Growing through experiencing and overcoming strangeness and communication barriers

The essential structure of becoming a foreign nurse

A phenomenological study

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‘Facing your fears
is
a challenge
if
you have overcome it
it is like
a feeling
of fulfilment and success
you moved on
you
didn’t just
stay there’

(Angela,
a foreign nurse)

Statement of authorship

This dissertation is submitted to the RCN Institute in part fulfilment of the MSc in Nursing and has been conducted and presented solely by myself. I have not made use of other people's work (published or otherwise) and presented it here without acknowledging the source of all such work.

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Abstract

The *research question* in this study is 'What is the lived experience of foreign nurses of working at a hospital in Iceland?' It is conducted in the international *context* of a rise in migration of nurses and the local context of changes from a homogeneous towards a multicultural society. The *aim* of the study is to generate an understanding of the foreign nurses' experience. The *purpose* is to facilitate a constructive international climate and recruitment strategies in Icelandic hospitals and to increase knowledge of what it is like to be a foreign resident in Iceland. The methodology that guided the study is *phenomenology*, a variation termed "the Vancouver school of doing phenomenology." *Sampling* was purposeful. The *sample* consisted of eleven RN nurses from seven countries and three continents working at three hospitals. Most of them had no, or limited, knowledge of Icelandic at the onset of employment. The *data were collected* in dialogues and the *analysis* was thematic. The overall f*indings* are presented as '*Growing through experiencing and overcoming strangeness and communication barriers',* and five main themes describe the essence of the experience. The first theme is '*Meeting and tackling the initial, multiple and unexpected simultaneous challenges*.' It was distressing for most of them to start to work in Iceland, also for the nurses from near-culture countries. They received support from various people and a quitters-never-win attitude assisted them also to persist. The second theme is '*Becoming an outsider and the need to be let in, to belong.'* Having been insiders in their own countries, they experienced the troublesome feeling of becoming an outsider. They needed to belong, particularly at work. Belonging meant to be valued, accepted and trusted and to make Icelandic friends. The third theme is '*Struggling with the language barrier*.' Lack of effective means to express themselves was distressing and affected the other domains of their adjustment. Learning Icelandic was pressuring even though they received support from colleagues and patients. Once they started to speak the language, they encountered the problem that their fluency was overestimated and the telephone became a

fearsome device. The fourth theme is '*Adjusting to a different work culture*.' They encountered a work culture that was different from what they were used to. Some aspects they appreciate, such as less workload and stress, and more equality and informality. Others make them uncomfortable, such as excessive individual freedom in practice and insufficient discipline, precision and use of protocols. The fifth theme is '*Overcoming challenges to win through*.' This happy turning point commonly occurred after about six months to one year. They had overcome most of the challenges they faced initially: achieved substantial sense of belonging, become more at ease in the different work culture, and could use the language with some confidence. They feel they have grown personally and professionally by the experience and half of them are on the track of further study. Some hurdles remain such as difficulties in establishing close friendships with Icelanders, and less than desired fluency in Icelandic. The findings correspond to a *difficult but benevolent acculturation process*. In some aspects, they correlate to findings in similar studies but they are different in other aspects. The *reasons* for the differences might be different environment and composition of the samples.

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Contents

Chapter 1 Introduction

The focus of this MSc dissertation in nursing is the experience of eleven foreign nurses of working at a hospital in Iceland. Their experience was explored in hermeneutic phenomenological dialogues with the researcher. The local context is hospitals on a sparsely-populated N-European island that by tradition has been a relatively homogeneous society, until about 15 years ago, when it started to become increasingly multicultural. The international context is international migration of nurses and other professional workers.

In this *first chapter*, I will state the research question (1.1.), the aim and purpose of the study (1.2.), its local (1.4.) and international (1.5.) context and significance. My place as the researcher in the study is also considered (1.3.).

1.1. The research question

The research question is "What is the lived experience of foreign nurses of working at a hospital in Iceland?"

1.2. The aim and purpose of the study

The *aim* of the study is to generate an understanding of foreign nurses' experience of working at a hospital in Iceland. Phenomenology seeks to generate an in-depth understanding of a phenomenon through the experience of those who have lived through it (Oiler, 1982) by exploring the meaning an experience has for people (Spiegelberg, 1982). I believe this is an important prerequisite for productive communication, relations and action. The *purpose* of the study is therefore to contribute to a constructive international nursing/health-care climate, recruitment and integration strategies in Iceland by giving voice to one of the core groups in that partnership, foreign hospital nurses. As foreign nurses are a part of the evolving multicultural society in Iceland, the study is expected to contribute to increased knowledge and understanding of what it is like to be a foreigner on the workforce in Iceland.

1.3. The place of the researcher in the study

My *interest in the subject* stems from a work-related project that was assigned to me in November 2000: designing a training course for foreign nurses working at Landspítali, the National University Hospital of Iceland, the largest hospital in the country. While assessing their training needs, I discovered that fundamental issues in recruitment and orientation of foreign nurses in the hospital had not been addressed. The project was therefore expanded and I became a project manager in matters related to foreign nurses. During my interaction with them, a difficult experience was revealed and I was surprised

that it seemed also very difficult for nurses from neighbouring countries. My *preconceptions* of the phenomenon are also coloured by my international work as a nurse and manager of health care for war-stricken populations in six countries in Europe, Asia and Africa and from living for various reasons in a few other countries. Additionally, I have worked with foreign nurses on a hospital ward in Iceland and been a preceptor for one of them. This background has also promoted my development towards culturally competent research practice, as stipulated by Papadopoulos and Lees (2002).

1.4. The local context and significance of the study

Icelandic society has changed over the past 15 years from being relatively homogeneous into an *increasingly multicultural society*. Residents who were born in other countries comprised 2.6% of the population in 1980, 3.8% in 1990 and are 6.6% (19072 persons) at the end of 2002. If the indicator of people with foreign citizenship is used, the respective numbers are 1.4%, 1.9% and 3.5% (10221 persons), compared to 4.1% to 4.8% in the neighbouring Nordic countries (Statistics Iceland, 2003). Another change is that the foreign residents now come from *countries further away* geographically, culturally and linguistically. The increase has mostly been a response to the needs of the labour market while refugees and asylum seekers remain a minor part (Guðmundsson, 2000).

Nurses are the largest group of health-care professionals working in Iceland, making them a relevant group to explore. During 1990-2000, 88 foreign nurses

were registered for licence purposes at the Ministry of Health and Social Security: 57 from countries within the European Economic Area (EEA) and 31 from other countries (Sveinsdóttir, 2000). A moderate increase in recruitment of nurses from distant countries is taking place, particularly from the Philippines. A *multicultural workforce* has become apparent in some health-care institutions including the main hospital in Iceland, where Asians are particularly noticeable in jobs that do not require prior training.

The *experience* of the approximately 250 foreign employees at the main hospital in Iceland has not been explored. Tension between them and Icelanders is noticed and discussed among employees. Gaining insight into what it is like for some of them to work in Iceland could enhance bridge building between the foreign and the native employees. The findings can also assist in the formulation of policy and orientation programmes for foreign hospital nurses in Iceland. Even though generalisation of findings is not an aim in phenomenological research, the findings may have local transferability because eleven out of about fifty-five foreign nurses working in Icelandic hospitals participated, and because demographic variation in the sample was high. Very few studies have explored the experience of foreign residents in Iceland and even fewer have been published. Some official reports on related matters have been issued. Media coverage on foreign residents has appeared very negative to me. It has depicted them either as refuges, or as a workforce employed in jobs that Icelanders do not wish to perform, including highly educated people who are not given the opportunity to work in their profession

(Gunnarsdóttir, 2002). A survey by the Reykjavík City Executive Council (2001) supports the latter statement. This study has the potential to focus on a different aspect: the experience of a group of foreigners who have been employed in their profession. The European Commission against racism and intolerance published in early 2003 a report which recommends that research be conducted in all domains of Icelandic society regarding the situation of immigrants (ECRI, 2003). This study addresses this recommendation.

1.5. The international context and significance of the study

Professional workers are becoming an increasingly large group in international *migration* (Iredale, 2001). A rise in international recruitment and migration of *nurses* has been a major issue within nursing in recent years (Buchan, 2001; Hawthorne, 2001), and the current trends are the subject of a new report issued by WHO with support of ICN and RCN (Buchan *et al*., 2003) (see 2.2.1). The migration *experience* of nurses had not been the subject of much research when I commenced on the study. The knowledge is increasing but it contains almost exclusively information from English-speaking countries. The findings of this study will be a contribution to expand this still limited knowledge base. The focus of the international discussion has been on the difficulties of nurses who work in countries that are far from their own countries, particularly those from developing countries coming to work in industrialised countries. I have the notion that it is assumed that the experience of other nurses is not difficult, but

my interaction with foreign nurses in Iceland indicates that it is and I think it is relevant to explore this. The findings of the study can assist nurses that are interested in coming to work in Iceland in making a decision and preparing themselves. It can also add to existing knowledge on the occupational experiences and career dynamics of immigrants, which according to Bhagat and London (1999) is limited but growing.

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To sum up: exploring the experience of foreign nurses in Iceland has value both for the local context of a young multicultural society, and for the current international focus on nurses' migration. In *this chapter*, I have stated the research question, outlined the aim and purpose of the study and my placement as the researcher. In the *next chapter*, I will explore relevant knowledge in the domain of the study.

Chapter 2 Literature review

In the *first chapter*, the research question, aim and purpose of the study were stated. I explained my place as the researcher and the local and international context and significance of the study. *This chapter* commences with a definition of key terms (2.1.). I go on to explore international migration as a context for the exploration of migration of nurses internationally and to Iceland, as well as the situation of foreign residents in Iceland (2.2.). Then I explore relevant existing knowledge on what it is like to be a foreign nurse (2.3.) and briefly compare it with similar knowledge in other professions (2.4.)

2.1. Definition of key terms

The terms that are used in the discourse on international mobility of people vary, but "immigration" and "immigrants" are commonly used. I will use the term "foreign resident" unless I am citing other people but then I use the terms these people used. *"Foreign resident"* refers to people who have come to work and/or live in a country other than their country of origin for varied duration

and reasons. I do this because the term *"immigrant"* is commonly associated with permanent settlement and this does not apply to all foreign nurses or "immigrants" in Iceland. Some have come here as *sojourners*, a term used by Berry *et al*. (1992) for people who migrate in order to work for a limited time, up to a number of years (Berry *et al.*, 1992). *"Foreign nurses"* are foreign residents and additionally, their primary nursing studies were not conducted in Iceland.

2.2. Migration and nursing

2.2.1. International context within and outside nursing

A key component in current international migration is an increase in the mobility of *knowledge workers*, so called skilled or professional migration (Iredale, 2001). Nurses are one of the key groups even though a significant increase in international recruitment is not noted everywhere (Buchan *et al*., 2003). Incomplete, inconsistent and incompatible *data on migration* of professionals, and its effects on the disciplines and the receiving and sending countries, appears to be a global problem (Iredale, 1999; Stalker, 2002). According to a new situational report on nursing by Buchan *et al*., (2003), issued by WHO with support from ICN and RCN, this is also evident within nursing where it hampers evidence-based policy formulation and assessment. Most of the global migration takes place *from the developing to industrialised countries* that lack skilled workers in certain professions (Pellegrino, 2001; Stalker, 2002). A similar trend is noted within nursing, even though many

countries mostly recruit foreign nurses from industrialised countries, particularly from their neighbours that speak similar languages. The open employment boundaries within the EU have not resulted in a flow of nurses between these countries, mostly because of language barriers (Buchan, 2002). Active recruitment has been practised in some countries such as the U.K., Ireland, Norway and the U.S.A (Buchan *et al*., 2003), sometimes in groups by individual recruiters or through governmental contracts (Gibbs, 2001; Buchan, 2002). Currently about 26% of registered nurses (RN) in Australia were born in another country (Hawthorne, 2001). For the U.K. the figure is 8.3% (28% in London), and has doubled in the last three years (Buchan, 2003). The main *stimulus for migration* is lack of nurses in the receiving countries (the main pull), higher salaries and better career prospects, working conditions and environment (Buchan *et al*., 2003). Reports from some of the main "donor" countries imply that the exodus has resulted in depletion of their national sources for nurses, and a lowering of the quality of services (Hawthorne, 2001; Buchan *et al*., 2003). The implications and extent of this "*brain drain*" is debated within nursing (Buchan *et al*., 2003; Meleis, 2003) and other professions (Stalker, 2000; Pellegrino, 2001) but the potential positive aspects are also discussed in terms of "brain exchange" and a "reverse brain drain" (Stalker, 2000). Another criticism of active international recruitment is that it fails to address the shortage of nurses as a long-term problem, which demands more effort to seek *local solutions*. Migration is not expected to halt in the immediate *future* due to unmet demand for labour in the industrialised countries

(Kuthiala, 2001; Stalker, 2002). Mobility of nurses is expected to follow the same trend (Kingma, 2001).

2.2.2. Foreign residents in Iceland and their experience

In chapter one, the recent changes in Iceland from a homogeneous into an *increasingly multicultural society* were portrayed. This is evident in the unskilled workforce in some health-care institutions but less in nursing, except in geriatric care. If Icelandic society and nursing follow the expected *future trend* in migration in Europe, the immediate future will bring flows of migrants from Eastern Europe (with the expansion of the EU and EEA) while people from the developing countries will be more prominent in the long-term picture (Stalker, 2002). The *public system* has responded to the current development by policy formulation, construction of public services for immigrants and new legislation (Althingi, 2002). It is postulated that emphasis should be on creating conditions so that foreigners who wish to settle in Iceland can become active participants in the society. Respect for their culture and language is emphasised, as is the facilitation of conditions for learning Icelandic (Ministry of Education, 1997; Reykjavík City Executive Council, 2001). Nevertheless, residence and work permits for citizens of countries outside the European Economic Area (EEA) and support for learning the language remain *restricted*.

Since these changes only started to take place less than 15 years ago, it is not surprising that *few published studies* have explored the experience or situation of foreign residents in Iceland. A qualitative study by Thórisdóttir *et al*., (1997)

is the only published study I could locate. It explores policy formulation and adjustment of Icelanders of foreign origin to society, with the focus on education of children and adolescents. It indicates *a positive and problematic* experience. Fullon (2000) outlined the findings of her ethnographic narrative study on Philippine women in Iceland as "To be seen and not heard: immigration stories in Iceland" where *loneliness, alienation, silencing*, *segregation* and *exclusion* are the main themes while *silent celebrations of success* are also described. In the past 2-3 years an increase is noted in graduate and postgraduate students' exploration of subjects related to the wellbeing of foreign residents. This work, some of it comprising research projects, will not be explored here, because it could not be traced as publications and because of the limited design of the few that might bear direct relevance to this study. It is reasonable to state that the experience of foreign residents in Iceland today is not well documented by academia but that *interest in the subject is growing*.

2.2.3. Foreign nurses in Iceland

In Iceland, an official analysis of nurses' migration has not been issued. The researcher did an informal analysis of the situation with the purpose of crude outlining of the situation. An analysis of such small numbers should be examined with caution. The number of foreign nurses currently working as RNs in Iceland is estimated (early 2002) to be about 55 in hospitals (51 are known) and about 10 in other health institutions, totalling *about 65 nurses*. No active massive recruitment has taken place and is not planned. A moderate

increase in total recruitment is noticed because of an increase from the Philippines. Nurses from the Nordic countries remain the largest group, the second-largest group is Filipinos and the remaining ones come from various (mostly) industrial countries. The main reasons for employment appear to be similar to those in other countries, with financial security being the main reason for nurses from developing countries. Marriage with an Icelander appears to be a common reason for nurses from industrialised countries; a reason not noticed in reports from other countries. Some come because they are interested in travel in the country.

2.3. The experience of foreign nurses

A study of the *experience of foreign nurses in Iceland* has not been conducted and their voices are barely heard within nursing. During this study, an interesting international development took place. At the time of the initial literature review in late 2001, the experience of foreign nurses did not appear to have been subject of much international research. Then, at the time of the (delayed) writing of the report in July 2003, a knowledge base was forming. Therefore, nearly all the relevant international literature regarding the experience of foreign nurses informed the study after the findings had been formulated.

Two *international studies* resemble the present study: one from Australia and one from the U.S.A. The one from the U.S.A. is a grounded theory study (Yi and Jezewski, 2000) that examined the adjustment of twelve Korean nurses to

hospitals. The focus was on the experience as a process. The initial adjustment (2-3 years) was characterised by *relieving psychological stress*, *overcoming the language barrier* and *accepting U.S.A. nursing practice*. Later (5-10 years), they were dealing with *adopting the U.S.A. styles of problem solving strategies* and *interpersonal relationships*. Those who managed to adjust successfully felt *proud and satisfied* and some described their success as 'a miracle' (p.727).

In Australia, Omeri and Atkins (2002) conducted a phenomenological study where five multinational nurses (four with a non-English-speaking background) participated in unstructured interviews where the main focus was on their struggle to get a job, and less on their experience after employment. The experience is described as *'mostly unhappy'* (p.503), where the main findings are *professional negation*, experienced in lack of support; *otherness*, experienced in cultural separateness; *silencing*, experienced in language and communication difficulties. In Australia, a database on the nursing workforce has been formed in regular censuses and surveys by various governmental bodies. Hawthorne (2001) has performed an analysis of certain variables on foreign nurses from this database and additionally she interviewed foreign nurses. She concludes that foreign nurses from a *non-English-speaking background experience major barriers* before, during and after employment. The *barriers are* high failure rates on English testing and pre-migration qualification screening, limited access to competency assessment courses, concentration of employment in the geriatric sector and peer rejection. This is in sharp contrast to a *seamless passage of nurses with an English-speaking*

background into initial and later, senior positions.

A few studies have been published in 2002 and 2003 as official reports focusing on international recruitment of nurses in the U.K. Most of these reports are quite extensive, address many issues and include statistical analysis, opinions and accounts of experiences. Two of them will be described here. Allan and Larsen (2003) conducted a focus group interviews with 67 nurses from 18 countries and 5 continents (83% from developing countries, 78% non-white and two-thirds African) working in three cities in England. The name of the study, *"We need respect"* encapsulates the overall central experience. Main findings reveal a *demanding and pressuring* experience with perceived *discrimination, exploitation, professional exclusion* by colleagues (all ethnic groups), *conflicts with local practices* in nursing, initial lack of *professional recognition* and *language problems*. In a case study in ten NHS and private organisations (Buchan, 2003), nurse managers reported the main challenges in international recruitment as *language problems*, differences in clinical and technical *skills*, *racism* in the workplace and *negative reactions of some patients* to being cared for by a foreign nurse.

An international study and report was recently published by WHO with support from ICN and RCN (Buchan *et al*., 2003) where findings from focus groups with recently arrived foreign nurses of four nationalities (two thirds Filipinos) in Australia, Norway and Ireland are described. The nurses reported on a set of questions related to their recruitment, motivations for migration and, to a lesser extent, their experience in the work. I have not located studies from countries

where English is not the primary language, except the Norwegian part of the report by Buchan *et al*. (2003). The information (see above) from Norway does not add to what already has been said.

2.4. The experience of other foreign professional workers

The review of relevant literature concludes with a glimpse into the experiences of *other foreign professional workers.* The purpose is to explore whether the nurses' experience may be somewhat similar. Comparable studies from *other health care professionals* were not located but some reports from physicians do exist. Remennick (2002) states that most of the few studies that have examined the situation of professional immigrants have been *surveys and statistical analyses of engineers and specialists in high technology* and that research that gives insight into the challenges of *occupational integration* is limited. Bhagat and London (1999) maintain that most of the limited research knowledge on the psychological dynamics of immigrants has been formed in U.S.A., but that there is a growing interest in other countries. Israel, a country with a high proportion of highly educated immigrants appears to be in the forefront there. Remennick (2002) interviewed 36 Soviet schoolteachers who had settled in Israel. The overall theme of her findings, *"Survival of the fittest"* indicates the central experience. L*anguage proficiency* was the key determinant of *occupational success* in retention and job satisfaction. Other major attributes were *personal traits* of self-confidence and resilience and ability to adjust to

more *informal student-teacher relationship*. Those who persisted in their career experienced a sense of high job satisfaction and professional achievement (Remennick, 2002). Unstructured interviews with Indian IT specialists in Germany showed their major problem as inability to speak German or speak it well, and lack of mutual *language* in their immediate environment, a daily struggle of *trying to establish a sense of home* and *reluctance to establish contacts with Germans*. They also feared racial discrimination (Meijering and van Hoven, 2003). I believe that these two studies indicate both general and specific similarities with the experience of the nurses. Yeoh and Willis (1999) state that studies on professional migration suffer from *gendered biases* as the focus has been mostly on men. Migration studies within nursing have the potential to bring in the voices of women.

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In *this chapter*, I have outlined issues related to migration generally and in Iceland as well as within nursing in Iceland and internationally. Studies that have looked at the experience accompanied with being a foreign nurse were explored and a glimpse given into the experience of other professionals. In the *next chapter*, methodological and ethical issues are portrayed where the focus is hermeneutic phenomenology.

Chapter 3 Methodology, philosophical and ethical foundations

In *chapter two*, published knowledge related to the subject was explored. In *this chapter*, methodological and ethical issues are explored. Firstly, I will first define key research terms (3.1). Secondly, I will portray phenomenology generally (3.2.), and briefly account for the diversity within it (3.3.). The bulk of the chapter is, however, devoted to the variation that guided my study, the Vancouver school of doing phenomenology and its philosophical underpinnings (3.4.) as well as the rationale for my choice (3.5). Finally, I will discuss ethical issues (3.6.).

3.1. Definition of key research terms

Guba and Lincoln (1998) define a *paradigm* as a set of basic beliefs that deal with basic principles of how we view the world. The basic beliefs rest on ontological, epistemological and methodological assumptions and the disparity

in these assumptions forms the diverse paradigms. *Ontology* deals with the nature and form of reality and *epistemology* with the nature of knowledge, what can be known and the criteria for accepting knowledge (Guba and Lincoln, 1998). A classic sense of the term *methodology* is described by Tuchman (1998) as 'the study of epistemological assumptions implicit in specific methods' (p.225). It deals with how the researcher goes about finding out what she or he believes can be known (Guba and Lincoln, 1998). It reflects and rests on the philosophical foundations and guides the choice of methods of data collection and analysis. *Research methods* are the specific techniques for gathering information (Silverman, 2001). The term *co-researcher* is explained in section 4.1.1., and *dialogue* in 4.2.1.

3.2. Origin and common features of phenomenology

The methodology that guided the study is phenomenology; a variation termed "the Vancouver school of doing phenomenology." Phenomenology is a naturalistic orientation and one of the main philosophical currents in philosophy at the beginning of the 19th century. It arose as a movement in protest against the positivist assumptions (Moran, 2000) which were deemed to deprive human phenomena of the full and fair hearing they warranted (Spiegelberg, 1982).

A central concept in phenomenology is *"lived experience."* The subject of research is the world of everyday life seen from the perspective of the people who have experienced it, a return to and re-evaluation of the taken-for-granted experiences of the "life world" (Oiler, 1982). *"Phenomenon"* is defined as

'that which shows itself in itself, the manifest' (Heidegger, 1980, p.51), 'anything that appears or presents itself to someone…' (Hammond *et al*., 1991, p.1). Things show themselves in different ways depending on our mode of access to them. The mode might hide its meaning and appear as ways that things are not (Heidegger, 1980). Phenomenology seeks to find this meaning, to describe it and, in the hermeneutic branches, to interpret it (Moran, 2000).

3.3. Diversity in phenomenology

Within the phenomenological movement, there are multiple modifications (Spiegelberg, 1982). Moran (2000) maintains that this diversity is true to the core of phenomenology but that it has constrained a wider spread and understanding of phenomenology. The most fundamental and earliest *philosophical* distinctions originate from Edmund Husserl, the founder of the movement, and Martin Heidegger, the transformer of the movement (Moran, 2000). The *fusion of phenomenology with hermeneutics* in the 20th century (see 3.4.3), is mainly attributed to Martin Heidegger, Hans-Georg Gadamer and, more recently, Paul Ricoeur (Thompson, 1981). None of these philosophers presented phenomenology as *methodology* but primarily as philosophy. Scholars within humanistic sciences such as nursing, pedagogy and social sciences have built on their philosophy for shaping a methodology for research within their disciplines (Cohen, 2000), resulting in intra- and cross-disciplinary variations. Consequently, phenomenology as a methodology is no more unified than it is in the philosophical domain. The orientation that guided this study is

the Vancouver school of doing phenomenology, a hermeneutic (interpretive) orientation that particularly is influenced by the thought of Paul Ricoeur. I will now portray its main features and philosophical underpinnings.

3.4. The Vancouver school of doing phenomenology: the methodology and philosophical foundations

3.4.1. Main features

The Vancouver school of doing phenomenology originates with Dr. Joan Anderson, professor at the University of British Colombia, Vancouver, Canada (Halldórsdóttir, 2000) but has been developed into a comprehensive and published methodology by Dr. Sigríður Halldórsdóttir, professor at the University of Akureyri, Iceland. It is an orientation primarily influenced by the analytical work of Herbert Spiegelberg (phenomenology), Paul Ricoeur (hermeneutics and phenomenology) and Tomas A. Schwandt (constructivism). The Vancouver school stands for moderate realist ontology, a transactional epistemology and hermeneutic dialogical methodology. The processes for data analysis share some common features with the guidelines of the phenomenologist Paul F. Colaizzi. The aim is primarily to understand people's experience so they can be guided better, for example through a transition in life (Halldórsdóttir, 2000).

There are 12 basic steps in the research process. They are explored and applied in chapter four, but are listed here briefly (Halldórsdóttir, 2000, p.57):

Step 1 Selecting dialogue partners (the sample).

Step 2 First, there is silence (before entering a dialogue).

Step 3 Participating in a dialogue (data collection).

Step 4 Sharpened awareness of words (data analysis).

Step 5 Beginning consideration of essences (coding).

Step 6 Constructing the essential structure of the phenomenon for each case.

Step 7 Verifying the single case constructions.

Step 8 Constructing the essential structure of the phenomenon from all cases.

Step 9 Comparing the essential structure with the data.

Step 10 Identifying the over-riding theme, that describes the phenomenon.

Step 11 Verifying the essential structure with some of the co-researchers.

Step 12 Writing up the findings.

During each of these non-linear steps, the researcher *repeatedly enters stages of* silence, reflection, identification, selection, interpretation, construction and verification. These are also explored in various sections of chapter four.

I will now explicate the main features of the mainstream schools of thought, beyond phenomenology, that influence the Vancouver school: constructivism and hermeneutics and the work of Paul Ricoeur.

3.4.2. Constructivism

The constructivist paradigm or, according to Guba and Lincoln (1998), the constructivist part of the naturalistic paradigm, agrees with phenomenology in

the ‘emphasis on the world of experience as it is lived, felt [and] undergone by social actors’ (Schwandt, 1998, p.236).

The *ontological stance* is contextual, relativist and pluralist (Guba and Lincoln, 1998). The world consists of multiple realities or constructions. Constructions are realities created from our interpretations from interacting with the world and they undergo continuous alterations in light of new experiences. What is real is created by our minds and is therefore local and specific in nature even though the constructions may be shared (Guba and Lincoln, 1998; Schwandt, 2000). In terms of research findings, this means that generalisation outside the site and time, and even the participants themselves, is not assumed, even though the experience can be shared among people. While agreeing with these core characteristics, Crotty (1998) understands the ontological stance as being both relativism and realism. The Vancouver school adopts this view: one of ‘moderate realist ontology, believing in one real reality while embracing multiple co-existing realities within the subjective domain’ (Halldórsdóttir, 2000, p. 54). This means that the overall findings in the study are created by all the different realities of the co-researchers (participants).

The epistemological stance is transactional and subjectivist, where knowledge is seen as created or constructed by the human mind (Guba and Lincoln, 1989): an active process where the mind works on the data and understands it in its own individual way (Schwandt, 1998). The aim is to reach some consensus over the most informed and trusted constructions (Guba and Lincoln, 1998).

3.4.3. Hermeneutics and the phenomenology of Paul Ricoeur

Hermeneutics is a centuries-old philosophical and applied discipline. The work of Heidegger, Gadamer and Ricoeur in fusing hermeneutics and phenomenology was not only important for the evolution of phenomenology but dramatically extended the understanding and scope of hermeneutics (Bernstein, 1983). Bleicher (1980) defines *hermeneutics* loosely as 'the theory or philosophy of the interpretation of meaning' (p.1). Reality is not pure experience but interpreted (Thompson, 1981). Understanding *is* interpretation; in order for understanding to take place one must interpret (Schwandt, 2000).

The *"hermeneutic (interpretive) circle"* or the "circle of understanding" is a central concept in hermeneutics. Customarily it is explicated as moving back and forth between the parts and the whole of a text or the phenomenon we seek to understand (Koch and Harrington, 1998; Genaellos, 2000). Gadamer's and Ricoeur's understanding goes further, to address also the relations between the interpreter and what he or she seeks to understand (Bernstein, 1983). They further maintain that the task is not to close the circle or to totalize knowledge, but to keep open the plurality of discourse with constant replacement and projection of prejudgements (Gadamer, 1975; Kearney, 1984).

The Vancouver school has adopted the principal thought of *Paul Ricoeur* (Halldórsdóttir, 2000) whose work is an outstanding contribution to hermeneutic phenomenology (Thompson, 1981; Spiegelberg, 1982). Spiegelberg (1982) maintains that Ricoeur 'clearly advocates a phenomenology of his own, though one related to that of his predecessors' (p.588). The

foundation of his philosophical work lies in his claim of mutual affinity or belonging between phenomenology and hermeneutics (Thompson, 1981). In his theory of interpretation, Ricoeur sought to illuminate an *epistemology that can be applied to interpretation* taking into account language, reflection, understanding and the self. He focused on textual interpretation by addressing the means through which understanding is made possible (Geanellos, 2000), where the notion of meaning has two dimensions: an objective or the system aspect (what the sentence means) and a subject or discourse aspect (what the speaker means) (Thompson (1981)

3.5. Rationale for choice of methodology

What is it like for foreign nurses to come and work in Icelandic hospitals? This is what I was interested in knowing myself and making known to others. I wanted to construct this knowledge in the depth, and the open and case-orientated manner, that is central to *phenomenology*. I was not interested in categorising and quantifying the experience, nor did I consider setting out with a hypothesis, as would have been appropriate in a positivist survey. Limited international and local published knowledge related to the subject also supports my choice (see chapter two). I think the dialogical, thematic and narrative method fits the subject and the aim and purpose of the study. *The Vancouver school* provides clear guidance, while maintaining an open attitude that encourages the researcher to exert his or her individuality in the process.

As indicated by the literature review (see 2.2.2), the reality of at least some

immigrants in Iceland suggests a picture that correlates to the ideology of the *critical paradigm.* The critical paradigm could therefore be a feasible orientation for guiding a study like this. If phenomenology was still applied, it would then become critical and hermeneutic, an interesting combination. The *feminist* standpoint (feminist paradigm?) could also be a potential perspective. However, I am uncomfortable with the value-bound ideological presumptions of these perspectives, that the researcher is encouraged to incorporate into the research process (Hedin, 1986; Henderson, 1995). I am not prepared to go so far with my *preconceptions* and am sceptical about the trustworthiness of such an ideologically flavoured process. Furthermore, the aim of research within these perspectives is primarily to transform and emancipate (Campell, 1991), while my aim is primarily to understand, even though increased understanding is expected to promote changes. Nevertheless, these assumptions existed as a possible outcome and served as a reminder for my awareness of myself as a potential power authority in interaction with the foreign nurses (see 1.3.).

3.6. Ethical soundness

I made use of several guidelines on how to ensure ethically sound research within nursing, such as those from the International Council of Nurses (1996), Lipson (1997) and the Royal College of Nursing (1998). They were also useful as a reminder that a researcher must be on guard during all stages of the research process.

I obtained *ethical clearance and permission* for the data collection in

appropriate places (appendices 3-7) and informed consent from the co-researchers (appendix 1). The co-researchers received written and verbal *information* about the study (appendix 2). *Confidentiality* and *anonymity* is essential in research and I have made every effort I can imagine to ensure it. The population of Iceland is small and there are many small hospitals. Foreign nurses working in hospitals number only about 55, and those that fit my criteria are even fewer. If I revealed characteristics such as their gender, nationality, area of practice and places of work outside the capital, I would risk some of them being identified. For this reason, I do not disclose this information and speak of all the nurses as if they were female. I gave all the nurses pseudonyms that bear no resemblance to who they are, and I was careful not to reveal any characteristics (such as being very young or being highly experienced) unless it was essential. I switched names in a few places where I judged it necessary. I kept the tape-recorded material and the verbatim transcripts safe during their use and I will destroy them after use.

Another ethical point applies to the part of the co-researchers that work at the hospital in the capital. I might be judged to be in a *power position* towards them, as a project manager in matters related to foreign nurses. I tried to reduce the threatening effects this might have both during and after recruitment by emphasising that my study was not a part of my job, and by making all contacts strictly through private routes. The co-researchers are a potentially *vulnerable* group as foreigners. I was open to such cues in their expressions or behaviour. In instances where the co-researchers would *reveal experiences* that I feel

should be acted upon, I had planned to discuss it with them and only act if they wished me to do so. No such incidences occurred in the study.

*

In *this chapter*, the methodological and philosophical foundations of the study and the rationale for my choice have been portrayed, both generally (phenomenology) and specifically (the Vancouver school). The abstract nature of these issues, limits direct referencing to the actual study. Ethical issues were also addressed. The *next chapter* connects more directly to the actual study, as it addresses the methods I applied for collecting, analysing and interpreting data as well as how I ensured rigour throughout the study.

Chapter 4 Data collection, analysis and trustworthiness / validity

In *chapter three*, I explored the methodology, philosophical and ethical foundations of the study. In *this chapter* I describe topics concerning the co-researchers (participants) (4.1), the collection of the data (4.2.), the analysis of the data (4.3.), and how conditions for trustworthiness were endorsed (4.4.).

In the Vancouver school, data collection and analysis is not a linear process where one step takes over from the previous one; the stages are *overlapping* and *circular* as they run *concurrently* (Halldórsdóttir, 2000). During the time of the data collection and analysis, I moved constantly between the twelve steps and the various intrinsic stages or phases that are described in this chapter.

4.1. The co-researchers and the sites

4.1.1. Introduction

In the Vancouver school, the people who participate in research are seen as *co-*

researchers or dialogue partners (Halldórsdóttir, 2000) rather than participants or informants as is the common terminology in phenomenology. This correlates to the constructivist thinking regarding mutual and active creation of knowledge, and the openness and dialogical core of hermeneutical understanding that was explored in chapter three. Such a relationship is also one of the components of the model for culturally competent researchers proposed by Papadopoulos and Lees (2002).

4.1.2. Permission for the study

I obtained permission, or a written statement that a formal permit was not necessary, from ethics committees, and separate written approval from the Chief Nursing Executives where appropriate (appendices 3-7).

4.1.3. Selection of the sites and identification of the study population

I chose *three hospitals*: one in the capital city and two in the regions. There is only one hospital in the capital city after a merger in 2001, a national university hospital and by the far largest hospital in Iceland. The inclusion of that hospital is essential, as about two-thirds of the study population worked there at the time. I contacted the largest hospitals outside the capital. In February 2002, they had 17 foreign nurses working with them: one had 11 and the remaining ones had 0-3 foreign nurses. This makes the known population 51 nurses, and to allow for the smaller hospitals, I estimate the *study population* to be 55

nurses. I chose two of these hospitals but I do not reveal their identities as it could jeopardise the anonymity of the co-researchers there.

4.1.4. Access to the sites and the co-researchers

I knew the population in the capital city due to my work and I found out how to contact them privately through the telephone directory, if I did not have this information already. The names of the others I found through the Chief Nursing Executives at the hospitals but their contact means I found through the telephone directory. The *initial contact* was through a letter to their home addresses: information about the study with a request to participate (appendix 2) and informed consent (appendix 1). If I was unsure of their mailing address but had their phone or email address, I used these routes first. *Further contacts* were by telephone, email or mail. All contacts were through *private routes*.

4.1.5. Sample criteria, selection and recruitment

The first step in the Vancouver school is "Selecting dialogue partners." I did this by *purposeful sampling,* i.e. a type of sampling where people who have experienced a phenomenon are chosen as the source for understanding it (Halldórsdóttir, 2000). This is a common sampling type in phenomenological research (Morse, 1986) and essential in constructivist research (Denzin, 1994). Purposeful sampling requires a critical examination of the parameters of the study population (Silverman, 2001). My task was to endorse maximum *phenomenal variation* through a *demographic variation* that resembled the

study population, as recommended by Sandelowski (1995). The main demographic variations I considered were nationality, continent, duration and place of employment, and age, and others were area of practice, gender, education, religion and marital status. I realised that this might delay *data saturation,* but I was not prepared to compromise the aim of sampling in the Vancouver school, which is to ensure that it harmonises with the aim of the study and the research question (Halldórsdóttir, 2000). I felt this was particularly important because of the potential for transferability of the findings due to a small study population. The latter half of the recruitment took place gradually and was driven by the analysis of former dialogues, that is, with my perception of which demographic characteristics of additional co-researchers might best enhance saturation. Being prepared for filling in the gaps (thin categories) during the second dialogues was also a saturation strategy. Meadows and Morse (2001) describe a similar sampling method as one component of rigour. Some researchers might classify this as theoretical sampling (Cutcliffe, 2000).

The specific criteria for the sampling were:

1. Nationality other than Icelandic at the onset of employment.
2. Primary nursing studies had been conducted outside Iceland.
3. A licence to practise nursing (RN) in Iceland had been issued or will be once fluency in Icelandic has been attested (for nationalities outside the EEA).
4. 1-10 years of employment at a hospital in Iceland.

I set a *lower time limit* so they would not be in the middle of the initial experience, because those who have gained some distance from an experience are believed to reflect more fully (Halldórsdóttir, 2000). The *upper time limit* was initially 4 years. My supervisor had advised me not to have an upper time limit, but I was reluctant to follow her advice. Firstly, I was interested in capturing the initial experience before it became too remote. I was, however, ready to expand the limit should I not be able to recruit a sufficient number of co-researchers and this turned out to be desirable for better demographic variations. After having recruited more than half of the sample, I expanded the upper limit to 10 years because of this, and because I had become interested to see whether a longer reflection would present a different experience. It did not, but was very valuable in giving longer-term insights, particularly into the issue of close friendship with Icelanders (see 5.3.4. and 5.6.3.).

I *offered participation* to all the nurses in the hospital in the capital city that fitted my initial criteria (4 years upper limit). I did this to avoid my biases from my acquaintance with some of them directing the choice. This yielded less than half of the sample. The others I recruited one by one as explained earlier.

4.1.6. Sample size and quality of data

As explained in the last section, I did not fix the number of the co-researchers initially but allowed my perception of the quality and saturation of the data to guide me, as recommended by Meadows and Morse (2001). The sample consisted of *eleven nurses* and I am reasonably satisfied with the *saturation*.

The sample is well mixed (demographic variation), and both typical and atypical experience emerged (phenomenal variation). Additional co-researchers would probably bring more bricks to the construction of the phenomenon, but I believe the essence is already there except for the limitations that are described in section 6.4. I have reasonable faith in the *quality of the data.* The co-researchers appeared open and reflective and some had interpreted their experience on a substantially high level, as I believe is demonstrated in their narratives. Furthermore, most of the time, they maintained a good phenomenological focus.

I estimate the study population to be about 55 nurses working at hospitals in Iceland. Twenty-nine of them fitted my criteria and the sample consisted of eleven nurses. The sample therefore consisted of about 20% of foreign nurses working at a hospital in Iceland and about 38% of those that fitted my criteria.

4.1.7. Characteristics of the co-researchers

The characteristics of the co-researchers *at the onset* of their employment *reflect reasonably well* the demographic variation of the study population. They are from seven countries in three continents. In order to protect the identity of this little group living in small communities, I will not specify their nationalities but instead define two major groups: western (7) and non-western (4). They were 20-35 years of age, all Christian by religion, half were married to or cohabiting with Icelanders, and most had no children. They came here either because of an Icelandic partner or to make a financially secure life for

themselves and their families at home. A few came here out of interest in travel in the country. Half had a BSc degree in nursing, half had a diploma and some had completed further studies. Their working experience as a nurse prior to employment in Iceland was 1-20 years. They had been employed in Iceland for 1-10 years (criteria), half of them for 1-2 years. They worked at present in three hospitals. When most of them started to work, there were two or three hospitals in the capital city. A merger had taken place at the time of the study, but the sample was chosen from all the former hospitals and many of their annexes. They had worked in six areas of practice or specialities and on eighteen different wards. Most did not know the Icelandic language, two had fairly good command of the language and one was quite fluent. The level of fluency is here judged by themselves. Some of the nurses had not realised beforehand that they could not use other languages at work while others were surprised that they were employed without fluency in Icelandic.

4.2. Collection of data

4.2.1. Introduction

I used the most common method of data collection in phenomenology, *unstructured* interviews, as I could not see that an other method could answer the research question with the type of data I was interested in collecting. The Vancouver school uses the term *"dialogue"*, as hermeneutic phenomenologists commonly do, rather than "interview" to emphasise that this is not an exchange of questions and answers (Benner, 1994) and that they are not conducted but

participated in (Sorrell and Redmond, 1995).

4.2.2. Piloting and preparation

I decided *not* to do a pilot dialogue because I decided I could not afford to lose one nurse from the sample and I was confident that my question was straightforward. I judged this from my interaction with foreign nurses through my work and because I had been a foreign nurse myself. *Instead* of piloting, I chose as the first co-researcher a nurse that I knew, in order to give me scope for being insecure without compromising the dialogue. Otherwise, I prepared myself by reflecting on my interaction manners and consulting the literature on phenomenological interviews. For understanding the true dialogical way of the Vancouver school, I consulted my supervisor. Prior to entering the dialogue, I focused on creating optimal conditions: silencing. Formerly, I had reflected on and written down my preconceptions of the phenomenon. This is the *second step* of the Vancouver school, the step termed: *"First there is silence – before entering a dialogue."* The aim is to sharpen and open up the receptive senses by moving from one's habitual thinking (Halldórsdóttir, 2000). I repeated the silencing before the other dialogues.

4.2.3. The dialogue method

In the Vancouver school, the dialogue is hermeneutic, constructed and collaborative and it is the *third step* of the research process: *"Participating in a dialogue."* The co-researchers are asked to describe and reflect on their

experiences as fully as they can from a broad and non-categorised question (Halldórsdóttir, 2000). *The dialogues* in the study were a slight modification of the 'actively debating and exchanging points' nature as recommended by the Vancouver school (Halldórsdóttir, 2000, p.60). I was not comfortable with promoting such dialogues with partners who might feel vulnerable because of my position as a power figure. My participation was therefore not very active except at times during the verification in the second dialogues, but I realise that the line between probing and debating may be vague. I tried to create a psychological rapport of bridge-building (Halldórsdóttir, 2000) with an atmosphere of equality, empathy, trust and encouragement, and with probing and active listening. The probing aimed at a deeper understanding and verification of the interpretations that formed during the dialogue and other dialogues, as is ideal in the Vancouver school (Halldórsdóttir, 2000). The dialogues were all *tape recorded* and *transcribed verbatim* by *myself*.

The dialogues took place at a *location* chosen by each co-researcher. My only request was that they did not choose our workplaces and that there was privacy. Fourteen took place in their homes, seven in my home. I believe this sharing of our personal domains contributed to our bridge-building. The *timing* was also their choice, and I asked them to choose a time when they would probably not be tired and could devote about three hours to the process. This all worked well, even though the phone rang during some of the dialogues. The co-researchers could choose a *language* within the limitation of my fluency: English, Norwegian, Danish or Icelandic. Five of them chose English and six

chose Icelandic. It was a wonderful experience to participate in the dialogues, the best part of the research process. I was amazed and very grateful for how articulate most of them were and how meaningful their expressions were.

4.2.4. First and second dialogues

As is common in hermeneutic phenomenology (Kahn, 2000) and in accordance with the Vancouver school (Halldórsdóttir, 2000), there were *two dialogues with each* co-researcher. I made one exception, totalling twenty-one dialogues. *Before the dialogues started*, we chatted for about 15 minutes and I repeated some of the information in the letter of introduction and the informed consent.

In the *first dialogue*, the question I posed to them was the research question: what is your experience of working at a hospital in Iceland? I emphasised that the aim of phenomenology was to capture their experience (what it was like, what it felt like) and not their opinions, even though they were not prohibited from talking about their opinions, particularly if they were derived from their experience. The formal part of the first dialogue took around 90 minutes. At the end, I explained the process of data analysis and the purpose of the second dialogue and we decided on the time and location of the second dialogue.

The *second dialogue* took place 1-3 weeks later and was usually shorter. Its aim was to obtain a verification of my interpretation and to give us a chance to add information or seek clarifications. I had analysed and interpreted their experience with a case construction consisting of 3-5 themes and 5-15 sub-

themes. I gave them a printout and we went through each theme. All but two agreed (with minor changes) and most said they were amazed at how well it captured their experience. One felt that I was too strong in the use of adjectives. One tended to disagree with several constructions, and we could not reach a consensus over some. I discuss this in section 4.3.5. Some of the dialogues yielded additional information. I also used the second dialogue to ask about issues they had not mentioned but other nurses had.

4.3. Analysis of data

4.3.1. Overview of the steps of analysis

I followed the *eight steps for analysis and interpretation* that the Vancouver School applies. The hermeneutic circle (see 3.4.3.) is influential in all the steps, as are the processes of explanation and understanding in Ricoeur's (1976) theory of interpretation and the analytical steps of the phenomenologist Paul F. Colaizzi (1978) (Halldórsdóttir, 2000). The aim of the analytical steps is primarily to reach gradually an understanding of the meaning of the phenomenon through interpretation (Halldórsdóttir, 2000). *I will now* present the analytical steps in combination with their application in the study and some of the challenges I encountered. These are steps 4-12 of the research process (Halldórsdóttir, 2000) as outlined in section 3.4.1.

4.3.2. Sharpening awareness of words (step 4)

The first reading of the transcribed dialogue is carried out like reading a novel.

This, together with repeated listening to the audiotape while transcribing it, allows the data to soak in, and a sense of the whole to form (Halldórsdóttir, 2000).

4.3.3. Beginning consideration of essences (step 5)

The transcript is read with the aim of understanding the essence of the experience. First, key statements are identified and then themes of key statements are constructed and coded (Halldórsdóttir, 2000). I did this with a pen and a highlighter and used the wide left margin for overall categorising (language, work etc.) and the right one for the content (feeling mute, no hierarchy etc.). Then I read the transcript with the purpose of extracting good narratives and marked them with an "N." In order to obtain a better overview, I organised key statements and categories in a separate document I called "analysis." During this step, I lived intensively with the transcripts in a hermeneutic circle.

4.3.4. Constructing the essential structure of the phenomenon for each case (step 6)

Case constructions are made for each co-researcher (Halldórsdóttir, 2000). In this study, they consisted of 4-5 themes with 5-20 sub-themes each. I knew that the numbers of sub-themes was too high, but I was unable to combine them because I wanted to present a full picture to the co-researchers, and I felt I had not yet gained a sufficient sense of the experience to start condensing it. I

encountered a problem when I started to work on the case constructions. Where is the dividing line between a description and an interpretation? Or rather on which level of abstraction does one interpret? What if the co-researchers have already analysed and interpreted their experience, as I felt many of them had done? Should I attempt to heighten the level of abstraction? I was reluctant to do so but felt unsure of how adequate that was. I consulted the literature, examined published phenomenological findings and discussed this with my colleagues and supervisor. This cleared my doubts sufficiently to enable me to complete the work. Perhaps the only answer is that each researcher must do this in accordance with the level his or her mind works on? I kept the conceptual framework of my findings close to the level of the interpretations of the co-researchers.

4.3.5. Verifying the single case construction with each co-researcher (step 7)

This I did in the second dialogues and encountered *two problems*. One of the co-researchers felt I used over-strong adjectives. We concluded that it was probably because I had become emotionally affected and ashamed of how her initial period had been unnecessarily hard, and because her difficult experience had become milder for her by talking about it with me. This exemplifies the term of a researcher "going native" (Halldórsdóttir, 2000) and the potentially therapeutic effects of participating in research. Another nurse did not understand some of my constructions, and when we discussed it, she tended to disagree or was so vague in her expressions that I was not sure what she meant.

We were both speaking English as our second language. I am not sure whether this was a cultural, personal or linguistic problem. This addresses the issue of whose interpretation is the "reality" and the different meaning words and concepts can have for people. Some constructions I modified, others I decided I could not use because of uncertainty, and there was one instance where I overruled her interpretation on the grounds that I knew the local behaviour better than she. Such member checks are debated in phenomenology (Koch and Harrington, 1998), partly because of problems similar to those I encountered. In spite of, or rather because of, such problems, I think such verifications are essential for the soundness of the findings.

4.3.6. Constructing the essential structure of the phenomenon from all the cases, comparing it with the data and writing the findings (steps, 8, 9 and 12)

All the case dialogues are compared in order to find common threads and differences that form the essential structure. The findings are presented as a combination of the researcher's interpretation and the co-researchers' own expressions, a *multi-voiced narrative text* (Halldórsdóttir, 2000). I collected the main themes of all the case constructions together and grouped them according to content. It was difficult to see the essential and overall picture through the details and the uniqueness of each experience. The main categories had appeared earlier, but forming and naming the essential structure was not straightforward. I did not directly use the themes in the individual case constructions, and that troubled me. Their main role for me turned out to be in

the work that was necessary to construct them: the immersion in and organisation of the data through endless hermeneutic circles. I actually created the essential structure during steps 9 and 12, i.e. by writing myself into the findings and consulting once again the transcribed dialogues.

4.3.7. Identifying the over-riding theme which describes the phenomenon (step 10)

The meaning of the phenomenon is interpreted by identifying the overall theme that describes it, commonly presented as a single statement (Halldórsdóttir, 2000). It was very difficult to find an over-riding theme that fitted the experience of all the co-researchers. The final construction is "Growing through experiencing and overcoming strangeness and communication barriers."

4.3.8. Verifying the essential structure of the phenomenon with some of the participants (step 11)

The final analytical framework is preferably introduced to some of the participants with the question of whether they recognise their own experience (Halldórsdóttir, 2000). I decided to offer this to all of them (except two that I knew were not in Iceland). I deemed that all of them had the right to comment. I also think it increases the trustworthiness of the study that I did not select co-researchers for the verification (researcher biases). Four nurses gave me feedback where they verified the findings with minor advice for adjustment.

4.4. Trustworthiness / validity measures

4.4.1. General issues

Terminology and methods for evaluating and promoting the soundness of constructivist research is a debated issue. Researchers working within the *constructivist paradigm* commonly use the concept *trustworthiness* instead of validity as the overall term for soundness. Some advocate the use of the positivist concepts "validity" and "reliability" while others suggest the use of parallel concepts (Meadow and Morse, 2001) resulting in assortment of terms that have same or similar meanings. I agree with Avis (1995) who suggests that researchers should concern themselves more with convincing the readers of the value of their *epistemological and ontological arguments*. One of the evaluation criteria suggest by Thorne (1997) for qualitative research is epistemological integrity. I have made efforts to respect these principles through my emphasis on explicating the philosophical underpinnings of phenomenology and the Vancouver school (chapter 3), and with consistency throughout the research process.

4.4.2. Intrinsic processes of the Vancouver school: overview

Koch and Harrington (1998) and Meadow and Morse (2001) suggest that the trustworthiness criteria is made intrinsic to the research process. This is evident in the Vancouver school. The particular steps of the data analysis which I described in section 4.3. are only a part of the analytical and interpretative process. There are other processes that are *repeated continuously*, are *intrinsic*

throughout the research process. *These are* audit and decision trails, reflective journal, reflective silences, disciplining of preconceptions, hermeneutic circle, member checks, constant comparison and selections (Halldórsdóttir, 2000). *I will now* explain the functions and utilization of these processes.

4.4.3. Audit and decision trails and reflective journal

The research process is made visible with *audit and decision trails*; a detailed and contextual and reflective account of various aspects of the research process (Sandelowski, 1986). This is done with the help of a *reflective journal* (Koch and Harrington, 1998) that is a kind of a diary where the researcher records his or her thoughts, silences and decisions during the research process (Halldórsdóttir, 2000). Decision trails from my journal are presented in various sections of this chapter. Presenting the findings with narratives from the co-researchers is one form of audit trail.

4.4.4. Silences and preconceptions

Repeated silences are practised throughout the process. The goal is to empty oneself in order to be able to take in something new. This requires reflecting on and writing down (in the reflective journal) one's own pre-conceptions (biases) of the phenomenon (Halldórsdóttir, 2000). *Bracketing* or phenomenological reduction is a widely discussed term in phenomenology. This mathematical metaphor originates from Husserl and means that we can see the pure essence of a phenomenon by suspending our beliefs in it (Spiegelberg, 1982). In

congruence with hermeneutic phenomenology, I believe that we cannot eliminate our preconceptions by bracketing them because we are moulded by our experience and culture. It is, however, possible to modify, correct and discipline them (Koch, 1995; Walters, 1995) in order to be open for other views than one's own, for example in dialogues with co-researchers and in interacting with the text. My placement as the researcher in the study is explained in chapter one.

4.4.5. Hermeneutic circle, constant comparison and verifications

In the study, dialogues were the data collection method but there are *other dialogues* inherent in the process. One is the return to the participants for *verification* in steps five and nine, or what Guba and Lincoln (1989) call a *member check.* It is not an attempt to seek an absolute truth but to prevent the researcher from manipulating the data (Jasper, 1994). Another form is the *hermeneutic circle*: a continuous dialogue between the researcher and the various forms of the text by returning repeatedly to the transcripts and the constructions for re-reading and modifications. This is hermeneutic quality control (Guba and Lincoln, 1989), that assists the researcher in avoiding premature descriptions and interpretations (Spiegelberg, 1982). Hence, there is a *constant comparison*, as in grounded theory (Strauss and Corbin, 1994), inherent in the research process. The cross-comparison between the co-researchers' experience that I carried out in the second dialogues (see 4.2.4.) is another form of this. I always did this after they had indicated that they had

said what they wanted to say. As there was variation in whether the nurses agreed or not on these cross-verifications, I believe they did not force a unified outcome.

4.4.6. Selections

There are bound to be several interpretations and realities, and the researcher is therefore continually faced with the need for selecting (Spiegelberg, 1982) between 'more or less informed and/or sophisticated' constructions (Guba and Lincoln, 1998, p.206). This applies both to the interaction of the researcher with the text and the collaboration with the co-researchers during the dialogues (Halldórsdóttir, 2000). An example from a selection I did during the data analysis is given in section 4.3.5.

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In *this chapter* I have discussed issues related to the collection, analysis and interpretation of the data and the trustworthiness/validation of the findings. I have combined theoretical issues with their actual application in the study and reflected on my experience of learning through the research process. I will now move on to the *next chapter* which displays the findings of the study.

Chapter 5 Findings

5.1. Introduction

In chapter four, I discussed topics concerning the collection and analysis of the data and how trustworthiness/validity of the findings was ensured. In *this chapter*, I present the findings of the study.

The essence of the nurses' experience is described in five themes with the overall theme of *"Growing through experiencing and overcoming strangeness and communication barriers."* The *five themes* are:

1. Meeting and tackling the initial, multiple, and unexpected simultaneous challenges.
2. Becoming an outsider and the need to be let in, to belong.
3. Struggling with the language barrier.
4. Adjusting to a different work culture.
5. Overcoming challenges to win through.

While they all described how they were dealing with all these domains, most

encountered the major challenge in one or two. Some were most affected by having become outsiders, others by losing the ability to communicate effectively, and yet others by encountering the different work culture.

Their mission was *not easy*. Each domain (themes 3, 4 and 5), was a challenge on its own, so the inevitability of dealing with all of them at the same time was quite a handful for most of them. Angela *summarizes* this as: 'They were expecting too much of me. I think they were thinking that I would be working as any other nurse after like 3 months or a month. They didn't understand that it was so hard to start because it's a new place, a new language, everything was new: new people, new patients, new way of treating patients and things like that.'

The findings are presented with *narratives* that are the voices of the foreign nurses. In order to preserve their identity, they are given pseudonyms that are in no way connected to their real identity.

It is useful to read the findings with background information on the *language* in mind. Icelandic is the language of communication in Iceland. It is a Germanic language closely related to Norwegian, Swedish and Danish. These languages and English are the most commonly spoken foreign languages in Iceland. In the larger hospitals, foreign nurses have been hired without knowing Icelandic, but are expected to learn it. Eight of the co-researchers had no knowledge of Icelandic at the onset of employment, two had fairly good knowledge, and one was fluent. More information regarding their linguistic background is presented in section 4.1.7. Their stories start with the first theme, a theme that illustrates the multiplicity and urgency of their mission and how they tackled it.

5.2. Meeting and tackling the initial, multiple and unexpected simultaneous challenges

When you come here in a new place
it comes all at the same time
That is why it is hard for you to put the priority
You come to the country like you don't have knowledge
It is like you have just been born in this country
All the needs, it is so hard to meet them all
(Angela)

Angela expresses here the essence of the potential scale of taking on the challenge of starting a new life and career in a foreign country. Her interpretation is shared by most of the co-researchers. In *this section,* I will elucidate the distress they felt during the initial period, when they were facing all the unexpected and multiple challenges they encountered at the same time (5.2.1.). Then I proceed to portray their "quitters never win" impetus to endure their circumstances (5.2.2.), and where their sources of strength came from (5.2.4.). This exploration addresses solely *general concerns* after which each theme of these challenges is explored in sections 5.3., 5.4. and 5.5.

5.2.1. Feeling distressed

For all but one of the nurses, starting to work in Iceland was hard and *harder than they expected,* and they were not sufficiently prepared for this. Nearly all of them repeatedly expressed the phrase *"really hard"* in various contexts.

During the first 3-6 months, many experienced at times an *overwhelming strain* over the multiple and insurmountable adjustments they had to cope with

simultaneously. The *metaphors* they used to describe how they felt were quite dramatic: as if running a marathon or the hurdles, becoming a child again, becoming mute and deaf, having a cerebral haemorrhage, being in a massive dense wood, standing at the roots of an insurmountable mountain, trying to speak underwater and being in a whirlwind. Two very experienced nurses from different western countries describe here how they felt. Fiona said 'I felt so down and felt this was all just impossible to cope with .. to learn all this .. just .. like a 4000-metre-high mountain. I just can't go all the way.' Helen said 'I was crying all the time. (NN) would sometimes pick me up from work and I would sob all the way home. It was hard. You felt like such a loser. I don't know why I'm even trying .. the language and everything.' … 'You are overwhelmed. You are trying to learn all that stuff at once.'

Only one of the nurses did not find the initial period difficult, the one that had fluent command of the Icelandic when she started to work. Others did *not feel so overwhelmed* or were more moderate in their description, like Ingrid, who said 'One always has to adjust to a new place of work. The first period is always the most difficult.' … 'It was very exciting but as always it was up and down, a bit difficult.'

Half of the nurses were granted a good *orientation period* and they felt this eased their strain, but the other half did not. Grace was one of them: she felt it was a positive challenge while it was happening but later she saw the negative effects it had on her and the safety of the patients. For Brenda, limited orientation was a traumatic experience: 'They just sort of threw me in the cold water and sort of expected me to tell them if I needed help. But sometimes there was nobody I could ask.' Helen was: '.. really scared sometimes, and really nervous. Just a lot of things were just put on you at once .. [it] felt overwhelming because you didn't want them to think you

didn't know what you were doing.'

5.2.2. Quitters never win

Despite the difficulties, they did not give up, but at times, it occurred to some of them to do so. For Brenda there was '..half a year that was extremely difficult and I was always thinking about whether I should quit, shall I do something else? On the other hand: "no I will just endure here until I feel better."' She did not give up because '.. there were always *positive periods in between*. It wasn't all just negative, then I would not have gone on.'

It was a matter of *endurance* and *challenge*. As with Angela who said to herself '"Oh, oh my God, I just have to be strong because I'm already here, you know, I cannot go back. I just have to move on.' … 'You just have to be strong even if you feel weak, you know. It's more like how stable your inside is and how good is your coping mechanism, that wouldn't make you freaked.'

It was important for the young single nurses who came alone, to gain *independence* from their families. This group showed admirable strengths and maturity towards their often *lonesome struggle*. Like Evelyn who said 'I'm away from home and I have to make my home life here. I can't live like I miss this and that. I have to go on. It makes me feel better, I'm reaching out.'

For the nurses from developing countries, it was a combination of the impossibility of returning home as a *failure*, not giving up their quest for a *brighter future,* and an *obligation* towards their families that relied on their *financial support*. Like Kay who said, 'I knew my family needed me, my support. And I prayed a lot every night. I don't want to go back to [NN country] as a failure. If I go back it would be hard because then I wouldn't have a future, a brighter future, as when I'm here.'

The nurses that came here to live with an *Icelandic spouse* were additionally motivated to take on the challenge, for the sake of that relationship.

5.2.3. Sources of strength

The nurses gained support and strength from their *patients* and *colleagues*. Kay speaks for them when she says 'I got strength from my patients. It really touched me when I made them happy. It made me happy too. And the girls from work, when I felt they appreciated what I do, I felt good.'

Some reflected on wonderful moments of praise from the *patients' relatives*, moments that had given them strength. Diane describes how she felt during such an incident: 'I just grew.. like 10 centimetres.. and gained a kind of an energy to go on. When you receive such feedback it's like.. like being born again. Wonderful.'…'Yes, and it's also like being welcomed into society.'

Other sources were their spouses, fellow-countrymen living in Iceland, and Icelanders who in turn sometimes introduced them to their family and friends. Those who were blessed with a supportive ward manager highlighted how important he or she had been for them, a manager they felt cared about them and was easily accessible. With these people they cried, talked about how they felt and received cultural education and assurance. They also used their own *private internal ways* such as anxiety-reducing techniques and tried to analyse the situation in a less emotional and personal way. Some maintained good phone contact with their people at home, and others used prayer.

However, many of them, particularly those who came alone, felt they *needed*

more support, and they felt quite alone in their struggle. Like Angela who said 'You feel like oh, you are really alone here.' … 'Nobody is calling you, you know, asking you if you are all right, if you are feeling bad.'

While not all of them felt *alone* in their struggle, they all became "outsiders" by coming to Iceland. Their sense of belonging to the environment was, to a large extent, lost. The *next section* depicts this experience.

5.3. Becoming an outsider and the need to be let in, to belong

It is important to me
to have this sense of belonging
to make it worthwhile going to work
that people are happy to see you
that they think I do a good job and
that I am a good person in the group
It makes a big difference
(Helen)

What it feels like to become an outsider (section 5.3.1.) and the need to be let in, to belong, is the domain of their experience that will be elucidated in this section. Helen expresses here most of the main issues of the essence of what belonging means to them in relation to their work and its closest environment. She addresses the need to be valued, accepted and trusted, the themes that are explored in sections 5.3.2. and 5.3.3. The need for close friendship with Icelanders was not as important to her as it was to many of the other nurses.

That theme is explored in section 5.3.4.

5.3.1. Becoming an outsider

Having been natives, insiders, in their own countries, they experienced in Iceland what it feels like to become a foreigner, an outsider, most of them for the first time in their lives. An outsider at work and in society, as a professional and as a person. *Feeling like* '..not an outcast but.. I just didn't feel accepted, quite accepted by the group. Things like.. you can see they are like stand-offish, distant, not very open.. you don't feel like a part of the group' (Helen).

While this was not a main issue of concern for some of them, becoming an outsider was very difficult for most of them and troubled them considerably for the first six months to a year. They needed to be taken in, to fit in, to belong. Those who had an Icelandic spouse did not seem to feel any less that they were outsiders when it came to the workplace.

Some of them emphasized that belonging is a *holistic concept,* that one needs to belong in society, to a family, to friends and to work. Until belonging is achieved in all these areas, belonging is not complete. The importance of belonging at work is explained by Ingrid who said that belonging 'even affects my work. You get respect from those around you too, because you belong.'

5.3.2. The need to be valued and accepted

For Diane, *belonging means* 'Just that I feel I am good enough, just a feeling you have, to feel positive feedback from others, that what I do has a meaning for someone else. It's always

good to have the feeling that I am important too.' For Angela it means 'that I'm accepted socially. Like when going to social gatherings, I'm just not left in the corner. [That] they really give me a chance to talk even though I pause a little.'

But many of them felt initially like Diane who said she felt '…that I was totally useless. I didn't do anything but I still got paid.'

5.3.3. The need to be trusted

It was important to the nurses that their *colleagues* trusted them, that their professional knowledge and accountability were acknowledged. They felt that they trusted them generally, within their language limitations.

Most of them felt also that the *patients* trusted them, even while they did not speak the language. Some felt they needed to prove themselves, and to have their professional abilities doubted like this was very hard, '..you know, proving… proving.. always, every day in my life when I have a new patient.' … 'They seem not to trust you and when people seem not to trust you, it feels so bad. Because then you are trying to think, I'm a nurse, why is she not trusting me?' (Fiona). There were clear instances of dislike or even rejection with remarks like 'I don't want you to take care of me, you are a foreigner' (Kay), but in other instances the nurses interpreted their gestures in such a manner. This was a hurtful experience, particularly when there was (verbal) aggression. They usually gained the patients' trust if they gave them a chance to care for them. This experience was rare, and limited to old and confused patients and only felt by non-white nurses. This indicates the presence of *racism* or *prejudice* towards foreigners, but its extent cannot be

judged with such a small and demographically varied sample.

It happened from time to time to some of the nurses (white and non-white) that the *relatives* did not wish to speak to them, at the wards or on the phone, requesting an Icelandic nurse. Often this occurred while they had not a good command of Icelandic and these instances they understand. However, when they felt their fluency had become sufficient, this felt offensive. This happened to Ingrid who said 'But I can speak Icelandic. I can explain the patient's problem or how he feels, but they don't want to talk to me, want to get to talk to an Icelandic nurse.'

5.3.4. The need for friendship with Icelanders

Most of them spoke about their need for close friendship with Icelanders and how *hard* it is to establish such relationships. Fiona experienced for the first time in her life what it is like to have no "soul mates" and it was the hardest part of her life here; '… to be taken into society, all this about having friends, to be accepted totally. It is difficult to get in there totally. It's no problem to get acquainted, sort of superficially but.. but to be taken into like private contacts.. it's really hard. It is like people here only want to get to know me superficially. It makes me feel uncomfortable.' She felt it *diminished her ability to cope* with the multiple adjustments she faced. Grace is married to an Icelander and has been here for 10 years. She said 'It's like you never get to form a strong friendship with Icelanders. I have friends I can talk to but still none I'm totally open with.' Only one of the nurses said she had a close Icelandic friend. Kay was caught in a dilemma: 'I wanted to make friends with them [the colleagues] but I felt like it's too much burden to them to speak English with me.'

This difficulty in making Icelandic friends troubled most of them and they

associate it with still partly seeing themselves as foreigners. Jade wishes to live here and feels good in most aspects 'But if I'm talking about friendship, to make good friends, to do things together, then I still feel like a foreigner. I am always welcome but.. you get here but not further. Still.. still it's like this.' … 'I do visit people, drink coffee and chat and that's fine but it's not enough. I do miss that friendship.' While it was not the only reason for their finding it hard to be let in, the inability to communicate effectively in *Icelandic* played an important role. The *next section* portrays their struggle with the language barrier.

5.4. Struggling with the language barrier

Like this feeling
that you are like a child
you need help with everything
Not exactly like a child because
you really know how to do it
but you just can't do it
You can't express it
you have the knowledge
but..
(Diane)

Diane's "but" carries the importance that "but" often does in negating the expression that preceded it. One of the nurses was fluent in Icelandic, two were semi-fluent and eight had no knowledge of the language at the onset of their employment. This handicap devalued their professional abilities and impeded their adjustment, learning and sense of belonging. The mere inability to express themselves effectively was also devastating in itself. First, I will

portray what this felt like and how it influenced their work (5.4.1.). Then the process of learning the language through pressure and support is explored (5.4.2.), and the troubles they encountered when their fluency was overestimated (5.4.3.). Lastly, a specific dilemma is discussed: their fear of speaking on the phone (5.4.4.).

5.4.1. The feeling and professional effects of not knowing the language

The nurse who was fluent in Icelandic was the only nurse that described her whole experience as positive. The inability to talk, read and write and not understanding what was said around them, was a *devastating* feeling for those who came here without knowledge of the language. Fiona said 'Every day at work I was sort of in a state of shock because of the language.' For Angela it felt like 'You are mute and you are like deaf. All your words are blocked inside you.' The nurses that speak a language that is closely related to Icelandic did not feel any better initially than the others did. Diane is one of them and she said 'It's like trying to speak.. like when you are underwater. You speak but only.. like.. bubbles.. bubbles.. come up to the surface.' Grace said she '[felt] paranoid because everybody is talking Icelandic in front of you and you don't understand.'

This inability to communicate effectively played a major role in making the *learning and adjustment* to the job difficult. Helen stated that 'The nursing part wasn't hard, it was the language. I didn't feel confident with the patients because I didn't understand what they were saying.' She expresses here their main concern for not knowing the language: not being confident in giving nursing care to the

patients.

Their *self-image* and *sense of professionalism* suffered. Angela said 'You feel like an idiot, oh my God, they are asking you, and the patients are talking to you, and you don't understand it and you are calling yourself a nurse.' Diane stated 'I am a nurse, it's like 50% of my self-identity and then that is suddenly taken away from you… I knew I was still a nurse but I couldn't really show it.'

Some patients and relatives could and were willing to speak *other languages,* but most did not. The patients were, however, usually tolerant towards their language insufficiency and even taught them some Icelandic but there were nurses who encountered patients that were not so tolerant. This relates to "being trusted," which was explored in section 5.3.3.

Some of them mentioned that they are not taken seriously in *discussions with* their *colleagues* unless they use Icelandic, as shifting to English or a Nordic language was usually not accepted.

The nurses that had gained *expert status* prior to coming to Iceland or were very experienced, found it particularly hard to be in this situation. They had lost an important tool for demonstrating their expertise. Kay is one of them: 'I had been a recognised expert and a lot of my work consisted of teaching. Now at the age of [xx], I had suddenly become a student in this area again. Every day I felt like the most stupid person in the world because I didn't understand anything that was said or written.'

5.4.2. Learning the language through pressure and support

All of them found it *very difficult* to learn the language, including those whose

mother tongues are close to Icelandic. The latter group still learned faster and could manage to communicate sooner because they could mix Icelandic and their own languages. Some nurses had been determined to learn the language and took several courses but others had been more passive. Ingrid said: '[I] saw that it's no good to be in Iceland and not learn the language. That's why I put so much emphasis on learning the language the first year here. I couldn't stand the thought of being here alone.' … 'I am so sociable, I need to have people around me and to talk to people. I didn't like the idea of only being able to speak with a few people, those who speak English.'

It took them a few months to *start to speak* a little. Nearly all of them spoke of how *reluctant* they had been to start to speak. Some of them termed this shyness, other perfectionism or embarrassment over speaking broken Icelandic. Jade said: 'I was very slow to learn the language because I didn't allow myself to speak incorrectly. I said to myself: yes, yes, I have never learned Icelandic and if I just speak, then I will learn. But then I just couldn't do it.' They *started to understand* a little earlier, and felt that their understanding of the written and spoken word always exceeded their ability to speak.

After about one year, most of them reached a *certain breakthrough level of fluency*. It took them additional six months to two years to feel confident with the language in their daily work. Some still feel that lack of greater fluency restrains them in fully demonstrating their capacity and in moulding their career as they wish to. Jade said after almost 10 years here and good command of Icelandic; 'I still think my capacity is larger than is reflected in my work. I feel it is the language. I lack many words.'

Most of them received *formal information about their work* in a language they understood (English or a Nordic language) while other communication was usually in Icelandic. The nurses realise that the purpose of this is to speed up their learning, but they are not sure of how proper and effective this is. They found it extremely pressuring and, at times, they felt their limits were overstretched, resulting in exhaustion, blockage of learning and accountability liability. Jade said 'I became so tired of constantly listening and therefore I started to pretend to understand even though I did not. I was perhaps asked to do something and then the next day they asked me why I hadn't done it. It was like this the whole time.' There was an exception where only Icelandic was spoken from the beginning and the nurse did not understand anything.

Another problem a few of them encountered was that '.. not all Icelandic people speak *so good English* so when that is the case with the people who are teaching you, it can be really difficult' (Angela).

They were *thankful* and *surprised* over the *efforts* their *colleagues* made to help them with the language, for example with writing the reports: 'The staff pushed me to write also. I kept saying "oh, can't you just write" but they said "no you write" and then they corrected me. I received very good assistance' (Jade). Their colleagues, particularly nurse associates, played an important role in translating for them while speaking with the patients. Kay said 'When I had patients that did not understand me, perhaps confused, I called the one that was working with me and she would interpret for me. And they were always there to save me when I was in trouble talking to the patient. They would step in and talk for me.' Some of the *patients* also helped them to learn the language and this they appreciated highly.

They were glad over how much *positive feedback* they received when they tried to speak. No matter how little they spoke, they were praised for it and this surprised them: 'When you start to speak Icelandic, maybe it sounds terrible but everyone is so positive and…. "wow, are you speaking Icelandic, how long have you been here?" If you try, you get enormously positive responses, both from the patients and colleagues' (Diane).

Many of them wish to be *corrected more.* They feel embarrassed over having for years used words that are impolite in Icelandic but not in their language.

5.4.3. The problem of overestimation of language fluency

Once they started to use the language, they encountered another problem: an overestimation of their fluency. The two nurses that were fluent enough to have their integration period conducted in Icelandic encountered this problem immediately, the others later. They could handle basic communication, but their understanding and vocabulary were more limited than people seemed to realize, particularly when people spoke at normal speed. Brenda explains this: 'When I speak I can use my own words but when you speak, you use your words and there can be about five words I don't understand and that can be dangerous. This is the big problem.'

They had yet to learn the *nuances* in the language. Many feel that Icelandic has many words for things that the languages they know have only one word for. In the Germanic languages, *similar words* can also have a *different meaning*. Diane comes from a country linguistically very close to Icelandic. She said 'I had not expected it to be so difficult to learn Icelandic. I was so determined when I arrived. I thought I would manage well in one year. Perhaps I could, but everything was either black or

white, good or bad. I couldn't tell jokes… there are different words in Icelandic than in [NN language] that mean the same thing.'

This was sometimes sufficient to create *misunderstanding* and even *offence*. Brenda said 'At the beginning I was also afraid that I would hurt someone just because I said something wrong. This misunderstanding. Oh, I sometimes cried just because I misunderstood something or said a wrong word. The atmosphere just changed immediately into .. thick air.'

The nurses felt that managing everyday Icelandic is not sufficient for effective communication at work. *The professional use of the language* is somewhat different from the everyday use, and from what they learn at language courses. The nurses that started without knowledge in Icelandic learned this part at the same time as the everyday use. The nurses who started to work with semi-fluency in Icelandic had no knowledge of this professional part, another aspect of overestimation of their abilities.

They were often *reluctant to ask for clarification* because they felt they had to do it all the time. This all created *anxiety* and *insecurity* within them because they felt it could be dangerous for the patients they were responsible for.

At the same time they were feeling like this, they were *praised for their fluency*. It was an uneasy feeling that people did not seem to understand their limitations but they realise that this was also meant as encouragement.

5.4.4. Fear of the phone

It took them *longer* to become comfortable in phone conversations than in person, even up to a few years. Some experienced *profuse sweating* or *rapid heartbeat* when they were asked to come to the phone, or during a phone conversation. One nurse even ran to hide in the bathroom when she knew she was wanted on the phone. The problem was that the *non-verbal* part of the communication was lost, an important complementary aspect when the linguistic part is impaired. During phone conversations, they were not able to use hands, to read from people's gestures, facial expressions or eyes, both to make themselves understood and to see whether they themselves had been understood. Old people were particularly difficult 'because they don't hear well and when I speak broken Icelandic, they don't hear it well and don't understand me' (Fiona).

They particularly feared the *rejection* they sometimes experienced from the patients' *relatives*, even after they felt they were fluent enough to manage such communication. Helen said 'You got someone on the phone and if you had an accent or something .. like: "you get me someone who speaks Icelandic." You kind of get a little bit shocked.' Speaking people they had already spoken to in person was easier because 'I know what kind of person she or he is' (Grace). These people tended not to ask for an Icelandic nurse to speak with. It was particularly difficult for them to speak on the phone when their *colleagues were around* because they felt embarrassed over sounding stupid to them with their imperfect Icelandic.

Phone conversations seem to *happen too quickly* and hospital staff does not always *introduce themselves*, so often they did not know who they were talking to. This absence of the context makes it more difficult to understand the

essence of the conversation. Brenda explains this: 'When someone calls, then everything happens so fast. I don't know immediately who it is. Icelanders just say "hello" or he says a name. I have no idea who he is. I have no time to think or try to understand. Who is this and where is he speaking from? I have to think about so many things at the same time and maybe also to write down.'

The last domain is nursing within the hospital settings. This is explored in the *next section* through their task of adjusting to a different work culture.

5.5. Adjusting to a different work culture

I was surprised
First I thought this is Europe
more or less the same culture
But when I got deeper into the culture
at work and [in other places]:
this is quite different
(Brenda)

The nurses came from seven countries on three continents. It is therefore not surprising that they perceived nursing and other health-care in Icelandic hospitals in quite *varied* and often *contrasting* ways. I will present the essence of their direct nursing experience through their encounter with and adjustment to a different work culture. Their experience is here organised around *three areas* that centre on *care for the patients*: relations and communication (5.5.1.), practice and procedures (5.5.2.), and organisation and environment (5.5.3.). Some aspects of the work culture they appreciate, either immediately or when

they had adjusted to it and even to some extent adopted it themselves. Other aspects they feel uncomfortable with.

5.5.1. Relations and communication

They see communication and relationship between people as being characterized by *informality*, *equality* and an *absence of hierarchy*. This is demonstrated by the use of first names, in not using titles, in a more collegial and equal relationships of professions and better access to and more open communication with nurse ward managers. Most of them felt uncomfortable with this at the beginning but have grown to like it, like Fiona who said 'Yes, I like it but it was very difficult to start with. Just addressing the chief doctor by his first name, very strange.. difficult.. embarrassing.' They have learned to value being able to be 'more open when you talk to the doctor, no difference, no hierarchy. Because it is more holistic caring of the patient if you do that' (Evelyn). They are, however, not pleased with the loss of status and respect which they feel affects *old people* in Iceland because of this informality and equality.

They find the *patients* usually polite, friendly and thankful, and this eases their stress. The relationship with the patients is in the main pleasantly easygoing, demonstrated for example in their understanding in times of busy shifts, replying to the nurses' excuses of being late in attending to them with comments like "whenever you get around to do it" and "oh, it's no problem dear, I knew you would come along sometime" (Helen).

5.5.2. Practice and procedures

They feel that employees have too much *individual freedom* in performing their work: one person does this and the next one that. They miss the *protocols* they are used to being obliged to adhere to. If they exist at all here, people do not necessarily follow them. This confused them while they were learning their role, and it troubles them in that they feel this compromises the desired continuity of care.

They are uncomfortable with the *insufficient discipline and precision* they feel they encounter. The colleagues and even the patients take making mistakes, or not having done what you should have done, lightly. Helen said it is like 'Nobody wants to get too upset about anything, they don't want to be mean to each other.' … 'It's like when you forget to do something or you don't have time to do something, they always say, "oh don't worry about it, I'll do it for you, don't worry." At home, it's just more stress. You always have to be on your toes, on your toes all the time.'

These reactions are in some way appreciated because it helps to ease their stress, but they do not readily accept such practice for themselves. In their home countries, they would risk losing their jobs for such practice. The fear of making *mistakes* also lives within many of them in their daily work. Like with Brenda who said 'I cried here a few times over mistakes I made but the others said: "well it worked out well, nothing happened." I was surprised that no-one said: "yes, of course this is serious but we will learn from it."' … 'In [NN country] I am much more dependent on my job. If I get fired I will be unemployed. There is much more pressure on working well, you must work accurately.'

Some judge the *quality of care* to be affected by this culture. A positive aspect is that the patients appear not to be rushed through the system. On the other hand, a few of them feel that things sometimes move too slowly both in regard to medical treatment and nursing care. These nurses feel uncomfortable when they feel that a "wait and see" or "it will all work out" attitude is applied to the handling of the patients. Like Helen who said 'Sometimes things just move very slowly. I guess that's the whole thing. Things move too slowly here and people watch too long.'

5.5.3. Organisation and environment

They all agreed that there is *less workload, rush and stress,* and better staffing than they are used to. They appreciate highly the time this gives them time to relate to the patients: 'I can sit down and have a cup of coffee with the patient and talk to him about things where in [NN country] you are running more from task to task' (Fiona).

Most of them spoke about the multiple and formal coffee *breaks* that are practised in their hospitals. Generally they enjoy being able to rest and chat with their colleagues, but some of them they feel this is overused, resulting for example in delayed morning care. Breaks in their countries are commonly only in the form of taking a glass of juice or coffee, while standing, and there is no breakfast break. A break for lunch is not a common practice in their countries (no time) but they all appreciate highly that they are often able to have a lunch break here.

Many of them feel uncomfortable that *punctuality* appears not to be a virtue in

Iceland as being repeatedly late for work is taken lightly, whereas in their countries they would risk losing their jobs.

A few of them are ashamed of how *chronically untidy* they find their ward to be. Diane wonders whether the relatives connect this with the quality of care: 'If the ward looks messy, what will the relatives on visits think? You know: if they can't even keep the bedside table tidy, how is the patient care?'

The presentation of the findings started with a general description of the multiple challenges they faced simultaneously at the onset of employment and how they dealt with them. The *last theme* describes how they started to overcome the initial challenges, they had formerly perceived as insurmountable.

5.6. Overcoming challenges to win through

It is like winning in the lottery
almost
when you actually manage
to work somewhere
where you felt it was absolutely impossible
in the beginning
(Diane)

This last theme portrays how their rainy days came to an end. When the light started to shine in their lives again (5.6.1.), they saw how the rain had brightened their colours and helped them to grow (5.6.2.). Having overcome the essential challenges, some hurdles nevertheless remain to overcome or

adjusted to (5.6.3).

5.6.1. Seeing the light

Most of them reflected on a happy turning point of a sudden revelation when their life started to be easier and more enjoyable. This took most of them about one year to achieve, while a few described this after six months or three years. They felt this took place when ey had reached a *certain level of fluency in Icelandic*. Helen said 'Suddenly I started understanding more Icelandic, started talking more Icelandic. It was the language that was the main thing. It was night and day when I started understanding and speaking better. I mean, things just started going better for me.' Far from being fluent, they had overcome an important barrier: they could now communicate with more confidence. They finally started to see the rewards for their struggle as *the multiple challenges were being won through.*

Their sense of being outsiders faded with signs that they now belonged. Evelyn feels that people don't regard her as a foreigner '… [when] they approach you and they don't talk to you in English, they talk to you in Icelandic. It means they don't see you as a foreigner, if they speak to you first hand in Icelandic.' Helen felt a part of the group at work '…[when] they [native colleagues] would come up the hallway.. like tap my shoulder or tease you' … 'People seemed happy to see me when I came to work. Then I started feeling more at ease, more at home.' Grace used social acceptance and friendship as her indicator: 'Just suddenly [it is] easier to make friends, because I speak Icelandic.' … 'Now it's all right to invite me to parties. I understand everything. It's more and more enjoyable to be here because of the Icelandic.'

Their broken sense of *professional recognition and competence* started to be re-constructed when they felt trusted. Angela said 'I feel that I belong now because people at work trust me, they give me my own patients, yeah. And like, I work independently and my patients believe in what I say. '

Their *increasing ability to communicate in Icelandic* radically improved their professional self-confidence, assertiveness and their relationship with the patients. Grace explains this: 'The more I speak, the more.. it's like I believe in myself. And the patients, it's like they believe in me more because I am talking to them in Icelandic.' … 'If you speak Icelandic, they listen to you.' Angela is content 'because I can assert myself more because I can talk now.'

Evelyn glowed when she reflected on the moment when she had reached a much-longed-for aim in her work. It was a sign for her that she had *overcome the multiple and overwhelming challenges,* that she had met unexpectedly and simultaneously at the onset of her employment: 'I was so happy. It was a day for me. It means that I have more confidence, that I belong, that I can now understand the language. Oh, I did it! I became big.'

While not undermining the key role of the language, Helen was among the nurses that felt that *learning Icelandic was not the sole tool* for overcoming the challenges. She said 'part of it probably was the language but even when I started understanding little more, it took me a while to fit in.' Evelyn agreed and specifically included professional competence, and reaching out to people in the immediate environment, as important conditions.

5.6.2. Rewards of growth

Nearly all feel they have grown by their experience: '[as with] all difficult experience [it] can help you to go on… to maturity' (Brenda). For Evelyn, simply living in a foreign culture has also been beneficial: 'I am still the same person but I am open to changes. And it gives me a lot of learning that I'm here in another culture.'

The *personal achievements* they spoke about were being stronger persons, having developed their personality further with better self-knowledge and a more positive self-image and independence. They feel they are more open-minded, more expressive, open to changes, and softer persons that understand better their priorities in life. Grace said 'I learned a lot about myself the first month here because I was completely alone and had no friends' and she has realized that a life without friends is no life for her. Jade has learned that there is more to life than work and has '…experienced for the first time here in Iceland the feeling of having a home, found some tranquillity.' Some of the positive changes they describe are attributes they sense they have *adopted from the Icelandic culture*, such as the easygoing part of the (work) culture. Helen said that 'After you get into the more easygoing ways things are here, you yourself kind of ease up a little bit, too. It has made my nerves a lot better.'

Kay, a specialized nurse, projects the positive personal changes over to increased *professional competence*. She thinks she is 'a better nurse because now I am more relaxed in chatting with people' and a better tutor for the students on the ward because now she understands better '…this feeling of insecurity, to be a newcomer. I had never experienced it myself, not had the feeling in my heart, that I am useless.'

Today they are generally content with living and working here although one is going back home. They all started as staff nurses. One of them has taken on a management position and more than half of them have moved on to further study (programmes in Icelandic or other languages), or are in the process of doing so, some after living here only for 2-3 years. These achievements have exceeded their expectations. It appears that the strength and growth they have gained from taking on the challenges has given them confidence and set them on a track of needing further growth. The professional environment of Diane, and many others, has responded positively to these needs. She said 'I'm surprised about how much I have achieved here, these positive responses of the working environment, considering that I'm just a foreigner. When I say this, I am thinking of how it is in [NN country]. I would not have been given the opportunity to do half of the things I have done here if I were a foreigner there' (Diane).

5.6.3. Remaining hurdles

Some hurdles nevertheless remain for them to overcome or live with. Two of them are not satisfied with how their *career* has developed here. Most of them still need to reach a higher level of fluency in *Icelandic* for fuller professional development and further study in Icelandic educational institutions.

Additionally, *none of them feels they have been let in totally* and they do *not expect* that they ever will. Ingrid has been in Iceland for almost 10 years. She said 'Icelandic nurses also stick together, you know, as a group, also outside work. I'm still a bit an outsider in that respect. She thinks that '…one can never be like an Icelander. One

never gets 100% in. We will always be foreigners for some people and that will never change. But I feel I am well into the society now.' Grace speaks very good Icelandic and is from a highly respected neighbouring country. She received the following comment recently: 'There was a woman who said to me the other day: "you are a foreigner, and you have to understand that." I don't like getting comments like that.'

Jade has also been in Iceland almost 10 years and expresses herself well in Icelandic. However, she states 'I am still a foreigner when I experience this feeling of having had a stroke, if I can't express everything I need to. I feel uncomfortable that I can't speak perfect Icelandic.'

On whatever level of belonging they sense themselves to be on today, they *wish to become more integrated* than they are. Grace is not the only one who has received a comment similar to the one above, so one wonders whether their wishes will ever be fulfilled.

This concludes the elucidation of the essences of the lived experience of foreign nurses of working at a hospital in Iceland. *I will now* sum up the findings.

5.7. Summary

The overall theme of the findings is 'Growing through experiencing and overcoming strangeness and communication barriers.' Five themes describe the experience.

The *first theme* is 'Meeting and tackling the initial, multiple and unexpected

simultaneous challenges.' They had to deal with many unfamiliar domains. Each was a challenge, so encountering and dealing with them all at same time, was quite a handful for most of them. They were not prepared for what awaited them and starting to work in Iceland was harder than they expected. Many of them felt at times an overwhelming distress during the first 3-6 months, but for others the experience was not so harsh. The experience was not easier for the nurses that came from countries that are culturally and linguistically close to Iceland. They gained strength from their patients, colleagues, spouses, Icelandic and foreign people outside the workplace and from within themselves. The bottom line of why they did not give up was what Angela interprets as 'quitters never win.'

The *second theme* is 'Becoming an outsider and the need to be let in, to belong.' Having been natives in their own countries, they experienced in Iceland what it feels like to become an outsider. For some this was revealed in lack of trust from the patients and instances of rejection by patients and their relatives. Other felt they were initially kept at a distance from the group at work, and yet others suffered from an unfulfilled need for friendship with Icelanders. Their quest for regaining a sense of belonging commenced, where belonging means to them to be valued, accepted, and trusted and have Icelandic friends.

The *third theme* is 'Struggling with the language barrier.' All but one of the nurses had no or semi-fluent knowledge of Icelandic at the onset of employment. While not being the sole cause of their difficulties, this devalued

their professional abilities and impeded their adjustment and sense of belonging. The mere inability to express themselves effectively was also devastating in itself. Their task of learning the language was pressuring, but they received support from colleagues and patients. Once they started to use the language, they encountered the problem that people overestimated their abilities and the telephone became a threatening device.

The *fourth theme* is 'Adjusting to a different work culture.' They all encountered a work culture that was different to what they were used to but it was different in varied ways. Some aspects of this culture they appreciate, such as less workload and stress and more equality and informality in relationships with colleagues and patients. Others make them uncomfortable, such as excessive individual freedom in practice, insufficient discipline, precision and use of protocols.

The *fifth and last theme* is 'Overcoming challenges to win through.' After about 6 months to one year, the challenges they had faced at the onset of employment were largely, overcome. Most of them reflected on this as a happy turning point when their life started to be easier and more enjoyable. They had started to gain a sense of belonging and to adjust to the different work culture, and were able to use the language with some confidence. They feel they have grown personally and professionally by the experience and more than half of them are in the track of further study. Some hurdles nevertheless remain for them to overcome or live with such as the difficulties in establishing close friendships with Icelanders, and less than the desired fluency in Icelandic.

Advice from Jade concludes the findings and commences the *final chapter* where the findings and their implication and recommendations are discussed as well as the limitations of the study:

Wherever you are
you should primarily look at
what you gain
and why you chose this place.

Chapter 6 Discussion

In *chapter five,* the findings were portrayed where the essence of the phenomenon was interpreted as "Growing through experiencing and overcoming strangeness and communication barriers." The main *themes* are (1) Meeting and tackling the initial, multiple and unexpected simultaneous challenges (2), Becoming an outsider and the need to be let in, to belong (3), Struggling with the language barrier, (4) Adjusting to a different work culture and (5) Overcoming challenges to win through.

In *this chapter*, I will discuss the findings under the main topics of acculturation (6.1.) and language (6.2). I will discuss their implications and usefulness (6.3.), the limitations of the study (6.4.), and make suggestions for further research and directions (6.5.). I end the dissertation with an epilogue (6.6.).

6.1. Acculturation

6.1.1. Introduction

Intercultural adjustment or acculturation is a major concern for millions of

people. It concerns not only those who are adjusting to unfamiliar cultures, but also those in the host countries that interact with them (Matsumoto *et al*., 2001). An understanding of what it is like to go through acculturation can assist in making the interaction and mutual adjustment constructive. Promoting such understanding is the *aim and purpose of this study* (see 1.2.). It is therefore not surprising that the findings reflect the concept of acculturation. *Acculturation* is here referred to as 'a process individuals undergo (usually later in life) in response to a changing cultural context' (Berry *et al*., 1992, p.271).

6.1.2. The strain of acculturation

Immigration to a foreign country displaces the individual from his or her culture and places him or her in unfamiliar environment. This can result in *dramatic and overwhelming* experiences (Berry *et al*., 1992) where the acculturation process is often replete with conflict, frustration and struggle (Matsumoto *et al*., 2001). This correlates well to the experience of the nurses in the present study. These difficulties are also shared with their colleagues from the studies in the U.S.A., U.K. and Australia (see 2.3.). A surprising aspect of my findings might be that the experience of the nurses from the *neighbouring countries* that are linguistically and culturally close to Iceland was as strenuous as the experience of the others. It was in fact striking to me how some nurses from such disparate backgrounds described their experience in identical ways. This is not visibly congruent with the literature I explored (Bhagat and London, 1999), and I believe is accepted wisdom; that adjusting to distant cultures and

languages is more difficult than adjusting to those closer to one's own. I do not see any obvious possible reasons for this difference, and I am reluctant to speculate on it without more material to base it on.

6.1.3. The concept of the outsider

Being a stranger, being 'the other' versus 'the same' or 'the outsider' versus 'the insider' is a well-known phenomenon in anthropology and sociology, and has been explored in psychology and philosophy. In the present study, the nurses felt initially like outsiders, in the sense that they did not fit in or belong to the environment, were not always trusted or accepted in the beginning and found it difficult to establish close friendships with Icelanders. Instances of racism or dislike of foreigners were also encountered. However, they were far from describing the sense of rejection by native nurses, alienation, marginalisation and, in some cases, discrimination that are reported by nurses in the studies in the U.K., Australia and the U.S.A. (see 2.3.) and are reported as potential symptoms of acculturation stress and the acculturation outcome (Berry *et al*., 1992; Canales, 2000). In some instances I was inclined to interpret their experience in this direction but when I sought their verification they rejected it, saying I was over-reacting. The nurses in the present study eventually gained the main part of the belonging they longed for, which Gadamer (1975) states is the main challenge of culture: to overcome strangeness and achieve familiarity. They feel they have been let in, not completely, but to the extent that enables them to feel at ease at their workplaces. In the absence of alternative

interpretation, I am inclined to conclude that the nurses in the present study experience *more benign mode* of being a foreign nurse than their colleagues in the U.K., Australia and the U.S.A. studies. One can only speculate on the *reasons for this difference*. Shusterman (1998) maintains that the context we are placed in, and the others who make up the environment, influence how we see ourselves. Hence, a possible reason might be a more supportive environment and a higher tolerance for foreign nurses (because they are so few?). Some of the aspects of the work culture they encounter, such as less stress and workload, more breaks and friendly relations with co-workers, are likely to ease their acculturation stress and promote job satisfaction. These aspects are partly an expression of a strong nurses' union. It might be relevant that in Iceland a young multicultural society is evolving, whereas in Australia, the U.K. and the U.S.A. there is a long history of multiculturalism that is simultaneously characterised by integration and friction. The number of nurses of non-white ethnicity was much higher in the samples in the U.S.A. (all) and the U.K. (up to 78%) studies. I wonder whether this contributes to a stronger voice of disempowering perception. The explanation might also be a phenomenon described by Canales (2000): the nurses in the present study do not perceive themselves as being different because they are not aware of the excluding ("othering") processes around them. Half of the nurses in the sample in the present study came to live here with their *Icelandic spouses,* but this reason is not mentioned as a push factor in any of the other studies. The relevance of this motivation, and assumed better personal support and social

networking, is perhaps less than one might expect, as these nurses did not perceive their initial experience to be any easier than the others did. The findings of this study support the idea that *co-workers and supervisors* may be more important than personal support, as is suggested by Ward (1996, cited in Bhagat and London, 1999).

6.1.4. Growing through cultural encounters

Shusterman (1998) maintains that getting to know "the culturally other" enlarges the self and defines with more clarity and richness who we are, through the contrasting, comparison and assimilation that takes place. He acknowledges that this can be a painful and destabilising process, as quests for self-knowledge usually are but that the end is often peaceful. One of the most *encouraging and pleasing findings of the present study* is the track of career achievements and mobility (mostly in further study) more than half of them are on, and the personal growth nearly all of them feel they have accomplished. This is not brought forward in the U.K. and Australian studies, but it is in the U.S.A. study. This might be yet another comparison worth looking into. If we examine the ways the nurses in the present study handled their struggle (see 5.2.2. and 5.2.3.), it is apparent that they did it in *constructive ways,* but the coping strategies of the nurses in the other studies are not clear enough to allow for comparison. The nurses in Iceland regulated their emotions instead of allowing negative experiences to take over. Bhagat and London (1999) and Matsumoto *et al*. (2001) maintain that effective management of emotions with a

problem-solving attitude is central to successful acculturation. Bhagat and London (1999) have constructed *a model* that links acculturation stress to career-related outcomes. Explicating the model and comparing it to the findings of the present and the other studies is beyond the scope of this dissertation, but the model appears to fit this situation well and it may therefore be useful for both foreign nurses and employers to examine this model. *I will now* change the focus of the discussion over to the central importance of a shared language.

6.2. Man is language

6.2.1. Importance of a shared language

Language is the most important medium for human communication. As portrayed in the findings, the language barrier was central to the nurses' experience. This barrier is common to all the international studies I traced (see 2.3. and 2.4.) that explored the experience of foreign nurses and other skilled immigrants who did not speak, or speak, well the language in the country they came to reside or work in. The sub-theme "fear of the phone" in the present study is also described in the U.S.A. nursing study, but not in the others. Dummett (1989) explains the principal dual function of language as an instrument of communication and a vehicle of thought. When the nurses in the present study lost a language in which to express themselves effectively, they lost an important reciprocal vehicle for bonding and expressing how they felt and they could not assert themselves. They could not convey their professional

knowledge to their colleagues, or to patients and their relatives, and could not receive and impart information effectively. Losing both these vehicles was therefore a major contribution to their loss of a sense of belonging, and feeling like outsiders. The highest pressure was at work where they were exposed to constant demands for effective communication, besides all the other unfamiliar domains they were confronted with. The language barrier therefore contributed heavily to their initial struggle. When two people do not share a common language, they realize that their communication is restricted, but this is less obvious when a person uses the language but does not have a good command over it (Berry *et al*., 1992). The nurses in the present study felt that Icelandic people do not realize this and it created anxiety and frustration within them as they feared this compromised their nursing care. Such semi-fluency is the subject of the next section.

6.2.2. Language, context and culture

It is not surprising that an inability to speak the language of the country can create overwhelming difficulties, but I did not expect the language barrier to be such a central problem in the English-speaking countries, the U.S.A., U.K. and Australia. In these countries, passing a specialist test in English is required for licensing (Xu *et al*., 1999; Hawthorne, 2001) and the majority of their foreign nurses come from English-speaking countries (Buchan *et al*., 2003). It appears that these tests do not measure language competence in the work setting. In congruence with the studies that examined the nurses' experience, nurse

managers in the U.K. have reported (Buchan, 2003) that language problems are a major obstacle with international recruitment. Even nurses who have fluent command of spoken English have difficulties in writing and understanding. This is linked to local accents or colloquialisms. These nurses appear to share with their colleagues in Iceland the experience I interpret as "the problem of overestimation of language fluency": fluency that is not sufficient for the effective communication that is required in health care. They lack knowledge in what Gupta and Chattopadhyaya (1998) call the 'many fuzzy subforms nested within it [the language]' (p.21): a richer general and nursing/health-care vocabulary, the nuances and the cultural part of the language that is acquired gradually by living in the culture. This cultural and communal aspect of language is highlighted by Gadamer (1975), who maintains that we are already thrown into a tradition whose nature is to exist in the medium of language. It is in the language that we shape our understanding of the world. I conclude that an initial language problem appears to be inevitable in international recruitment of nurses, but that its scope varies. This needs to be taken into account during the integration period at the workplaces as it compromises the nurses' ability to work independently, and the quality of their care.

6.3. Implications and usefulness of the findings

The findings add to the limited but growing knowledge base on the experiences of immigrants. While the findings depict a difficult experience, they also portray a *brighter picture* than is commonly presented in the Icelandic media of

the experiences of non-white or non-western foreign residents with professional skills. Through publishing and other dissemination, the *aim and purpose* of the study (see 1.2.) could be reached. The findings could promote *bridge-building* among staff in hospitals through better understanding. They could contribute to the design of *recruitment strategies* and *integration programs* for foreign hospital nurses. Through the work of the researcher, the findings have already been used in this way at Landspítali, the National University Hospital, and some of this work has been extended to non-professional workers at the hospital. The study emphasises the importance of learning the *local language* as well and quickly as possible, and it is hoped that authorities in Iceland will recognise this and provide more support to foreign residents in learning Icelandic. The key role of *supportive colleagues and supervisors* in the acculturation and career outcome of foreign nurses is implied. The findings could contribute to the development of *questionnaires* that examine immigration and acculturation experiences.

Generalisation of findings is not an aim in phenomenology. The samples are usually only a fraction of the people who have experienced the phenomenon under study. The sampling in this study (see 4.1.5.-4.1.7.), gives scope for transferability to foreign nurses who have worked for 1-10 years at a hospital in Iceland, and had little or no knowledge of Icelandic at the onset of employment.

6.4. Limitations of the study

The study is not a good source on the experience of foreign nurses that are

fluent in Icelandic when they start to work. Only one such nurse participated in the study, and her experience was much more positive than that of the others. This limitation may, however, be of small importance in practice, as most foreign nurses begin their employment in Iceland with little or no knowledge of the language. The study did not include nurses that have worked here for over 10 years, those that had quit their work or work in other places than hospitals. The literature review is biased by a high representation of material from western and English-speaking countries, due to difficult access to other voices.

6.5. Further research and future directions

For the *young multicultural society in Iceland*, it would be desirable to extend the limited knowledge base on the experience and situation of foreign residents. More input is needed for better understanding and bridge-building, and as a base for policy, legislation, service regulation and assistance with integration into work and society. For *nursing and health care in Iceland*, it would be relevant to explore the experience of other health-care workers, such as staff in cleaning, ward kitchens and auxiliary nursing posts. *Addressing the limitations of this study* would mean an exploration of the experience of foreign nurses who have quit their jobs, those that have worked in Iceland for more than 10 years and those working in other places than hospitals. Foreign nurses that were fluent in Icelandic at the onset of employment would also give an important comparison but such nurses might be difficult to find. Exploring the attitudes and experience of *native Icelandic patients* towards receiving services

of foreign nurses would be worthwhile, as well as examining the attitudes and experiences of *native health-care workers* towards their recruitment.

Recruitment of nurses with *diverse cultural backgrounds* similar to those of the clients of the health-care services, has been suggested as one of desirable strategies to promote care that is culturally competent (Glaessel-Brown, 1998; the Canadian Nurse Association, 2000; Josipovic, 2000). It would be desirable to enforce research evidence to support this. A comprehensive exploration (beyond graduate and postgraduate level) of the experiences and access of foreign residents to health care is probably the *most important issue for research related to health care and immigration in Iceland today*. One may wonder how the language barrier and the different culture the nurses experienced in the hospitals, is perceived from patients' side. Development of *culturally competent nurses* (see Canales, 2001 and Mendias and Guevara, 2001), *researchers* and *research measurement methods* (see Gonzaléz *et al*., 1997 and Papadopoulos and Lees, 2002) is another important issue that should be addressed in Iceland as a response to the increasingly multicultural society.

The voices of foreign nurses in international data banks are predominantly the voices of nurses from developing countries that migrate for financial reasons and work in *English-speaking* industrialised countries. The samples are frequently fairly homogeneous with regard to nationalities. Research from other countries and nationalities is needed for a more comprehensive global picture.

6.6. Epilogue

My notion is that researching various facets of global migration, and the health-care of diverse populations, will become increasingly important. The young multicultural society, nursing and health care in Iceland, nursing worldwide and phenomenology should be on that train. Phenomenology has inherent potential for promoting peace and prosperity through the bridge-building an explication of experiences can construct. Arnswald (2002) speculates whether the single most important contribution of the philosopher and phenomenologist Hans-Georg Gadamer to humankind will turn out to be his conceptual scheme of fusion of horizons that can overcome cultural conflicts and clashes of diverse forms of life. Through hermeneutic circles, the horizons of people of diverse cultures, experiences and languages fuse, and we come to be open toward the "others" with the aim of reaching an understanding and common agreement. Through my international work, travel and education in various cultural, linguistic, ethnical and political contexts, I have learned that such fusions can also lead to an insight of that what is unfamiliar on the outside will actually be familiar if one cares to go inside. That people have more in common than what separates them. To demonstrate this, I conclude this dissertation with the words of a philosopher who is an American-Israeli second-generation from East Europe. The experience he describes here is amazingly similar to the essential structure of the experience of the foreign nurses in Iceland:

> 'I am writing this paper in Berlin, where I have come to learn (once again) a foreign language and culture, that for all its painful otherness (which I suffer daily), is helping me to discover who I am' (Shusterman, 1998, p. 107).

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