expensive or not and you find it difficult.’ (Hospital A: male Mauritius – IRN 1)

It is evident here that more information regarding general life was required.

Discussion

Generally nurses were happy working in the UK. Although they came from four different countries, there was a general consensus that more needed to be done in terms of cultural adaptation to help them settle in the country. The IRNs experienced cultural shock while adjusting to the new ways of life and to the working environment. Cultural shock is a feeling of disruption, which an individual might feel when confronted with a different culture (Lawson and Garrod, 1996). The first few weeks of their stay were the most difficult. IRNs felt isolated and home-sick.

The way IRNs conceptualised their culture had an influence too on their adaptation process. Two forms of cultures emerged from the data. For the purpose of this research they have been termed 'primary' and 'secondary' culture. These concepts stem from the sociological concepts of primary and secondary socialisation which take place in life (Taylor *et al*, 1999). In primary socialisation one learns basic lessons for life from the family; for example, language and forms of dressing. Secondary socialisation happens when the individual moves into the wider world such as the workplace. For example, the individual learns discipline at work (Taylor *et al*, 1999).

In terms of 'primary' culture, language proved more of a problem. Language is more than just words; it includes (among other things) accent and tone (Henley and Schott, 1999). Although all nurses spoke English, the accents and the use of colloquial language by the 'host' nurses posed communication problems. The accents of the IRNs also posed communication problems when interacting with some of the patients and other members of the healthcare team. This seemed to be a two-way communication problem. Patients are often confronted with these variations daily, yet no one talks about them (Castledine, 2000). The important issue to note is that every communicator has an accent, which can possibly be a problem to whoever listens. Therefore, it is a matter of speaking clearly and listening to one another.

As stated above, the majority of the nurses interviewed had a great deal of knowledge and experience of nursing that they were bringing from their own country to the UK. The assumption among nurses was that 'nursing' learned in their country was not going to change. Therefore they had felt very comfortable about the secondary culture (nursing) until they actually started working on the wards and units. The experience has been summarised in Figure 1.

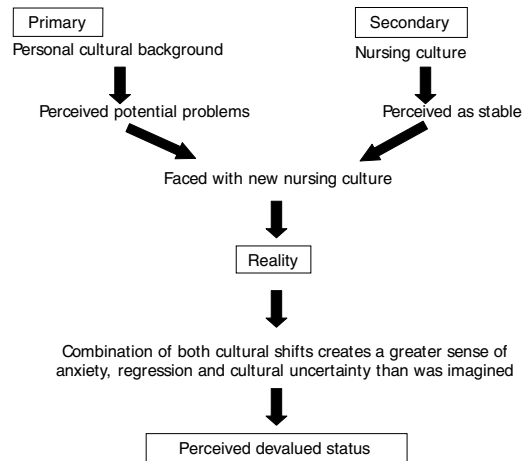


Figure 1 Conceptualisation of culture

Nurses were sometimes told not to perform tasks that they had been trained for and experienced in their countries. The 'nursing' which they valued and thought was nursing was not being recognised. This was a challenge to what they perceived as 'nursing'. Therefore, there was no match between the IRNs' values and the organisational values. This is what Verplanken (2004) termed 'value incongruence' in her study. This could lead to job dissatisfaction. Among the IRNs, there was a feeling of 'the whole nurse' being compartmentalised and at times almost feeling a fragmented person and being devalued. The findings of this study are consistent with previous studies such as those of Yi and Jezewski (2000) and Allan and Larsen (2003) who also found that IRNs were being exploited and their skills being undervalued. Not allowed to perform tasks which they were trained for in their countries resulted in the IRNs being confused and experiencing role change. Alexis and Vydelingum's (2004) study confirmed these feelings among IRNs. It is important to value the knowledge, skills and experience that the nurses already have, and recognise that they are not arriving from their own countries as novices in nursing. Their experiences can benefit the host nation rather than being seen merely as a crisis intervention to overcome a nursing shortage.

The support nurses got from host healthcare workers also influenced their adaptation process. They were grateful to a number of nurses, patients and other staff for the general support they received to settle in the country, and while working in the ward and units. Our data reveal that the IRNs had some cultural orientation on an *ad hoc* basis. It would have been more effective if it was an organised cultural orientation in terms of preparation while still in their country. Such an induction programme could discuss matters including accommodation, working in the wards and life outside work. All these findings support

the claim that IRNs do not adapt well culturally without some personal cost or external support.

Implications for practice, management and research

Although this study has been carried out in the UK, the results have wider implications. Managers and recruiting bodies who recruit international nurses should provide a well-structured cultural orientation programme. It has to be thought through in terms of what needs to be included in terms of culture. It is vital that they are culturally supported. This could also be useful for the 'host' nurses.

The limitation of this study was that it was based on experiences from only a few nurses from four countries and was limited to one geographical area. However, more can be learnt from this study and more research is required, as culture is a complex phenomenon. As planned, the researchers will carry out similar research in two more countries. Other studies could, for example, examine each theme in detail such as the influences of language and non-verbal communication on nurses' adaptation and also how these influence patient care. The qualitative approach remains the appropriate choice for further research in exploring IRNs' experiences. Observational methods could also be used to observe nurses in practice.

Recommendations

Preparation

There is a need for better pre-recruitment information in relation to both personal and professional cultural issues. This will increase IRNs' insight into the British way of life before they leave their home culture. It should be emphasised that some aspects of nursing practice may be very different in the UK.

Induction

Less generic induction programmes are needed. Time needs to be set aside to explore cultural issues including those concerned with coping mechanisms for homesickness and language difficulties. IRNs should be made aware that there are different English accents. One idea was to establish a 'buddy system' during their settling in phase, to enable them to 'offload' and share both positive and negative elements of their cultural adaptation process.

There are further issues around activities such as the completion of paperwork, that is perceived as problematic, which also give rise to anxiety and uncertainty.

Being deskilled/devalued

Nurses' previous knowledge and experience need to be valued and recognised as a resource. Employers should develop a system of making courses/updates more user friendly by creating a more 'tailor made' approach, based on a clear assessment of IRN's professional qualifications, previous status and experience.

Life outside work

Life outside work should be developed as part of a pre-recruitment package and continued within an induction programme. More realistic information should be given about cultural changes such as climate and diet.

Conclusion

The focus of this study was to investigate how culture influences the adaptation of IRNs. The study has given an insight into how international nurses experience the process of adaptation to a different culture. The findings suggest that culture has an influence on the adaptation process and it is hoped that the findings of this study will stimulate positive changes relating to the orientation programmes of overseas nurses.

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CONFLICTS OF INTEREST

None.

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