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Lived Experience of Overseas-Qualified Nurses from Non-English-Speaking Backgrounds in Australia

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ABSTRACT

The globalisation of the world has facilitated the international movement of the nursing workforce. Along with other immigration destination countries, Australia is now accepting nurses from more diverse national and educational backgrounds than ever before, in order to secure adequate staffing for its nursing workforce. This thesis reports on a research project which investigated the lived experiences of overseas-qualified nurses (OQNs) from non-English-speaking backgrounds (NESB) in coming to, and working in, Australia.

The study used a qualitative design informed by the philosophy of Hermeneutic Phenomenology of Heidegger and Gadamer. The researcher individually interviewed a total of 24 OQNs of NESB from all over the world using a semi-structured interview method. The data were analysed by the case studies and thematic analysis method.

From the analysis, a total of four important themes emerged that structured the lived experiences of the OQNs from NESB. 1) *From the Past to the Future* is concerned with Heidegger's notion of temporality (lived time). The two sub-themes are: *the Past* which describes the cultural, social and linguistic backgrounds of the OQNs which brought them to their present experiences in Australia, and *the Future*, which refers to future possibilities which have been opened up by their experiences in Australia. The past and the future co-exist within the OQNs' understanding of their present moment. 2) *New Environment* is concerned with Spatiality (lived space). The OQNs' felt working environment in Australia is described. 3) *Living in the English Language* considers the notion of 'lived body' in relation to English-learning when working as nurses in Australia. 4) *Shared World* is concerned with Heidegger's notion of Shared World; the OQNs from NESB's needs for a supportive inter-subjective environment is described and discussed.

By using Parse's phenomenological synthesis method, these four themes were then conceptualised into a core structure of phenomena that describes the core nature of the participants: "*The lived*

experience of OQNs from NESB working in Australia is the process of obtaining a new identity in the English language, while actively formulating reality through interplay with new surroundings". In conclusion, recommendations for improved support for OQNs from NESB derived from the study are presented.

Declaration:

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University of Adelaide Library, being available for loan and photocopying.

RIE KONNO

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANMC	Australian Nursing and Midwifery Council
CN	Clinical Nurse
EN	Enrolled Nurse
HIV	Human Immunodeficiency Virus
IELTS	International English Language Testing System
IV	Intravenous
IOM	International Organization of Migration
JBI	Joanna Briggs Institute
JBI-NOTARI	Joanna Briggs Institute, Narrative, Opinion and Text Assessment and Review Instrument
ICN	International Council of Nurses
ICU	Intensive Care Unit
NBSA	Nurses Board of South Australia
NESB	Non-English-Speaking Background
OQN	Overseas-Qualified Nurse
OECD	Organisation for Economic Co-operation and Development
QARI	Qualitative Assessment and Review Instrument
RN	Registered Nurse
TL	Team Leader
TB	Tuberculosis
UN	United Nations
USSR	Union of Soviet Socialist Republics

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Chapter One: Introduction

1.1. Introduction to the study

This study is an investigation of the lived experiences of overseas-qualified nurses (OQNs) from non-English-speaking backgrounds (NESB) in coming to, and working in, Australia. Like the UK and USA, Australia is experiencing a severe shortage of nurses and accepting nurses from overseas has been one solution to this problem, particularly in the last five years., Although there has been a large increase in the number of OQNs from NESB entering the Australian nursing workforce, their experiences have been rarely examined by nursing scholars in Australia.

This research employs hermeneutic phenomenology, mainly informed by Heidegger and Gadamer, as its research methodology. This hermeneutic phenomenology is located in the qualitative and interpretive paradigms and it aims to understand human phenomena in terms of lived experiences. A total of 24 OQNs who had obtained their basic nursing education outside Australia from a total of 11 non-English speaking countries participated in the research project. Data were mainly collected from individual face-to-face interviews. Following the notion of the hermeneutic circle of understanding of human phenomena, two analytical methods were conducted, namely, individual case analysis and thematic analysis. The results were further conceptualised to capture the core essence of the OQNs' experiences in Australia to inform the knowledge base of nursing as social practice, in Australia.

In this Chapter, firstly, my personal background that brought me to conduct this particular research is set out in order to explicate my standpoint and influence on the study. Then, a brief overview of background information and previously conducted studies are presented in order to articulate the significance of the study. An overview of the actual research process including the research aims, research questions, research designs, the research participants, the data collection method, the data

analysis methods and precautions to enhance rigour are also provided. Finally, a short introduction to each Chapter is presented to provide a broad picture of the thesis.

1.1.1. Personal interest in the area

My personal interest in the phenomenon of the lived experiences of the OQNs started when I left Japan in 1998 to be enrolled in a bridging program to obtain nursing registration in New South Wales, Australia. I was one of the early international students in the bridging program for nurses from NESB and I was the only international student from a non-Commonwealth country where the nursing education system was not based on the Anglo/British style. I managed to survive the theoretical aspects of the program but it soon became clear that the required clinical placement was much more difficult.

In particular, I needed guidance about what I should expect in Australian nursing settings, which was a radically different problem from the academic subjects in the program. However, there was no such support available for nurses like myself who simply did not know anything about the culture of Australian nursing practice. The clinical educators were willing to support me but they could not understand what my problems actually were, as they had only had very limited exposure to the particular problems of OQNs from NESB. In the end, I passed the registration requirement but this experience stayed in my mind for many years. When I decided to undertake the doctoral program, this problem was an obvious research topic in which I had particular interest, experience and a personal stake.

1.1.2. Background to the study

The movement of the nursing workforce between countries has accelerated in recent years. This is generally associated with ‘globalisation’ in the sense of a more accessible and inter-connected world but, in particular, the rapid expansion of the information network and the advancement of public

transportation systems have accelerated the process (Wickett & Mccutcheon, 2002, p. 163). With federal immigration policies that welcome skilled workers from overseas in recent years, the number of OQNs from NESB has dramatically increased in most states of Australia (e.g. Nurses and Midwives Board New South Wales, 2006; Nurses Board of South Australia, 2006; Nurses Board of Victoria, 2006). Despite the rapid increase in employment of OQNs from NESB, very little attention has been paid by Australian nursing bodies to such nurses' experiences in the post-immigration and post-employment periods.

Both international and Australian trends in immigration policy and trends in international migration of the nursing workforce are further discussed in Chapter Two.

1.1.3. Previous studies and significance of the study

A detailed review of previous studies of OQNs working in Australia is presented in Chapter Three, as a report within the systematic review. In this present section, only a brief review of the key literature is presented in order to illustrate the significance of the study. Concerning issues of OQNs from NESB working in Australia, there have been two major qualitative studies (Jackson, 1996; Omeri & Atkins, 2002) conducted with the aim of understanding the experience of nurses from 'varied' backgrounds in Australia. Both studies employed a phenomenological approach and reported that it is difficult for nurses from ethnic backgrounds to adjust to Australian nursing culture. Feelings of loneliness and being 'other' (Omeri & Atkins, 2002) and feelings of being a stranger in the workplace (Jackson, 1996) were commonly described by participants.

Pittman and Rogers (1990) reported from their seminal study of OQNs (including OQNs of any background), that in contrast to the harsh realities confronted by OQNs from NESB, OQNs from English speaking countries largely did not experience particular difficulties. This was the first large scale research of OQNs in Australia and the mixed method of survey questionnaires with open-ended questions, clearly demonstrated the problems confronted by OQNs from NESBs and successfully drew

attention to the presence of OQNs of NESBs within the Australian nursing workforce. In more recent years, from the perspective of international skilled immigration policy-making, Hawthorne (2000) also examined the experiences of OQNs from NESB working in Australia using a mixed method of postal survey and individual interview. The findings were consistent with those of Pittman and Rogers (1990) and Hawthorne recommended the need for transparent and systematic qualification assessment for OQNs who want to come to work in Australia.

Concerning the issue of having to learn and work using a second language, Anzaldua (1990) argued, from ethnic scholars' discourse, for the inseparable nature of language, culture and identity. Each language is embedded in the social, cultural and historical contexts of the society where the language is used (Halliday, 1994). Therefore, second language learning is not only a simple conscious activity; neither is it merely a process of learning how to use a new tool to communicate with others. Learning a second language means learning how to live *in* the language. Through language learning, the learner's self-perception undergoes radical change (Foster, 1997).

For OQNs from NESB, to speak English is to think and also to behave in English which might often be in direct opposition to their pre-existing behaviour and previously constructed lifeworld. Considering the complexity of issues involved in English language-learning and in working in a socially, culturally and linguistically different context, together with the difficult experiences which are reported in previous studies, there is a clear need for studies specifically focusing on OQNs from NESB in order to understand their experiences of adjusting to Australian nursing practice. Using the results of this study it will be possible to provide adequate support to facilitate adjustment with the goal of maximising job satisfaction and retention of staff nurses.

1.2. The study

1.2.1. Research aims

The research aims to describe and interpret the lived experience of OQNs from NESB in order to facilitate understanding of such individual nurses and to articulate common issues experienced by OQNs of NESB in coming to, and working in, Australia.

1.2.2. Research questions

The research questions are: “What are the experiences of individual OQNs from NESB working in nursing practice in Australia?” and “Are there common or shared experiences among the participants? If so, what are these common issues?”

1.2.3. Research design

From the various qualitative approaches, hermeneutic phenomenology was chosen for the research methodology and some of Heidegger’s and Gadamer’s central ideas inform the study as a philosophical framework. Since the late 1970s, nursing researchers have been questioning the objectivist/positivist approach to nursing knowledge development (Benner, 1984; Carper, 1978; Silva, 1977) which has generally predominated in the field, at least until recently. The traditional objectivist/positivist science and the biomedical Cartesian model of the human body have been challenged in terms of their appropriateness for understanding human phenomena, of which nursing practice is a good example. Alongside the realisation of the biomedical/positivist model’s strong link with institutional power of knowledge development and maintenance of power structures within ‘the academy’ (Kuhn, 1970), many nursing researchers have started viewing the qualitative research paradigm as an answer to the epistemological debate within nursing research culture. Given this paradigmatic re-orientation in nursing, hermeneutic phenomenology has been well received as a

research methodology that can provide an alternative direction to the positivist tradition for nursing scholars in Western societies.

Phenomenology entails the study of the lifeworld (Husserl, 1970) where people's everyday life is carried out and it aims to gain a deeper *understanding* of the nature and meaning of people's everyday experiences (Van Manen, 1997). Hermeneutic phenomenology grasps the wholeness of phenomena and its primary concern is to describe and interpret how participants make sense of their own experience, while accepting the limitation of the model in *explaining* human related phenomena (Heidegger, 1962). Natural science attempts to explain by scientifically derived theories, but in the case of human life, we must *understand* (Dilthey, 1976) and phenomenological studies readily acknowledge the role of subjective interpretation by researchers in this paradigm. Since the study aims to provide a better understanding of the lived world of OQNs from NESB working in Australia, hermeneutic phenomenology was the most appropriate approach for the study. van Manen's (1997) approach to hermeneutic phenomenological research was employed to inform the study's approach and methods.

1.2.4. Participants

The inclusion criteria for the research participants were as follows:

- Nurses from overseas currently working as nurses in Australia,
- Nurses whose native language is not English,
- Nurses who have obtained basic nursing qualifications outside Australia.
- Nurses with at least 1 month of work experience in clinical settings in Australia.

Exclusion criteria for the research participants were as follows:

- Nurses from overseas who did not have work experience prior to arrival in Australia.

Research participants were recruited from 30 health care facilities accessible to the researcher in the general Adelaide region and one from a remote hospital in South Australia. The researcher contacted ward managers and directors of nursing by letter, fax or email to ask for help in identifying possible research participants in their organizations. The initial contact with the participants was made after obtaining verbal consent for making such contact by the researcher.

1.2.5. Data collection

Individual interviews with the participants were the main source of the data. The purpose of the phenomenological interview is not to explain but to understand meanings, by drawing from the respondent a vivid picture of his/her lived experience, complete with the richness of detail and context that shape that experience (Sorrell & Redmond, 1995). Interviews were conducted in a conversational style and were unstructured, to encourage participants to tell their life stories (van Manen, 1997) in a way that was relatively unconstrained by the 'framing' of precise questions.

1.2.6. Data analysis

The interviews were tape recorded and transcribed after each meeting by the researcher. Two types of analysis were used to answer the research questions: case analysis with the narrative approach was used to answer the first research question, "What are the experiences of individual OQNs from NESB working in nursing practice in Australia?" and the thematic analysis method was used for the second research question, "Are there common or shared experiences among the participants? If so, what are these common experiences?"

1.2.7. Rigour

The JBI-NOTARI (Joanna Briggs Institute, Narrative, Opinion and Text Assessment and Review Instrument) was used to present the analysis clearly so that readers can follow the decision trails (Koch,

1995). The analyses were double checked by experienced supervisors to ensure that the results were derived from the data. The participants' reassurances concerning the data and the data analyses were also used to enhance the credibility of the research, particularly the data analysis and presentation of the results.

1.3. Structure of the thesis

Chapter One: Introduction. This chapter introduces the study and provides a brief overview of the thesis and associated approach and methodology.

Chapter Two: International movement of the nursing workforce. Social policy and the international movement of the nursing workforce are examined in relation to current skilled migration policy and health care workforce status in Australia.

Chapter Three: *The systematic review*. This review includes studies conducted previously on the topic of the experiences of OQNs from NESB working in Australia.

Chapter Four: Methodology. As the philosophical framework of the study, key ideas of Heidegger's and Gadamer's hermeneutic phenomenology are discussed in relation to the research approach.

Chapter Five: Method. The actual research method employed to examine the lived experiences of the OQNs from NESB in Australia is presented and discussed.

Chapter Six: Case Analysis. In this chapter, 23 individual case studies are presented to address each participant's individual experiences.

Chapter Seven: Thematic Analysis. This chapter includes thematic and cross case analysis of the data from the participants, which mainly addresses the common themes in the studied experiences.

Chapter Eight: Discussion. These analyses are further elaborated with the use of Parse's approach to Heuristic Interpretation. The conceptual map that describes the nature of the experiences of the participants is articulated.

Chapter Nine: Conclusion and Suggestions. To conclude the study, a summary of the main findings and key points, and suggestions concerning support structures for OQNs from NESB coming to work in Australia are discussed, with implications for hospital management, universities and policy makers.

1.4. Summary

This chapter presents a brief overview of the study which examines the lived experiences of OQNs from NESB. Firstly, I discussed my personal experience as an overseas-nursing student in Australia which initiated and influenced the study process. Secondly, to demonstrate the significance of the study, a brief background to the study and a critical examination of previously published research articles on the phenomenon of OQNs in Australia was presented. A brief overview of the study included the research aims, research questions, research design, criteria for the participants, data collection method, data analysis method and efforts to enhance rigour. Finally, an overview of each chapter was presented to provide 'a map' of the structure of the thesis, showing how the different components integrate with one another. In the following chapters, the actual research process is discussed in detail. The following chapter provides a background to the study, such as social policy and the international movement of the nursing workforce, in relation to current skilled migration policy and health care workforce status in Australia.

Chapter Two: International Movement of Nursing Workforce

The world has become a 'smaller' and more interconnected place in recent decades with rapid advances in information technology, public transportation systems, and globalisation of the economy, including human capital. One feature of this last trend has been an escalation of the international movement of skilled workers including nurses. In this chapter, in order to discuss the global movement of the nursing workforce, I firstly examine international trends in skilled migration from the point of view of both labour-exporting nations and labour-importing nations. Secondly, I highlight the general climate of immigration policy in Australia by investigating the history of government policy and current immigration trends. Thirdly, I discuss current trends in the international movement of the nursing workforce, with a particular focus on nurses' immigration status in other major English speaking nations such as the USA and the UK. Finally, I attempt to broadly evaluate the current status of nurses' immigration into Australia from the perspectives mentioned above.

2.1. Overview of international immigration

International immigration has rapidly expanded since the mid-20th century, as a result of advanced public transportation systems and the development of information technology; globalisation of the world has facilitated the movement of humans (Iredale, 2002). The United Nations (UN) (2005) reported that from the year 1960 to 2005, the number of international migrants in the world more than doubled, from an estimated 75 million in 1960 to almost 191 million in 2005, an increase of 116 million over 45 years.

Kingma (2006) analysed category types of migrants according to their motivation for leaving their country of origin; these included: 1) economic migrants, 2) quality-of-life migrants, 3) career-move migrants, 4) partner migrants, 5) survival migrants, 6) return migrants, and non-permanent migrants, including 7) student migrants and 8) holiday workers. For instance, one fifth of the increase in

international immigration described above involves survival migrants or economic migrants related to unstable social conditions in the former Union of Soviet Socialist Republics (USSR), the former Yugoslavia and the former Czechoslovakia (UN2005).

In recent years, migratory movement from developing to developed countries has become a significant part of international immigration. According to The International Organization of Migration (IOM) (2007), the majority of migratory movements has historically been evident within developing countries (i.e. from developing country to another developing country) but in 1995, migratory movement to developed countries from both developed and developing countries exceeded that to developing countries for the first time. By 2005, the more developed regions hosted 94 million international migrants, while 70 million migratory moves to developing countries were reported (UN2005).

As for types of migrants, instead of family reunion, skilled migrants became increasingly significant in terms of global migration trends in the modern world, where the circulation of skilled workers was one of several significant flows, including capital, goods, services and information (Bach, 2003; Birrell, Hawthorne, & Richardson, 2006; Iredale, 2002).

In the following section, some key push factors (factors which facilitate workers to leave countries of origin) and pull factors (factors which facilitate workers' migration to destination countries) involved in the international movement of skilled workers will be examined.

2.2. Push factors of skilled immigration

The factors that push workers from developing countries can be analysed at an individual and governmental level. Firstly, the majority of individual skilled workers leaving developing countries for more developed societies do so to seek improved economic opportunities, including better job opportunities and a safer environment (Kingma, 2006). At the governmental level, some countries

intentionally *export* skilled workers in order to generate remittances to pay foreign debts, financial trade deficits and improve balances of payment (Academy Health, 2006; Hugo & Stahl, 2004; Huston, 2006). In 2005, it was estimated that developing countries had received US $167 billion of remittances from overseas, which was more than twice that of development aid from all sources (IOM2007). In this sense, sending workers overseas is seen in the same context as the export of any other commodity, as a means of generating foreign earnings. Although most developing nations have relatively low rates of open unemployment, underemployment is quite common and many governments also view labour exports as a partial solution to the lack of job opportunities (Hugo & Stahl, 2004).

In some countries, national governments have become actively involved in marketing their workers abroad. In the Philippines, for example, the Philippine Overseas Employment Administration has gone beyond simply regulating and registering recruiters and workers; it actively promotes the export of Philippine workers abroad. The government and private agencies are together responsible for the outflow of their skilled workers. The Indian government also encourages professional workers to go abroad (Hugo & Stahl, 2004).

Countries such as India and the Philippines (Bach, 2003) are often described as major labour-exporting countries to developed countries. For example, almost 10 percent of the entire Philippine population lives overseas (Go, 2003); it has been estimated that 6.2 million Pilippinos are spread across 130 countries (Saywell, 1997). Similarly, 1.4 million Indians, 2.4 million Indonesians and 0.8 million Pakistani workers have been reported to be working outside their countries of origin (Hugo & Stahl, 2004).

2.3. Pull factors of immigration

Developed countries, particularly English-speaking countries including Australia, Canada, the UK and USA are generally reported to be major host (labour importing) countries (IMO2007). The most

obvious pull factor is demographic change to the population of developed destination countries. The World Bank (2007) reported that for OECD (Organization for Economic Co-operation and Development) countries, international migration has become a heightened issue among policy makers because these nations expect to have a large fall in their numbers of workers beyond 2010, due to a decline in birth rate and increasingly aged populations. Developed countries need to secure sufficient numbers of workers to maintain a healthy national economy and flow of services, which contributes to 'pulling' workers from overseas.

Another pull factor for skilled immigrants is economic and social pressure caused by high percentages of unskilled immigrants. A shift in immigration policy to economic outcome-focus (skilled migration programs) over family reunion programs in countries such as Australia (Birrell et al., 2006), Canada (Woroby, 2005) and the UK (Home Office, 2007) might have been inevitable. Australia was one of the earlier countries to implement strict immigration assessment criteria based on skills (discussed later in this chapter); Canada has also shifted to favour skilled immigrants over immigrants in the family reunion category since the 80s (Birrell et al., 2006). The UK has also introduced immigration policy which anticipates the immigrants' economic and social contribution to the society (Home Office, 2007).

In contrast to these countries discussed above, for a long time the US government has avoided explicit discussion of economic outcomes in their immigration policy making. As a result, a majority of immigrants to the USA have been in the family reunion category, lowering the economic characteristics of US immigrants. In the late 90s only 20 percent of immigrants entered USA because of their skills, while approximately 60 percent of immigrants to Canada were skilled immigrants, and only 25 percent were under family reunification criteria (Woroby, 2005). In the last few years, the US government has finally started considering a 'Merit System' that would be a US version of the skill-assessment systems for immigration already in place in countries such as Australia, Canada and the UK. Though it takes time to obtain public consensus and political acceptance of the new skill-oriented immigration policy/systems (Krikorian, 2007; Pear, 5 June 2007 ; Thomas, 2007), it is probably

inevitable that economic outcomes and the social contribution of immigration programs will assume greater importance.

2.4. Immigration status in Australia

2.4.1. Brief history of migration to Australia

Since the original British settlement in 1788, Australia has accepted a great number of immigrants. Before the Second World War, immigration to Australia was restricted mainly to Britons and the Irish under the White Australia Policy (Iredale, 1997). After the war, the Chifley Labour Government announced plans for a large-scale immigration program with the catch phrase of 'Populate or perish'. The government's objective was to increase the population by 2 percent per year (Collins, 1997) but this projection did not work out as hoped, with only half the required number of Britons applying for immigration to Australia. The government had to consider accepting non-British immigrants from other parts of Europe to build a strong nation in terms of population and economic development and, as a result, 50,000 Southern Europeans and 34,000 Northern Europeans were allowed into Australia in the 1947-51 period (Collins, 1997).

In the last half century, immigration policy has dramatically changed in Australia. The White Australia Policy was formally abandoned by the Whitlam Labour Government in 1973 (Iredale, 1988) and opportunities for immigration into Australia were extended to people from increasingly diverse nationalities. Under the social policy of Multicultural Australia, introduced by the Commonwealth Government of Australia (2003), the Australian population is officially recognised as consisting of immigrants from diverse countries. In 1947, only 3 percent of the Australian population was born outside Australia or the UK (Collins, 1997). According to Toner (2001) in the year 2001, the Australian-born group comprised 75.4 percent of the total of employed persons and one in four workers in Australia was born outside Australia. Of these migrants, 10.7 percent were born in 'Mainly English Speaking Countries' and 13.8 percent in Non-English Speaking Countries. In February 2007,

Australia's population was estimated to be 20,751,662 and approximately 43% of the population was born overseas or had one parent who was born overseas (White, 2007).

Australia has accepted a significant number of immigrants under the humanitarian program such as the 14,000 Hungarian refugees who arrived following the Hungarian Uprising in 1956 (Metcalf, 2006) and more recent refugees from the former Yugoslavia in the 1990s (Colic-Peisker, 2005). There were also unauthorised boat arrivals from Vietnam in the late 1970s, and subsequently boat people from Cambodia, China and the Middle East; a large group of asylum seekers from China arrived after the Tiananmen Square incident (Metcalf, 2006).

2.4.2. Current immigration conditions in Australia

Australia has accepted increasingly high numbers of skilled workers from diverse national backgrounds under the social policy of Multicultural Australia and the economic-focused/skill-focused immigration policy.

The skilled migration category has overtaken the family reunion category as the largest immigration group (Shah & Burke, 2005). Australia's migration program for the period 2005-2006 consisted of 142,930 places. In 1999-2000, the skilled migration category represented 35.1 percent of all permanent arrivals and increased to 68.1 percent in 2005-2006, while family reunion entrants made up only 31.7% (White, 2007). Similar to countries such as Canada and the UK, this increase in skilled migration was due to the Australian government's focus on the economic outcomes of immigration policies (Betts, 2003).

Regarding countries of origin of migrants, the leading country continued to be the UK but significant numbers of immigrants entered from Asian countries. The Department of Immigration and Citizenship (2007b) reported that in the years 2005 to 2006, the top five countries of origin for skilled migrants were the UK (24,800), India (15,865), China (14,688), South Africa (4,293) and Malaysia

(3,838). The number of workers from India, China and Malaysia exceeded the number of workers from the UK by over 10,000 and workers from South Africa with non-Anglo and non-native English speaking backgrounds were accepted for immigration.

The Numerical Assessment Scheme (point system) was introduced in 1979 to select immigrants to Australia (Iredale, 1997). Specifically the objective of the 'points test' was to (Birrell et al., 2006, p. 128):

- systematically and objectively select the skilled migrants most likely to contribute to the objectives of the General Skilled Migration program;
- regulate the size of the Skilled Stream (by varying the points required according to planning levels set by the Australian government).

The immigration categories to which the points system applies underwent frequent revisions to meet the government policy of the time and needs from professional, training and union bodies in Australia (Birrell et al., 2006). Additional points are allocated to persons whose occupation is on the Migration Occupation in Demand List, a list of occupations in which there was a significant shortage of skilled persons in the Australian economy (Department of Immigration and Citizenship, 2007a). The Australian government and professional bodies, registration boards and other occupational bodies are involved in the pre-migration assessment (Toner, 2001) for the selection of appropriate workers to enter the workforce.

2.5. International movement of nurses

In the previous section, the general immigration status of both labour exporting countries and destination countries has been examined in order to clarify the societal and political background of the recent expansion in globalisation of the nursing workforce. In the following section, an overview of the international movement of the nursing workforce and related ethical concerns which have attracted world-wide attention are discussed.

2.5.1. Overview of international movement of nursing workforce

Nursing has, for some time, been a profession of international mobility and this trend has expanded in more recent years. This acceleration in the international movement of the nursing workforce strongly relates to the shortage of nurses which has become a serious problem in providing health care services in developed countries such as the USA (Goodin, 2003; Morlock, 2005), Canada (Mcguire & Murphy, 2005), the UK (Buchan, Kingma, & Elegado-Lorenzo, 2005) and Australia (Cowin, 2003; Wickett & Mccutcheon, 2002).

Seeking solutions abroad by recruiting nurses who already possess nursing qualifications to ease domestic shortages had been common practice for some time but it has been accelerating in more recent years. Aggressive recruitment of nurses from overseas has became standard practice in these developed Anglophone societies mentioned above (Buchan et al., 2005; Buchan & Sochalski, 2004; Morlock, 2005). However, other non-Western countries such as Japan and Singapore are also becoming significant nurse-importing countries (Primomo, 2000; The Japan Institute for Labour Policy and Training, 2007).

2.5.2. Ethical problems in international migration of nurses

There are essentially two ethical concerns caused by the acceleration in nurses moving from developing countries to destination countries. Firstly, the resulting brain/skill drain in the nursing workforce in the country of origin has proved disastrous and many developing countries face an insufficient number of workers to provide reasonable health care services (Chikanda, 2005; Kingma, 2006). For instance, in 2001 alone, 40 percent of the total 1995-2000 nurse deployment in the Philippines had left the country (Nelson, 2004). In rural areas of Zimbabwe where nurses were already required to take on extended roles including those of pharmacist, doctor, physiotherapist and others, on top of regular nursing responsibilities, the impact of the brain/skill drain was reported to be

serious (Chasokela, 2001). Due to a lack of qualified nursing staff, under-qualified or un-qualified staff were often forced to provide nursing and other health care services (Chikanda, 2005).

Over the last few years, this problem of a brain drain from developing countries has attracted much public attention. Many scholars (Huston, 2006; Kingma, 2000) claim that destination countries are concerned with easing shortages among their skilled workers in health care but they have neglected to consider the disastrous effects on health care systems in labour exporting nations. There have been no reasonable solutions for improving staffing levels in such countries.

Attention has also been drawn to possible cases of exploitation by host countries. Unethical recruitment and employment status of OQNs by recruitment agencies and employers, and other forms of discriminatory treatment have been reported (Alexis & Vydelingum, 2005; Allan & Larsen, 2003; World Health Organisation, 2003). For instance, in the case of the UK (Allan & Larsen, 2003), two main kinds of ethical problems have been highlighted. Firstly, some recruitment agencies systematically deceive their clients (OQNs seeking employment in the UK); one typical case concerns nurses from the Philippines who had been promised by their Philippine agencies that they could obtain places in UK hospitals for adaptation programs but these turned out to be fake. Possible unethical working conditions are another concern; for instance, some OQNs were sent to work under the supervision of unqualified carers which made them feel humiliated. A manager of one African nurse took her passport away so that she could not leave her job until she finished her 2 year contract (Allan & Larsen, 2003).

Such reports concerning unethical recruitment of nurses from developing countries have started to attract international attention from professional bodies and governmental organisations. Guidelines for international recruitment of nurses and health care workers (American Federation of Teachers Healthcare Program and Policy Council, 2003; Commonwealth Health Ministers, 2003; International Council of Nurses, 2001) have been released by professional bodies and governmental organisations.

Statements from various organisations are quite similar in their modelling of ethical principles. For instance, the Commonwealth Code of Practice for the International Recruitment of Health Care Workers (2003) emphasised three ethical principles in recruiting staff from overseas including: 1) transparent communication between recruiting countries and recruiters, 2) fair and accurate information on immigration and employment, 3) mutuality of benefit between host countries and exporting countries. International Council of Nurses' (2001) statement presented more specific guidelines to protect OQNs, for instance: equal payment, effective orientation/supervision, clear employment trial periods, freedom of association and even access to grievance procedures. This ICN statement was revised in 2007 (International Council of Nurses, 2007) and a suggestion for effective human resources planning, leading to national self-sustainability was included.

2.5.3. Nurses' immigration to Australia

In the past, there has been relatively little official concern with issues around immigrant nurses coming to work in Australia, since it has traditionally been assumed that these nurses shared similar cultural and educational backgrounds with Australia and they were expected to speak English as their first language. However, like the other professions and skilled areas of work this migratory pattern of nurses mostly operating between English speaking countries has changed rapidly, and Australia has started accepting more OQNs from diverse backgrounds in recent years because of serious domestic shortages of nursing staff.

In 1999, Department of Immigration and Citizenship (2007a) listed registered nurses and midwives on its Migration Occupation in Demand List, thus providing OQNs with extra credit points for skilled migration assessment scores. In this way the conditions of nurses' migration to Australia has been modified and the Australian government expects that these new migrant nurses would enter the nursing workforce to ease domestic shortages.

From 2005 to 2006, a total of 97,340 skilled migrant visas were granted, representing 68.1% of the total migration program. Registered nurses (3.1%) were the third largest professional group of skilled migrants following accountancy (16%) and computing professionals (6.1%) (Department of Immigration and Citizenship, 2007b).

In the early 2000s, the largest group of OQNs were from the UK and NZ but the number of nurses from other countries such as the Philippines, Thailand, Singapore, Hong Kong and former Eastern Block countries started to rise such that almost one in five migrant nurses were from Asian countries (Australian Institute of Health and Welfare, 2001; Commonwealth Department of Education Training and Youth Affairs, 2002). In more recent years, larger numbers of OQNs from more diverse national backgrounds arrived to work in Australia. According to the Nurses Board of South Australia (2006), the number of newly registered OQNs increased from 118 in 2001-2002 to 435 in 2005-2006 – a tripling in five years. Also there were 1,189 locally educated nurses and midwives newly registered in the years 2005-2006, which was only a little over double that of newly registered OQNs in the same year. While the largest OQNs' groups continued to be from the UK, China, which was not even on the census data 3 years ago, suddenly became the second largest group. There was also a significant increase in OQNs coming from South Africa and Zimbabwe. With expanded immigration opportunities to move to Australia, the number of countries of origin has increased from 15 to 34 in the last 5 years (Nurses Board of South Australia, 2006).

This trend of nurses' immigration into Australia from such diverse backgrounds could be expected to increase in tandem with multicultural policy (Commonwealth Government of Australia, 2003; Office of Multicultural Affairs, 1989). Considering the international debate around the ethical issues of employing nurses from overseas (ICN2001), the Australian Nursing and Midwifery Council (ANMC) (2002) also released a statement of commitment to recognise individual migrant nurses' rights for career development. The ANMC has recently released guidelines for the orientation of internationally qualified and registered nurses and midwives relating to the Australian healthcare context

(ANMC2007) in order to facilitate adjustment of the rapidly expanding OQNs' group from diverse backgrounds to Australian nursing practice.

2.6. Summary

In this chapter, I have firstly examined international trends in skilled migration, paying particular attention to social and political conditions in both labour exporting countries and destination countries. An overview of immigration policy in Australia has also been set out with a focus on the historical development of migration policy and the current emphasis on the skilled immigration program. Then, an overview of the international movement of the nursing workforce was discussed in relation to other major English speaking nations such as the UK, Canada and the USA. Ethical issues in the international recruitment of nurses were presented. Building upon this point, with Multicultural Australian policy and the preference for skilled migration over other immigration categories, the Australian nursing workforce has increasingly become more diverse in terms of country of origin and ethnic culture.

Detailed analysis of the existing literature on OQNs coming to, and working in Australia from diverse national backgrounds will be discussed in the following chapter in the form of a systematic review, with a specific focus on qualitative evaluations of their experiences of working in Australia.

Chapter Three: Systematic Review of Existing Literature

In this Chapter, a report of a systematic review which summarised the best available evidence for supporting OQNs' adjustment to Australian nursing practice is presented.

3.1. Objective

The aim of this systematic review was to identify issues and needs of OQNs in gaining nursing registration and working in Australia and to articulate effective interventions for the support and education of OQNs to facilitate their adjustment to nursing practice in Australia.

The objective of the review was to summarise the best available evidence supporting OQNs' adjustment to Australian nursing practice.

The specific review question was:

What supportive interventions assist OQNs to adjust to Australian nursing practice?

3.2. Methods

3.2.1. Inclusion criteria

1. Types of studies

The review considered qualitative and quantitative studies that addressed adjustment issues of OQNs coming and working in Australia using the Joanna Briggs Institute (JBI) levels of evidence (The Joanna Briggs Institute, 2005). Papers of the highest level of evidence rating were given priority, and the types of papers considered for inclusion in the review include: meta-analyses, randomised

controlled trials, quasi-randomised controlled trials, cohort studies, case–control studies, descriptive studies, correlation studies, interpretive studies. Critical studies were excluded. Descriptive studies with qualitative data such as program evaluation studies were not included in the synthesis but significant information from these papers was included in narrative summary form. If there were no research papers being identified, then expert opinion or reports that addressed the adjustment issues of overseas qualified nurses were considered.

2. Types of participants

The types of participants were nurses who have received basic nursing education outside Australia where English is not the first language and have worked as nurses outside Australia where English is not the first language before. This included nurses who were already registered and working as nurses in Australia and who were undertaking courses required for registration in Australia, provided by universities in Australia or other agencies. The participants were included regardless of their length of stay in Australia.

3. Types of interventions

The types of interventions included in the review were any intervention to support and facilitate the adjustment of OQNs to Australian nursing practice, such as overseas nurses' refresher courses, first-year support programs, bridging programs and any other educational programs and interventions aiming to support overseas nurses. Qualitative or descriptive studies that examined OQNs' experience working in Australia were also included.

4. Types of outcome measures

Types of outcome measures that were examined were issues that affect OQNs'

• job satisfaction level in Australia;

• retention rate;

• competence level;

• educational achievement; and

• success rate in gaining nursing registration in Australia.

3.2.2. Search strategy

The search included both published and unpublished studies in the period from 1985 to 2003 (inclusive). Unlike the UK or the USA where the aggressive recruitment of nurses from overseas has been standard practice, it was only after the late 1980s Australian Government started accepting overseas nurses from non-English-speaking backgrounds (NESB) to work in Australia. Therefore, the search was limited to studies published after 1985. The databases searched included Medline, CINHAL, ERIC, AUSTRUM, Expanded academic index APAIS, Sociological Abstracts, ProQuest and Dissertation Abstract International. The reference lists and bibliographies of retrieved articles were also hand-searched to identify other studies. Relevant worldwide websites were also searched (Appendix I).

All abstracts that appeared to meet the inclusion criteria were assessed by two reviewers and full reports were retrieved for all studies that appeared to meet the inclusion criteria. Search terms that were used to conduct searches for each database are listed in Appendix II. In total, 64 articles were identified. Twelve studies that met the inclusion criteria were included and 52 studies were excluded. Included studies are listed in Appendix III. Reasons for exclusion for each study are listed in Appendix IV.

3.2.3. Assessment of quality

Identified studies that met the inclusion criteria were grouped into one of the following categories: qualitative studies (interpretive studies), program evaluation, descriptive studies, expert opinion papers. Identified research papers were assessed by two independent reviewers for methodological quality prior to inclusion in the review. Assessment of the quality of the quantitative study methodology was planned to be undertaken by using the critical appraisal form for experimental studies but no experimental studies were identified. To assess qualitative studies, the Qualitative Assessment and

Review Instrument (QARI) Critical Appraisal Tool (Appendix V) developed by the JBI was used. The opinion papers were appraised on the basis of academic merit, namely, the author's standing in the field, the logic of the argument and reference to the broader literature. Disagreements between the two reviewers were resolved by discussion with a third reviewer.

3.2.4. Data collection and analysis

It was planned to conduct statistical meta-analysis but there were no experimental studies being identified in the literature search. Findings from program evaluation reports and descriptive studies are presented in narrative form. Within three identified qualitative research reports that examined the adjustment issues of overseas qualified nurses in Australia, two reports utilised a phenomenological approach (Jackson, 1996; Omeri & Atkins, 2002). Thus, it was judged to be appropriate to meta-synthesise their findings. Data from these studies with a phenomenological approach were extracted and meta-synthesised utilising Data Extraction Tool from the JBI-QARI developed by the JBI (Appendix VI).

At the time that the systematic review was conducted, it was considered inappropriate to include the findings from different methodological approaches in the meta-synthesis. Therefore, another retrieved qualitative study using a grounded theory approach (Teschendorff, 1993) was included in the narrative summary alongside the other types of evidence.

3.3. Results

3.3.1. Issues experienced by overseas qualified nurses

• The amount of published research focusing on overseas nurses' experience was very limited.

• The majority of immigrants' studies focused on immigrant patients and little attention has been paid to OQNs.

3.3.2. Evaluation of programs and other supportive interventions

• Most program evaluation studies involved a single program from a single institution.

• Most program evaluation studies were around 10 years old and there were no course evaluation studies found in more recent years.

• Some original program evaluation studies were no longer available due to their age.

• Apart from program evaluation reports, no other specific supportive intervention reports were found.

• No evaluation studies have been published since the implementation of competency-based assessment in the late 1990s.

• No evaluation studies have been published since the implementation of Bachelor of Nursing conversion course for overseas nurses in the university sector.

• Some expert opinions on supportive interventions were available.

3.3.3. Description of studies

A total of 12 papers, qualitative, quantitative and textual in nature, were included in the review. Of the 64 papers that were identified, 52 papers were excluded as they did not meet the inclusion criteria. There were three papers utilising qualitative methodology (two phenomenology, one grounded theory), three program evaluation reports, two descriptive studies and four expert opinions being included. Types and numbers of included studies are listed in Table 1. A list of excluded studies, including the reason(s) for exclusion, are presented in Appendix IV.

3.3.4. Quality of studies

Most articles that addressed issues of OQNs were not research-based and the number of research-based reports was very limited. There were no experimental studies identified; only three qualitative studies and three program evaluation and program reports were identified. There were some non-

research-based articles on the topic of OQNs identified. However, the general quality of these papers was not very high; they consisted mainly of personal reports of working overseas or very short comments from experts. Only four expert opinion papers were considered to provide academically robust discussion and were included in the review.

Table 1. Types and numbers of included studies

Study type	Total number	Reference
Phenomenology	2	(Jackson, 1996; Omeri & Atkins, 2002)
Grounded theory	1	(Teschendorff, 1993)
Program evaluation or program report	3	(International Institute for Policy and Administrative Studies, 1990; Menon, 1992; Palmer, 1989)
Descriptive studies	2	(Hawthorne, 2000; Pittman & Rogers, 1990)
Expert opinions	4	(Gonda, Hussin, Gaston, & Blackman, 1995; Groutsis, 1999; Hawthorne, 1997; Teschendorff, 1995)

3.3.5. Meta-synthesis of qualitative data

Interpretive studies were assessed using the JBI-QARI. The process of meta-synthesis involved the aggregation or synthesis of findings to generate a set of statements that represented that aggregation, through assembling the findings rated according to their credibility using the JBI-QARI degrees of credibility scale. This is based on three levels of credibility (Appendix VII):

• Unequivocal: evidence beyond reasonable doubt that may include findings that are matter of fact, directly reported/observed and not open to challenge.

• Credible: evidence that is, although an interpretation, plausible in light of the data and theoretical framework; the interpretations can be logically inferred from the data but, because the findings are essentially interpretive, they can be challenged.

• Unsupported: when none of the other level descriptors apply and when, most notably, findings are not supported by the data.

These findings were then categorised on the basis of similarity in meaning. The resulting categories were then subjected to a meta-synthesis in order to produce a single comprehensive set of synthesised findings that could be used as a basis for evidence-based practice.

A total of two phenomenological papers were meta-synthesised while the other qualitative paper using grounded theory was not included in the meta-synthesis. This was included in the narrative summary. One of the phenomenological papers included in the meta-synthesis investigated the experience of nurses from culturally diverse backgrounds as they enter and become part of the nursing workforce in Australia. Conversation-style interviews were conducted on a purposive sample of nine nurses who completed their basic nursing education in which English was not the dominant language although they are now working in Australia as nurses. The selected participants were from various parts of the world such as Scandinavian countries, Central and Eastern Europe, the Asia-Pacific region and South America. The length of working experience as nurses in their country of origin ranged from 3.5 to 12 years. At the time of the interviews, all the participants were working as nurses in the acute clinical area in New South Wales and the majority (n = 5) had working experience as nurses in Australia of less than 5 years. Analysis of the data was conducted using phenomenological thematic analysis method. To ensure the validity of the research findings, several participants were involved in the validation process (Jackson, 1996).

The other phenomenological study included in meta-synthesis investigated the meaning of working in Australia for migrant nurses from NESB. It consisted of a purposive sample of five OQNs who were born outside Australia where English was not the dominant language, who had experience of work in their countries of origin. The selected five participants were from different regions of the world and different countries. The majority of the participants (n = 4) had immigrated to Australia for political reasons and two were political refugees. The length of work experience prior to immigration ranged

from 10 to 16 years. Naturalistic, open-ended interview/conversations were conducted. The hermeneutic, phenomenological analysis method was used (Omeri & Atkins, 2002).

The key findings of both phenomenological studies and illustrations to support those findings were:

Finding 1: Participants were feeling lonely at workplace.

> I had nobody to share it with, much of the day, I was totally alone and I was nervous to approach people. When you did approach, if the person was too busy or off handed to you, it was like a slap in the face (Jackson, 1996, p. 123).

Finding 2: Communication problems in the workplace was large cause of stress.

> People speak so quickly and some people get annoyed when you need to ask them to repeat what they have said, some they just mutter and walk away and you do not know what to do (Jackson, 1996, p. 123).

Finding 3: Language problems are a major issue.

> Language was a problem, have to concentrate very hard, much more than anybody else to understand, so very often I did have a stress headache from concentrating, trying to understand what people were saying (Jackson, 1996, p. 123).

> Language was one of the great disadvantages. It was a set back. My ethnic background, it gave a lot of negative experience (Omeri & Atkins, 2002, p. 502).

> My first interview was so bad, I could not understand. I had a translator. I did not understand what an enrolled nurse or a registered nurse is. No body explained this. I went back a year later when I was able to at least talk a little better (Omeri & Atkins, 2002, p. 503).

Finding 4: Experience of lack of support in registration and work as a nurse was common.

> At the time I did not see any support seeking registration. There was just an office, you go and write letters, you give them your qualifications and they give you letters, and that was it. I know that in many communities they have got information provided in their community language and it is easier. Unfortunately, there is limited information to be accessed by community members (Omeri & Atkins, 2002, p. 500).

> All I knew before I came here, that Australia needs a lot of nurses. This is all that I new (Omeri & Atkins, 2002, p. 500).

> I rang, made an appointment and took all my qualifications. I was given a letter and was told I need to do a refresher course for six months and I am to find a hospital that would accept me for the refresher course. I took a letter to a nearby hospital, but they did not accept me and gave no explanation. So I gave up for a year, then took the letter to another hospital in a different suburb and was accepted and completed the six month refresher course (Omeri & Atkins, 2002, p. 500).

Finding 5: Informal networks with nurses who can share their experience, provide consolation and some redress to the feeling of not belonging.

> I do know some nurses from X [country of origin] . . . they can understand my feelings. Most of them had the similar experience to me. Yes, the same troubles (Jackson, 1996, p. 124).

Finding 6: Developing collegial relationships was made difficult by the attitudes and actions encountered from within the workplace.

> They give you the feeling that they would rather deal with someone else, they look around for someone else and deal with you if no-one is around. Then if someone comes along when they have started to tell you they will then tell the other person as though they do not trust you. They will do this even with students or enrolled nurses. It seems as if you are not to be trusted. I think that some nurses are better than doctors but not all of them. Some are also very rude (Jackson, 1996, p. 124).

Finding 7: Feeling of being a strange at workplace was commonly found.

> When you come here, you have so many things to learn, so many things to learn about everything, not only the language, also the way people behave, the way people treat you. I still find I cannot be completely natural; I don't behave as I would in my own country. I still feel like I don't belong and I think that many people from overseas feel this way (Jackson, 1996, p. 122).

Finding 8: Participants described being inferior to the mainstream, which made no effort to understand the diversity.

> Most people I came in contact with did not have any knowledge of difference people from different backgrounds. They were treating me like I was stupid, that I was from a third world country. It was not nice (Omeri & Atkins, 2002, p. 502).

> After a while I realised that even if we are a very egalitarian society, I am a second class citizen. I still feel like that and this is because of the fact that I come from a different culture, with different ideas and language. And regardless of how well I speak I am still treated as a stranger (Omeri & Atkins, 2002, p. 502).

Finding 9: There is a conflict and tension between expected work roles and the culturally accepted roles that they adopted when not at work.

> My life and background is so different from an Australian person's background and I think that makes me different. Australian girls and girls from other countries are freer than girls from my country. At work, many girls will argue with men and sometimes I am expected to argue with men like doctors too, but at home I cannot argue with my husband. It is different for us (Jackson, 1996, p. 122).

Categorisation and synthesis of findings

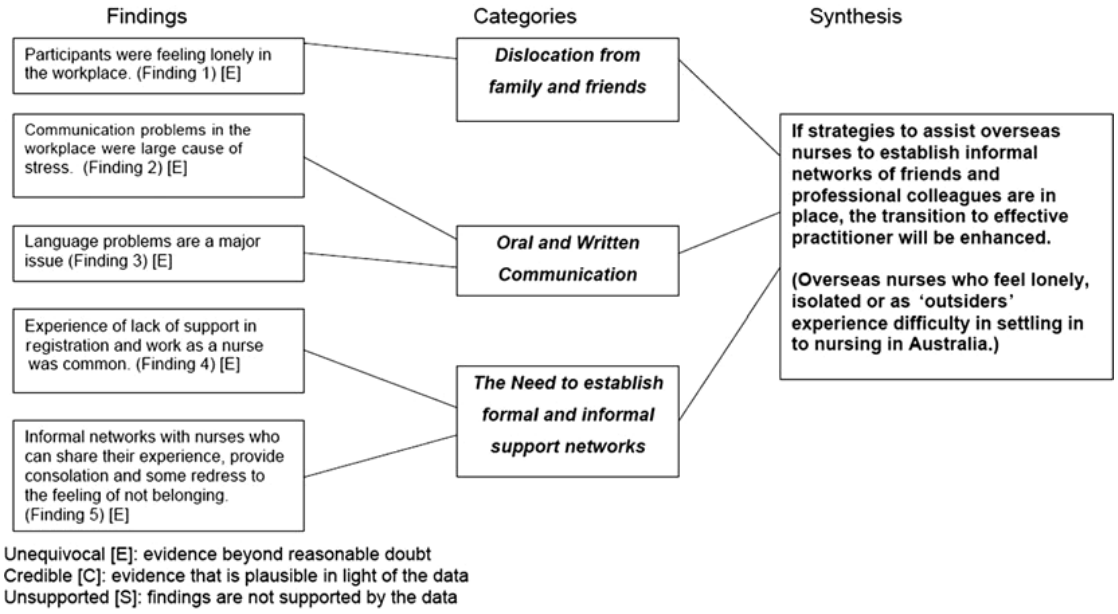
These nine findings were then analysed and grouped into four categories according to commonality of meaning. These four categorise were then further analysed into two.

3.3.6. Synthesised findings

Synthesis 1

A total of five findings were grouped into three categories and developed into a synthesis related to loneliness and being 'others' or 'outsiders' (Figure 1). The first category related to the difficulty of oral and written communication in the English language, which was reported to be a major source of stress experienced by the participants. The second category was related to the difficulty of being dislocated from family and friends. The third category was related to the need to establish formal and informal support networks. These three categories were synthesised into the first synthesis of 'overseas nurses who feel lonely, isolated or as "outsiders" experience difficulty in settling in to nursing in Australia' (Synthesis 1). If strategies to assist OQNs to establish informal networks of friends and professional colleagues are in place, the transition to effective practitioner will be enhanced.

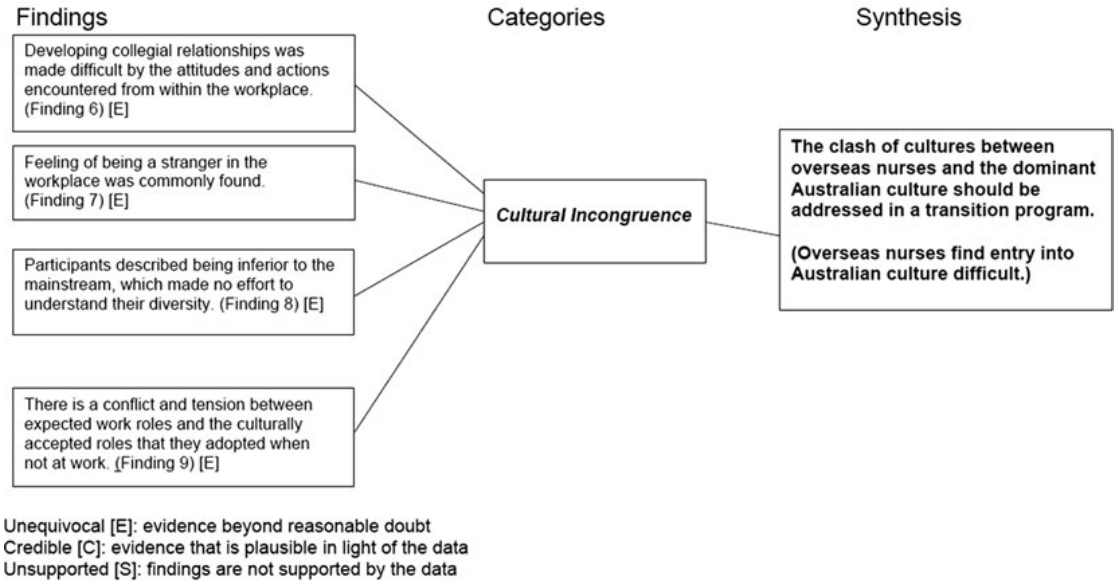
Figure 1 QARI view – synthesised findings



Synthesis 2

One category relating to cultural incongruence was derived from four findings (Figure 2): the experience of being set apart from the main group, a tension between expected work roles in Australian nursing settings and the cultural values, feeling of being a stranger at work, difficulty in forming a collegial relationship, contributed to feelings of cultural incongruence. This category led to the development of the second synthesis, 'overseas nurses find entry into Australian culture difficult' (Synthesis 2). The clash of cultures between overseas nurses and the dominant Australian culture should be addressed in a transition program.

Figure 2 QARI view – synthesised findings



3.3.7. Qualitative study – not included in meta-synthesis

One grounded theory paper was identified but was not included in the meta-synthesis because of the incongruence of the research methodology to the other qualitative research papers (phenomenology) included in the meta-synthesis. A total of 21 nurses from the Philippines who were working in Victoria were individually interviewed. The interview data were analysed using grounded theory

analysis method and findings from the paper were found to support the two meta-syntheses presented above. As a particular illustration of language difficulty, the paper reported problems with Australian slang, abbreviations, terminology, pronunciation and Australian nurses' fast delivery of speech in clinical settings. Issues of culture shock and conflict in value systems upon entering the Australian nursing workforce were also identified (Teschendorff, 1993).

3.3.8. Evidence from program evaluation studies

In total, three program evaluation studies were identified. Due to their use of descriptive methods and inconsistency of the length and structure of the programs, it was not possible to produce strong suggestions for future program structure and contents. All of the identified studies were conducted more than 10 years ago and their relevance of findings for current practice may need to be considered carefully. Issues of English language problems experienced by overseas nurses from NESB were largely discussed in all identified papers; strategic approaches to meet the linguistic needs of NESB overseas nurses in clinical settings were also commonly discussed.

A qualitative case study of one vocational English course for nurses of NESB in Victoria was conducted. The largest issue identified from the study was the importance of English language support for NESB nurses. Pronunciation was reported to be a significant factor in both understanding and being understood between local nurses and OQN. Australian nurses' use of highly complex language in clinical settings was reported to be a large source of difficulty for OQN. It was felt that 10 minutes was the longest effective period for communication between local nurses and overseas nurses; after this period, communication was less effective. In the program, each student was assigned to work with a buddy nurse during the clinical practice, which was reported to be very useful in terms of promoting cross-cultural comparisons, mediating links across cultures and facilitating culturally appropriate nursing skills. However, the buddy nurses required consciously developed preceptorship skills (Menon, 1992).

The second program report examined a bridging course for OQN. Survey questionnaires and personal interviews were conducted with 38 overseas nurses and the data were analysed by descriptive methods. The paper emphasised a need for bridging programs for overseas nurses to prepare for entering the Australian nursing workforce. Cost effectiveness of the program was also identified; it costs only 10% of the higher education-based courses. A need for more involvement of English language education specialists and more specific English preparation such as medical jargon, colloquialism and modern terminology was identified (International Institute for Policy and Administrative Studies, 1990).

The third paper reported a 16-week childcare bridging course that was designed to prepare overseas qualified nurses to work in childcare settings in Australia, with seven overseas nurses from various cultural and linguistic backgrounds. Two issues were discussed. Language needs must be seen as a first priority in programming, timetabling, staffing and budgeting; it is not possible to 'bridge' both quickly and effectively where there are language and cultural differences (Palmer, 1989).

3.3.9. Evidence from other research-based papers

Two studies using a combination of descriptive statistics and qualitative methods were identified. The first study examined the status of spoken language and cultural diversity in Victoria and OQNs' perceptions of the advantages and disadvantages of working in Victoria. The study involved 1160 registered nurses from overseas and 2349 registered local nurses and the data were collected by means of survey questionnaires. It was reported that 60% were born of English-speaking background; nurses from the Asian region was the second biggest group after the group of nurses from English-speaking countries; over 60 languages were spoken fluently and certificate qualifications had been obtained in 59 countries. As the demographic data were over 10 years old, the findings may not reflect the current picture of the community; therefore, the findings above should be updated. From qualitative data, it was identified that nurses from NESB often felt that they were not accepted by Australian colleagues (Pittman & Rogers, 1990).

Another paper examined the disadvantages being confronted by nurses from NESB coming to work in Australia. Data were collected from 712 survey responses and 33 qualitative interviews; descriptive correlation analysis and qualitative thematic analysis method were used. Several structural and educational disadvantages for nurses from NESB concerning registration and working as nurses in Australia were reported. NESB nurses were reported to receive inferior outcomes in registration because of the lack of Australian research on the actual calibre of their courses. NESB nurses were reported to have a much higher failure rate in the Occupational English Test than medical doctors. Problems related to bridging programs' lack of national consistency were also identified as a barrier for registration for overseas nurses. NESB nurses were found to be clustered in the public sector, or based in the nursing home sector (Hawthorne, 2000).

3.3.10. Evidence from expert opinion

Four expert opinion papers were identified. Difficulties in English language use in clinical settings and consideration of diverse cultural backgrounds were two common themes discussed in the identified expert opinion papers.

Awareness and understanding of strategic help for nurses from NESB staff was discussed (Gonda et al., 1995). The need for training and several key factors in language problems faced by nurses from the Philippines was also discussed. Australian pronunciation and accents, fast delivery of speech, idiomatic language, slang, differences in abbreviations and medical terminologies and telephone conversations were sources of difficulties for nurses from the Philippines (Teschendorff, 1995).

A number of other strategies were also identified:

• the need for effective support for nurses from NESB;

• the need to learn about professional terminology and jargon;

• the need for improved ability to communicate with staff and patients;

• the need for acquiring note-taking skills in clinical settings including relevant use of abbreviations; and

• the need for training in Australian social and medical norms.

It was suggested that even after passing English tests and clinical placements, many NESB nurses continued to face language challenges (Hawthorne, 1997). Problems of adjusting to Australian mainstream culture were seen as major issues for overseas nurses alongside language problems. Conflict between expected cultural behaviour and Philippine nurses' culturally derived behaviour was discussed in terms of making the learning of new knowledge difficult (Teschendorff, 1995). The structure of competencies assessment was described as monocultural and monolingual and was questioned as a valid basis for describing and evaluating culturally diverse communities in the assessment of professional competence (Groutsis, 1999).

3.4. Discussion

The results of the review identified a number of research papers and expert opinion publications related to the topic under investigation. As there were no experimental studies identified on the topic, a meta-analysis was not conducted. Critical appraisal and synthesis of two interpretive studies examining experience of overseas nurses working in Australia were conducted using JBI-QARI. This resulted in two syntheses that related to difficulties in entering Australian nursing practice and loneliness or feeling of being treated as 'outsiders'.

Out of the two syntheses from the qualitative research findings, two needs can be identified:

• the inclusion of cultural difference issues in a transition program for overseas nurses; and

• the provision of formal networks for overseas nurses and support to facilitate the establishment of informal networks.

This synthesised evidence should be taken into account in the planning of support programs and the findings of this synthesis should bring about new insights for professional bodies, educational institutions and nurses working with overseas qualified nurses. Other identified studies include: a grounded theory study, program evaluation reports, descriptive correlation and qualitative descriptive studies; all these met the inclusion criteria but were only included in narrative summary.

Although their evidence levels were not considered high and application to the practice of findings from such studies requires careful consideration, there was a clear trend that the findings from these other identified studies largely support the two syntheses from the interpretive studies.

The first synthesis of OQNs' experience of loneliness, isolation and feeling of being an 'outsider' has a strong link to OQNs' inability to communicate effectively in English. The feeling of being an outsider and its relation to language problems was also discussed in all identified research-based papers and expert opinion papers; findings from such papers were congruent to the synthesis. Findings such as problems concerning the complexity of English use in nursing practice and a need for more involvement of English language education specialists for programs such as bridging courses have been identified. Without meaningful communication with various co-corkers and patients, nursing cannot be practised effectively. It is important to recognise that the required language skills of nurses are highly complex and good language support for overseas nurses of NESB is needed.

The second synthesis of difficulty in entering Australian culture from diverse cultural backgrounds was also discussed widely in all the identified research-based papers and expert opinion papers and this literature supports the synthesis. The use of preceptorships or buddy nurses was reported to facilitate overseas nurses' adjustment to Australian nursing culture but the evidence level of these reports is low. There should be more empirical studies examining the effectiveness of such interventions to support overseas nurses.

A lack of interest from researchers and probably a lack of funding have resulted in very limited numbers of recent studies on overseas nurses' adjustment to Australia such as examination of certain supportive interventions or evaluation of programs that aim to assist OQNs. In recent years, particularly, the amount of research on bridging programs has been extremely limited and the provision of such programs has not been fully research based. If the Australian government and the Australia nursing institutions continue to encourage OQNs to enter the country, the qualification assessment and provision of support programs such as bridging programs should receive more attention from researchers and leaders. At the very least, regular evaluation studies of existing bridging programs are needed.

3.5. Conclusions of the review

The conclusions of this review are limited by the design of the studies and the number of the studies conducted on the topic. It is also important to note that some of the results are also based on single studies. However, meta-synthesis was able to be conducted on the qualitative papers and these syntheses were supportive of findings from other studies.

3.5.1. Implications for practice

From the overall results of the review, a number of recommendations can be derived for future practice (where possible levels of evidence are assigned for each recommendation):

• The clash of cultures between overseas nurses and the dominant Australian culture should be addressed in a transition program. (Level of Evidence 4).

• If strategies to assist overseas nurses to establish informal networks of friends and professional colleagues were in place, the transition to becoming effective practitioners could be enhanced.

• A buddy or preceptor system may be widely used to support overseas nurses' linguistical and cultural needs.

• Close work with English language education specialists in bridging programs is necessary.

• Clinical nurses, nurse educators and team leaders should have an understanding of strategies for supporting the linguistic needs of overseas nurses.

3.5.2. Implications for research

Many initially identified as quantitative papers were actually descriptive in nature and there were no experimental studies identified. Further research using an experimental design is required to examine the effectiveness of particular supportive interventions to assist OQNs. Finally, many studies identified in this review were conducted five to eighteen years ago. Considering the rapid changes in the demographic picture of OQNs and in the health care climate in Australia, regular studies to update evidence are crucial.

Chapter Four: Methodology

Within the qualitative research paradigm, methodology does not mean a set of practical procedures associated with a research project as in the scientific/positivist research tradition. Instead, methodology refers to the philosophical framework of a research project and defines the fundamental assumptions and characteristics of the research (Van Manen, 1997). In other words, methodology means the epistemological and ontological assumptions that specify how the research is to be carried out (Racher, 2003). Methodology sets the direction of the research project and the *choice* of methodology defines the research methods and procedures, i.e. the relationship between the researcher and the research participants, the types of research questions to answer, the data collection methods, the data analysis methods, the interpretation of the findings, and the actual presentation of a research report. Therefore, it is critical to choose a methodology appropriate for the purpose and nature of the topic under investigation.

This study employs hermeneutic phenomenology as its methodology. The purpose of the study is to examine the experiences of OQNs from NESB. In this chapter, I will articulate my methodological choice by firstly discussing some important concepts of hermeneutic phenomenology, mainly those of Heidegger and Gadamer, and other significant philosophers' ideas that have influenced them in turn, such as Descartes, Husserl, and Dilthey; and secondly, by examining the current status of hermeneutic phenomenology in research in nursing.

4.1. Phenomenology

Phenomenology is essentially the study of 'human phenomena'. van Manen (1997, p. 7) defines the aim of phenomenology as "…to gain a deeper understanding of the nature or meaning of our everyday experience." Based on the recognition of the categorical incompatibility of traditional natural science

to investigate 'human' phenomena, phenomenology provides an ontology and epistemology for understanding the human lifeworld – the recurring patterns of interaction and social experience that constitute one's understanding of 'the world' and one's place in it.

The phenomenological movement was initiated by the German philosopher Edmund Husserl. He criticised the Cartesian dichotomy of mind/body or subject/object separation; and proposed his transcendental phenomenology as a way of providing a solid knowledge base for the discipline. Building on Husserl's work, Martin Heidegger transformed the latter's transcendental phenomenology into a phenomenology of being (ontology). Having been influenced by previous hermeneutics scholars like Dilthey, Heidegger's phenomenology is usually termed Hermeneutic Phenomenology and other well-known phenomenologists including Merleau-Ponty and Sartre, developed their work based on Husserl or Heidegger. The rise of phenomenology has had a large impact on the development of contemporary philosophical areas such as hermeneutics, critical theory, post-structuralism, post-modernism and others. Phenomenology is significant in that it has contributed to an expansion of understanding human-related issues, especially in disciplines of the humanities and human sciences.

To discuss Heidegger's philosophy, it is crucial to first analyse and understand Husserl's main philosophical points. Husserl is generally recognised as the founder of phenomenology and there are several biographical publications on Husserl (Spiegelberg, 1978; Hammond, Howarth & Keat, 1991; Luft, 2004). Very briefly, Husserl was born in 1859 into a wealthy Jewish family in Germany and his original interest was mathematics; he received a PhD in mathematics with a thesis (Luft, 2004) on the theory of the calculus of variations at the age of 24. Although he later became interested in philosophy and completed his education in philosophy under Franz Brentano, his earlier mathematics background influenced his philosophical work throughout his academic career. Husserl's philosophical focus changed over time, moving firstly from mathematics, to then seeing phenomenology as equally objective and subjective, and later having subjectivity dominate his pursuits in seeking a foundation of the philosophy of science (Laverty, 2003).

4.2. From Descartes to Husserl

4.2.1. The Cartesian model of knowledge and human being

Since the Enlightenment, modern Western thought has been dominated by influences from the Cartesian rationalist/scientific model (Crotty, 1998). Enlightenment thinkers like Descartes are concerned with how we can 'know' knowledge including knowledge of the experience of the external world; for Descartes, a mathematically-based scientific knowledge of the material world is possible. For Enlightenment thinkers like Descartes, how to demonstrate epistemological certainty was also a crucial question and this carries the assumption that absolute truth objectively exists although it is not simple to demonstrate that this is so.

Barnacle (2001) uses an example of a chair to describe the problem that thinkers like Descartes faced in searching for absolute truth. There is a chair and we can see it but how can we prove that the chair really exists? Any attempt to do so would inevitably involve sensory perception. However, it is not clear how to distinguish without doubt between reality and illusion with our senses alone.

Descartes sought to answer this question through introspection. His discovery of self as a constantly present entity that guarantees the presence of other things led to his famous dictum, *"I think, therefore I am"* or "*Cogito ergo sum*" (Descartes, 1996, p.49) which is thought to ground knowledge in the thinker's awareness of his/her cognitive processes, that is self. Thus, by claiming the fact that "I think" as a basis, Descartes sought to overcome epistemological uncertainty known as *Cartesian doubt* (Barnacle, 2001).

Attempts to distinguish what can be known without doubt led to the development of a subject/object, or mind/body dichotomy, known as Cartesian dualism (Husserl, 1977). In the Cartesian model, human is understood as a disembodied consciousness. Conscious knowledge/self is superior to bodily

knowledge and this consciousness /the self possesses a body. The consciousness/the self is seen as subject and the world or environment is seen as object. Thus, the world is understood through conscious/cognitive activity which is detached from the rest of the world including its body.

4.2.2. Critique of the Cartesian model

Certain assumptions of the Cartesian model of understanding and knowledge are often criticised by scholars in human-related disciplines. For instance, Barnacle (2001) analyses two problems of Descartes's model when applied to human subjects. Firstly, a hierarchy is established where cognitive knowledge, or that which is independent of sensory perception, is treated as superior to that obtained by the senses; secondly, being human is defined through *disembodied* consciousness: the human subject is defined through its own capacity to "know itself".

Following the Cartesian tradition, Husserl seeks a solid foundation of knowledge. However, Husserl criticises Descartes's failure to free himself from various philosophical prejudices (Husserl, 1977). In Husserl's view, Descartes, despite his intention of making a radical new philosophy of science, remains within a specific paradigm of science/mathematics. Husserl also rejects Descartes' evidence on the basis of *Cogito ergo sum* for its failure to connect with the wide open world of subjective life (Luft, 2004).

Husserl's goal is to establish a philosophy of science which will provide the foundation for all sciences. McKenna (1982) claims that Husserl believes that such a science is needed because modern humanity has lost faith in reason as a means toward a truly satisfying life. Husserl (1980) claims that existing science abstracts from the real world and lives in its own world of formulas; the life-world in which human activity is carried out has been forgotten. In his view, science not only loses sight of the lifeworld but it *replaces* it with the scientific world. The lifeworld has become obscured by a scientific view that does not see the world as it is in its original and pre-formulaic sense (Luft, 2004).

Husserl (1980) specifically criticises the discipline of psychology as a science that has gone in the wrong direction by applying methods of (natural) sciences to the understanding of human issues; recognition of the limitations of the scientific model to human phenomena could be one of the major contributions that Husserl has made to modern philosophy.

Husserl has proposed an alternative model of science to the Cartesian model called transcendental phenomenology that is expected to be the science of all the other sciences: the study of phenomena. Husserl's transcendental phenomenology is one response to the question of the relationship of mind/body, object/subject and internal/external world. He has shifted from Cartesian dualism to the relationship *between* consciousness and objects of knowledge (Barnacle, 2001).

Husserl (1980) speaks of his phenomenology as 'pure thought' and contends that it has reached the point where it is explicitly concerned with returning to the things themselves as phenomena that are transcendentally pure. Transcendental phenomenology is "…in fact, a purely descriptive discipline, exploring the field of transcendentally pure consciousness by pure intuition" (Kersten, 1989, p.20). For Husserl, being pure means being free from pre-assumptions and prejudice, and remaining neutral.

For Husserl, phenomenology is also 'pure' in the additional sense of being eidetic: "…pure or transcendental phenomenology will be established, not as a science of matters of fact, but as a science of essences (as an eidetic science); it will be established as a science that seeks to ascertain exclusively 'cognitions of essences'." (Kersten, 1989, p.20). In short, Husserl's phenomenology is a description of the science of consciousness and its objects.

4.2.3. Intentionality

McKenna (1982) indicates that the concept of intentionality is one of the core themes of Husserl's transcendental phenomenology. Husserl (1970, p163) explains the concept of intentionality as "We must say to ourselves again and again that without them (intentionality or intentional mental

processes) objects and the world would not be there for us and that they are for us only with the meaning and mode of being that they constantly derive or have derived from these subjective achievements." Contrary to the Cartesian view, for Husserl, there is a relationship between the world and consciousness; these are interconnected, and to experience the just- mentioned moments of consciousness is to have the world on hand.

4.2.4. Life-World (*Lebenswelt*)

It is Husserl who introduced the concept of the "lifeworld (*Lebenswelt*)" to modern philosophy. In *Crisis of European philosophy and transcendental phenomenology* (Husserl, 1970), the importance of a science of the lifeworld and the importance of the experience of the lifeworld are presented. Existing sciences are not the only field in which knowledge is an issue; there is a pre-scientific life and the ordinary performance of life being carried out in the lifeworld. Lifeworld, for Husserl, is the field in which life in general is carried out in its ordinary 'everydayness'. For Descartes, *I am the conscious of the world*, while for Husserl, *the world is there for me.* Not only self/consciousness but also the world is for us at first, most fundamentally and always (Mckenna, 1982).

4.2.5. Phenomenological reduction

Phenomenological reduction has probably been one of the most important themes of Husserlian research over several decades. The idea of phenomenological reduction is, according to Luft (2004), derived from the Skeptic tradition of gaining a view unbiased by the theories of the past. The procedure of bracketing/epoche is essential to Husserl's phenomenological reduction -- the methodological procedure. By suspending our prejudgement, we are led from the *natural attitude* in which we are involved in the actual world and its affairs, to the *phenomenological attitude*, in which the analysis and detached description of the content of consciousness is possible (Hammond, Howarth, & Keat, 1991).

It is argued that phenomenological reduction helps us to free ourselves from prejudices and secure the purity of our detachment as *observers*, so that we can encounter things *as they are in themselves* independently of any pre-suppositions (Husserl, 1977). Thus, the detached analysis of consciousness in which objects, as its correlates, are constituted, can be achieved.

Husserl's transcendental phenomenology is opposed to philosophical realism. For Husserl (1977), philosophical realism involves a philosophically naïve misinterpretation of *the natural attitude*, the everyday assumption of the independent existence of what is perceived (Hammond et al., 1991). His phenomenology aims to reach and describe the *essence* (ultimate structure) of the phenomena/conscious activity, not merely a description of the everyday world. What makes Husserl's transcendental phenomenology different from philosophical realism is the use of *bracketing* technique in approaching/observing the phenomena of investigation; one must suspend his/her assumption/prejudgement, and investigate these experiences with a *phenomenological attitude* as opposed to a 'natural' attitude.

4.2.6. Criticism of Husserl

Despite Husserl's great contribution to the human sciences, there has been substantial criticism of his Cartesian perspective, particularly the concept of phenomenological reduction. For instance, Luft (2004) claims that there are two not necessarily related points: a Cartesian discourse and a lifeworld tendency. 'Cartesian' and 'lifeworld' are two fundamentally opposed concepts in philosophy. Husserl finds himself unable to systematically integrate these fundamentally contradictory strands.

There can be no doubt about Husserl's high esteem for science. For Husserl, phenomenology does not devalue the achievements of the positivist approach, but he also wants to embed this in an all-embracing scientific endeavour that should remain "in touch" with the lifeworld from which it has sprung (Luft, 2004). It appears that as Husserl criticised Descartes for not having abandoned his mathematical/scientific view, Husserl himself is also trapped in a mathematical/scientific orientation.

Concerning Husserl's interest in the lifeworld, Landgrebe (1981), Husserl's former junior staff, argues that Husserl's turn of attention to the lifeworld is a departure from Cartesianism. According to Landgrebe, Husserl actually realised that he could not lay an indisputable foundation in the Ego/consciousness; he more or less consciously abandoned this view and turned to the lifeworld as the actually working field of phenomenology. However, this view is not widely accepted. There is little evidence in Husserl's own writing to justify his alleged departure from Cartesianism and so it is probably fair to conclude that if Husserl abandoned his Cartesian view, it was not until the end of his career.

4.3. Hermeneutic Phenomenology

Hermeneutics refers in general terms to the discipline of interpretation of texts. The word hermeneutics is derived from the Greek *hermeneuein* which means 'to interpret' or 'to understand'. Historically, the term 'hermeneutics' was originally used for the interpretation of the Biblical texts (Seebohm, 2004).

Philosophers around the turn of the nineteenth century, such as Ast (1990/original published in 1808) and Schleiermacher (1990/original published in 1819) expanded the notion of hermeneutics beyond the scope of historical Biblical interpretation to include textual interpretation, generally. However, as Barnacle (2001) argues, it was not until Dilthey (1833-1911) that hermeneutics really started addressing the broad sense of human action generally, and the understanding of such, in the disciplines of history and philosophy. Dilthey developed the concept of rigorous method/methods of the human or historical sciences, which rely on understanding, as opposed to the natural sciences (Rockmore, 2000). The idea of the former centres on a science of 'meaning' in contrast to the natural sciences (Pillay, 2002).

According to Crotty (1998), Dilthey's goal was to elaborate a methodology for gaining objective knowledge that is different from that of natural science: a methodology that can take account of the *historical nature of life*. For Dilthey, natural sciences (*Naturwissenschaften*) are concerned with *explanation* while human sciences (*Geisteswissenschaften*) are concerned with *understanding*. While natural science aims to scientifically explain the natural world, the human sciences interpret and understand human life (Palmer, 1969). In other words, natural science deals with facts while social or cultural science must deal with both facts *and* human values. In these terms, the classical empiricist position set out from the time of J. S. Mill in the nineteenth century, which advocates the value of causal, inductively established explanation for all phenomena, including both natural and social sciences, is flawed. From the German position, the human sciences (*Geisteswissenschaften*) or cultural sciences (*Kulturwissenschaften*) are different in kind from the natural sciences (*Naturwissenschaften*).

Parallel with the criticism toward Husserl's remaining Cartesian influence, Dilthey's search for objective knowledge has been similarly criticised (Crotty, 1998; Gadamer, 1976; Pillay, 2002). From Dilthey's perspective, understanding is the process of mind reconstructing the mental objectifications of another (Ormiston & Schrift, 1990). He places man in the flow of history and presents the importance of a methodology that embraces human phenomena as distinct from natural science; but his standing point may still be 'trapped' (i.e. a categorical error) in the Cartesian quest for objectivity.

In more recent years, the possibility of providing rational justifications or 'correct' interpretations for human actions has been a large concern among contemporary thinkers of hermeneutics (Bohman, 1991). Heidegger transformed hermeneutics' concern from establishing a so-called objective methodology to developing an ontology of Being. His introduction of the concept of *fore-structure* in the course of understanding Being has also had a great impact on latter hermeneutics thinkers and other contemporary philosophers. After Heidegger, Gadamer has taken up Heidegger's ontology and advanced his legacy. For Gadamer, all understanding is interpretation (Gadamer, 1975).

In the following section, I will articulate some of Heidegger's and Gadamer's central ideas in relation to their philosophy of hermeneutic phenomenology.

4.4. Heidegger

Martin Heidegger is widely recognised throughout the Western world as one of the most significant philosophers of the 20th century. His ideas have contributed to the development of other philosophical fields and philosophical ideas including phenomenology (Merleau-Ponty), existentialism (Sartre), hermeneutics (Gadamer, Ricoeur), postmodernism (Derrida) and other fields such as political theory, psychology, and even theology (Dreyfus, 1991b). The core of Heidegger's philosophy is ontology, in other words, the study of Being or the study of human existence, that has been neglected since ancient Greek times (Heidegger, 1962). Heidegger built on previous philosophers' ideas, such as Dilthey's historical hermeneutic and Husserl's transcendental phenomenology; he combined these two strands of philosophy and transformed them into his hermeneutic phenomenology. With this, he has moved beyond an epistemological debate to an ontological one, with its existential tone.

4.4.1. Brief biography of Heidegger

To better understand any philosopher's ideas, it is useful to have some understanding of the historical, social and personal context behind the development of the ideas. This seems particularly true in the case of Martin Heidegger. Heidegger was born in 1889 in south-west Germany to a Catholic family (Wolin, 1993). According to Wolin (1993), his father was a sexton in the local church and wanted him to become a priest. With a scholarship from the church, he attended high school and later started studying theology at Freiburg University in Baden-Württemberg in Germany. He left the course due to ill health or possibly a lack of passion for the priesthood. However his original background in theology and Catholicism has been claimed to have had a large influence on the development of his thought (Wolin, 1993). Then he studied philosophy and other subjects including mathematics. He

undertook a PhD in philosophy with a thesis on The Doctrine of Judgement in Psychologism under the supervision of Heinrich Rickert who was a neo-Kantian philosopher (Dreyfus & Hall, 1992).

Heidegger was then appointed as Husserl's assistant at the university. Husserl soon found evidence of Heidegger's unusually sharp intellect but despite Husserl's intention to make Heidegger the chosen heir of Husserlian phenomenology, Heidegger was not his master's faithful follower (Wolin, 1993). Heidegger dedicated his monumental book *Being and Time* (Heidegger, 1962) to Husserl but in reality, it was a radical reinterpretation of Husserl's transcendental phenomenology. His ideas had moved fundamentally from Husserl's phenomenology of conscious activities to a phenomenology of being (ontology) (Dreyfus & Hall, 1992).

Hopkins (1999) describes Husserl and Heidegger's rather bitter relationship and disagreement over each other's works by quoting from personal letters written by Heidegger and Husserl themselves. For instance, Heidegger wrote to his friend that he had burnt Husserl's publications during his lecture in front of his students. Heidegger knew his up-coming publication (*Being and Time*) would further strain their relationship but he published it regardless (Hopkins, 1999). As Heidegger had anticipated, Husserl could not accept Heidegger's new phenomenology. Husserl thought Heidegger was distorting his phenomenology and was deeply disappointed. Husserl erased all trace of Heidegger from their collaborative work in an Encyclopaedia Britannica article before publishing it. Nevertheless, although they lost contact, Husserl supported Heidegger's career until the very end.

Heidegger had a controversial involvement with Hitler's National Socialist German Workers' Party during the early stages of World War II and often received criticism after the war (Lacoue-Labarthe, 1990; Victor, 1989) for his alleged complicity in Nazi ideology. As a result, immediately after the end of the war, he was forbidden to teach and was dismissed from his chair of philosophy. Later he was returned to his academic job as a Professor emeritus in 1951 (Wolin, 1993).

After the 1930s, his thinking and writing changed, and this became known as *the turn* (Feher, 1996, p. 9). His style became less systematic and less academic than in his previous works and he became interested in an exegesis of philosophical and literary texts, and poetry. He continuously wrote until his retirement and died in 1976.

4.4.2. Heidegger's hermeneutic phenomenology

Heidegger does not provide objective procedures for his hermeneutic phenomenology and this is a crucial point for researchers who consider using Heidegger's phenomenology as a theoretical framework. The central aim of this thesis is not to delve deeply into Heidegger's philosophical world but instead, I will articulate and highlight some of his important ideas that inform the present study.

Heidegger (1962, p.51) examines the semantics of the original Greek for the word 'phenomenon' and comments "The concept of phenomenon signifies that which shows itself in itself, the manifest." Heideggerian phenomenology is "…to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1962, p. 52).

As Heidegger has done in his own work (1962; 1982), it is common practice to discuss his work in contrast to that of Husserl; this contra-distinction helps to explicate some of Heidegger's ideas and it is logical as, in many ways, Heidegger developed his ideas as a reaction to Husserl. So in the following section, the ideas of these two scholars will be contrasted in order to achieve a clearer understanding of some of Heidegger's central ideas.

Glazerbrook (2000) captures the essence of the differences between the two philosophers: Husserl's phenomenology seeks to investigate meaning while Heidegger investigates the nature of 'Being'. Being is the *a priori* question for Heidegger. Husserl suggests a phenomenology of consciousness as opposed to a natural science about consciousness (Glazerbrook, 2000). Husserl argues in 'Philosophy as Rigorous Science' for a philosophy that is scientific, rather than either a naturalistic or a

Weltanschung philosophy. Husserl claims that natural science or the naturalist seeks to discover the natural laws of thinking but this is misguided. Natural science deals only in bodies, and consciousness is not a body; Husserl sees implicit in naturalism the preclusion of *the very things* it seeks to investigate. In essence, Husserl's phenomenology investigates the intentional correlates of consciousness. It pursues the relation between consciousness and being, not as the relation between mind and bodies but rather as the relation between subjective consciousness and intentional objects within consciousness (Glazerbrook, 2000).

In contrast, Heidegger's phenomenology raises the question of the grounding of the human sciences in their *a priori* projection of being (Glazerbrook, 2000). For Heidegger, the positive sciences are only possible on the basis of that prior understanding of being. The task of ontology is inquiry into this prior understanding.

Glazerbrook (2000) highlights the different approaches to phenomenological reduction for Heidegger and Husserl. Husserl's concern is so-called 'meaning', not being. Husserl's phenomenological reduction concerns bracketing: the bracketing of ontology. Husserl turns away from the question of being and seeks to achieve objective knowledge (Wrathall, 2005). In contrast, Heidegger's does not bracket ontology and takes it as a central question. Phenomenology is for Heidegger the method of ontology, and he therefore rejects Husserl's phenomenology, which begins by overlooking or by-passing the question of being. These two phenomenologies are based on fundamentally different views of the world and 'human-ness', and are therefore incompatible (Van Manen, 1997).

van Manen (1997) explains the different approach to the concept of lifeworld taken by Husserl and Heidegger. Husserl attempts to investigate the human life-world using the concept of conscious activity as a key to explore it. In contrast, Heidegger' approach to lifeworld is more worldly and emphasises existential aspects of Being: the study of our modes-of-being or ways-of-being-in-the-world. Again, Husserl and Heidegger are talking about fundamentally different 'lifeworlds'.

4.4.3. Question of Being

In his monumental work, *Being and Time* (1962), Heidegger's main question is "What is meant by 'Being'?" a central question concerning how people organise and make sense of their own existence as 'Being in the world'. This is a question which has been largely overlooked and neglected by philosophers (Heidegger, 1962). Heidegger argues that the question of being is the fundamental question: the *a priori* question. Then he claims that Being must be made transparent by means of an appropriate way.

Philosophers have tried hard to provide answers to the epistemological problems (questions of knowledge). In contrast, Heidegger has moved *beyond* the epistemological quest to the more fundamental stage: that of ontology (questions of being, existence) (Dreyfus, 1991b). Probably this shift away from epistemological questions is Heidegger's greatest contribution to contemporary philosophy in general, and cultural and human sciences in particular.

To clarify Heidegger's theoretical standpoint by way of contrast, Dreyfus (1991b) has made a five point analysis of the traditional assumptions which Heidegger rejects: explicitness, mental representation, theoretical holism, detachment and objectivity, and methodological individualism.

Rejection of explicitness: for Heidegger, it is not possible to make our everyday understanding totally explicit with neutral, objective 'data' like a computer. There is no way to control the *variables* of everyday-life in order to reduce it to a context-free object. Thus, one always remains within the hermeneutic circle of subjective interpretation and that is all one can do in understanding human phenomena (Dreyfus, 1991b).

Rejection of mental representation: Heidegger rejects the concept of mental representation derived from a Cartesian understanding of person (Rice & Ezzy, 1999) to explain human-related phenomena. Before and after Heidegger, many philosophers have used mental representation models in issues

relating to the human lifeworld; for instance, Husserl uses intentionality of consciousness in his argument. Other examples of mental representation models include cognitivism and information processing models of the mind. Instead, Heidegger has taken a non-representable and non-formalisable approach (Dreyfus, 1991b).

Rejection of theoretical holism: Heidegger rejects a traditional assumption that there must be theorisable rules in every orderly domain. He criticises constructs in traditional theoretical holism such as object/subject, conscious/unconscious, reflective/unreflective and calls for a return to the phenomena themselves (Dreyfus, 1991b). In other words, Heidegger seeks to understand the human phenomenon as it is and he rejects approaches that attempt to grasp human-related matters from some holistic-like approach. In reality, such an approach is based on a deductive world-view.

Rejection of detachment and objectivity: from Plato to Descartes, or even Husserl, philosophers have believed in the superiority of the detached theoretical viewpoint over the viewpoint that is involved in human practice. But Heidegger rejects such traditional assumptions and calls for 'Dasein' as the preferred mode of investigation (Dreyfus, 1991b) . For Heidegger, the researcher of human values and culture is already involved in the world of investigation and therefore it is not possible to detach oneself. Instead of aiming for some kind of detachment from the subject of study, the researcher instead aims to align his/her perspective and 'fore structure' (vor-struktur) (Heidegger, 1962, p. 151) of the situation with that of participants, in much the same way as an anthropologist in the field might do.

Rejection of methodological individualism: Being influenced by Dilthey, Heidegger believed that the meaning and organisation of a culture cannot be traced back to each individual. For Heidegger (Dreyfus, 1991b), it is not possible to explain social context such as meaning and organisation of culture from a reductionist individual person's level; all we can do is carefully describe everyday practices.

4.4.4. Dasein

For Heidegger, traditional philosophy or traditional science does not answer the questions of Being. To examine human phenomena or Being, Heidegger uses the concept of *Dasein* (Heidegger, 1962). *Dasein* means 'life' or 'existence' in German; Heidegger uses the term in connection with socialised and cultural human beings. In his *Being and Time*, Heidegger comments on the concept of *Dasein* as follows (Heidegger, 1962, p. 27):

> *Thus to work out the question of Being adequately, we must make an entity -- the enquirer--transparent in his own Being. The very asking of this question is an entity's mode of Being; and as such gets its essential character from what is enquired about namely, Being. This entity which each of us is himself and which includes enquiring and the possibilities of its Being, we shall denote by the term Dasein.*

While Husserl formulates his philosophy based on intentionality of conscious activities, Heidegger takes a more fundamental approach; only by analysing *Dasein*, can one understand Being. Phenomenology for Husserl is based on detached observation and description of consciousness. In contrast, for Heidegger, it is *Dasein*; *Dasein* implies both a method for access to being and a formation of historically and culturally lived experience (Laverty, 2003).

Heidegger (1962) explores temporality as fundamental to the constitution of *Dasein*. *Dasein* is not something concrete or fixed; temporality is the primordial meaning of *Dasein*'s being. Heidegger defines human existence not as an object or something concrete, but "instead as a 'happening' or 'event' (Geschehen) in which *Dasein* is what it makes of itself in the course of living out its life" (Guignon, 1992, p.131). *Dasein* takes time into account in its daily activities; it projects itself into the future.

4.4.5. Understanding

For Heidegger, understanding is not a cognitive activity; it is practical and a kind of competence (Blattner, 1992). To understand something is to let it play some role for you, to cast it in the role. Heidegger's (1962) metaphor of the hammer to explain what understanding means in his sense, is well known. Understanding does not refer to being able to describe how the hammer looks; understanding means being able to use the hammer; being able to let the hammer play the role. Heidegger connects the concept of understanding and interpretation. He explains this interpretation as follows:

> *As understanding, Dasein projects its Being upon possibilities.……..The projecting of the understanding has its own possibility - that of developing itself (Sichauszubilden). This development of the understanding we call 'interpretation'. In interpretation, understanding does not become something different. It becomes itself (Heidegger, 1962, p.188).*

Later, Heidegger introduces the role of fore-structure in the process of understanding:

> *In every case, interpretation is grounded in something we see in advance-in a fore-sight. This fore-sight takes the first cut out of what has been taken into our fore-having, and it does so with a view to a definite way in which this can be interpreted.……..Whenever something is interpreted as something, the interpretation will be founded essentially upon fore-having, fore-sight, and fore-conception. An interpretation is never a pre-suppositionless apprehending of something presented to us (Heidegger, 1962, pp.191-192).*

Thus, for Heidegger, interpretation is always founded on a fore-having view (fore-structure). By fore-having, Ormiston and Schrift (1990) explain that Heidegger refers to the totality of involvements with Being, both that we already have and that we bring with us to each interpretive act.

4.5. Gadamer

4.5.1. Brief Biography of Gadamer

Gadamer is the decisive philosopher in the development of contemporary hermeneutics. He was born in 1900, in Marburg in Germany; his father was a professor of pharmacy. After completing his doctoral thesis with neo-Kantian philosophers, he worked as Heidegger's assistant for a time. In 1928, Gadamer submitted his habilitation dissertation on 'Plato's Dialectical Ethics' under the supervision of Friedlander and Heidegger. It was Heidegger who mostly influenced the development of Gadamer's philosophy. In the period of the 1930s and 1940s, Gadamer reluctantly aligned himself first to National Socialism and then to Communism but he was not an active supporter of either regime (Palmer, 1969).

In 1960, Gadamer published his work *Truth and Method* (Gadamer, 1975). He officially retired in 1968 but actively continued working until late in his life and engaged in a number of famous public debates with other well known thinkers such as Betti and Habermas (Palmer, 1969). Betti criticises Gadamer's subjectivism and objectivism while Habermas attacks Gadamer for being uncritical toward authority. The significant point in respect of the present study is that Gadamer's ideas have had a profound impact on the development of contemporary hermeneutics and related philosophical ideas and his ideas feature in some way in a majority of such works.

4.5.2. Gadamer's Hermeneutics

Gadamer basically adopts Heidegger's phenomenological approach to hermeneutics and develops Heidegger's insight into the 'linguisticality' (*Sprachlichkeit*) of understanding (Ormiston & Schrift, 1990). Gadamer focuses on the 'happening' of understanding, especially as it pertains to tradition and to the interpretation of works of art, literary texts, and history. Gadamer argues that the modern obsession with Method has distorted and concealed the ontological character of understanding (Bernstein, 1983). Despite the title of his famous book *Truth and Method*, he did not actually present practical procedures or so-called methods with which to conduct his claimed hermeneutic practice.

In the following section, I examine three features of Gadamer's philosophical ideas.

4.5.3. Prejudice and understanding

The word prejudice (pre-judgement) usually has a negative tone but Gadamer (1975) reinterprets it in a positive light as an inevitable aspect of understanding. Like Heidegger's idea of fore-structure, Gadamer's prejudice involves the process of understanding. For Gadamer, prejudice is something one brings into understanding but it does not restrict our understanding; instead, by our prejudice, the world opens up to us. The implication here is that one can understand things only from one's own point of view. It is not possible to understand others as they understand themselves; we only understand them according to our own prejudice (Bohman, 1991). Thus, inevitably, Gadamer appears to abandon the search for objective and indisputable truth, but he does not accept allegations of subjectivism and relativism (Ormiston & Schrift, 1990).

4.5.4. Understanding as fusion of horizons

Gadamer's work emphasises the dialogic nature of understanding. For Gadamer, understanding does not happen independently; essentially, it means coming to an understanding with others (Warnke, 1987). In the process of understanding, our prejudices are brought into question and thus understanding occurs in *negotiation* between oneself and one's partner in the hermeneutical dialogue.

The aim of hermeneutical dialogues is to come to an agreement about the matter at issue and coming to such an agreement, for Gadamer, is establishing an 'horizon'. Gadamer uses the notion of 'horizon' (*Horizont*) to explain his view of understanding; understanding entails a process of the fusion of horizons (Warnke, 1987).

For Gadamer, there is no independent context-free truth; everything is understood through interpretation. The act of interpretation is an act of encounter (dialogue) between the interpreter and the 'being of the thing' such that the latter discloses itself (Pillay, 2002). Hence, all understanding is trapped in the 'hermeneutic circle' where everything is interpretation, contextual and circular (Bohman, 1991).

4.5.5. Historicality

Gadamer employs the concept of historicality as a foundational assumption of understanding/ interpretation. For Gadamer, the aim of hermeneutics is " to discover what is common to all modes of understanding and to show that understanding is never subjective behaviour towards a given 'object' but towards its effective history -- the history of its influence." (Gadamer, 1991, p.228) Understanding is possible only in the context of our prior involvement (prejudice). Therefore, it is only possible on the basis of our history. Understanding/interpretation occurs always from within a particular horizon that is defined by our *historically determined situatedness*. Understanding is always affected by and results from history and our hermeneutical being is always historically affected (Gadamer, 1975).

4.5.6. Language

Gadamer focuses on the role of language as a central concern of hermeneutic understanding. Language is not just an instrument for communication but is a vehicle of thought and tradition (Pillay, 2002), and Being that can be understood is language (Gadamer, 1975). Thus, all understanding is

mediated through language. In other words, all interpretation takes place in the medium of a language which allows the object to come into words (Gadamer, 1975). For Gadamer, Being is manifested in language and language is where 'I' and 'world' manifest their original unity (Ormiston & Schrift, 1990). As Gadamer himself states: "Everything that is language has a speculative unity; it contains a distinction, that between its being and the way in which it presents itself, but this is a distinction that is really not a distinction at all" (Gadamer, 1975, p.432)

4.6. Hermeneutic Phenomenology in Nursing

4.6.1. Development of phenomenological research in nursing

Early works on phenomenology in nursing research appeared in the 1970s (Paterson & Zderad, 1976) and were followed by increased attention from nursing scholars, particularly Benner, in the 1980s (Benner, 1984; Olier, 1982; Omery, 1983; Parse, 1981). Her seminal works, clearly and strongly influenced by Heidegger and Gadamer, including: *From Novice to Expert* (Benner, 1984), *Primacy of Caring* (Benner & Wrubel, 1988), and *Interpretive Phenomenology* (Benner, 1994), have been enthusiastically welcomed by the nursing discipline world-wide. As a result, the utilisation of phenomenology in nursing research has rapidly expanded throughout the last two decades and phenomenology has become one of the most popular qualitative approaches in research methodology in nursing, and is particularly relevant for nursing researchers who wish to investigate human phenomena that are embedded in the everyday world.

4.6.2. Debates on the use of phenomenology in nursing research

There have been some tensions concerning the use of phenomenology as a research methodology in nursing. The major, and probably most controversial argument has been proposed by Crotty (1996) who argues that contemporary nursing researchers reduce and mis-interpret European phenomenological philosophy and that such scholars have produced and utilised a so-called 'new'

phenomenology with an uncritical approach to the actual original philosophy. His arguments have drawn wide attention from nursing scholars internationally. Indeed, the debates around Crotty have became rather over-heated. After Crotty's death, his former co-worker, Barkway (2001), called for more constructive arguments for the development of phenomenological research in nursing.

Following the critique of her own work by Crotty, in turn, Benner (1996) criticises Crotty's argument as being uncritical and unobjective and rejects his ideas. Similarly, Darbyshire and his co-workers (Darbyshire, Diekelmann, & Diekelmann, 1999) strongly support Benner's position. They have re-examined the original work by Heidegger and conclude that it is Crotty who interprets Heidegger narrowly in a reductionist way.

Lawler (1998) on the other hand, does not totally agree or disagree with Crotty's arguments. Instead, she claims that there are regional differences in terms of the use of phenomenology in nursing research. She criticises the American trend of phenomenology as a methodological foundationalism which tends to be seen there as the norm in nursing, whereas other regions, such as Australia, are more concerned with consistency with the original philosophy of European phenomenology, rather than the development of procedural techniques.

Other scholars have also compared American and European approaches to phenomenological research. For instance, Caelli (2000) concludes that the major differences between the two approaches are the concept of experience and the role of culture. According to Caelli, in the standard American approach, experience is analysed by describing the participants' experiences within the situated culture while the European/traditional approach may "search for universal meaning of experiences outside the cultural context" (Caelli, 2000, p.375). So the European traditional approach may seek universal meanings or universal truth in a sense, while in the American approach meanings may be culturally constructed. Thus, these two approaches are founded on very different fundamental assumptions about human phenomena.

Considering the importance of scientific/rational research methodology rather than "nurses doing philosophy" (Giorgi, 2000b, p.12). Giorgi claims that Crotty is encouraging nurses to practise nursing philosophy. For Giorgi, phenomenology should be the means of producing new knowledge for nursing practice rather than researching philosophical perspectives. Therefore, for Giorgi, what Crotty claims as phenomenology is philosophical phenomenology and what nursing scholars should be concerned with is "scientific phenomenology (Giorgi, 2000a, p. 3)".

Phenomenology is originally a "pure" philosophy after all. Therefore, there are no indisputable phenomenological research methods. Any attempts to establish objective and clear research methods in phenomenological research are open to criticism. Nursing researchers should not blindly adopt some procedural guidelines called phenomenological research methods. A critical attitude based on a reasonable understanding of philosophical phenomenology is required. At the same time, since nursing is a practical discipline, nursing research should aim to improve practice directly or indirectly. It is of doubtful relevance if nurses are just "doing" philosophy.

The bottom line is that if nursing scholars wish to continue using the term phenomenology in nursing research, more heed should be paid to the original philosophers' ideas. Although we might be trying to establish a phenomenological science to produce new knowledge for the discipline of nursing, we should not abandon efforts to establish methods that are as consistent with the original philosophy as possible. Thus, phenomenological researchers are challenged to embrace two fundamentally different concepts: establishing clear methods while maintaining consistency with the abstract philosophy of phenomenology. Since the leading philosophers in phenomenology did not provide any procedural indications for researchers, what we should do is to continue discussing and developing this issue and maintaining meaningful dialogue among different academic parties.

4.7. Summary of key Concepts

In this chapter, firstly, key ideas from Husserl, the founder of the phenomenological movement's transcendental phenomenology, were discussed, focusing in particular on the relation to the Enlightenment thinker, Descartes. Descartes sought to solve the epistemological problem by going inwards to the mind and presented conscious activity as the foundation of knowledge. Descartes' view is based on the assumption that conscious knowledge is superior to sensual/bodily knowledge which led to the mind/body separation, sometimes termed the 'Cartesian dichotomy'. The Cartesian idea has had a profound influence on modern Western thought in the form of the dominance of scientific and reductionist approaches to the human sciences.

Husserl asserted the importance of a science which could investigate the pre-scientific lifeworld where people's everyday life is carried out. Through Husserl's transcendental phenomenology, the Cartesian dualism of mind/body or internal/external is shifted to the lifeworld. Husserl has proposed a mode of investigation of the human life-world using the concept of conscious activity as a key to explore it; he seeks pure knowledge from a neutral perspective, free from pre-assumptions. To obtain access to the pure essence of the phenomena of investigation, Husserl has proposed the use of 'phenomenological reduction' which observers require to sustain their pre-assumptions, but this has been widely criticised for being yet another logical adjunct of a Cartesian view to the human world.

Secondly, the philosophical underpinning of this study, hermeneutic phenomenology, is articulated with particular emphasis on some central ideas of Heidegger and Gadamer in relation to the understanding of human experience. Following his mentor Husserl, Heidegger combined Husserl's transcendental phenomenology and Dilthey's historical hermeneutics and presented his new phenomenology which seeks to answer the *a priori* question of Being. With Heidegger, the debate around epistemology has shifted to ontology, which is the study of human existence. In contrast to Husserl's use of conscious activity, Heidegger's approach is more worldly and emphasises existential aspects of Being (*Dasein*).

In a methodological sense, Heidegger rejects conventional methodological assumptions (Dreyfus, 1991b) and has proposed a drastically new mode of investigation of human-related phenomena. Heidegger accepts the impossibility of a total understanding of the life-world with 'objective' data in the sense of data as generated by a computer. One always remains within the hermeneutic circle of subjective interpretation and that is all one can do. To understand the phenomena of investigation, Heidegger strongly disagrees with the use of mental (conscious) representation models. In a similar way, he also rejects theoretical holism such as subject/object as being based on a reductive world-view. All we can do is carefully describe and interpret everyday practice. Following Dilthey's notion of *understanding* as the aim of *human sciences*, Heidegger calls for *understanding* human phenomena rather than trying to *explain* by adopting the scientific theoretical approach to the life-world.

Heidegger claimed that the research of human values and culture is already involved in the world of investigation (Dasein) and therefore it is not possible to detach oneself. Thus, he strongly rejects Husserl's phenomenological reduction. Furthermore, Heidegger accepts the concept of fore-structure (fore-having-knowledge) in understanding human phenomena. Dasein is the mode of inquiry and we are always being-in-the-world with our fore-structures. Heidegger also addresses temporality as a central asset of Dasein: we are in the temporal world as temporal existences (Being).

Gadamer develops Heidegger's insight further into linguistic and dialogical understanding. He emphasises dialogical nature in the process of understanding; through dialogue, we negotiate meaning. In a similar way to Heidegger's concept of pre-understanding, Gadamer uses the notion of prejudice in the process of human understanding. His positive interpretation of prejudice is something one brings into understanding and by our prejudice, the world opens up to us. Understanding is possible in the context of our prior involvement (prejudice); therefore, it is only possible on the basis of our history. Understanding/interpretation occurs always from within a particular horizon that is defined by our *historically determined situatedness*. Understanding is always affected by and results from history and our hermeneutical being is always historically affected.

Gadamer also asserts the role of language as a central concern of hermeneutic understanding. From Gadamer's perspective, language is the primary vehicle of thought and tradition and Being can be understood in language practices; all human understanding is mediated through language. In short, all interpretation takes place in the medium of language while language enables the life-world to come into words.

4.8. Summary of the Chapter

In this chapter, the central idea of hermeneutic phenomenology, in particular, some key ideas of Heidegger's and Gadamer's philosophy, have been articulated in relation to research methodology concerned with exploring human experience. Phenomenology is increasingly gaining recognition and acceptance among humanity disciplines including nursing, where researchers are interested in understanding the complexity of the everyday human world. There has been substantial debate around the use of philosophical phenomenology as a research methodology in nursing and some scholars have criticised the over-emphasis of the "phenomenological method" as a methodological foundationalism. In return, other scholars have criticised a perceived tendency by nursing researchers towards an "over-emphasis" of the philosophy.

As discussed earlier, phenomenology is a fundamentally abstract philosophy and adherents of phenomenology have not presented an indisputable phenomenological "methodology" or "method" in an objective and practical sense and one has to accept the view that this is not a fundamentally possible task to achieve. Nevertheless, it is fair to say that it is the researchers' duty to seek a phenomenological research 'method' which is as consistent with the philosophy as possible. Therefore, it has been necessary to demonstrate some key ideas and assumptions of hermeneutic phenomenology in this chapter before embarking on a discussion about what actual research method should be informed by Heidegger's and Gadamer's hermeneutic phenomenology. In the following

chapter, the actual method of my research is presented, namely, van Manen's phenomenological research approach.

Chapter Five: Research Methods

This chapter presents the method employed in the study. Within the Interpretive Paradigm it is a big challenge for researchers to *establish* practical and indisputable research methods that are consistent with the selected philosophical frameworks. As discussed in the previous chapter, despite ongoing debates on establishing a clear and valid phenomenological research method, a single 'standard' phenomenological method that is in wide use across the world simply does not exist. Moreover, it is not realistic to expect that progress will be made towards such a clear research method (in a positivist sense) at some future date, because phenomenology is originally an abstract philosophy and no philosophers have presented clear associated research methods. Therefore, it is each researcher's responsibility to discuss and articulate his/her own phenomenological method based on the underlying selected philosophical framework to investigate his/her phenomena of interest.

5.1. van Manen's approach to phenomenological research

van Manen's (1997) approach to hermeneutic-phenomenological research has been widely adopted to provide a broad structural framework for research. Several other scholars have also articulated their own phenomenological research models or procedural guidelines such as van Kaam (1969), Spiegelberg (1978), Colaizzi (1978) and Giorgi (1989). Their models provide broad approaches or philosophical perspectives, rather than objective guidelines in a positivist sense and these scholars have developed their methods based on particular strands of phenomenology. It is therefore crucial that researchers be aware of the philosophical underpinnings of such approaches. Only then can one judge if the model is suitable for the selected philosopher's epistemological and ontological standpoint.

Following Heidegger's and Gadamer's epistemological and ontological standpoints, van Manen argues that researchers 'understand' on the basis of their assumptions and he encourages researchers to make explicit their pre-understandings in bringing the phenomena into view.

van Manen criticises Husserl's concept of *bracketing* technique to *forget* one's pre-assumptions or pre-understandings in order to maintain a kind of neutrality towards the phenomena under investigation. By contrast, other proposed phenomenological approaches (mentioned above) such as those of van Kaam (1969), Giorgi (1989), Colaizzi (1978) and Spiegelberg (1978), are influenced by the ideas of Husserl's transcendental phenomenology with its emphasis on the bracketing technique. Therefore, the latter scholars' models are not appropriate for this study as the philosophical framework of this project is hermeneutic phenomenology that asserts that there are no value-neutral facts that have not been influenced by the researcher's pre-understandings.

5.1.1. Incorporating pre-understanding

One criticism of van Manen's approach concerns the concept and role of the researchers' pre-understanding of the research process. Unlike many other scholars' methods, van Manen's posits the impossibility of 'understanding without pre-understanding', as discussed earlier. However, he did not actually elaborate on the role of pre-understanding in his method. For Gadamer, understanding is a fusion of horizons/pre-understandings (Gadamer, 1975) and understanding is only possible in the context of previous knowledge that researchers bring into the research process. As Fleming, Gaidys and Robbs (2003) claim, Gadamer sees the concept of pre-understanding in a very positive way that is the complete opposite to Husserl's (1970) negative attitude that one should bracket pre-understanding in the process of understanding.

It appears that van Manen has managed to move beyond the quest for an 'objective' truth, unlike other scholars within fundamentally Husserlian epistemological standpoints, but he is still reluctant to accept the concept of pre-understanding as a critical factor in interpreting human activities. In other

words, there is a certain limitation intrinsic in van Manen's concept if we use this as a theoretical basis for conducting research employing Gadamer's concept of understanding.

I have tried to overcome this possible problem with van Manen's approach, by looking for ways of incorporating the researcher's (my) pre-understanding/prejudice. Keeping a reflective journal is a commonly used method to provoke one's pre-understanding (Fleming et al., 2003; Koch, 1998). By writing a personal reflective journal, I have managed to examine my own personal views or attitudes towards my own research topic. I have also included my personal and professional background in relation to the research topic in Chapter One in order to make explicit my biography and possible influence on the research project.

5.1.2. van Manen's six research activities

The following six activities/methodical structures have been adopted as a broad guideline for the research process included in the present study. These guidelines provide a certain sense of order and structural approach to the research project, consistent with the fundamentally abstract and vague philosophical ideas of hermeneutic phenomenology in the tradition of Heidegger and Gadamer:

1) Turning to a phenomenon which seriously interests us and commits us to the world;
2) Investigating experience as we live it rather than as we conceptualise it;
3) Reflecting on the essential themes which characterise the phenomenon;
4) Describing the phenomenon through the art of writing and rewriting;
5) Maintaining a strong and oriented pedagogical relation to the phenomenon;
6) Balancing the research context by considering parts and whole.

These guidelines have been adapted from van Manen's methodical structures of hermeneutic phenomenological research (Van Manen, 1997, p. 30).

As van Manen (1997) emphasises, these steps cannot be performed in isolation. The six steps are fundamentally and ontologically inter-connected and cannot be used in a step-by-step manner and thus I moved backwards and forwards between the steps throughout the research process. In a sense, I was often involved in all six steps at the same time to some extent. The following section discusses how this process took place and the actual method used in the project.

5.2. Turning to the phenomenon

In van Manen's approach, firstly, researchers are required to commit themselves to the phenomena of interest. This concept of commitment to the project is one of the major differences from a natural science inquiry. van Manen (1997, p.31) explains:

> *Phenomenological research is a being-given-over to some quest, a true task, a deep questioning of something that restores an original sense of what it means to be a thinker, a researcher, a theorist.*

The formulation of phenomenological research questions is the next step of the research (Van Manen, 1997, p.42). For van Manen, it is not possible to decide research questions unless the researchers find interest in the topic. Phenomenological questions do not ask about the relationships of variables nor do they seek explanations. Phenomenological questions ask "What is it like (to be something)?" They ask for a detailed description and interpretation of the phenomena of investigation rather than an objective investigation into cause and effect.

5.2.1. Research aims

I set my research aims and questions as follows:

- To describe and interpret the lived experience of OQNs of NESB to facilitate understanding of such individual nurses;
- To articulate common issues experienced by OQNs of NESB in coming to and working in Australia.

5.2.2. Research questions

- What are the experiences of individual OQNs of NESB working in nursing practice in Australia?
- Are there common or shared experiences among the participants? If so, what are these common issues?

5.2.3. Explicating my pre-understandings

As discussed in Chapter One, I developed my personal interest in this research topic during a bridging program to obtain nursing registration in NSW. When I started my doctoral study, I chose to examine something I would be interested in and something that I felt could contribute to some kind of improvement in practice. Being an overseas nurse myself, it was not difficult to choose the topic for my study. In a way, I discovered my research topic as I had already 'entered the field' as van Manen (1997) describes, the first step of hermeneutic research. The concept and the roles of pre-understandings as described by Heidegger and Gadamer have provided me with a sense of justification for my standpoint as both an overseas nurse and a research student in the research project. Not only that, it also encouraged me to bring *myself*, particularly my pre-understanding to the process, into the data collection, the data analysis and the presentation of the results.

5.3. Investigating the phenomena

In the following section, the data collection process is outlined. van Manen (1997) asserts that the phenomenological researcher needs to be Being in the world in the fullness of life. To conduct phenomenological research/to be in the world with the participants, I found that there were no clear-cut data collection steps in a positivist sense; instead the process was rather messy. It involved constant reflection and re-examination of practical data collection methods in order to obtain a rich insight into the lived world of the OQNs from NESB.

5.3.1. Data collection

I had just arrived in Adelaide when I started my research project. I found myself in a challenging situation in terms of data collection. As I did not know anyone personally or professionally in the Adelaide area at first, only a very small number of nurses showed any interest in participating in an interview. The early participants often explained to me, “There are many other overseas nurses but they say they don’t know you.” (Cindy). Since the snowball sampling method has become discredited for ethical reasons in recent years, I could not expect that the early participants would introduce me personally to all their co-workers or friends.

Moreover, there was an unexpected political/cultural difficulty in finding voluntary participants from one particular country, which was becoming one of the largest exporting countries of the nursing workforce to Australia. Some nurses from this particular Asian country told me that there were many more nurses from their country but they did not want to co-operate with a Japanese researcher. It is not within the scope of this thesis to discuss international politics and modern history but instead, I have decided to introduce this factor in order to illuminate some of the challenges in conducting a qualitative research project with people from diverse national/cultural backgrounds.

This incident was a real turning point in my data collection. I became convinced that the selection of hermeneutic phenomenology as the philosophical underpinning for the study was appropriate. In essence, the incident made me realize that I was already 'Being in the world' with my contextual and historical background without being aware of it. Since phenomenological research is only possible in a relational process with the participants, it appeared that Husserl's phenomenological reduction was not realistic, at least in my research with the nurses from diverse national/political backgrounds.

This incident also taught me the importance of being known personally by OQNs in the Adelaide area. I attended formal and informal gatherings of overseas nurses as much as my schedule allowed. I visited several hospitals and universities in order to meet overseas nurses and their co-workers and managers. By becoming known among overseas nurses, I tried to recruit research participants without pressuring them to participate. Later, I started to receive some inquiries from OQNs who had read my distributed information sheets (Appendix IX), or who had heard about me from their friends or co-workers.

5.3.2. The criteria for participants

The following criteria were used to find research participants:

- Nurses from overseas currently working as registered nurses in Australia;
- Nurses whose native language is not English;
- Nurses who have obtained basic nursing education abroad where English was not the first language;
- Nurses with at least 1 month of work experience in clinical settings in Australia.

Nurses from overseas who did not have any work experience prior to their arrival in Australia were excluded.

5.3.3. Recruitment methods

To commence recruiting, I contacted the Director of Nursing or officer in charge of nursing personnel from 30 health care institutions in the Adelaide area by letter, email, telephone or fax (Appendix VIII). If they agreed to cooperate, they were asked to distribute my information sheets and advertisement flyers (Appendix IX and X) to OQNs working in their institutions. As explained earlier, I also visited nurses at formal and informal gatherings to make myself known and, if possible, to explain the research project and to seek participation in the study.

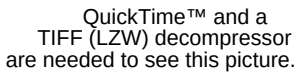
All participants were volunteers. To avoid feelings of coercion to participate, I waited for potential participants to contact me after reading and understanding the information provided. If the participants made it clear that I could contact them directly, then contact was made by phone or email.

5.3.4. Characteristics of the participants

In total, 24 nurses from 11 countries participated in the study (Figure 3); they worked in both the acute care and the aged care sectors. The age range was from 24 to mid-60s and experience in Australia ranged from 6 months to 30 years. There were three cases which required special consideration for inclusion in the analysis. One nurse had retired 2 years before; whereas the original criterion was that nurses must be currently working as nurses. There was one couple who participated in the interview as a couple, while the original data collection method was planned as an individual interview.

I first considered discarding the data regarding these three participants and excluding them from the analysis. However, the retired nurse had had 30 years of wide experience in working in Australia while the couple had had interesting experiences working in another English speaking country prior to coming to Australia. It was very clear that their stories could add much depth to my findings and analysis. Thus, the data from these three participants were also included.

Figure 3 Participants' countries of origin



5.3.5. Length of interview

The interviews usually lasted from one to one and a half hours. On one occasion, the participant had to return to work and the interview had to end after less than half an hour. If I thought that there were some topics or issues needing further exploration and the participants agreed to come to another meeting, second interviews were also organised. One interview was conducted on the phone as it was the participant's preferred method. After the initial interview, some participants maintained contact by email and telephone to provide additional information.

5.3.6. Settings

Since the participants were contributing to the project in their private time, the settings for the interview were chosen by the participants according to their convenience. The settings included an interview room in the Royal Adelaide Hospital, the participants' homes, various cafeterias, at universities, or in the park. To obtain a high quality of recording, quiet and non-distracting environments were preferred but this was not always possible. Any place that was convenient for the participants basically became an interview room. If possible, a snack and tea or coffee were provided to induce a warm and relaxed atmosphere.

5.3.7. Recording

Prior to each interview, the participants were asked for permission to record the interviews and a small tape recorder was used. All the participants agreed to record our conversation. Occasionally, the participants made some comments that might have been interesting for analysis after the researcher had turned off the recorder. In such cases, permission to use the comments for data analysis was sought.

5.3.8. The individual interviews

At the beginning of the interview, each participant was asked to complete the personal information form (Appendix XI). This was actually used mainly as an ice-breaker for the conversation and not for the purposes of statistical analysis. I found this method of initiating individual interviews to be very useful as many participants were not confident with their English and were reluctant to talk about their personal experience at first. The participants appeared to become relaxed in the process of filling out the form. This process also provided me with a brief background of each participant before starting the interview, which helped me to focus on the best questions to ask.

The interviews were conducted using a semi-structured and conversation-style interview method. As the interview progressed, the participants were free to choose whatever they believed to be important or significant in terms of coming to and working in Australia as nurses. If the participants were not talkative or were reluctant to talk, I waited until they felt comfortable and started talking. Often the participants were not confident about whether they were talking about the right topic, and asked questions such as, "Is this kind of thing you want to hear?" and "Is this really useful for your research?" I repeatedly explained that they were providing useful information for the research.

5.3.9. Field notes and reflective journal writing

Field notes were written during and after each interview. Any information I could obtain apart from the audiotape recording was written down. Such information included the participants' facial and bodily expressions, the atmosphere of the conversation, other characteristics of the participants and any other information such as my impression of the participant and the interview.

As mentioned earlier, my personal reflective journal was written up after each interview and at any other relevant time. The journal writing was not meant to be a major part of the actual empirical data but it served as a clarification tool for my pre-assumptions or pre-understandings of the topic and related issues. Moreover, it was also useful for reflecting on any particular issues which had arisen during the research process.

5.4. Describing and interpreting the phenomena

5.4.1. Returning to the nurses with the analysis

The participants were encouraged to read their transcribed interviews and the analysis of the data. If there were any parts the participants disagreed with or wanted to delete from the transcription or the analysis, the text was modified according to their preferences. There were two reasons for this. One was to protect the participants' rights to their own information and how the information was presented; this is extremely important from an ethical point of view. The other aim was to enhance the credibility and validity of the findings by gaining confirmation from the participants.

Generally, the participants were satisfied with their interviews and with the analysis. I always felt that the participants were happy to have someone who was interested in their experiences and who read their own written stories. One participant showed her written story to her co-workers so that she would be understood better. I rarely received negative feedback from the participants but one participant was very anxious about the (unlikely) possibility of being identified by her co-workers concerning her negative comments about her job-related experiences and she was extremely worried about possible reprisals from her co-workers. In cases like this, maximum effort was made to ensure that the identity of the participant would be very difficult to trace by possible readers, while still providing enough relevant background information.

5.4.2. Use of computer software

Each interview tape was transcribed and analysed after the interview. The JBI-NOTARI was used for two purposes. Firstly, it helped to manage and analyse the data in a structured style. Secondly it helped to present the data and the data analysis steps transparently so that the decision trails (Koch, 1995a) of the data analysis would be clear.

5.4.3. The Analysis: Hermeneutic circle as a process of understanding

The hermeneutic circle is a mode of understanding in hermeneutic phenomenology and refers to the circular nature of hermeneutic analysis (Heidegger, 1962). Dreyfus (1991a, p36) explains the hermeneutic circle as "The fact that in interpreting a text one must move back and forth between an overall interpretation and the details that a given reading lets stand out as significant."

In hermeneutic inquiry, the researcher moves backwards and forwards from the text, from the details to the whole and from the whole to the details in order to understand the subjects' lived experiences. This circular movement of the understanding process is the core feature of hermeneutic research.

Following the idea of the hermeneutic circle, two types of analysis were conducted: firstly, the analysis of the individual cases in the narrative approach and, secondly, the thematic analysis of the multiple cases. The case analysis chapter mainly addressed the first research question, "What are the experiences of individual OQNs of NESB working in nursing practice in Australia?", while the cross-case analysis/thematic analysis chapter mainly addressed the second research question, "Are there common or shared experiences among the participants? If so, what are these common issues?" In short, the case analysis focused on the details of each case and the thematic analysis was concerned with commonalities and the wholeness of the participants' experiences and, together, both comprise the circular hermeneutic process.

5.4.4. Case studies: Individual stories

The narrative/storytelling approach was used for the case analysis section in Chapter Six. As Welch (2001) explains, in the contemporary qualitative research paradigm, it is becoming increasingly important that researchers find each unique form that can best capture the essence of the subjective everyday life world beyond the scope of conventional scientific text writing. Alternative methods

include poetry, photography, music, painting (Welch, 2001) and the storytelling approach which is an emerging field.

Storytelling is a way of gaining access to the lived world of the participant's personal experiences. In other words, as Mair (1989, p. 3) asserts, "Stories provide access to a land of personal experience in which reason does not venture". Listening to and reading personal stories facilitates the generation of knowledge through which people are able to develop understanding of their lived world (Dwivedi, 1997) and this is consistent with the research aims. Such features of the storytelling method are all familiar to researchers from hermeneutic backgrounds. Rice and Ezzy (1999) explain the compatibility and the appropriateness of using the narrative and the storytelling approach in studies within the philosophical framework of hermeneutics. Like the hermeneutic approach, narratives focus on the details of the story and emphasise the context-dependent nature of the particular story told. Indeed, one of the great advantages of the storytelling approach is that it can minimise the risk of the de-contextualisation of the lifeworld. The experiences recounted by the participants were undoubtedly embedded in the multidimensional context such as the time, material condition, culture, value system, psychological condition and many others. In short, storytelling is the best way of presenting the details of their individual experiences because it can maintain the wholeness and integrity of the experiences without dislocating them from the lived world.

5.4.5. Cross-case analysis: Thematic analysis

van Manen describes the phenomenological thematic analysis as follows:

> *Phenomenological research, unlike any other kind of research, makes a distinction between appearance and essence, between the things of our experience and that which grounds the things of our experience. (Van Manen, 1997, p.32)*

From this perspective, phenomenological research is not simply a description of appearance. Rather, it articulates the *essence* of phenomena. van Manen uses the word 'essence' as semantically equivalent to 'meaning'; uncovering the meaning of phenomena is the same as uncovering the essence. Then van Manen (1997) explains structures of meaning as themes of the lived experiences. This is why van Manen terms the phenomenological data analysis method as thematic analysis. Phenomenological data analysis is thematic analysis that articulates themes and structures of the meaning/essence of lived experience.

The interview data were firstly entered into the JBI-NOTARI and then categorised into sub-themes and then synthesised into the themes. The process of categorisation and the synthesis were not carried out on the basis of formal and systematic principles. In the transcribed texts, each comment (sentence), paragraph, incident and each whole interview were examined and reflected on carefully to capture the essence of the phenomena (Pollio, Henley, & Thompson, 1997) in the lived world expressed by the participants. Data collection was continued while the data from previous interviews were analysed. The data collection was terminated when there were no new themes emerging from new interviews.

5.4.6. Rigour

Establishing rigour in qualitative research has been an ongoing difficulty. In the early 80s, Guba and Lincoln (1981) presented a set of criteria which was expected to advance the rigour of qualitative papers: credibility, dependability, transferability and confirmability. These criteria were introduced to nursing scholars by Sandelowski (Sandelowski, 1986) and have been widely accepted as the set of standardised criteria for qualitative research in contrast to traditional positivistic criteria.

However, in more recent years, with an increasing influence of postmodern ideas, qualitative researchers have been inevitably confronted with dilemmas in securing validity in qualitative research while embracing multiple realities, multiple truths and multiple voices which reject traditional, more positivistic discourse concerning the *validity* of research.

In Nursing, recent scholars have criticised criteria employed in research as being parallel to a positivistic tradition (Witt. & Ploeg, 2006). In response to such criticism, Sandelowski (2006) has claimed that the criteria of Guba and Lincoln (1981) criteria which she introduced to nursing over 20 years ago should not be blindly utilised by qualitative researchers as the qualitative research paradigm is rapidly evolving in the 21st century. When Sandelowski's paper was published 20 years ago, scholars were struggling to set a clear standard/guideline for qualitative research in order to gain recognition as opposed to the traditional positivistic/quantitative paradigm. However, the focus of debate concerning qualitative research has moved beyond quantitative vs. qualitative discussions to embrace the notion of 'multiple truths'. As Sandelowski (2006) strongly argues, her work in 1986 was only relevant in the historical context of research communities at the time of publication in the 80s; therefore, nursing scholars should not continuously reference and cite her work without careful consideration.

In short, parallel to qualitative research methods in general, there are no indisputable criteria to enhance the rigour of qualitative research. Nevertheless, it is fair to claim that phenomenological research is one form of empirical research; it aims to provide new knowledge concerning people's experiences which can be reasonably accepted by a professional community. It is the researchers' responsibility to justify the approach they employ in order to secure *rigour* in the research projects.

In this research, I have broadly employed four methods to enhance the rigour of the study. Firstly, the data analysis was double checked by academic supervisors to confirm that the it was appropriate and that the results were derived from the data. Secondly, in order to enhance the trustworthiness of the study, I used JBI-NOTARI to present the analysis clearly so that the readers could follow the decision trails (Koch, 1995b). Thirdly, the participants' reassurances concerning the data and the data analysis were also used to enhance the credibility of the research, particularly the data analysis and

presentation of the results. Finally, my personal background which might have influenced the research process, including the data analysis was explicated earlier in this chapter.

5.4.7. Ethical considerations

Prior to the commencement of the project, approval from the Human Ethics Committee was obtained from the Faculty of Health Sciences at La Trobe University in Victoria where I started my doctoral study. Before long, my principal supervisor moved to the University of Adelaide and my transfer to my candidature there and gained ethics approval from the Faculty of Health Sciences at the University of Adelaide. Ethics approval from the Royal Adelaide Hospital where the main data collection was planned to be conducted, was also obtained. The approval letters are attached (Appendix XII).

In order to protect the participants' privacy, their real names were not used in the case studies. When possible, the participants chose their favourite names to be used instead of their real names. Some superficial information concerning the participants was changed so that their individual identity could not be traced by readers while maximum effort was paid to maintain the authenticity of each story. Prior to each interview, written informed consent was obtained (Appendix XIII). The participants were guaranteed access to the transcribed data and the analysis of their interviews. They were encouraged to read their transcribed data and the analyses. If there were any parts they disagreed with, they were entitled to ask me to change the written text at any time.

5.5. Summary

Following discussion of the philosophical underpinning of the study, a practical research method has been presented in this chapter. In particular, van Manen's methodical approach provides a broad guideline to the research process. The steps from the data collection to the analytic approach have been discussed in relation to van Manen and the philosophical framework of the study. In the

following chapter, the case studies which aimed to illuminate the details of each participant's story are presented as one aspect of the hermeneutic circle of the process of human understanding.

Chapter Six: Case Analysis

In this chapter, 24 participants' case studies are presented in the narrative storytelling format as discussed in Chapter Five. The case analyses are presented to address the first research aim "to describe and interpret the lived experience of OQNs of NESB" and my first research question, "what are the experiences of individual OQNs of NESB working in nursing practice in Australia?" to facilitate understanding of the unique world of each OQN.

For the case analysis, I initially planned to select some specific cases that would contain *more* information and *deeper* insight. However, as the data collection and the analysis progressed, it became very difficult to select some sample cases that were particularly representative of the 24 participants. Though some cases did contain commonalities in terms of preliminary themes and similar ways of interpreting experiences or similar reactions to particular incidents, every case had its own insights and story to be told that was embedded in each of their multidimensional historical, material, cultural and psychological contexts.

I also had an ethical and moral dilemma in choosing sample cases for the case analysis; I believed that I was not in a position to judge which case contained *better* information and *deeper* insights to be presented. Though some interviews did not last as long as others and the length of each transcript differed, it did not mean that the shorter transcripts were inferior or contained less important data than the longer transcripts. In the end, the decision was made to include all 24 cases for the case analysis though the word limitation for the thesis was of concern.

Apart from the interview data, other forms of data such as field notes and my personal reflective journal are also included in the analysis. The stories were basically written to describe and to re-construct the lived world of the participants. Being informed by Gadamer's (1989) understanding as

fusion of horizon, which emphasizes the dialogical and conversational nature of the phenomena of understanding about the human world, I also included my specific interpretation of the stories in some cases, if it was considered necessary and appropriate. However, from Gadamer's view, what I write *is* already my own interpretation.

The cases were categorised and presented according to the participants' countries of origin and region. This presentation format was an obvious choice but it was not intended to emphasise stereotypical views of national characteristics. Instead, it helped to illuminate a diversity and complexity of the participants' making sense of their own experiences, even among participants from the same countries. At the same time, the profound influence of the participants' previously gained value and belief systems on their interpreting reality in Australia is also portrayed.

6.1. Nurses from China

6.1.1. Yun's Story

Yun is from a Northern province of China and is in her mid-thirties. After high school, she went to the nursing school of a medical school in her hometown and obtained her nursing registration. Her clinical experience totalled 12 years in the surgical ward and the Intensive Care Unit (ICU) in the university hospital.

Yun was the first participant in my interviews and I felt that I was lucky to have her as the first interviewee. As our interview progressed, I soon realised what a strong and determined person she was despite her rather small figure and feminine manner. For her, going abroad was something she had to do.

Determination to go abroad

When she was in China, she felt as though she was at a dead end at work since there were no further educational or promotional opportunities available to her. In her work place, nurses who did not have university degrees could not receive promotion. She could see herself doing the same work ten years later, which she could not bear.

The management style at her work was also causing her stress. One day, one of her co-workers broke a respirator in the ward by mistake and the manager told the nurse to pay for a new respirator, which was obviously very expensive. It was usually not the individual nurse's responsibility to bear such expense but the manager demanded that the nurse pay for it as the relationship between them was not very smooth. Yun thought that she could be the next one to have a similar experience.

When she finally left her job to prepare to go abroad, people around her could not understand why she had abandoned such a stable and good job. They even told her that she was going crazy, which motivated her even more to advance her plan to go abroad. In the end, she convinced her husband that they could have a new life abroad.

First she tried to go to the UK but her visa application was rejected. It was a private nursing recruitment agency that provided her with information about studying and working as a nurse in Australia. Though she did not know much about Australia, the idea of going appeared to be an attractive option for her and her husband.

She burst into tears at the airport when she left China for Australia. She told herself that she needed to be brave being on her own abroad. Her husband had to wait in their home country for more than a year until she obtained registration and started working. When I met her for the second interview, her husband had just arrived to live with her in Australia. Now she works as an RN and her husband is with her in Adelaide. The people at home could not believe that she could ever accomplish this.

Yun was very happy working in Australia. She felt that her work environment was very supportive and that the Australian patients appreciated and respected her as a nurse, which motivated her to work more.

Graduate Nurse Program

After completing a bridging program at a university in Adelaide, Yun started working in an acute care hospital six months ago. Despite her 12 years of experience, she chose to work as a newly graduated nurse in order to receive support from the Graduate Nurse Program, which was provided by the hospital. For instance, if she had some problems or questions at work, an educator nurse from the nursing development unit came to help her. Yun believed that she had made the right decision to start as a first year nurse as she was not confident enough to function as a year eight or nine nurse with large responsibilities as a leader. Considering the lesser expectations of first year nurses by the other staff and the good support she received from the Graduate Nurse Program, she was happy to have started as a first year nurse despite receiving almost $10,000 less in income per year compared with year eight nurses.

Different roles and expectations of the nursing profession

Yun found that nurses' roles in Australia were more professional than in China in terms of the knowledge and responsibility required. The Australian nurses' professional knowledge provided her with positive stimulation and she wanted to update her knowledge in order to practise as a professional nurse. She felt that during her work in China she had not needed to *think* or to know so much compared with working in Australia.

Yun commented that nurses in Australia worked as members of health care teams, which she felt to be very inspiring. Nursing in Australia appeared to be an independent profession from Medicine, and required autonomous decision making based on good professional knowledge. The sense of being a professional nurse provided her with a great deal of satisfaction and with motivation to work.

English is the problem

Yun stated that English was her main problem at work. Though her English at our interviews sounded fluent, she felt that if her English improved, it would be much easier to function well at work. Her biggest problem in English was telephone conversations with other departments in the hospital. Particularly when she had to deal with information about new patients, for example, listening to a report from the emergency department about a newly admitted patient could be extremely difficult and made her nervous about picking up the phone.

6.1.2. Cindy's Story

Cindy is in her early thirties and came to Australia from one of the Southern capital cities in China about one and a half years ago. She went to a nursing school and worked in an intensive care unit (ICU) in a large teaching hospital for ten years prior to her arrival in Australia. She liked learning English when she was a nursing student, which eventually pushed her to seek an opportunity abroad. She was initially planning to go to the USA but her visa application was not successful. She explained that obtaining a US visa had become very difficult since September 11th 2001.

Cost of moving

Starting a new life in Australia was expensive. Firstly, she sought help from a private agency in China to come to Australia. The agency charged her RMB 20,000 while her monthly salary was 5000 RMB (approximately A$300-400). Still, she thought that it was necessary as the agency successfully helped her to obtain a valid visa to enter Australia. Then, the bridging program at a university in Adelaide cost her A$9000 on top of the relatively high cost of living in Australia in comparison with China.

Supportive environment: Comparing to China

Cindy was impressed by the very supportive work environment in Australia and felt that the health care system and the nursing system were very well organised in Australia. In daily work, she found that it was easy to ask for help from the team leader nurses and other staff. The fact that the

physicians were available most of the time when she needed them made her work in the recovery unit less stressful. Overall, she felt that she was supported by the other workers including physicians, nurses and the hospital management.

Cindy was also happy about other working conditions such as the relatively low patient/nurse ratio compared with that in her home country. In China, she did not have to provide bedside personal care such as bedpans and the bathing of patients. Usually the family of the patients were staying with them to provide personal care. Cindy thought that the Australian system is better for the patients.

Horizontal violence among OQNs?

During our two meetings, only once did she raise her voice, looking upset when she described one incident that had happened in the ward. One of her patient's oxygen saturation was low and Cindy recognised fluid retention in the lungs on the X-ray. It was not clear on the film but she felt that retention was occurring. Then the Team Leader who was also from overseas disagreed with her in an angry manner and the Team Leader shouted at her that Cindy was wrong. She was deeply shocked and offended but she could not stand up for herself as she was a new nurse there. Cindy felt that Australian nurses in general were very nice and supportive but sometimes other OQNs could be difficult to work with.

Cindy explained that this particular nurse's aggressive behaviour was not only towards the OQNs in her ward but to the local and less experienced staff as well. Cindy suspected that this aggressive nurse had experienced a hard time when she started working in Australia, which might have caused her aggressive behaviour toward the junior staff.

I will divorce you if you don't cooperate! : daughter's future as motivation

Like many other OQNs, Cindy was also willing to work in Australia so that she could bring her family to settle. According to Cindy, due to the many years of the One Child Policy in her home country, the environment for children to grow up in was becoming unreasonably harsh. Each couple was allowed

to have only one child which had resulted in intensive attention and expectation with regard to each child by the parents.

When she told her husband that they should move to Australia, he did not agree with her idea. It was not a realistic choice for him to leave everything behind to come to Australia. But Cindy was very determined. She even mentioned possible separation if he really did not want to cooperate with her plan. In the end, he agreed to come to Australia with their daughter once she had obtained the appropriate visa for him and their daughter.

In the process of moving to Australia, Cindy was the one who made the first decision as she believed that it was the best move for them. Her husband was reluctant at first but she gradually convinced him that it was a better option to move to Australia for their daughter's future. Soon after Cindy started working in Australia, she applied for a permanent residence visa which allowed her and her family to live in Australia permanently. The last time I contacted Cindy, she had finally finished the legal immigration process and she was about to go to China to bring her husband and daughter back to Australia.

6.1.3. Lin's Story

Lin is from China and is in her late twenties. She had enjoyed working at a local hospital in China for seven years; she recalled that it was a remote area and the people were simple and the patients respected the nurses. The nursing and medical staff there shared a good collaborative relationship. After having worked in China, she sought new experience in a hospital in Singapore, where she worked for four years. Two years ago she moved to Australia looking for better professional opportunities and Lin currently works in an acute care teaching hospital in Adelaide.

Difficulties in gaining access to information about overseas from China

In China, when she considered working abroad, all she could find was information on how to get to Singapore. No information regarding working in Australia was available to her and to the nurses around her. Realistically, going to Singapore was the only choice if anyone from her province wanted to work abroad. Lin thought that there was a regional disadvantage in gaining access to information like this. Possibly private agencies were available to nurses in the capital cities but not to nurses in the remote provinces.

In addition, at the time when she left China, the Chinese government was not encouraging people to go overseas. The information system was quite closed but this has drastically changed in more recent years by means of the internet and a more open emigration policy.

Working in Singapore was suffering (insufferable)

During our meeting, Lin talked about her experience in Singapore more than her current experience in Australia or earlier experience in China. While she did not make any negative comments about working in China, working in Singapore was not a happy experience for her. Particularly, she was not satisfied with the working conditions in Singapore, which she described as *suffering (insufferable)* and she felt terrible going to work everyday. She thought both the hospital management and the patients were unreasonably demanding while she received no support from the management. All the nursing staff (including locals) worked under very stressful conditions. For instance, if someone made a mistake, the management staff came and took a photo as evidence, which scared the nurses.

However, she thought she was still one of the lucky Chinese nurses in Singapore. At least she was employed as a RN. She explained that as the Chinese population was huge, you needed to be a very good and competent nurse to have a chance to go to Singapore. However, Chinese nurses were often forced to work as health attendants with much lower payment than the RNs even though they were actually conducting some nursing technical work like checking vital signs. They were often trapped in an unfair contract with employers. Some Chinese nurses broke the contract and returned to China

with only debts after paying a large fine for breaking the contract. Lin explained, many young and good Chinese nurses had gone to Singapore and had become old while not ever being able to work as RNs yet. In the case of Lin, she went to Singapore through the government's program, which she thought made the difference.

I can feel respected to work here

As soon as she finished her work in Singapore, she took a flight to Adelaide. Compared with her hardship in Singapore, adjusting in Australia was not a big issue for her. She appreciated the good working conditions and the support system in Australia. She felt that she was respected and supported by people including the hospital, the management and the other staff members. The supportive environment encouraged her to study and work more.

She explained that if she had come to Australia directly from China, she would not have appreciated Australia as much as she did. She encountered several unpleasant incidents at work in Australia but she thought that such things could happen anywhere and she did not let them upset her.

6.1.4. Fei-Yen's Story

Fei-Yen is from China and is in her mid-twenties. She took a Bachelor of Nursing degree in China and worked for six months in a university hospital in her hometown. Then she came to study at a bridging program in Adelaide in 2004. After one year of study in Adelaide, she obtained her nursing registration in South Australia and started working at a teaching hospital in Adelaide. One year later, she moved to another hospital because she saw a better opportunity and it was convenient for commuting. When I met her, she was working in the Neuro-surgery unit in a university hospital while undertaking the Master of Health Management program at the same university.

She wanted to come to Australia to gain overseas experience both for her professional work and life in general. Though she was hoping to work at the university hospital at which she had studied the

bridging program, the hospital was not willing to employ OQNs without permanent residence status at the time when she was looking for her first job after the bridging program. Two hospitals offered her sponsorship for the working visa and she chose one of them.

Graduate program

During her first year at work, she entered the Graduate Nurse Program, which was provided by the hospital. There were many OQNs from NESB working in the hospital and the support system for such nurses was very good. She appreciated her opportunities to experience working in four different wards throughout her first year in the GNP. Even if she had worked in one ward for ten years, she would not have had the chance to know other wards at all. It was good to be able to see what the protocols were in each ward in the different medical specialties and she felt that she had learned a lot.

Working with difficult staff

When I asked her to describe her best day and worst day at work, she replied, *"My best day is when you have a good partner at work. My worst day is when my partner is not cooperative"*. Being a registered nurse (RN), it was her responsibility to make sure everything was done correctly but some enrolled nurses (ENs) were not co-operative. Sometimes, she just did things herself but it frustrated her, which eventually made her move to another ward for better relationships with other nursing staff. When I asked her, *"But since you are an RN and in charge, they have to listen to you?"* Her reply was, *"NO!! There is nothing you MUST do in Australia!!"* She felt that some ENs were more experienced than she was and often they did not want to listen to her as they were confident with what they had been doing. She thought about talking to the team leader but she could see that it would only make the relationship with the ENs worse. So she chose to leave the ward instead and she thought that her decision was right.

Advice for newly arrived OQNs from NESB

She described how many OQNs were reluctant to ask questions at work as they didn't want to bother the local staff or they were not confident to ask. She thought that they should not hesitate to ask questions as the Australian nurses would not know what problems the OQNs were having unless the

OQNs themselves opened up to the Australian staff. She believed that she had learnt all her necessary skills in China and usually the OQNs had good skills and knowledge but they tended to be very quiet as they were not confident. If she had any problem, she would go and talk to her manager or other staff for advice. She thought that the key for success at work was to be communicative and to be confident.

Different clinical culture

To be understood by and to understand the Australian staff, she said, "*Sometimes you have to think about which race you are thinking?"* because she felt that communication was difficult in both the language and the way people were thinking behind the language. When I asked her to explain more about the different ways of thinking between her and Australian nurses, she gave me the following example after a few seconds of thought. In China, she was taught the importance of individualized nursing care while the strict use of protocols in Australia was something she found she could not argue about even if it did not appear to be right in some cases. She believed, "*Care should be individualized! In practice, you need to change the protocol a bit"* but usually her view was not supported or permitted in nursing practice in Australia. She thought that her co-workers and the manager were very nice and supportive but she was not very happy about the *inflexible* protocol-oriented culture in practice.

6.1.5. Anming's Story

Anming is from China and is in her mid-thirties. She undertook a Bachelor of Nursing degree in China and worked in a medical ward for twelve years before she came to Australia. After completing a bridging program in Adelaide, she started working in a nursing home.

Coming to Australia

When she thought about going abroad, Australia was her first choice. The USA seemed too dangerous a place to her while her Chinese friends working in Europe had told her that the countries there were not very keen on welcoming new immigrants. Anming heard that Australia was a multicultural

society and many people were immigrating to Australia from diverse backgrounds, so Australia appeared to be a nice country to settle in with her husband. After completing the bridging program, Anming decided to work in a nursing home which was willing to sponsor her visa.

I was too soft to the carers

It was Anming's responsibility to manage the carers' work on her shift but she found that was the hardest part of her work as a new RN. Anming thought that administering medication and other nursing activities were not very difficult but she had problems working with the carers. Still, she did not realize that she was having problems in dealing with them until the manager warned her.

One day, the manager told Anming that she might be too soft on the carers and that she should be firm with them in order to maintain a good level of care. The manager also thought that the carers were taking advantage of Anming as she was a new RN from overseas. It took Anming a few days to change her attitude to the carers. Soon the carers realised that Anming had decided to change and they stopped arguing with her; they became more cooperative towards her. It was the hardest part of her adjustment to working as a RN in Australia in the initial phase.

Stressful morning calls from work

Anming also struggled with demands on her caused by a shortage of nursing staff. The nursing home often called Anming to come to work on her day off. These morning calls were becoming intolerable for her. At first, Anming thought that she should not refuse if she was asked to come to work. In some way, Anming wanted to help the nursing home when they were desperate to find a nurse. She felt as though she owed something to the nursing home for her visa that she had obtained with their help and for her job. Moreover, she was a new RN while the other Australian staff had worked there for several years, which made her think that she should be more flexible than the other staff in terms of changing her shifts.

Her mobile phone was ringing in the early morning on her days off to ask her to come to work. She found herself not being able to relax at all even on her days off and she decided to turn off the mobile phone. Then the home phone was ringing instead: she could not disconnect it as her husband was also using the same phone. Then her mother in China had some problem and she was trying to call Anming for a whole night but Anming did not answer the phone as she thought it was from work. She felt as though she was living for the nursing home and her private life did not really exist. Her husband was also increasingly annoyed with the phone calls.

Breakdown

When Anming started working, the nursing home did not have enough RNs and the manager and the staff more than welcomed her. At first, Anming was very happy and was willing to be useful to the nursing home. However, she increasingly felt that she was not treated well by them. The other nurses were taking all of their favourite shifts while Anming was receiving the 'rubbish' shifts. Her shifts on the printed roster were often changed at the last minute to meet the other nurses' preferences without seeking Anming's agreement.

Anming increasingly felt powerless and became ill. Though she had never taken sick leave for one year, she finally decided to take it. She just could not go to work with the feeling of not being treated fairly and it was her lowest point at work. Later she moved to another nursing home where her friend from the bridging program was already working.

6.2. Nurses from Japan

6.2.1. Mika's Story

Mika is from Japan and is in her early thirties. She studied in a Bachelor of Nursing program and also in a postgraduate program to be a midwife in Japan. She worked as a midwife for four and a half years and also as a general agency nurse for one year in Japan. She came to Australia in 2006 to be

enrolled in a bridging program in Adelaide. When she finished her study, she registered both as an RN and a midwife and then she left Adelaide for Port Augusta to work in a public hospital there. At the time when we met in Adelaide for an interview, she was mainly working as a midwife but she also needed to do general nursing work as well, because the hospital was a general hospital in a remote region.

Hoping to go to the UK

Before Mika came to Australia in early 2006, she had lived in the UK for one year to study English and she was hoping to return there one day to work as a midwife/nurse. In the process of gathering information about studying and working in the UK, it became clear that it was more expensive and difficult to find a job. The health care system in the UK was experiencing problems with hospital funding and many newly graduated local nurses were not able to find a job. It appeared to be too risky for Mika to go to the UK directly from Japan. Instead, Mika decided to come to Australia to see how the situation would develop in both Australia and the UK while she could gain some good experience in Australia.

Working in Port Augusta (regional Australia)

Alongside her dream of working in the UK in the future, it was also her dream to work in developing nations as a part of foreign aid. When she started working in Port Augusta, she felt as though she was working both in the UK and in some developing country at the same time. There were English/Australian communities and the local indigenous community around the area. Both English/Australian people and the Aboriginal people were her clients, co-workers and neighbours. She said, *"In a way, my working condition at the moment is what I have dreamed for!"*

So different from Japan!

She thought that working in cities like Adelaide would not have been much different from working in Japan once she had got used to working in English. As the salary in Australia was much lower than she used to receive in Japan, she thought that she needed to have some good reason to work in Australia. She wanted to experience something very different from Japan and something unique to

Australia. She found that working in Port Augusta was very different from working in Japan and she found that she could experience new and exciting challenges which she could never do in the major cities or in Japan. Mika was excited to tell me about the flying doctor service for the Aboriginal community in Port Augusta. There were pregnant women just about to give birth coming to the hospital for the first time. Some patients did not even know how many weeks pregnant they were and it was often a challenge for the hospital staff to manage the delivery safely without any previous information about the clients.

As it was a public hospital in a remote region, they had to deal with all kinds of patients with various health problems, which she would not have the chance to experience in Japan. When Mika was describing her work in Port Augusta, she kept on saying, *"It is so different from Japan!"* in an excited tone. She also found that working with Aboriginal patients was very interesting. They welcomed her as well and Mika and these patients often developed a good patient/nurse relationship. After we met at the interview in Adelaide on her day off, Mika went to visit one of her Aboriginal patients who had been transferred to a specialist hospital in the city.

Living in remote Australia

Though Mika was enjoying working in the remote hospital, she found that it could be hard to live there sometimes. Port Augusta was a small country town with a very small population where she found only one Japanese person apart from herself. Though the staff were very nice and supportive, she found that it was very hard to find new friends. She did not have much private life as there were no social events. It was about three hours' drive to Adelaide so she came to Adelaide to meet her friends and to see the city on her days off. Her co-workers also encouraged her to go to the city to get refreshed as it was clear that she needed to have a break from the isolated environment.

Very supportive environment

Mika explained that she found herself as the only Asian in the hospital. There were some Indian people and South Africans but she was the only *yellow face* (directly from her comment). There used

to be some Chinese staff but they had returned to Adelaide. She sometimes felt very isolated but her co-workers were very nice and supportive.

Once she was in tears when she had some problem with a physician. Later, one staff nurse took Mika to her daughter's birthday party to cheer her up. The next day, she had a phone call from the manager to find out if she was feeling better. All the hospital workers remembered her name and face and greeted her even though she could not remember so many people in the hospital. Everyone asked her how she was in the corridor, in the ward, even on the streets. She continuously felt that the whole hospital was trying to make her feel comfortable working there. She repeatedly described that she had been *very lucky to work there*.

My instinct was telling me not to work there

When she finished her bridging program, she went to take two job interviews. One was in Adelaide and the other in Port Augusta. According to her, the first interview was *terrible* and she still sounded very upset telling me about what had happened even though it was almost one year ago.

At her first interview in Adelaide, there were three interviewers in the room; one was from Human Resources and the others were Mika's possible future bosses including the manager and the CNS (clinical nurse specialist) from the maternity ward. During the interview, the manager asked her, *"Do you think in English or Japanese?"* Mika wondered if she wanted to know purely out of curiosity in order to find out how her mind was functioning in the use of two languages or if the manager was indirectly telling Mika that her English was not good enough to work with her. Mika interpreted it as being the latter. She had felt that the atmosphere of the interview was not very pleasant, either, even before the manager asked her the question.

Her intuition was telling her not to work there as she would not be welcomed. She would still be able to cope with some staff who were not sympathetic about her language problems but she thought that it would be impossible to work under such a boss who lacked understanding. In the end, before the

hospital contacted her about the result of the interview, she rang the hospital to withdraw her application and told them that she had decided to take another job offer when she was actually still looking for a job.

I immediately had a positive feeling about working with them

When she went to another interview in Port Augusta, the atmosphere was very different from her first interview in Adelaide. She immediately had a positive feeling about working there. The manager said to her at the interview, *"Your English is very good"* to make her feel at ease. Mika found that job interviews were very important and a useful process not only for the employers but also for the nurses to find out what the future bosses were like.

6.2.2. Sakura's Story

Sakura is from Japan and is in her late twenties. She went to a nursing school to become an RN in Japan and worked in acute care hospitals for six years before she came to Australia in early 2006 to study in a bridging program in Adelaide. At the time we met, she was working in the surgical ward of a private hospital.

After she started working as an RN in Japan, she thought about taking a bachelor's degree in nursing somewhere. When she found information about the bridging programs in Australia that would lead to a bachelor's degree, she decided to come to Australia.

The bridging program was not very organised

Studying in the bridging program to obtain the degree of bachelor of nursing was an interesting experience for her. She found that the clinical lab was a very useful and simulating subject as she could learn about the kinds of equipment which were being used in Australia and how to react to some clinical situations. She also enjoyed discussing with other students from overseas the sample cases which were demonstrated during the lab class.

Some subjects were not very well organised and she felt that the university was, to some extent, abusing the international students' fees. The program was basically designed for local nurses to upgrade their qualifications to a bachelor's degree so a self-directed learning style was often used, which was an unfamiliar approach to her and other international students. One subject was for international students to learn about the health care system in Australia but the assignments were about the health care systems in the students' countries of origin, which did not make sense to her and other students. In the end, she went with other students to complain to the course co-ordinator.

Getting a Job was difficult

When Sakura completed the bridging program, she was planning to return to Japan as she had obtained the bachelor's degree which was her goal while in Australia. However, the lecturers from the program pushed and encouraged her to work in Australia. At first, she was reluctant as she was not confident with her English and she had not really thought about working in Australia. She explained a negative quality about being Japanese; this was a lack of motivation and ambition about building a new life overseas.

For three days, she thought about the option of working in Australia. After she decided to work in Australia, she sent her resume to over twenty hospitals. It was nearly Christmas time and her visa was expiring soon, which made her anxious but one private hospital offered her a position in the surgical ward. When I met her, she had worked in the hospital for nearly one year. She said that the first six months had been very hard. She found that the workload in the private hospital was quite heavy and that it was almost as heavy as her previous job in Japan.

The epidural tube came out: no blame policy in Australia

At the orientation when Sakura started working, she was told that, "*We have a no blame policy*", which meant that even if someone made a mistake, the other workers were not supposed to blame the person. It was based on the idea that it could be anyone and blaming the person would only intimidate that person.

One day, Sakura had a patient with an epidural tube. The patient was sitting by the bed and the tape was coming off and the tube came out when she went to check it. It was a shocking sight but the CN (Clinical Nurse) did not blame her at all. The CN repeatedly told Sakura that; *"It is OK if you learn from this"*. If she had been in Japan, the clinical nurse would also have been nice to her but she would not have forgotten to remind Sakura that she had made a bad mistake. The CN told her that everyone makes mistakes and it could be anyone so they should not blame someone who made a mistake, which enabled Sakura to recover her confidence.

At work, there was a preceptor system to support the new nurses from overseas and one nurse from Malaysia was her preceptor who helped her adjustment to work in Australia. Sakura found that her preceptor was very supportive and nice. The preceptor also looked after her private matters such as cheap travel agencies. One day, the preceptor explained to all the OQNs how to do their tax returns, which Sakura thought was very useful.

In Australia nurses don't have to be saints

Sakura found that the meaning of nursing in Japan was different to that in Australia. She thought that the practice of nursing was embedded in each culture so she should not expect nursing in Australia to be the same as that in Japan. She came to realise that it was not possible to directly compare nursing practice in the two countries.

One very big difference she found from her practice concerned attitudes towards the patient. In Japan, complaining about particular patients with other nurses was considered to be somewhat immoral and wrong while she found that it was acceptable to do so in Australia. Of course there might be some ethical arguments against it but still it seemed to work well as a way of releasing stress and building relationships among the nursing staff. She did not have to maintain a sanctimonious demeanour as a nurse in Australia. After talking through her stress with other nurses, she could move on and continue working.

Different from TV dramas

Sakura used to watch the American TV program "ER (Emergency Room)". In this hospital-based drama, people were arguing all the time. She found that it was not the case in Australia and that the health care staff did not actually argue as in the American TV program. Instead, she noticed that everyone appeared friendly and happy at work.

There was another thing which she found different from what she had expected. She used to have an oversimplified and stereotypical notion that Australian/Western people were very direct in their method of communication but she found this is not necessarily the case all the time and she needed to look at each situation on its own merit. Once Sakura told a doctor that the family of his patient was angry with him as he had kept them waiting for a long time; then, in turn, the doctor became angry with Sakura. Later the CN told her that it would have been better to use gentler words such as *"The family is anxious"*. For Sakura, the family was more *angry* and the word *anxious* did not report the situation accurately but this was how she was advised after the incident with the doctor.

Becoming an insider

There was one incident when Sakura changed her attitude toward working in Australia. She felt that she had moved from being a visitor from Japan to being a member of the staff on one particular day. This day, there was not enough staff in the ward; there was only the CN, the leader, Sakura and the agency nurses who had come to help in the ward. Then the agency staff came to ask her many questions as they did not have much knowledge about working in the surgical ward. She found herself being able to help the agency nurses as the staff did. When she went home, she thought that even an OQN like herself had responsibility as a staff nurse. That was the day when her attitude changed and she started thinking about helping other nurses as a member of staff.

6.3. Nurses from Korea

6.3.1. Alice's Story

Alice is from South Korea and is in her early thirties. She took a Bachelor of Nursing degree in Korea and worked in the medical ward for seven years before she came to Australia. She attended a bridging program for six months in Adelaide and obtained her nursing registration in 2006. When I met her, she was working in the Coronary Care Unit in a hospital in Adelaide.

Hoping to go to the USA

Initially she was hoping to go to the USA but it was difficult to obtain a visa as the immigration policy in the USA became more stringent after September 11th 2001. So she changed her plans and came to Australia instead. She believed that it would become easier to obtain a US visa if she could have some experience in Australia. The Korean education system was based on the US system and Korean society has been heavily influenced by the USA since the end of World War II and the Korean War. It appeared that it was an obvious choice for her to go to the USA and she did not know much about Australia before she came.

Surviving in English

Alice was very scared and nervous when she started working in Australia. She was not confident with her English although she had met all language requirements for the nursing registration. She could read but direct verbal communication with the patients and staff was not easy. For her, sometimes the patients were easier to understand than the staff as the patients often repeated the same thing. Compared with the patients, she found that it was usually harder to understand the local nursing staff's English as they tended to speak very quickly and colloquially and they expected her to understand everything. At first, the local staff thought that she could understand everything they said to her as she was doing her duty well, but actually this was not the case. She understood the main point of what the local nurses had said to her but she was actually figuring out what she should be doing for the patients

from her knowledge from her previous experience. It was also very hard for her to communicate with other health care workers whom she did not usually work with, such as the pharmacist.

Working hard to be accepted

Alice felt that the OQNs from NESB needed to work extra hard to be accepted and to have a good working relationship with the local staff. She felt that there was a barrier between her and the other staff because she was not a native English speaker. In order to overcome the barrier, she had to work harder than the others. As she needed help with English, she thought that it was not sufficient to just do the same amount of work as the local staff. If the local nurses could see that Alice was working hard, they would want to help her but if she did not look as though she was working hard, they would not do so. She had noticed that when one OQN from NESB had started to work at the same pace as the local staff the local nurses started to ignore her.

Feeling defeated and inadequate

Alice usually tried to keep a positive frame of mind and tried to stay happy working in Australia. But sometimes she felt very sad about not being able to properly express her feelings in English to Australian people. There was one such incident at work which she described to me. When her senior nurse told her to do something, she did exactly what she was told to do; however, the senior nurse had expected Alice to do something more. Alice was confident that she had understood what the senior nurse had said but she could not explain well enough to defend herself from being accused of a possible misunderstanding. She was very upset and the senior nurse was surprised to see this but the miscommunication made Alice feel inadequate and helpless.

You start from Year One?

Basically Alice thought that working conditions in Australia were better than in Korea. For instance, she could have twice the number of paid holidays in Australia than in Korea, which obviously she preferred. However, one thing that she was not very happy about was the recent change in the state health care funding policy in the public sector which simply ignored OQNs' previous experiences and considered every new OQN as a newly graduated nurse, in order to reduce the costs in all public

hospitals in South Australia. Private hospitals were still calculating and including the OQNs' previous experience in their salary but it did not mean that all private hospitals would sponsor the visas that enable OQNs to work in Australia. *"So we have to… we don't have much choice"*.

6.3.2. Irisa's Story

Irisa is from South Korea and is in her mid-twenties. She studied in a Bachelor of Nursing program and worked as an RN for three years in a psychiatric ward before she came to Australia in early 2004 to undertake a bridging program in Adelaide. She came to Australia to face a new challenge and she also enjoyed travelling. After obtaining nursing registration, she started working in a nursing home.

Working in a nursing home to secure a visa

When she finished the bridging program, she looked for a job in the acute care hospitals in Adelaide but it was not easy to find an employer who was willing to sponsor her visa. One aged care organisation offered her a job and visa sponsorship so she decided to take the offer.

On her first day at work, the manager asked her how much she knew about the care of people with dementia. Soon she realised that most of the residents had dementia and required special nursing care. Since she had no experience in working with people with dementia, she found things very difficult; she could not manage the residents very well and sometimes the carer knew what to do better than she did, which often made her very stressed. She felt rather inadequate and she did not know why she had chosen to work in a nursing home in Australia. She often cried at home, feeling depressed about the situation.

People are curious about what I am doing: being the first RN from overseas

Though Irisa was trying to be an efficient and competent nurse, she found herself being ignored by the carers and the ENs. Apparently, they did not consider her to be 'professional', so they did not listen to her. The fact that she was the first nurse from overseas in the whole organization was creating a lot of pressure for her. There were some carers from overseas but there were no ENs or RNs from overseas

apart from herself and the staff had never worked with nurses from outside Australia. She felt that the staff were curious to see what she was doing when she was on the shift, which made her uneasy, and she began to feel that people were talking about her behind her back. In the end, she found that she was still working in her dreams at night. Her manager and the staff were very supportive and willing to help her but it was taking her quite a long time to adjust to the Australian environment.

Challenging behaviour from dementia

When I asked her to describe her best day in Australia, she answered that it was the day when none of the residents fell, collapsed or died during her shift which could be very messy and hard, especially if the weather was not very good. The patients tended to be unsettled in cloudy weather. Irisa sometimes felt that the behaviour of the Australian residents was much more aggressive than that of Koreans. Sometimes the residents shouted at her, “I will kill you!” or they could even use some ruder and more aggressive words when they were unsettled. Even though she understood that it was due to dementia, she often found this very depressing.

Gradually she became used to it and learned how to cope with it by letting it go. When Irisa had problems or questions, she sometimes communicated with her manager by email, rather than face to face, as she found it easier to express and explain what she was thinking.

Though she was not very happy working in the nursing home, she found that the working conditions were better than she used to have in Korea. In Australia, she found that it was easy to have holidays and to take sick leave if it was necessary.

6.4. Nurses from Thailand

6.4.1. Jane's Story

Jane is from Thailand and is in her early thirties. She studied for four years in a Bachelor of Nursing and Midwifery program in Thailand and worked in an ICU (intensive care unit) for ten years, and then in a maternity ward for six months before she came to Australia in 2005 with her Australian husband. She studied in a bridging program in Adelaide and started working six months ago in the surgical ward. At the time of our interview, she had moved to the ICU where she had originally wanted to work.

Experienced ICU nurse but getting paid as a year one nurse

Jane had had ten years of experience working in an ICU in Thailand but her first employer in Australia did not give her a job in the ICU and explained to her that this was because she did not have an appropriate certificate in ICU nursing. She was told that as her qualification from Thailand was from a hospital, her qualifications were not equivalent to Australian postgraduate certification in ICU nursing from the university system. She was confident with her skills and knowledge in ICU nursing but she could not sway the employer.

She was placed in the surgical ward but she much preferred working in the ICU. After three months of work, she moved to another hospital where she was allowed to work in the ICU. It was not a very large ICU but she loved working there though she had to learn about some new machines and equipment, and adjust to a new environment.

Jane had another problem concerning qualification recognition in Australia. The South Australian government had recommended that public hospitals employ any new OQNs as newly graduated nurses without giving recognition to their previous experience. At the time we spoke, Jane was receiving the pay of a newly graduated nurse while she had to take a lot of responsibility as an experienced ICU nurse. Jane was planning to ask for an increase in her pay when she finished her ICU certificate course.

Unfamiliar individualism: different working culture from Thailand

Jane felt that Australian nurses were generally pleasant and helpful to one another. However, when they were busy, the atmosphere could become bad as everyone wanted to finish their job on time. She also felt that people in Australia only came to work and went home. In Thailand, the workers worked like a family and they shared everything together. She meant, not only their work; they built strong interpersonal relationships and they wanted to improve the hospital together. Compared with Thailand, everyone appeared to be absorbed in their own areas of work with little communication with others or vision of the hospital as a cooperative endeavour.

Jane described one incident at work that frustrated her. On one night shift, one of Jane's patients suddenly developed a critical condition and she called the doctor and she started working on the lines and catheter. She asked another nurse to go and seek help from another nurse who was taking a break. However, the nurse told her to wait until someone else came back from her break. Jane thought it was impossible and went to ask the nurse on her break to come. Jane was very surprised that someone could think that taking a break came before duty of care especially in an emergency situation. While she understood that nobody wanted to work at night, the nurses were being paid for their duty of care. Sometimes Jane found this type of attitude frustrating.

Learning not to interfere with other staff to maintain good relationships

Basically Jane was happy working in Australia and if she could feel that she was providing the best care for her patients, she was satisfied; however, cases like the one above, did cause her stress. She could not help feeling sorry for patients and could not help feeling frustrated if some nurse was not doing her best. However, to avoid unnecessary stress, she was learning to try not to manage other nurses' work unless it was necessary. This was one of the things to which she had to adjust while working in Australia.

English could be a problem for Jane but she thought that it was not the most important factor in working in Australia. From her experience it was more important to have good interpersonal skills with other staff than to have excellent English.

6.4.2. Pim's Story

Pim is from Thailand and is in her mid-thirties. She studied for a Bachelor of Nursing in Thailand and worked as a registered nurse for twelve years in the ICU and neo-natal ward. After studying in a bridging program in Adelaide, she obtained her nursing registration and started work in an ICU one year ago. Originally she wanted to work in a neo-natal care unit but she could only find a part time position there, which was not enough for her visa requirements.

Working in Australia to support her younger family members

My impression of Pim was that she was rather quiet but when it came to her young family, her eyes beamed with excitement and she suddenly became very talkative. When Pim decided to come to Australia, her family was very worried about her as they were not certain if she could survive alone in Australia or not. But she was determined to move to Australia, not so much for herself but for her younger family including her younger brother, sister, niece and nephew. While she was working in a hospital in Bangkok, sometimes she had to use English to communicate with tourists coming to receive treatment. She felt she wanted to study English more in Australia and soon she realised that it might open up a chance for her young family members. She wanted to provide future opportunities for them such as studying at university or finding a job in Australia. If she were already living and working in Australia, it would make it easier for them to enter the country, and this thought obviously provided a great deal of motivation for her to continue working in Australia. At the time of our meeting, Pim was planning to buy a house so that her young family could stay with her.

We had to die on duty: comparisons with Thailand

Pim thought that working conditions in Australia were very good and reasonable compared with those in Thailand. She used to do overtime in Thailand without getting paid when she could not finish her work on time but she found that this was not the case in Australia. Basically, at three o'clock, even if she still had work to finish, she had to go home. Or she could stay and finish her work and be paid for the overtime. In Thailand, her workload was very heavy and she put it like this: *"We had to die on duty"*. Compared with Thailand, she thought her workload in Australia was reasonable.

One point that Pim appreciated was that if her patient was very heavy, she was encouraged to wait for someone to help her move the patient, in order to protect her back. Her clinical teacher said, *"If you think you can help the patient, and if you are happy to do so, then do it but if you think you can't, and you might hurt yourself, you have the right not to do so. You only have one back"*. Pim appreciated the high quality of occupational safety policy in Australia.

6.4.3. Mali's Story

Mali is from Bangkok in Thailand and is in her mid-thirties. She studied for a Bachelor of Nursing Science degree and worked in a coronary care unit as a registered nurse for 13 years. She studied in a bridging program for six months and obtained nursing registration. At the time of our meeting, she was working in the ICU at a teaching hospital.

Coming to Australia for professional experience

Mali was not particularly looking for an opportunity overseas when she visited a Thai nursing expo but information about bridging programs for overseas nurses in the information booth of a university from South Australia caught her attention. She approached the staff from the university and asked basic questions such as how long it would take her to obtain nursing registration in South Australia. She thought that it might be a good chance for some new experience and she then asked her boss at work. What the hospital told her was that she could gain some experience in Australia for 2 years and then she could decide if she wanted to come back to the same hospital or not. She was actually one of

the more experienced nurses and the hospital wanted her to come back with new knowledge of nursing from Australia.

Many international students spend 6 months in an English language proficiency course prior to an actual 6-12 months bridging program but Mali did not want to waste her time learning English only. So while she was still working in the same hospital, she studied English for a few months until her IELTS (International English Language Testing System) score was good enough to enrol in the bridging program.

Answering the phone calls: English problems

Mali was very articulate and quite talkative with good English. She did not have many difficulties with technical English, terminology or abbreviations but her problem was listening to casual conversations with local people. Not only did she find that listening to English was very hard but, more particularly, the Australian staff's use of colloquial English sometimes puzzled her. For example, she could not figure out what *loo* meant when she started working as she did not learn such words in the bridging program. Telephone conversations with patients' families used to scare her but now she had learned to say, *"Sorry I did not understand. I will get a team leader instead for you"* if she did not understand what the person on the phone was saying.

I can say, "No I don't want to do it" in Australia.

Mali thought that the working environment in Australia was professional and well organised compared with Thailand. She used to have very wide-ranging responsibilities in Thailand but in Australia she could concentrate on her patients without being disturbed by non-clinical matters or other indirect care matters. Many nurses with specialist roles were available in the Australian context, such as clinical nurses, managers, co-ordinators, while the clinical and support staffing level is generally higher than in Thailand.

Even with the strict use of protocols, she thought that nurses were more independent than those in Thailand. For instance, there are clear guidelines for blood sugar levels no matter which doctors are in charge, reducing the need to contact doctors. Another good thing about working in Australia for her was that she could say, *"No, I don't want to do it"* if she was not confident to look after a particular patient or for some other reason. She also felt that it was great to be able to work for only 8 hours and then go home without doing overtime.

During our meeting, Mali never said anything negative about working and living in Australia. She said that she had never met anyone who was unpleasant in Australia, either at work or outside. When I mentioned this to her, she replied, *"I don't know how to complain. It is not useful to feel bad about the things. Just positive thinking help me. Just I keep on going"*.

6.5. Nurse from Tibet/India

6.5.1. Tenzin's Story

Tenzin was born in Tibet and she moved to India with her parents in her childhood as a refugee. She went to school in India and studied nursing and midwifery for three and a half years there. After obtaining nursing registration in India, she worked in acute care settings such as general wards and paediatric wards for 2 years before she married her Australian husband and moved to Adelaide in the late 90s. Tenzin studied at a bridging program in Adelaide for 1 year and obtained nursing registration. At the time of our interview she was in her late thirties and had worked in a nursing home for 5 years after receiving her registration.

Around the time when Tenzin came to Australia in the late '90s, it was not easy to find information about working as nurses for overseas nurses. Her Australian husband helped her but it took her a while to find the bridging program; she thought that if she had been in a bigger city with a larger

international community such as Sydney or Melbourne, it would have been easier for her to establish herself than in Adelaide.

Problem with Clinical Educator

Since Tenzin had studied and worked in English in India, the subjects in the bridging program were not very difficult for her. However, during her study, she attended a clinical placement in one hospital and had a bad experience with her clinical educator.

In her clinical placement, Tenzin usually worked with the hospital staff and the clinical educator came to see her only once every two weeks. One day when Tenzin was very busy finishing up her tasks for the day, the clinical educator came to her and told her to draw a picture of a heart. She did not understand why she was asked that particular question at that very busy moment; she would not have been surprised by the demand had she been in a classroom, but she was very busy with many tasks to finish. Then the clinical educator asked her some more questions that did not have any direct and clear connection to what she was doing on the ward and she demanded that Tenzin answer. Tenzin told the clinical educator that she was sorry but she did not have the time to answer her questions as she had many tasks to finish. Tenzin felt that she was being deliberately intimidated and that these demands were intended to make trouble rather than help in her clinical placement.

Later, the clinical educator told her to do another three month's practice as Tenzin was not competent enough. She went to another hospital later and her placement went very well. There was no one to intimidate her or make her feel nervous on the ward. At the end of her second clinical placement, the staff told her to return to work after her registration as they liked her and they could see that she was competent.

That incident scared me off working in acute care

Though she completed her second clinical placement successfully, the experience with the first clinical educator scared her off working in an acute care hospital and she started working in a nursing

home. At first, it was quite difficult and she had to learn a lot but the staff were generally pleasant and supportive in the nursing home. Sometimes she found that the carers and ENs could try to take control over her and she had to learn how to handle it.

6.6. Nurses from the Philippines

6.6.1. Catalina's Story

Catalina was born and raised in the Philippines. She is in her early forties. Before she came to Australia in 1980 with her Australian husband, she studied for the Bachelor of Science degree in nursing and midwifery in the Philippines and worked as a midwife for 5 years. At the time when we met, she was working as an EN in a large teaching hospital in Adelaide.

Working abroad as an expected course of life

Catalina explained that working abroad was not a radically unexpected event for her. She had an uncle working in Saudi Arabia and one of her aunts was working in the USA. She was brought up in an environment in which working and living abroad was, to some extent, part of normal life. She thought that even if she had not married her Australian husband, she would have ended up working abroad. Many of her Phillipino friends had had experience working abroad prior to coming to Australia.

Lost qualification

When Catalina came to Australia in 1980, it was not possible to transfer her qualification to Australia. Her specialty was midwifery so she could not even be qualified as a general nurse in Australia because of the lack of some subjects required for registration. (The skilled immigration policy became more generous to OQNs and the overseas qualification recognition system became more generous and organized recently but this was not the case in 1984). By moving to Australia, she lost her qualification. She worked as an EN in a nursing home for 10 years. She had children to support so there was no time to stop and to complain about her lost opportunity. Many years passed and it had

been nearly twenty years since she had practised as a midwife in the Philippines and there was no way to get back to her original career now. When she was telling me about this, she did not seem to be especially bitter about it. She expressed it in a rather detached and objective manner as if it was something that had happened in a previous life.

I love my job

A few years ago, Catalina moved to a large teaching hospital to enrol in the Diploma program for ENs. At the time of our meeting, she was working as a resource nurse in the same hospital, which she loved. Everyday, she worked in a different ward or department where they did not have enough staff. Compared with the quiet and very stable nursing home job, it was actually a challenging job but she enjoyed meeting many people. She knew many people in the hospital, which made her work as a resource nurse easier, too. Last year, she was given an achievement award by the hospital. She was invited to the award party where the executives of the hospital, the director, managers and Clinical Nurse Consultants were also present to praise her for her achievement. It was the happiest moment in her life according to her and she hopes that her career will continue in this fashion.

6.6.2. Lucita's Story

Lucita is in her mid-forties and is originally from the Philippines. She had worked in the Philippines, Saudi Arabia and Ireland before she came to Australia two years ago. For financial reasons, she left her home country and started working abroad in the mid 80s. She came to Australia about two years ago to be closer to her ageing parent in the Philippines and to make a home in Australia with her children and husband. For many years, she went back to the Philippines twice per year to see her family, but they are now all living in Australia together.

Working around the world: Saudi Arabia and Ireland

Lucita's first destination after the Philippines was Saudi Arabia. She explained that Saudi Arabia was chosen not for the purpose of further professional growth but for financial reasons. However, she soon realised that the hospital where she worked was more than capable of providing her with a great

opportunity to advance her professional skills and knowledge. It was a multi-national tertiary hospital with high standard continuing education programs. The nursing staff were from the USA, the UK and many other countries. The *lingua franca* was English, while it was required to communicate with the patients in good Arabic.

Though she generally enjoyed working in Saudi Arabia and she ended up working there for many years, it was not possible for her to obtain citizenship of the Kingdom unless she agreed to convert to Islam from Catholicism. Eventually she decided to settle with her family in Ireland as she had had positive experiences of working with Irish people.

The Irish government started accepting nurses from the Philippines only in 2000 and Lucita was one of the first thousand Philippine nurses who went to work in Ireland. Irish media, health care institutions and people welcomed the Philippine nurses. According to Lucita, there was a media campaign consisting of advertisements in the newspapers and on TV to promote the 'brilliant' nurses from the Philippines who had just arrived to serve the country's health system.

Finally coming to Australia: the need to be close to the family

Though she liked working and living in Ireland, she decided to look for somewhere nearer to the Philippines as she wanted to be closer to her ageing parents who were still living in the Philippines. The agency provided information about working in the US and Australia. The Philippine community in the USA was huge and many of her friends were working there but she decided to apply for Australia as this would be closer to her parents.

Family seemed to always be the first priority for Lucita. Despite living overseas, over the years, she had three children, although her husband and children remained in the Philippines. Finally she came to Australia two years ago to make a home with her family. When we met they were building a house in Adelaide in which they would live together.

Being a professional overseas-qualified nurse

Lucita appeared to be a professional OQN. After working abroad for many years in three different countries, I could feel that she had developed her own psychological and professional strategies for adjusting to new environments. Unlike some other nurses who had just started working abroad, Lucita did not express any kind of significant adjustment problem or even sentiments of happiness about coming to work in Australia. She mentioned the difference in the accreditation system between Australia and other countries where she had worked before, but she was explaining objective differences rather than articulating difficulties due to the different accreditation system. Her transition to Australia appeared to have been very smooth because of her confidence in her professional knowledge and skills learned in other countries, including English skills and inter-personal skills. Moreover, her desire to settle with her family in Australia after many years of living separately might have made her adjustment even easier.

6.6.3 Isabella and Garcia's Story

Isabella and Garcia are a young married couple, originally from the Philippines and both around the age of thirty. I went to visit their house expecting to meet only Garcia for an interview but I soon found that his wife Isabella was also a nurse from the Philippines working in the same hospital as her husband Garcia. Isabella had just had a baby a few days earlier and there was a newly born son sleeping peacefully in a cot in the living room. They were a very friendly and easygoing couple and were extremely hospitable.

Working in Ireland prior to Australia

Both Garcia and Isabella had studied for a Bachelor of Science degree in Nursing and worked in acute care settings for a few years. They both went to Ireland, where they first met and later married, for the better professional and life opportunities there. Adjusting to nursing work in Ireland was hard for Garcia and Isabella because it was their first experience of working abroad. English particularly was a big problem for them even though they had studied the language in the Philippines. For historical

reasons, American English is commonly used in the Philippines and they were used to hearing American accents and expressions. Initially, they had problems understanding Irish varieties of English, although, with more exposure they found it easier to understand. Unfamiliar use of colloquial language was a headache for them, as with such terms as *comfort room* (toilet), and the different English names used for particular medicines used in the Philippines added to the difficulties.

They both said that working with 'white people' for the first time, was another major problem, on top of their language difficulties. I could understand that Garcia was not using the term 'white people' in the sense of racial resentment; he was referring to the local culture and social environment, with its assumptions, norms and rules of inclusion/exclusion. *"It was really, really hard. Just weather, environment, just people who work with, adjustment everything, it was quite different. Everything!"*

If we did not like it, we could move elsewhere

It appeared that moving abroad was a normal stage in their lives and they were enjoying being able to move around the world looking for better opportunities with their nursing qualifications. In that sense, they were professional OQNs and I could easily imagine them leaving Australia shortly to move to the USA for better working conditions or better life opportunities. *"We are still young and want to explore the nursing thing in the world"*.

Unlike some participants who had recently left their own societies, Garcia and Isabella did not discuss any hardships involved in working in Australia, or even happiness in working in Australia, and this was similar to the case of Lucita who was also from the Philippines. They described objective states of affairs clearly, such as differences between American English and Irish English, or differences in working conditions in Ireland and Australia but there were few clues as to their subjective reactions to their experiences, and the tone of their comments was very positive throughout the interview. Soon I realised that they did not really have any big adjustment issues in daily nursing practice which they could comment on. They said that there had been some problems when they moved to Ireland from the Philippines but compared with their experience of Ireland, moving to Australia must have been

quite easy as they had already learned to adjust to living and working in an English speaking environment and culture.

Money matters: financial issues

Though Garcia and Isabella appreciated the supportive working environment in Australia, they were disappointed with the financial aspects. In Ireland, the income was higher than in Australia and the work environment and visa conditions were more generous so that they could work extra hours to earn higher incomes. It was actually acceptable to do overtime or other casual agency work for extra money in Ireland, while this was not possible in Australia as visa regulations concerning working hours were stricter than in Ireland. Banking policy for OQNs in Ireland was more flexible than in Australia as they could borrow money without holding permanent residency. Garcia and Isabella felt that in Ireland, Philippine nurses were treated rather better than here in Australia in terms of banking policy and in general public attitudes.

6.7. Nurse from former Yugoslavia

6.7.1. Sabina's Story

Sabina comes from Sarajevo, Bosnia, in the former Yugoslavia. She moved to Australia with her family for political reasons in 1992 when she was 39. After completing the bridging program, she started working in a nursing home about 10 years ago. At the time of our meeting, she was working in two nursing homes as an RN.

Escaping from the war

Sabina studied psychology and nursing in Bosnia and was working in the psychiatric field. Her husband also had two degrees and they were preparing to work overseas to earn some money when the war started. In January 1992, her husband visited his brother and father who were living in Australia but as the war advanced, it became impossible for him to re-enter Bosnia. Sabina and her two children (her daughter was five and her son was twelve then) were left alone in the war and they struggled to

escape from Bosnia. Luckily, they managed to get a flight to Melbourne from Belgrade a few months later.

For five years in Australia, Sabina could not do anything from the shock of the war and worrying about her relatives still living in Bosnia. It was also impossible to accept the fact that everything they had built up in Bosnia had disappeared. She was deeply traumatised by the war and for a long time she could not open the curtains at home for fear of being shot at by snipers.

Hard adjustment period: starting a new life in Australia

In the unlikely event of Australia being attacked by another country and facing the prospect of moving to another country again, Sabina said that she and her family would rather stay in Australia and be killed together. Leaving Bosnia and starting a new life in Australia was extremely difficult for her and her family. To start with, Sabina had not learnt English in Bosnia and the only English word she understood on her arrival in Australia was “Adelaide”. Literally, Sabina and her family had to start everything from the very beginning. What made matters worse was that often Australian people did not understand or could not even imagine what they had gone through and what they were going through in Australia, as people around her had never experienced war or equivalent trauma in their lives.

Lost qualification

Apart from nursing, she had also studied for a Bachelor of Psychology and Behavioural Management and she had worked in a psychiatric hospital where she had organized group therapy. When she was enrolled in the bridging program in Adelaide, she was planning to work in the psychiatric nursing field again as that was the area she had been passionate about for 20 years in Bosnia. However, she was told that she had to take a 2 year bridging program if she wanted to work in the psychiatric field in Australia. She believed that she was already good enough to work as a psychiatric nurse and she could not justify studying for 2 years as she had two children to support. In Australia, she had met many doctors and specialists who came from overseas but it was often very hard for them to continue

their careers in Australia, which she felt was unfair. In the end, she gave up her ambition to work in the mental health field and started working in a nursing home instead.

Surviving in the English language

While Sabina had good language skills in five languages, and fair comprehension of a further seven, she lacked any knowledge of English. At the beginning, she did not have the energy or motivation to learn English because of trauma from the war and from leaving her own society. She was depressed and did not know where to begin. To construct a new life in an English speaking country, *"Like you have to open your eyes and see. I have to start but where to start? When can I start?"* It took her a full five years to be positive about learning English in order to work and to live in Australia.

However, it was difficult to learn English. Listening to orders from physicians on the phone was often very hard and she had to ask them to repeat instructions or tell her how to spell words. She also found that nurses often used unfamiliar terms to describe conditions such as 'loose bowels' for diarrhoea, which often confused her. Her co-workers often said to her, *"Your English is very good."* But she asked them to be kind enough to tell her if she made any mistakes in English as she thought that her proficiency was not very good.

Being with family

Before Sabina started the bridging program, she was working as a cleaner to earn some extra money, as the social security payment was not enough for her family. One day, her husband decided to work in the Mitsubishi car factory though he had double degrees in Engineering and Economics in Bosnia. When people asked him why he had to do the factory job, he replied, *"We have decided so that Sabina can go to the uni. She can get better job than me in Australia."* One of them had to start working to earn a reasonable amount of money so her husband decided to let Sabina study to be registered as a nurse in Australia while he worked full time at Mitsubishi.

Fifteen years after they arrived in Australia Sabin's family had already paid off their house and enjoyed regular holidays in Europe. Sabina's children learnt English very fast and now nobody could tell they were not 'Australians' from their accent. Her daughter was starting undergraduate study in psychology like her mother while her son had already started working in a company after studying at TAFE (Technical And Further Education) for four years. Her husband decided to leave Mitsubishi after ten years of work and was planning to find some casual work. Sabina and her family were very happy and enjoying life in Australia.

A few years ago, Sabina returned to their three-bedroom apartment in Bosnia. She did not feel that it was home anymore though she still recalled vividly the day when they had to leave in tears. After they moved to Australia, someone illegally moved into their apartment and Sabina and her husband had to use the black market to regain the apartment and hopefully, to sell the place. They had to spend enormous amounts of energy, time and money on the process of getting the property back while they were still struggling to adjust to their new life in Australia. In the end, they sold the apartment and this took one big worry off their shoulders. Sabina said, *"We had to leave with our head on our neck. My life, my children, my husband are important. Other things are…… (Not as important as her family)"*.

6.8. Nurses from Germany

6.8.1. Caz' Story

Caz is from Germany and is in her mid-twenties. She studied at a nursing school for 3 years to be an RN in Germany and worked in a paediatric ward for 4 years before she came to Australia to follow her fiancé who was moving to Adelaide for his job in 2006. At the time of our interview, Caz was working as an agency nurse in a children's hospital and as a carer in a nursing home.

Problem in transferring registration

Usually, the nursing license from Germany is transferable to Australia but it took her some energy and time to obtain her registration to start working in Adelaide. Firstly, she could not obtain a sufficiently high score in the IELTS language proficiency test, though she could communicate well in English in daily life. After she failed the IELTS twice, she went to ask the Nurses Board of South Australia for advice. The staff at the board were puzzled to find out that Caz had failed the IELTS because her English communication skills appeared to be excellent.

Her second problem concerning registration was her educational background in Germany. There, the nursing educational system is different from that in Australia and the students have to specialize either in paediatric nursing or general adult care nursing and Caz had chosen to be a paediatric nurse. The board had to consider her case individually and two weeks later it granted her limited registration for paediatric nursing

Working as an agency nurse in childcare

As her registration was limited to paediatric nursing, it was hard for Caz to find a full time job in Adelaide. Firstly, she went for a job interview at a children's hospital but her application was turned down, as the hospital considered her previous experience was not sufficient. Caz thought that if she could not get a job, she would not be able to gain the experience that was required to find a job: "Where could I get the experience then?" Soon she found that there was a nursing staff agency, which could find her casual jobs in paediatric. In the end, Caz started working as an agency nurse at the children's hospital that had originally rejected her application. To earn more money and to practise English, she also started working as a carer in a nursing home when she did not have a hospital job.

There was no agency nursing staff system in Germany. If someone was sick, the manager had to find someone from the permanent staff so being an agency nurse was very much a new experience for Caz. Working as an agency nurse could sometimes be challenging, as she had to work in a different ward every time. Meeting different people all the time required a high degree of concentration at work.

After five weeks of difficult work as an agency nurse, she found that things were getting easier as she had learned how to adapt to practical situations and survive.

On the day of our meeting, Caz did not know if she was scheduled to work on this particular day or not, until the early morning. Then the hospital called her in the morning and asked her to come to work in the afternoon. During our meeting around lunchtime, the hospital rang her again to cancel her shift as they had found someone else. Caz said, "It's like this to be an agency (nurse)".

Generally Caz's experience as an agency nurse was very positive despite some minor problems. She said that working as an agency nurse was giving her some sense of independence, as she did not belong to one ward as she used to in Germany. Being able to have a holiday whenever she liked was also an attractive option of being an agency nurse and the payment she received was also higher than that of the permanent staff.

Social problems in Germany

Caz liked living in Australia. She explained that the social welfare system was not functioning well in Germany due to the increasingly aged population and the high level of customers' demands on health care and social welfare. As a result, the tax rate was very high and Caz thought that she did not have enough money to enjoy her life after paying tax; inflation of the currency after the introduction of the Euro was also pressuring the German economy. She thought that things were getting worse in Germany and she brought all her insurance and pension with her to Australia for the eventuality of settling in Australia with her fiancé.

IELTS is not good for nurses!

Caz took the IELTS English proficiency test but she doubted if the test was useful for nursing practice. The IELTS required academic English writing skills while she had never written a single academic essay even in her own language. Though she could function well in English in her daily life, it was hard for her to obtain the required score in the IELTS test. She also thought that it would be very

helpful if the board could publish some booklet for OQNs from NESB that covered important abbreviations and medical terminology that the IELTS did not teach but which were very important for nursing practice. She also thought that the board should run a short program for the OQNs from NESB to learn some everyday English.

Australian nurses are all friendly

Caz loved working in Australia. The Australian nurses were friendly and very open to new people like herself. They were usually willing to help her so she could not recall any negative experiences in Australia. If she was not certain about anything, she always asked her co-workers, which she thought was very important. Sometimes the staff were too busy to answer her questions but she could step back and wait until someone was ready. She emphasized that it all depended on her communication skills in English and her own personality.

6.8.2. Char's Story

Char is from Germany and is in her late twenties. She studied in a nursing school for 3 years in Germany and worked for 4 years in a neurological ward before she came to Australia to live with her Australian partner. After working as an agency nurse in Adelaide for 3 months, she worked in a radiology department for 15 months. At the time of our meeting, she was working in the same radiology department.

Unlike the other German nurse in the study who was qualified as a paediatric nurse, Char was qualified as a general adult nurse, which made the transferral of her registration to Australia relatively easy. Although she had the appropriate IELTS proficiency test score there was some problem with the different certification systems between Australia and Germany, which delayed the processing of her application for 4 months. Char had to contact Germany to obtain more documents for the registration and could not work during this time.

I did not understand anything from handover…..

Char decided to work as an agency nurse for a while to find which hospital and which ward would suit her. She did not know anything about working in Australia so she wanted to take some time to experience the system before committing to one workplace. She had a high enough IELTS score to register but she soon found that the English used in clinical settings was very different from the IELTS or English used in daily interaction. At the agency office, she met a friendly Australian nurse who taught her some useful abbreviations such as BD (bis die: twice per day). Apart from that, she did not know any colloquial English which she would need in daily practice.

On her first day as an agency nurse, she went to work in a surgical ward but she did not understand anything from the handover she received from the previous shift. She thought that this was very dangerous for the patients and herself but she had to survive somehow. She went to her patients to ask them where they had had their operation. For the first 3-4 weeks of agency work, she sometimes came home crying as she felt very inadequate. She had to process so much information everyday that her brain was sometimes overloaded. However, after a while, she started feeling better and more confident. One day while working in an X-ray department in a hospital she found that they were looking for a full time nurse. She was successful in applying for this job, and was working there at the time of our interview.

Problems with clinical English

Though Char had a high enough IELTS score to be registered and she not have problems with daily conversation, she thought that the medical English and technical English required for effective nursing practice was very difficult. Additionally, communicating with other health care professionals with a different accent was also very hard for her. Reading physicians' handwriting was also a problem and writing patients' reports was also difficult, for example, describing wounds and wound healing. Other problems included the use of abbreviations in oral reports and a different measurements system from that used in Germany.

Until she became reasonably confident, the handover was a nerve-wracking experience for her. There were five native English speaking Australian nurses listening to her, which made her very nervous. She particularly found the tape handover impossible at first. The first time she received the tape handover, it was from an Irish nurse with a strong Irish accent and the tape was very old, which made it sound very unclear to her. She had never done the tape handover herself so she stayed for an extra twenty minutes to give an oral handover, as she was not confident with the tape handover.

This is the best job I have had in my nursing career

Char thought that nurses in Australia had more responsibility than in Germany. One day, a doctor wrote down, "The drain needs to come out (after the abdominal surgery)." It was not the nurses' job to remove drains and tubes in Germany so she went to ask the Australian staff who was going to remove it. The Australian nurse said, "You!" The nurse took Char to the patient and showed her how to do it.

She thought that the most important thing for OQNs was not to do anything unless they are very sure. She emphasized that generally, Australian nurses were helpful and supportive. German nurses were also supportive but they were often more introverted and quiet in comparison with their Australian counterparts.

Char also thought that there was a better continuing education system in Australia than in Germany, which motivated her to study more. Last year, she took a research course and currently she was planning to go back to university to study more. She was also enjoying attending study meetings and conferences given by MINA (Medical Imaging Nursing Association in Australia). She said, "This is the best job I have had in my nursing career."

6.9. Nurse from Slovenia

6.9.1. Zalka's Story

Zalka is from Slovenia and is in her early fifties. She and her family came to Australia to avoid the war in her country in 1991. Zalka studied nursing for 4 years in Slovenia and worked as an RN for 15 years in a respiratory ward. In Australia, she worked as a carer in a nursing home for a while and obtained her nursing registration when she completed the bridging program in Adelaide. She has been working in a nursing home where many residents are from Eastern Europe. At the time of our meeting, it had been 6 years since she had become a Clinical Nurse Consultant in the nursing home.

Zalka came to Australia in 1991-only forty days before the war started in Slovenia. It was becoming increasingly dangerous to stay there, so Zalka, her husband and their two children (aged 8 and 10) moved to Australia to seek a safer and more secure environment. Although the political situation in Slovenia eventually became stable, Zalka and her family preferred to continue living and working in Australia.

Although she had studied German in Slovenia, when she arrived in Australia she only knew five English words. At first, it was very hard to work in an English-speaking environment and she had to work twice as hard as other staff, as she could not communicate well in English. Despite her problems with English, she was keen to learn from what the other nurses and carers were doing. Gradually the staff started appreciating her hard work and they accepted her.

Multi-cultural nursing home

When she completed the bridging program, she was offered a job in the nursing home from the same organisation in which she used to work as a carer while she was studying. Since Zalka could speak Croatian, Slovenian, English and Serbian, she was a very useful nurse for this nursing home and she was happy to be able to use the languages she knew. To be able to communicate with the residents of other nationalities, she was also learning Polish and Ukrainian. Other staff were also from different

cultures, and for Zalka and many other staff, the nursing home was more like home rather than a work place. One of the staff even commuted for sixty kilometres every day, as she did not want to move to another work place.

After 5 years working as an RN, she was offered the position of Clinical Nurse Consultant in the same nursing home. Initially, she refused the offer as she was not confident with her English in dealing with all the patients, family and the staff. The organisation suggested that she should try for 6 months and that she could go back to being an RN if she did not like it. That was more than 6 years ago and she has not returned to working as an RN. She told me that she was receiving excellent support from some English staff who always helped her with formal writing such as letters in English.

Zalka commented that she never saw any OQNs from NESB working in management positions. She believed this was because of the language problem; many nurses are not confident with their language skills to function in management positions that tend to involve a high level of English proficiency.

Australia is nice and relaxed

Zalka generally thought that there was not a large difference between working in Slovenia and Australia; however, one thing - the doctor/nurse relationship - was very different. In Slovenia, the nurses were in a far more subservient position to doctors - nurses had to stand up if a doctor came into the ward and address the doctors by their correct title. In Australia, it is common for nurses to call doctors by their first name, and no such policy about standing exists. Zalka sometimes worked with a doctor from Slovenia and she was not quite sure if she had to show deference as she would have done in Slovenia or whether she should follow the Australian way.

6.10 Nurses from South Africa

6.10.1. Efia's Story

Efia is from Cape Town in South Africa. Her native language is Afrikaans and she studied in Afrikaans until high school. After high school she worked as an informal teacher on the staff of a local primary school but she had always wanted to be a nurse following her mother's heart attack when they were living on a large, remote farm. Her mother was lucky to survive as there were no adults around to help. This incident stayed in Efia's mind for a long time and she finally took steps to become a nurse in 1988. She enrolled in a nursing program but she failed the course as it was conducted in English and was difficult for her. Undiscouraged, she tried again. It took her many years until she actually received her nursing registration in South Africa as she not only had difficulties with English but also some family tragedies slowed down her study. Later, she worked as an EN for a couple of years but stopped working when she married and had her first child. After many breaks in between studying, she finally started working as an RN in 1999.

Working in South Africa

She still remembers her first day working as an RN in South Africa as it was not a very pleasant experience. Nobody wanted to talk to her when she arrived at the medical ward where she was supposed to work. As time went by, the situation improved but it was still sometimes hard to work with the other nurses, especially if they chose to speak a language that she did not know.

During her work in South Africa, she increasingly felt burnt out from stress. The moral standard among the nursing staff was not very high at the hospital where she was working. The nurses often did not turn up for work whatever the reason and some nurses slept during the night shift. The wrong medication was often given to the patients but it was not considered a very serious mistake. There were often thieves at work, and the employer neglected occupational safety aspects. At one stage, several nursing staff had contracted the same skin infection from work but the hospital did not want to take any action until the nurses insisted.

Outbreak of HIV

Human immunodeficiency virus (HIV) infection was breaking out in South Africa and there were many patients coming to the hospital to die. Efia was finding it increasingly difficult to look after patients dying of AIDS (Acquired Immune Deficiency Syndrome). Depressingly, the age of the AIDS patients was becoming younger and younger. As there were so many people dying on one shift, she sometimes did not know any patients on her next shift. It was breaking her heart and she felt herself burnt out. It was not enough just to take a long holiday to get refreshed; she decided that she needed to have a new environment in which to work outside South Africa.

Safety

In Efia's society, crime was worsening and hold-ups and burglaries were becoming regular features of people's lives. One day, Efia had her car stolen from the garage but at least nobody was injured or killed. Innocent people could lose their lives for only a few dollars there, so she started wondering what the point was of going to work while burglars came to steal her earnings. The security issue was becoming intolerable for her and her young children. They wanted to have a better and safer environment than they had in Cape Town.

Immigrating to Australia

Efia decided to come to Australia because a private nursing agency had shown her pamphlets about working in Australia. Australia appeared to be an attractive country with beautiful nature and a good working environment. After completing the required paper work, she came to Adelaide in November 2003. When she arrived at Adelaide airport, a person from the hospital came to pick her up. She did not have to go through a bridging program, as her qualification from South Africa was transferable to Australia. Moreover, Efia was already working in an English speaking environment, which was usually a big hurdle for OQNs from NESB in obtaining nursing registration in Australia. The OQNs' support program provided her with the necessary support to settle in Australia.

Supporting family adjustment

Efia's teenage children joined her soon after to start their new life in Australia. Her husband did not want to live in Australia, as he did not want to lose his good job in a scientific laboratory. His qualification would not be recognised and it would be harder for him to find a good enough job while Efia's qualification was recognised as being of the same quality as the Australian qualification. After his arrival in Australia, the kinds of jobs he could find were only casual construction work and he stopped working, as he did not like it at all.

So Efia did not have the luxury of spending time thinking about her adjustment problems with nursing work in Australia, as she had to work for her family. After a few months, her husband went back to South Africa, as he basically could not adjust to his new life in Australia. Efia had to continue working to keep up the income while her teenage daughter was missing South Africa very much. After a few months, her husband came back to Australia to join her and the children again. During all these family upheavals, she kept working as an RN and kept the children going to school in the unfamiliar environment of a new country.

Working in Australia

Efia did not talk much about the actual working part of her life in Australia. It seemed as if she did not have a chance to sit down to think about her working environment in Australia as she was busy with family issues, although she said that the style of nursing practice was different from that in South Africa. The accreditation system was also very different as it was acceptable to perform nursing skills without worrying about accreditation in South Africa. She was very impressed at finding that there were so many different workers available in the hospital such as electricians, plumbers and many kinds of health care professionals. If she had any problems, it was easy to contact these people in Australia, which she thought was great because she had had to deal with basically every problem herself at her South African work place.

6.10.2. Keisha's Story

Keisha is from South Africa and is in her mid-fifties. Her native language is Xhosa while she studied in English from primary school to university where she took a Bachelor of Nursing degree. She worked as an RN for 25 years in South Africa before she came to Australia in 2005. As her qualification from South Africa was transferable to Australian registration, she did not need to take any pre-registration program in Australia. Currently she works in a medical surgical ward as an RN in a large teaching hospital in Adelaide.

It is just matter of adjustment

Though she agreed to participate in the interview, she was not overly talkative about her experiences either in South Africa or in Australia. When I asked her to describe why she came to Australia, she just said, *"For experience. Just to go abroad"*. I felt guilty for coming to interview her in her workplace even though that was her suggestion. When I asked her, *"You wanted to advance your career in Australia?"*, as was commonly reported by the other participants, Keisha looked annoyed and said,

> My career has been advanced from home! Just matter of change to another country. Here to advance my self is just to adjust and place to Australian procedures but I have done degrees whatever back home. Here there is nothing I can advance my career…….it is just settling myself…

After her comment above, we exchanged some words but it was clear that basically she did not wish to spend much time talking about her experiences. I asked if it was still OK to ask her one more question, and she said OK. I thought if my question was clearer and more specific, she might find it easy to understand.

> I had interviews with some other overseas nurses before and they told me about things like the accreditation system in Australia, or the relationship with their co-workers, things like that. Do you have anything you want to talk about?

Again, she refused to cooperate with my intention and said,

> That's not something I can talk about. I always say that it depends how you……It is always how to stand up for yourself. Because people can have conflicts. Even where they are from, they can have conflicts. I don't say I have never had those work related issues but I don't usually take those things more seriously. Only thing is just to stand up for yourself.

She had to go back to work so we left the interview room together. On the way to her ward, she was smiling and told me why she came to Australia because it would have been harder to immigrate to other countries (She agreed to allow me to use this comment in the study). After the interview, I wondered for a long time how to make sense of this interview with Keisha. Obviously Keisha did not leave me with many pages of interview data. The only comments she left with me amounted to a statement of refusal to cooperate by recounting her personal experiences. It was quite a shocking experience for me as a novice researcher as other participants were usually very happy to talk to me about their personal experiences. I even wondered why she had agreed to participate and sign the informed consent form after reading my information sheet when she did not want to talk about herself. After the interview, I lost contact with her so it was impossible for me to reassess her intention in the interview.

What I strongly felt at the interview was that she was probably refusing to be patronised or downgraded by being put into the category of OQNs even if that was not my intention. It was clear to me that she did not want to be treated as someone different from and less competent than local nurses and she did not want people like myself to make a big issue out of it. I once considered excluding Keisha's data but it should be presented, as this is also one of the dimensions of the OQNs' experiences.

6.11. Nurse from South America

6.11.1. Maria's story

Maria was born in Chile and immigrated to Australia in the early seventies as a 'political migrant'. She worked as an RN in Sydney and Adelaide for many years and retired two years ago. At the time of our meeting, Maria was nursing her mother who moved to Australia from Chile at the age of 96.

Political turmoil in the home country

Maria was born in South America in the late 1930s and worked as a registered nurse in an emergency department for 12 years in Chile. In the early 1970s, she moved to Australia with her husband and their two children for political reasons because at that time Chile was in political turmoil. At first the leftist party (Allende government) took power but the situation became much worse after the military coup. Luckily Maria and her family escaped to Australia before the coup.

Discontinuity of her career

When Maria and her family started their new life in Sydney in the early 1970s, there were no systematically organised bridging programs or competency assessment programs. The registration board examined her qualifications and work history and then she was sent to a paediatric ward for clinical placement because she did not have enough credit for paediatric nursing to meet New South Wales registration requirements. Maria was hoping to find a job in an emergency department but unfortunately this did not happen and she had to work in a paediatric ward.

She strongly felt that she would have been much more useful in an emergency department because she had had more than 10 years of experience before. For while, Maria was not happy with her work in the paediatric ward but she could not continue fretting about it; she had to work to raise her children and she had to move on. Many years passed and she never had a chance to return to the emergency nursing field. It was clear that the fact that she had to discontinue her work in the emergency area in

the process of moving to Australia deeply disappointed her. Overall, Maria's experience in Australia was described in a very positive tone but when she was talking about this particular issue, the tone of her voice became strident.

When patients died…. in multicultural Australia

When she started working in a medical ward, her senior staff showed her the long list of religious practice groups she had to contact in case someone died during her shift. These included Catholic, Orthodox, Protestant, Jewish, Muslim, Buddhist and many other religious groups. In the case of a patient's death, it was also the nurse's responsibility to contact the appropriate religious group in Chile. However, the great majority of Chileans were Catholic and so in daily work before Australia, she had not had much experience in working with patients of non-Catholic background. The diversity of religious practice groups in Australia was very much a new experience for her.

The worst experience in Australia: danger of taken for granted assumptions

One patient died during her night shift. Maria's manager had told her not to touch the body until the registrar certified the death. Unfortunately, the doctor was too busy to come to certify the death and as it was after mid-night she could not call her manager or anyone for advice. When the patient died, the body was sitting up as the patient had had pulmonary emphysema. She struggled to decide if she should put the body straight or she should leave it *untouched* until the doctor arrived. According to the protocol, the body should not be touched unless a registrar certifies the death.

If it had been in Chile, Maria would have laid out the body without hesitation. But she was in Australia where her assumptions from her previous experience often proved to be different or wrong. Especially in the case of treating death, she did not want to make a mistake. She wanted to lay the body straight but she decided to follow what the protocol suggested until the doctor came.

In the end, the registrar arrived but the body was already too rigid to lay straight. When her manager found out the next morning, she was clearly not happy. Maria was questioned why she had left the body in the sitting up position but for Maria, she had done what the protocol had indicated.

When I asked her to describe her worst day in Australia, Maria mentioned this incident. Though she could laugh at it at the time of our meeting, she still thought that the manager should have explained to her clearly what she should do and what she should not do. Obviously, the manager did not know why Maria could not figure out that it was acceptable to lay the body straight. For the manager, it was commonsense and something she took for granted that everyone could understand. In the case of Maria, as her assumptions from her previous experience often needed some consideration before being applied to the Australian context, following the written protocol literally appeared to be the best decision to her.

Becoming an "Australian nurse"

Unlike some less experienced OQNs in the study, Maria did not talk so much about difficulties, issues or even happiness concerning working in Australia. While many less experienced overseas nurses constantly related and compared their experiences in Australia to their experience in their previous countries, Maria mostly separated her experiences in Australia from her memories of Chile. It did not mean that Maria did not remember or did not want to talk about Chile; her memories were always with her. It appeared that she just did not need to connect with her earlier biography when talking about Australia. After 30 years of experience in Australia, her standpoint had gradually shifted from being an OQN, to that of an *Australian nurse* who had immigrated from elsewhere.

6.12. Summary

In this chapter, 23 case analyses including 22 individual cases and one case of a couple are presented. With the use of the narrative approach, the lived world of the OQNs from NESB was successfully illuminated and re-captured without the fragmentation and de-contextualisation of the data from the

participants. The narrative approach is a particularly effective and appropriate way in which to present and analyse the complexity of the lived world experienced by the OQNs from NESB who participated in this study.

In the following chapter, the data from each participant are analysed according to the cross-case/thematic approach with emphasis on the commonalities among the data, while striving not to alter the wholeness and integrity of the experiences being told.

Chapter Seven: The Thematic Analysis

Four emergent themes that form the lived experiences of the OQNs from NESB are presented in this chapter. The themes are: *From the Past to the Future, New Environment, Living in the English Language* and *Shared Worlds*. To present the four themes and to provide a clear decision trail, each sub-theme and the categories are described here and supported with direct quotations from the participants.

Table 2. QARI-View: Theme 1. From the Past to the Future

Theme	Sub-themes	Categories
From the Past to the Future **(Lived Time)** The OQNs' lived experience of understanding the present moment and their expectations for the future are formulated on the basis of their life history, including personal and professional experiences while the perceived lived time changes as more experience is gained.	**The Past**	Seeking better professional opportunities
		English as the language of opportunities
		Seeking safe environment
		Family
		Working abroad as a common course of life
		Nurse immigration industry
	The Future	Making Australia Home
		Seeking another opportunity after Australia
		Working for home country

7.1. The First Theme: From the Past to the Future

Summary of theme 1

The OQNs lived experience of understanding the present moment and their expectations for the future are formulated on the basis of their life history, including personal and professional experiences while the perceived lived time changes as more experience is gained.

The first theme, *From the Past to the Future,* is concerned with the lived time (temporality) (Van Manen, 1997) of the participants in coming to work as nurses in Australia. In phenomenology, time is not considered as a measurable object, but is seen as one of the subjective and temporal aspects of the life-world. As discussed in Chapter Five, Heidegger (1962) explores temporality as fundamental to the constitution of *Dasein*. Time is not something concrete or fixed and temporality is the primordial meaning of *Dasein's* being. For Heidegger, time is not an object, it is "instead a 'happening' or 'event' (*Geschehen*) in which *Dasein* is what it makes of itself in the course of living out its life" (Guignon, 1992, p.131).

Van Manen explains (1997, p. 104),

> *Whatever I have encountered in my past now sticks to me as memories or as (near) forgotten experiences that somehow leave their traces on my being-- the way I carry myself (hopeful or confident, defeated or worn-out), the gestures I have adopted and made my own (from mother, father, teacher, friend), the words I speak and the language that ties me to my past (family, school, ethnicity), and so forth…*

Similarly, *Dasein* projects itself into the future. The past opens up possibilities and provides a direction to the becoming of our lives at the same time. Through our experiences, we develop a perspective on the life to come (the future) (Van Manen, 1997).

The two sub-themes that structure the first theme are *The past* and *The future*. By adopting Heidegger's notion of *Time*, the terms *past* and *future* actually involve much more than the everyday understanding of "past" and "future"; they are two of the most important structures in understanding the participants' experiences in this study.

The categories that characterise the sub-themes are descriptions of the values, the life priorities, previous life environments and the present life environment which not only have brought the participants to Australia but also strongly affect their present and future experiences. In other words, the theme is concerned with the *life histories* of the participants.

7.1.1. Sub-theme 1: The past

The first sub-theme, *The past*, is concerned with the participants' experiences in relation to deciding and choosing to come to work in Australia that have brought them to the present moment. There are six categories that structure the first sub-theme, *The past*. The first five categories describe the participants' value systems, belief systems and life priorities in relation to their migratory move. The last category, *Nurse immigration industry*, describes the OQNs migratory move in the context of the big wave of the international nurse immigration industry which influenced the participants' move to Australia.

Categories

1. Seeking better professional opportunities
2. English as the language of opportunity
3. Seeking a safe environment
4. Family
5. Working abroad as a common course of life
6. Nurse immigration industry

1. Seeking better professional opportunities

Seeking further educational opportunities and chances to advance nursing skills and professional knowledge were some of the main reasons for coming to Australia. Due to a lack of systematic and organised continuous education systems in their home countries, some nurses felt trapped in a dead end. Coming to Australia was often thought to be a solution to their dilemma and in a sense, amounted to a kind of self actualisation for some nurses, keen for further study opportunities.

> I only get…..I am like high school level, that means even if I can get further education, I cannot get promotion. There are lots of nursing graduates from the universities, and they have got very high degree, so that means in China I have no chance to be promoted, and it is very hard for me to get further education even though I have worked many years….I was not very happy about it…. (Yun, p.12, line17-23)

Like Sakura's case below, many participants related to Australia as a country with a good working environment. The nurses felt that in their home countries it was very hard to provide good nursing care because working conditions did not allow them to do so. Frustration with unfair management styles, problems with senior staff or heavy workloads also pushed some nurses to seek a better work environment in Australia.

> Also my aunt was working in US as a nurse. She told me things like fairness and equality among health care workers and the rights of women, good working condition in the Western countries and wondering if these were true. If those things were real in some countries, they must be providing different (better) nursing care. It was hard to find information about such thing so I started hoping to go abroad…. (Sakura, p.1, line8-14)

Some participants described more specific and serious work-related problems which pushed them to come to Australia. Efia wanted to escape from harsh working conditions in South Africa and she could not deal with working with people dying from AIDS anymore.

> There are many AIDS patients in South Africa. I just felt, what's wrong? Now the young ones are dying, when I started nursing, only the old people were dying but now the young people are dying, too. I wanted to leave. Leave isn't just for a short time and you come back and burn out again… (Efia, p.6, line14-16)

The epidemic of HIV and AIDS is a national disaster in South Africa and working in the front line of health care, Efia witnessed the chilling sight of a large population dying from AIDS. In the early days, dying patients were generally older but as the patient population was getting younger the nurses could not remember the patients when they died as they did not usually survive long enough to leave impressions as individuals.

2. English as the language of opportunity

Opportunities for learning English and gaining experience in an English speaking environment were often described as the main factors that motivated nurses to come to Australia. English was seen as the most useful language which would provide advantages in professional advancement, and future career moves as well as life in general.

For all participants, working abroad meant working in English speaking countries such as the UK, the USA, Ireland and Australia. There was one nurse who had worked in Saudi Arabia but English was used among the hospital staff. Nobody mentioned future plans to work in non-English speaking countries other than in their home countries; for the participants, English was the world language with associated opportunities.

> I think the best thing (in working in Australia) is English country. So I can learn English and nursing skills in Australia…… (Mali, p.3, line33-34)

As Mali described, the advantage of coming to work in Australia was being able to learn both English and nursing skills. The implication here is that many of the participants believed that there would be something to learn in English speaking countries when they made their decision to come to Australia.

> ……..and I thought to go to Australia. It is also English speaking country. I wanted to learn some English and to learn something useful in English speaking country….. (Yun, p.13, line47-50)

Several nurses mentioned their failure in obtaining a valid visa to work in the USA or the UK, which made Australia an alternative choice within English speaking countries. In particular, some nurses explained that it had become extremely difficult to enter the USA after the September 11th terror attacks.

> I think I am good at English, so I wanted to go abroad to do something. Errr, I was thinking about going to America but it is hard to get visa after the September 11th in 2001… (Cindy, p.1, line10-11)

3. Seeking a safe environment

For some participants, securing a safe environment was the main motivation for their migratory move, due to unstable and dangerous situations in their home countries. In the study, four participants described their reasons for leaving their countries in terms of looking to escape war or political instability.

Sabina escaped from the war in the former Yugoslavia and came to Australia with her family in the early ’90s. She suffered from severe shock and feelings of despair from the war and the life they had lost and left behind; she was actually suffering severe symptoms of post-traumatic stress disorder as a result of these experiences.

> For a few months, I have been so scared with snipers. They would come to kill us in the house. All the time, I put the curtains down. My husband was asking me and what are you doing? The snipers are coming to kill us. Then he said, "You are in Australia, you are in safe country." If I heard any noise on the street, I would go, "Oh, somebody will kill us, kill us!" I could not control my reaction. It was so hard…. (Sabina, p.1, line46-50)

Efia was from South Africa and the living environment was becoming increasingly dangerous which pushed her and her family to migrate to Australia. The crime rate in South Africa was impossibly high and she was often burgled and things like her car were stolen.

> They broke into our house and one car was stolen from us things like that, sometimes you get to the stage thinking, why must I go to work, while people just came to steal my things. You know? In the end, you feel like they just take this for granted they can just take from you. It was just getting too much. I did not want to deal with it anymore….(Efia, p.9, line22-25)

4. Family

Family was one of the main sub-themes that had a large impact on where participants chose to migrate to. For married participants, partner and children were often the reason for immigration; for some nurses, their husband/partner had to work in Australia and they followed them in order to stay together. Some nurses decided to move to Australia for better life opportunities for themselves and their families and they convinced their partners to cooperate with their plans.

> I came to Australia because of my boyfriend now my fiancé, he is also German, and he has got a working contract job at one uni as a scientist. I told him that I am coming no matter what. I took all the insurance and everything from Germany. My whole life is now in Australia…….. (Caz, p.1, line3-6)

Parents were also an important factor in the participants' decision making. In some cases, parents did not like to let their children go abroad but gradually they came to understand and accept the nurses' decisions. One participant used to work in Europe but she decided to work in Australia in order to stay close to her ageing parents.

> Australia is near to my country..... I needed to go to the place where it is quite accessible to my own country. ...., Ireland is too far away it takes 36 hours flight. America is very far, too, actually, I was offered two, either going to America or coming over here……but I preferred to come here because it is accessible to Philippines. Quite near and my parents are so old…. (Lucita, p.1, line2-18)

The hope and desire to provide better life opportunities for children or young family members was the prime concern in their migratory move for some participants.

Cindy was an experienced Chinese nurse and she decided to move to Australia to provide her young daughter with a better environment to grow up in.

> Better school or better treatment, Uh, so if you, as a child in China, it is very stressful. You know? Lots of pressure to study. My daughter is only 4 years old but we have to start thinking about the school. You should send your child to some special school to learn everything, dancing, piano, violin to learn some more…….Yeah, so it is very hard for child to be grown in China. I don't think it is good, good environment. I think here (Australia), it's more relaxed. Yeah, more relaxed……..We would like to give her more space to be grown up……. (Cindy, p.15, line21-25)

Like Cindy's case above, the hope and desire to provide better life opportunities for her younger family members was the motivation to live and work in Australia for Pim from Thailand.

> In the past, they (her parents) were worried about me, how can I stay here (in Australia)? How can I living alone? I did not want to leave my family but I said, don't worry about me. I decided to do (go to Australia). I can do it. I still love Thailand but in here (in Australia), I have more chance to my young brothers and sisters. I want them to study in

> Australia……Because our occupation (nurse) is easy to stay here. I want to give chance to young generation!... (Pim, p.2, line12-18)

5. Working abroad as a common course of life

While some participants described working abroad as rather a tough and radical challenge which posed serious dilemmas and difficult decisions, for other nurses, it appeared that working abroad was not something that threw up unexpected or unanticipated problems. In these latter cases, family members, relatives or friends had often lived and worked overseas and so such nurses did not dwell on difficulties or issues concerning adjustment to life in Australia.

Catalina came to Australia from the Philippines after marrying her Australian husband. Even if she had not married her Australian husband, she would have considered the option to work abroad. As she explained, she was brought up in an environment where people seek opportunities overseas as a natural course in their lives.

> If I had not got married (her Australian husband), I probably would have ended up working, you know? Overseas than staying in the Philippines. I have got my uncle.....My uncle is still in the Middle East, Saudi Arabia. He is there at the moment, and one of my aunties and uncles immigrated to America. He is a doctor and she is a nurse. So if I would have ended up with following their footsteps if I did not get married and immigrated to here…… (Catalina, p.1, line20-26)

6. Nurse immigration industry

Finally, the role of private nursing staff recruitment agencies was commonly described by nurses from China, the Philippines and some other countries. The participants sought professional support from private agencies to obtain necessary information about bridging programs, visa applications and job opportunities in Australia or elsewhere.

> Err, look at the internet and look for information. I got here through agency …….Yeah. I was thinking about going to NZ but she told me about Australia. The agency organised all the paper works. She advised me some tips. She told me about UniSA, too……(Irisa, p.3, line1-4)

> paid the money for the agency. Like $2000…..they apply visa for you. Before I got here I did not know what kind of documentations I needed. I did not know what Flinders university offered. Flinders has got some relationship with the agencies so it was easier than doing it myself. They helped you to get a visa. After I finished the visa, they were finished. That's it… (Fei-Yen, p.6, line21-25)

In a way, the participants' experiences of coming to work in Australia were not driven only by personal agendas and ambitions; their relocation to Australia occurred in the context of a large expansion of the international nursing recruitment industry which involved both the university sector and employers in the host countries. The universities advertised their bridging programs in nursing journals, magazines, on web-sites and nursing expos overseas, to recruit future students, and they worked together with private immigration agencies in the student-exporting countries.

Mali found information about a bridging program in Adelaide at the Nursing Expo in Thailand.

> I went to Thailand education expo and I see…I saw the information about UniSA (University of South Australia). It had a special course for overseas nurses. At that moment, I think that it's good time for me to seek more experience and practice my English. So just came up suddenly. Thinking…….So before you did not think about going abroad……..I never thought that I was coming to Australia……..I talked and discussed with UniSA marketing people, they suggested me that I had two choices. Firstly, enter the English program in UniSA about half a year and pass the level of English, and then enter the nursing program… (Mali, p.1, line9-40)

Mali recalled that finding the University of South Australia's information booth at the Expo by accident had changed the direction of her life. She had not seriously considered the possibility of working abroad before but the UniSA was actively marketing information about their bridging program which would offer her a new career opportunity in Australia. By seeing an information

booklet advertising the program and by talking with marketing personnel from the university at the site, she started developing an interest in working in Australia.

7.1.2. Sub-Theme 2: The future

The second sub-theme, The future, is about the future horizons that the participants were considering in the present moment; in other words, this is the future that the past and the present have brought, regarding possibilities for the participants. The following categories describe three possible future visions and hopes that are the projection of this experience in the past and the present. Making Australia home and Seeking another opportunity after Australia might appear to be simple descriptions of life plans but they are formulated on the basis of the participants' making sense of their present experiences in Australia. Working in their country of origin is related to the participants' hope of contributing to nursing in their home country after obtaining advanced nursing knowledge and skills in Australia. In addition, this category is also related to Theme Three, New Environment, which describes the participants' discovery of the high standard of the nursing profession in Australia.

Categories

1. Making Australia home
2. Seeking another opportunity after Australia
3. Working for country of origin

1. Making Australia home

Making Australia home was often described by the participants as their future plan. In such cases, they had moved to Australia with family/partner and had built or were willing to build their life in Australia rather than return to their countries of origin to start again. For these people, Australia was seen as a comfortable society where they could have a stable, relatively easy and relaxed life with their family or loved ones.

Zalka had built her home in Australia with her family since they arrived in the early 1990s. She felt thankful for the opportunities Australia had given them and she liked the easy and relaxed Australian

lifestyle. She had no intention of returning to Slovenia and would continue working in Australia until her retirement.

> In the last 15 years, I have gained more than I could have in my home country. I bought my home, life is pretty good. I would not have my house over there…….Many people who are from Adriatic coast, they buy house for retirement. But I want to stay here. I like living here and my family like here, too…Here is easy. People are easy and relaxed….. (Zalka, p.5, line42-45)

Other nurses from socially stable countries were also attracted to the idea of making Australia home. Caz was a young German nurse who wanted to stay in Australia permanently with her German fiancé because of the good quality of life she could have. Australia was seen as a place with stable and comfortable social conditions, including a relatively well managed social security system, which was very appealing to her. The reasonable cost of living and the easy and relaxed Australian culture were also described as favourable aspects of living in Australia.

> But we don't have money to maintain (in Germany). There are no enough young people to pay the tax to support our ageing people and welfare system. At the moment, here is better……. I like here much more. People are nice and I like it. I would like to stay here. I brought everything from Germany…German people here say, don't go back to Germany…here is better…. (Caz, p.3, line15-18)

2. Seeking another opportunity after Australia

Hope in obtaining future opportunities outside Australia (in the UK and the USA) was also described. It was not always the case that participants wanted to leave Australia because they were not satisfied with working in Australia; rather, the nurses were following the original plans that they had made prior to coming to Australia. In their view, living and working in Australia was an opportunity to gain good experience in an English speaking environment so that the transition to the next English speaking country would be smooth.

> I wanted to work in England originally and went to study English there. Then I found their requirement was rather strict and hard….That's why I came here to Australia. If I have the Australian nursing registration and good English, it would become easier for me to go to England in the future……I really enjoy working in Australia but maybe I still want to see England….(Mika, p.1, line3-8)

> I want to go to America after Australia. I wanted to go there first but it was difficult to get visa. If I gain experience here (in Australia), it will be easier to go to work there….. (Irisa, p.1, line5-7)

3. Working for country of origin

The hope of contributing to nursing in the country of origin was repeatedly described by some participants. The knowledge and skills that they were gaining while working in Australia were often seen as more advanced and more sophisticated than they could have obtained in their home countries.

According to Mali, her move to Australia was purely for professional experience so that she could take back advanced nursing knowledge to her country of origin. Her employer and senior nursing personnel in Thailand expected her to return as a leader with new knowledge from Australia.

> I just want to learn more and get some experience here and come back to my country…..many doctor and nurses from my country come to Australia to study and return with skills and knowledge from here. Yeah. I want to…make some exchange program from Australia and my hospital (in Thailand)…My boss wanted me to come back with….new skills from Australia, too……. (Mali, p.1, line10-15)

Unlike Mali's case, there were more nurses who had left their jobs in their home country and had permanently migrated to Australia. As in the following Yun's case, they had come to Australia not only for professional advancement but also for better life opportunities in general. As they experienced the relatively sophisticated Australian nursing and health care system, they experienced feelings of achievement and these were followed by the hope of using their newly acquired knowledge to improve conditions in their home countries.

> Many years later, if I can do something for Chinese nurses, I really think about that! If I can do something to change the situation, I will go back there if I can get the chance. If I can't do anything for them…..I want to do something for them….. (Yun, p18, line18-20))

In a sense, this is an empowerment process for those nurses who were used to a powerless existence prior to coming to Australia. As the OQNs gained professional experience in Australia, it appeared that their self-image as nurses improved substantially, which provided them with a feeling of power and ability and the intention of contributing to nursing practice in their home countries.

Table 3. QARI-View: Theme 2. New Environment

Theme	Sub-themes	Categories
New Environment (Lived Space) The OQNs' lived experience of the new environment is a continuous process of overcoming difficulties to fit in to Australian nursing practice while receiving organisational, professional and personal support to facilitate adjustment.	Exciting new challenges	High standard of working environment in Australia
		Unique challenges in Australia
		"What is white tea?"
		Family
	Fitting into a new environment	Australia is very bureaucratic
		Clearing hurdles to enter practice
		You start from year one
	Supportive working environment	Financial reward
		Good working conditions
		Education system is better here
		Open and friendly working culture

7.2. The Second Theme: New Environment

Summary of theme 2

The OQNs' lived experience of the new environment is a continuous process of overcoming difficulties to fit into Australian nursing practice while receiving organisational, professional and personal support to facilitate adjustment.

The second theme, *New Environment,* is concerned with Heidegger's notion of lived space/spatiality which is part of the ontological structure of the human being (Heidegger, 1962). From the phenomenological perspective, space does not refer to mathematical space but is understood as a subjective phenomenon; in other words, space from the phenomenological standpoint is 'felt space' (Van Manen, 1997). Therefore, space is not something concrete and fixed; it is an individually experienced environment/place. Phenomenological space is not something detached from people but it affects the way people feel (Van Manen, 1997) . Thus, in a similar way to time in the phenomenological sense, as discussed in the previous section, lived space is also temporal and relative in nature.

Three sub-themes were apparent from the *New Environment* theme. These sub-themes are all concerned with the participants' felt-working environment in Australia and describe how the participants' *felt space* helped them to adjust to work in Australia. This is particularly apparent from the first sub-theme, *Fitting into new environments.* The second sub-theme, *Supportive work environments,* is concerned with the participants' felt space where they could obtain many kinds of support. The third theme, *Exciting new challenges,* describes Australia as a place where the OQNs could feel a sense of achievement and pride as nurses. These three sub-themes describe the relational

nature of the working environment and the individual participants, with their own cultural and social contexts.

7.2.1. Sub-Theme 1: Fitting into a new environment

The first sub-theme, *Fitting into a new environment,* is about the OQNs' experiences in adjusting to the Australian working environment. The first category, *Clearing the hurdles,* describes the OQNs' experience in their pre-registration period in Australia. *You start from year one* concerns the OQNs' experience in relation to a recently introduced employment policy in the public health sector in South Australia for OQNs that does not recognise their previous experience overseas. *What is white tea?* is related to experiences in encountering various adjustment issues that caused difficulties for participants. The last category, *Australia is very bureaucratic,* describes one aspect of the participants' experiences with the Australian health care culture, where they encountered frustrations or difficulties with bureaucracies.

Categories
1. Clearing the hurdles
2. You start from year one
3. What is white tea?
4. Australia is very bureaucratic

1. Clearing the hurdles

Attending English language programs and bridging programs formed a large part of the participants' experiences before entering the new work environment in Australia. Problems in learning the English language, particularly those involved in academic essay writing, were commonly described by the OQNs, and subjects in the bridging program were generally perceived as obstacles that needed to be

successfully completed in order to pass the registration requirements, rather than as intellectual opportunities.

> They teach us about how they do things here. We already have knowledge. They just teach you basic things. I think it is still useful. Get you more confident… (Anming, p.1, line48-50)

> English was really really hard at first. Nursing part was not very difficult. But English was very difficult….. (Zalka, p.4, line46-47)

Some participants worked as carers in nursing homes to gain some income and to learn English in clinical settings while they were enrolled in the bridging course.

> You know sometimes, some meaning, they don't know how to call like big sheets, draw sheets, flannel. These kinds of words, you cannot find in a dictionary. No, you cannot. It's not academic but it is like speaking words. Just you cannot understand. Yes, I think carer is good to start…… (Pim, p.10, line6-9)

During the pre-registration period, the OQNs sought information about the new work environment but sufficient information was often not available. The need for more systematic information about health care and nursing work in Australia was commonly expressed by the participants.

> It would be nice if you knew how things are. So that you can do things accordingly. So like….if you are doing nursing, little bit of information about the hospital system health care system, there should be some information to make transition easy. How to go about…. If you get that information, it will give you some clue. I would know what to expect…. (Tenzin, p.4, 16-20)

2. "You start from year one."

Obtaining recognition for previous qualifications and experience was another dimension of the experiences of fitting into a new environment. From 2007, public hospitals in South Australia started accepting newly arrived OQNs as first year nurses without considering their previous experience. Though employers had explained that payment conditions were negotiable depending on how competent an individual OQN was, nurses expressed the feeling of being treated unfairly by the health care system.

> I am very disappointed…..in this state. They don't recognise our previous experience of overseas nurses……..You start from year one. The government send a letter to the hospitals to recommend, to give year one for overseas nurses. I am year one I just started last month and I am looking after ICU patients. This is not fair for me…… (Jane, p.4, line10-15)

> Yes, other issue is, Australia especially South Australia, does not want to accept our experience. I got Year 1 even though I have experience in Korea. From last year, they did not give year 5 or 6 to overseas nurses. Just in case, if I go to private hospital, I can get year 6 experience this moment but they don't usually sponsor my visa……..it is unfair I think…..(Alice, p3, line8-13.)

Some OQNs felt trapped in different education and qualification systems between Australia and their home countries and they had to give up their original speciality area in nursing in moving to Australia. This sentiment was often expressed by nurses who had arrived before the late '90s when the overseas qualifications assessment system was not well organised and the assessment criteria were probably less generous than they are now.

Such nurses had to accept the available opportunities in Australia to support their families but still feelings of resentment and frustration about their lost careers seemed to remain, even after many years. Sabina used to work as a psychiatric nurse and was responsible for group therapy in Bosnia but now

she is working in a nursing home in Adelaide because her qualification and experience as a psychiatric specialist nurse were not recognised in Australia.

> Yes, I am cross (angry and unhappy about her previous qualification not being recognised in Australia). I have a degree in psychology and I think my education is well enough to work as a psychiatry nurse here. Just because of the law about education, I just cannot work as a psychiatric nurse. How many times I have seen doctors and specialists here, who cannot get any place because of education. I understand English is necessary but I cannot understand why…...if we are trained in hospital, I cannot see why they cannot bring educated people from overseas. I am very cross…..(Sabina, p.2, line30-35)

3. "What is white tea?"

> Yeah, (Coming to Australia was) a very big (move). Totally different. Totally different. (Cindy, p.3, line21)

The OQNs felt that there were many differences from their home countries to which they had to adjust in order to fit into their new work environments. It was often stated that the first six months was the hardest time because of the differences which had to be overcome.

> Yeah, they support me a lot. They encourage me. They teach me things and they are very friendly and kind. But you know, it takes us time to adjust…..first six months is really hard…. (Irisa, p.2, line6-7)

This range of problems encountered was one of the largest described by the participants and, obviously, the OQNs would have encountered many differences to which they needed to adjust. Such differences included: measurement systems, the use of protocols and guidelines, the accreditation system, medical equipment, management of lines, drug administration, the ways of delivering handover, documentation procedures and nurses' roles in general, including relationships with physicians, relationships with patients and individual workplace cultures. In addition, this category is

ontologically related to many other categories and sub-themes because living and working in Australia was already a "different" experience for the participants.

> Yes, different procedures, different...you know nursing in China do different things. Equipments are different, yeah, yeah. (Yun, p.2, line19-22).

> At the first hand over, I had a patient with BSL, it was 4.8 for example, it did not tell anything to me. But it was blood sugar level, But in Germany, 80 to 120 is the normal range, different measurement……for example, some people tell your weight with stone, like old English measurement? For height, foot, have you heard of foot? If you ask the patient how tall are you? They say, 5.8 feet. (laugh)… (Char, p,2, line45-p.3, line4)

It appeared that the most significant part of the OQNs' experience in Australia was adjusting to many small but important differences encountered at work. The different ways of handling drug administration were often described in detail as this was considered to be a critical aspect of nursing work.

> In Germany, the system is a bit different. You are not allowed to take blood, and you are not allowed to do antibiotic IV (Intravenous), but here you mix antibiotics in the bottle and give the patients by IV. And in Germany you are not allowed. For antibiotics infusion, doctors have to stand by the child so he can see the reaction. In here, you allowed to do it. That's different.....And the drugs, high pain drugs, in Germany, you have a key, one nurse has a key but you can give it to any nurses. And only one person has to sign the book. In Australia, it has to be 2 RN. And I think it is also allowed, RN and EN. But always two people. But in Germany, only one. Sometimes two persons have to do when tablets fall on the floor and cannot use it again and only those special occasion…..I think it is safer (than one person)…..Also in Germany, you prepare infusion by yourself, makes liquid with powder, and put it by the patient. In Australia, always two people have to sign, and some infusion machines, and needles are different. (Caz, p.2, line32-45)

Even knowing how to approach her patient, she had to look around to see what the other nurses were doing.

> And you don't even know how to talk to the patients. On my first day, I went to the patient and said, Good morning Mr Smith. Then another nurse came in, Hi Darling! (laugh) Everything is different but interesting…(Char, p.3, line44-46)

Yun could not understand what 'black tea' was as she had never had it in her life. A tiny unknown English word like this could be a large barrier to carrying on nursing care and some nurses had never heard of such English terms in daily use as they were usually not taught in the bridging programs.

> …….but first time when I started working, it was hard, because I don't know their culture, I did not know how to make a cup of tea, like that. Because I never drink tea at home. I did not know putting milk and sugar….what is black tea, white tea? And they don't teach thing like this at the bridging course! (Yun, p.16, line23-28)

The relatively large body size of Australian (non-Asian ethnicity) patients was also described as a big difference for Pim.

> OH, yeah, they are very big. They are not like Asian patients. I have heard many nurses hurt their back in nursing homes. (Pim, p.5, line39-40)

For some nurses, nursing roles in their home countries were very much medically/technically orientated and they had not been trained in basic personal care, which they found formed the major part of nursing work in Australia.

> In my country, we don't need so much personal care. Big difference. Nurses job here is more basic care. In my country, you have to do lots of injections, urinal catheters, we don't need to do personal care because normally there are personal carers. Because in my country, there are more patients, so we are very busy to do technical stuff, like IV but here you do more personal care….(Fei-Yen, p.2, line46-48)

Although most participants interpreted the working environment in Australia as being very friendly and supportive, some OQNs expressed feelings of frustration and isolation from a perceived

individualistic working culture. For instance, Jane used to work in Thailand where health care workers could work in a family-like environment which provided her with motivation to work and the feeling of belonging to an institution. However, she found that the Australian working culture was very different from that in Thailand. She did not disagree with the view that individual Australian nurses were friendly but she also felt that there was no feeling of bonding and community which she used to have back home.

> I feel like, people work, they go to work, and they go home. In my country, if you work, you have colleagues, it can be your friend……..We work like family. We share. We share our life. Not only our job, we share our lives. We feel like we are part of the hospital. My job, my duty, I want to improve the hospital. But here, go to work, get paid, that's all. What happens to the hospital is not my business. It is a Director of Nursing's business. It is the government's business. If you work in the morning, just do your job and go home. No sense of belonging. (Jane, p.2, line26-32)

Jane's experience is also related to the next category concerning the bureaucratic organisational culture. As discussed above, the feeling of belonging to the workplace had been a significant part of her work in Thailand and she said that she used to work for the hospital rather than for her own benefit. When she felt that it was not considered her business to think beyond her daily practice, she was disappointed. For Jane, each section of the organisation and the workers appeared fragmented and isolated from the rest of the institution.

4. "Australia is very bureaucratic."

The working environment in Australia was often described as being more bureaucratic than in the nurses' countries of origin. There were both positive and negative feelings expressed by the participants but the negative aspect was emphasised more. Several nurses described the skill accreditation system in Australia as being very inflexible and this was often a source of considerable stress for the OQNs with previous experience in other English speaking countries such as Ireland.

> Even though you are accredited in Ireland, but if you are not accredited here, you cannot do things, up to now, cannulation, I am not accredited for to give cannula to the patients……(Lucita, p.3, line28-31)

Excessive paper work and the requirements for frequent signing, concerning medication and other documentation, were viewed as being unnecessary and they were a source of frustration at work.

> In this country, we have to sign for all the medications. It is wrong. If we did not do from some reason, we should write it. In some situations I did not sign and two weeks later, did you give the medication? I cannot remember! Not necessary. Here also we have lots of paper works and documentations……..…(Sabina, p.5, line14-16)

A long waiting list for various tests and specialists was interpreted as an inefficient system.

> Little disappointing. And the process here is very, very slow, just to take X-ray, just to have a specialist, it takes long long time. It is crazy (Irisa, p.3, line16-17).

The rigid use of protocols was often reported as another source of frustration at work.

> They (Australian staff) do everything by the protocols. One by one but actually in practice you need to change a bit. But they don't want to change the rules. Care should be individualised!.... (Fei-Yen, p.5, line10-12)

Some nurses perceived this positively but more nurses felt that individualised care was neglected in order to adhere to the protocols.

7.2.2. Sub-Theme 2: Supportive work environment

This sub-theme concerns the participants' experiences of a generally supportive work environment in Australia. *"Education system is much better here"* articulates the participants' experience in finding

broad and accessible educational opportunities for nurses in Australia. *Financial rewards: money matters* describes the financial aspects of life in Australia that inevitably have a large impact on each participant's making sense of experience in Australia. *Good working conditions* refers to the OQNs' feeling that working conditions in Australia (compared with those in their home countries) were better, e.g. there were good occupational health standards to protect workers. *Open and friendly working culture* refers to the participants' perceptions of the democratic and supportive organisational and management culture in Australia.

Categories

1. "Education system is much better here."
2. Financial rewards: money matters
3. Good working conditions
4. Open and friendly working culture

1. "Education system is much better here."

The working environment in Australia was described as providing broad and generous educational opportunities. Many nurses had been offered places to take up further studies by their employers at post-graduate certificate level as part-time students while they continued working.

> I was offered a critical care course, one year course……they are good like that. I want to learn a lot here….. (Mali, p.9, line10-11)

> I work at X-ray. There is an imaging nurses called MINA, Medical Imaging Nursing Association in Australia……All the nurses in radiology are meeting and educating each other MRI, CT…….there is a big education thing going on……It makes you realise that you are not working only yourself. There are other nurses out there, with similar problems, education system is better here. Better than in Germany. They offer lots of

> courses. I did research course recently, I get paid for it. That is something good. Very helpful….." (Char, p.4, line42-p.5, line3)

Like Char's case above, the OQNs found that there were many educational opportunities which they had not had in their home countries, such as workshops, seminars, conferences and various post-graduate programs. It was repeatedly mentioned that for educational opportunities, Australia was much better than their countries of origin, which provided the OQNs with a great sense of encouragement and motivation to continue working as nurses.

2. Financial rewards: money matters

The better financial rewards in Australia compared with their home countries were often discussed in relation to the work environment. Australia was often described as a country where participants could gain a relatively good income compared with what they used to receive at home.

> And also salary (laugh). Three times more than Thailand! (Pim, p.6, line38).

> But in my country, pay is not as good as here so…..Maybe I work a few days here, means one month in China. Yeah, if I go back to China, I don't want to work in a hospital. Because too hard work and low pay. Better work here….I do lots of in charge shifts afternoon and weekends only you…..Very stressful but it is also good pay to do in charge. So pretty good… (Anming, p.1, line33-36)

Though there were nurses whose income had not increased markedly by moving to Australia, in these cases the relatively low cost of living was described as a positive aspect of Australia.

> Financially it is better here. I mean, if you convert the money in South Africa, you won't survive for 20 dollars. For 20 dollars you can buy lots of things here. But if you converted to the South African money, you can't. So expensive…..Yes, cost of living is very low here… (Efia, p.17, line1-3)

Alternatively, there were some nurses whose income decreased by a large amount in moving to Australia and these were mainly the participants who had come to Australia to gain experience in an English speaking society before moving on to the next English speaking country.

3. Good working conditions

Australia was often described as a place where the participants could work under good working conditions. Good working conditions in this category included no unpaid overtime policy and long paid holidays, which were felt to provide important support and encouragement for workers.

> The time you have to work over time….But they did not give the money for over time. But here, if you don't finish your work on time, you can continue working and you can get the money for over time. Also…I can get lots of paid holiday here. I had 6 days in Thailand but I can take 6 weeks in here. Ten times more…. (Pim, p.11, line36-41)

> If you do over time, you can get paid or you can go home. In Japan, I often stayed until late because I did not finish my work. I did not want to leave my job behind….(Sakura, p.3, line20-23)

The availability of various professionals and workers at the work place was another reported positive feature of the Australian working environment.

> It is really nice to work here. Different specialists. If I have a problem, I could just call someone for help. I can just do nursing job, which is great…I had to do everything by myself at home…..(Efia, p.10, line16-17)

A supportive occupational health policy in Australia was also described by one nurse.

> My teacher said, if you think you can help the patient, and you (are) happy to do it, you do. But, if you think you can't, and you (might) hurt yourself, you have the right not to

> do that. Because you have one back in one life. In our country, you have to die on your duty to save the patient… (Pim, p.10, line46-50)

4. Open and friendly working culture

The OQNs mostly described the Australian working environment as being open and friendly. The agency nursing system was often seen as a symbol of the openness of the Australian working culture, as working with unfamiliar people requires an accommodating attitude on both the agency nurses' side and the hospital staff side.

> I like the way people work here even (though) they don't know each other, they can work. In my country, they don't want to speak to strangers, but here people talking, talking, asking…..I think it is a good thing. We don't like agency nurse in my country…. (Mali, p.3, line33-37)

Similarly, "the no-blame policy" for workers was also seen as an embodiment of the non-authoritarian and supportive working culture in Australia. This education/management policy helped one OQN to recover from a very serious mistake at work.

> ……One day, the epidural tube's tape was coming off and the tube came out……It was shocking…..But the clinical nurse was very nice. She did not say much. If it was in Japan, clinical nurse would be also nice but she would have made it very clear it was a bad mistake to me. But the clinical nurse here was…..she told me, "It is OK if you learn from this" repeatedly. I was preparing for staff to look at me as a big failure…like Japan, but everyone was nice. I was told that anyone makes mistakes. It could be anyone. So we should not blame the person who made a mistake…(Sakura, p.3, line15-22)

Sakura understood that she had made a serious error and was expecting to be badly scolded by the CN as would have been the case in Japan. But the CN only told Sakura that she should learn from the mistake without intimidating her or blaming her. Here, the no blame policy was experienced as an effective and encouraging management style which derived from the open and friendly working

culture in Australia. This experience provided Sakura with a great sense of being supported by the institution and also provided her with the motivation to continue working there.

7.2.3. Sub-Theme 3: Exciting new challenges

The new environment in Australia was also perceived as a place of *Exciting challenges.* *Unique challenges* includes the participants' experiences in interesting work situations such as working with newly arrived refugee people from all over the world, and working as flexible agency nurses, which many nurses had not experienced in their countries of origin. Moreover, working in Australia as nurses itself was perceived as an exciting new challenge because of the relatively *high professional standard of Australian nursing.*

Categories
1. Unique challenges
2. High standard of nursing profession in Australia

1. Unique challenges

The participants described Australia as a place where they could have new and unique challenges. Such challenges were often described as being difficult but unique experiences which they would not have encountered in their home countries. In a sense, working in Australia was already a new challenge for the participants but some experiences, particularly those outside familiar urban acute care settings were emphasised in the interviews, such as working in a TB (tuberculosis) service with multi-cultural communities and newly arrived refugees, and working in remote hospitals with the Aboriginal community.

> TB service was run by the state…..Because you don't see only patients in the hospital, you also see them in community as well how they are going, you supervise the treatment,

> you do school screening, BCG (Bacille Calmette-Guerin vaccines) so variety of works to be done……..Then you started taking all the refugees!! All 70s, Timorese, and Vietnamese, we were very busy all the time. All the boat people Vietnamese coming, I was in Sydney. They arrived in Darwin and they were sent to us in Sydney, we had to screen them. We made sure if the children were OK….and we were very busy. And then it was always war somewhere…..Cambodia, and later on, Middle East people coming. From Kosovo, African, lots of African, lots more now than it used to…..so interesting…… (Maria, p.3, line23-40)

There was one nurse who began working as an agency nurse as soon as she obtained registration and she was enjoying the challenge and the sense of independence as an agency nurse. There is apparently no agency nursing system in Germany so she found the agency experience both novel and easygoing, compared with being a full-time member of a workplace.

> Yeah, you learn a lot if you are in foreign country. Lots of challenges, if you like challenges. I prefer working as agency (no agency nursing system at home country) because it is more flexible, you can see lots of different people, different settings. If you like challenging. If you are agency, you can pick up some knowledge everywhere…. (Caz, p.5, line41-45)

2. High standard of nursing profession in Australia

The Australian working environment was often described as professionally rigorous in terms of standards in the nursing profession. Though the participants felt that they needed to have a lot of knowledge and a faculty for critical thinking at work, work was also a place where the OQNs could gain a sense of achievement and satisfaction.

> I feel the nurses work here really work like professional, but in China, no, even though we learn a lot at school, we don't use them in the practice. So many years later, you will forget them, I feel empty, nothing in my brain. Even though I have got lots of experience, I don't have so many knowledge, I feel very happy to learn here. I need to think a lot, I need to make decisions by yourself. That makes me feel much much better to work here….(Yun, p.15, line28-33)

> I think here, nurses have much much knowledge, sometimes they will make more decisions. You know?.....And if something happens, we have a senior nurse, Team Leader….should really know what to do here….. (Cindy, p.10, line24-30)

The Australian nursing environment was depicted as being hard to adjust to, but, at the same time, as these comments show, it was also an environment where the participants could receive a sense of being supported and respected. In this way they could be proud to be working as nurses in Australia because of the perceived high standard of the nursing profession.

Table 4. QARI-View: Theme 3. Living in the English Language

Theme	Sub-themes	Categories
Living in the English Language The OQNs' lived experience in the English language is a process of formulating a new bodily/conscious identity through the English language while perceived English ability affects self-image and self-confidence.	Language and Self	Feeling defeated without defense skills Unique challenges in Australia
	Working in an English language environment	Clinical English is difficult Communicating with people in English

7.3. The Third Theme: Living in the English Language

Summary of theme 3

The OQNs' lived experience in the English language is a process of formulating a new bodily/conscious identity through the English language while perceived English ability affects self-image and self-confidence.

The third theme, *Living in the English language,* is concerned with the phenomenological notion of the lived body (Van Manen, 1997), in relation to learning to work in an English speaking environment. According to phenomenological thought, bodies are not seen as physical objects; it is our bodies that open to the world and we are being-in-the-world by our body as active presence (Crotty, 1996). Our being-in-the world is bodily involvement and it is language that makes us connected, in a *symbolic* sense, with others. The individual person is essentially a social being, and one whose lived-world is directly mediated through language, in the sense of daily and mundane interactions with others. In this way, language is the most significant social semiotic of human life (Halliday, 1994) and, according to the social anthropologist Malinowski (1935), the primary function of natural language is to coordinate activity in human collectives.

Natural language is embedded in the social, cultural and historical contexts of the society where the language is used (Halliday, 1994). Therefore, learning a second language in a 'foreign' community is not only a simple conscious activity and is not merely a process of learning how to use a new tool to communicate with others; learning a second language means learning how to live *in* the language and mediate a social identity with others through that language.

The theme *Living in the English Language* is about the OQN's adjustment to their new self in the English language in order to work as nurses in Australia. There are two sub-themes that make up the theme

including *Working in an English-speaking environment* and *Language and self-image.* The first sub-theme is concerned with practical problem-related experiences in English learning. The second sub-theme is about the OQN's experiences in being non-native English speakers in relation to their perceived self-image and identity.

7.3.1. Sub-Theme 1: Working in an English speaking environment

Sub-theme 1, *Working in an English speaking environment,* is formulated from the following two categories. *Difficulties with clinical English* is the OQNs' experience in the use of clinically specific English language in contrast to the daily English which many OQNs were already familiar with. *Communicating with people in English* concerns the nurses' experience in actual inter-personal communication including problems with telephone conversations with physicians, family and other people, and difficulties experienced in tape-recorded handovers.

Categories
1. Difficulties with clinical English
2. Communicating with people in English

1. Difficulties with clinical English

All OQNs had met the standard requirements in general English tests but problems with English in clinical settings were widely experienced.

> My first day (at clinical placement), I could not understand English at all. I was very nervous that made it even worse…..Then I could not figure out how to say let me take your pulse so on. I did not know how to say 'stethoscope' in English. I did not know the names of medicines, I could not even ask where things were… (Sakura, p.2, line6-10)

It was often emphasised by the participants that the English used in clinical settings was very different from the English for the IELTS proficiency test or the more colloquial language of daily conversation. Problems with medical terminology, abbreviations, Australian slang, reading and writing documents, were commonly expressed.

> Medical English and spoken English on the street are two different things I think.…….Then you have to read notes. Doctor's writing. Very difficult especially in the beginning…. (Char, p.2, line4-6)

> I had problem with listening…..In normal talking, normal communication. They have special words like, go to the loo? What is loo? What is a cup of tea? I did not learn it at the bridging program!... (Mali, p.3, line20-23)

Not knowing how to describe sudden changes in the patient's condition when the OQNs needed to report to the senior staff or physicians was described as very frustrating and this was a source of a negative perception of self.

> It really..... is bad feeling, sometimes, you know, you understand there's a problem and you need to talk with a doctor. You found out there is, patient have something changed, you need to recognise that. But you cannot explain it in English. You don't know how to say that. You don't know how to describe in English!…I am not happy about myself.. (Yun, p.1, line29-33)

It was commonly experienced by participants that their pre-registration preparation in English language proficiency was insufficient and several felt that there should have been educational opportunities to learn some English commonly used in clinical settings before going into practice. The IELTS proficiency test was often described as an inadequate language assessment system for nursing work, which entails hands-on-care of patients while communicating well with other health care team members. Instead of reading

academic literature or writing academic essays in English (as preparation for the IELTS test), the OQNs felt they needed the kind of practical clinical English which they could immediately use in practice on the wards.

> Language was very difficult. Yes, I had IELTS score but medical English is different…. They should have some short program with medical terminology, abbreviations, medicine…... (Char, p.2, line3-4)

> I think it is OK to have to do some test to work in Australia. But when you are specialised as RN, and you would like to work as RN here, the test should have something to do with after the registration….. (Zalka, p.3, line39-42)

2. Communicating with people in English

Apart from problems with unfamiliar clinical English, the OQNs reported that communicating with people in English at work was very problematic. The ability to understand what other people were saying, the ability to express verbally what they wanted to say, the ability to read other people's writing, the ability to write what needed to be written; these skills were all required immediately work began. In a clinical sense, understanding and giving handover and writing documents such as patient's reports were experienced as the largest source of difficulty and stress.

> Hand over is also very difficult. I think hand over and documentation are two big problems. First of all, I was very nervous with my hand over because my English was not very well. There were 5 nurses, 5 Australian nurses their English is perfect that makes it even harder….and I did not know how to describe my patient's wound in documentation….You know, I can't write, patient was OK!..... (Char, p.2, line10-15)

The tape recorded handover is replacing the conventional face-to-face handover in some hospitals in order to save time. For local nurses, this might be a convenient method of reporting the patients' condition to the in coming shift but it could be a huge problem for the OQNs from NESB.

Char described her experience with the tape recorded handover as something she hated. The OQNs generally preferred communicating in face-to-face mode as they could then ask questions if they did not understand anything in English. When Char went to work in a new ward as an agency nurse, she found only a tape recorded message (handover) from the previous shift; but unfortunately, the tape was difficult to hear and understand due to the poor quality of the recorded sound. Even if she wanted to check with the nurses from the previous shift, they had already left before she started listening to the tape. She somehow survived the shift but leaving her message for the next shift on the tape presented more problems because she was not confident with her use of clinical English and the Australian style of the handover system. In the end, she stayed an extra twenty minutes in order to provide a face-to-face handover to the nurses on the next shift without receiving payment for overtime.

> One thing I found very difficult was tape handover. I have never seen it in Germany (where) people talk to face to face. Here they do it by tape. To record your hand over about your 4 patients, then in the morning, you have to listen to the hand over from the night nurse who comes from Ireland (with strong Irish accent). The tape had been used for long time and the quality of the sound was not good. You cannot ask any questions because she is gone! At the first week, I said, I don't do handover by tape because I don't know what to say to the tape recorder. I am not doing it, I am staying for 20 minutes longer and wanted to go to the room to talk to the nurses……(Char, p.2, line21-26)

Answering the phone, particularly receiving medical orders or speaking with someone unfamiliar, was often described as being very difficult at first and this was another large source of stress for the OQNs.

> I was scared of picking up the phone. That was why I did not want to go to work. I could communicate face to face but…. Because it is surgical ward, we get phone calls from recovery room, ICU, Lab, X-ray, so on. Then I have to make a call about meals, and many patients discharge, phone calls from families, I hated it. I hated it. I did not want to go to work at all. I was hiding in patients' room. Usually someone else picked up the phone…… (Sakura, p.3, line24-30)

> Yeah, every time phone ring, very scary but after a month, when the other staff were too busy to get that, I had to answer the phone. I think all is not too bad now…..…. (Mali, p.5, line44-45)

7.3.2. Sub-Theme 2: Language and self

The second sub-theme is related to the impact of working in an English-language environment on the nurses' inner world and subjective self. The first category, Feeling defeated without defence skills, describes the OQNs' feelings of frustration at not being able to express themselves effectively in spontaneous English. The second category, Self-image, confidence and English abilities, describes the profound impact of the nurses' perceived English ability on their self-image and confidence at work.

Categories
1. Feeling defeated without defence skills
2. Self-image, confidence and English abilities

1. Feeling defeated without defence skills

The OQNs experienced feelings of frustration and being upset when they encountered problems in communicating with other people, particularly physicians and senior staff, because of a lack of English skills. This was often described through the metaphor of an inexperienced boxer getting beaten without knowing how to defend himself. In such cases, the OQNs often believed that they did not deserve to be browbeaten (to be criticised or scolded) by the physicians or senior nurses but they could not articulate their thoughts quickly enough in the English language to protect and defend themselves.

> …I have not seen the doctor since then so it is OK but still I feel angry about it. As my English is not quick enough, I could not even say anything back to him. I just got beaten without defending skills…..(Sakura, p.4, line45-47)

Such frustration could be more significant in the OQNs' group than in some other immigrant groups because the OQNs appeared to be generally confident with regard to their nursing skills and knowledge which they had obtained in the past.

> ……..So when she (senior nurse) came back, she said something like I did wrong, but I couldn't accept it. I did what she had told me to do…….But in this case, we can't communicate well. I can't talk well in Australia. So I was bit upset because I can't express my feeling…..I just avoid the place and she came to me and she talked about that she did not mean to…but…..Sometimes, sometimes…….because I can't express my feelings to Australian people, I feel sometimes sad… (Alice, p.2, line36-43)

That such frustration can only go inward and have a negative affect on their subjective self; this is addressed in the next category. In addition, as it was not easy to express exactly what they were thinking, some OQNs preferred using email to communicate with their senior staff on sensitive matters.

> I send email to my manager. Sometimes email is better than talking directly… (Irisa, p.2, line46-47)

2. Self image, confidence and English abilities

> Yes, yes, it is much better than when I started because my language is really better than before. I can answer the phone, most of the times, I can understand them, I can talk with doctors… (Yun, p.8, line10-13)

In the lived world of the OQNs, their English ability at work had quite a close connection to their sense of confidence and their perceived self image. Many nurses did not have major problems in nursing itself but the English language problem was largely described as the barrier in adjusting to work in Australia. Like Yun's comment above, as their English ability improved, their confidence level appeared to increase. In a

way, English proficiency was the fundamental issue for the OQNs that strongly affected their perceived self and experienced environment.

> Sometimes carers know better than me. They know English….I don't know what to do. Sometimes I regret why did I choose (to come to Australia) here? I am not better than carers. I am not better than anyone. Why do I work here? I don't need to stay here. And I feel depressed…. (Irisa, p.1, line27-30)

In my interviews with the 24 participants, Zalka was the only one who was working in a senior position (CN). Zalka felt that it was safe to work in her multi-cultural health care facility but she did not want to move to a higher level for fear of making serious mistakes in English in conventional Australian health care settings.

> Because of language. I don't feel confident. It don't know any other person (senior nurses from overseas). It is probably hard because of language you know? Here, people coming here speak with accent, English is their second language. It is manageable here……You know if I make a mistake, it would cost me my registration. I don't want to take a risk. I am happy here so I would not risk that……(Zalka, p.3, line11-14)

Finally, ability in English was often described as the key to success in working in Australia. The English language was experienced as the most important and fundamental factor for the OQNs' satisfactory adjustment.

> Prepare English. If you don't have communication problem, they should be OK….. (Fei-Yen, p.6, line46)

> Language is very important. You need to learn through language. Nursing itself is not much different. Nursing is the same everywhere but you need to have language…. (Zalka, p.2, line40-42)

Table 5. QARI-View: Theme 4. Shared World

Theme	Sub-themes	Categories
Shared World The OQNs' lived experience of a shared world is the ongoing process of communicating in an unfamiliar culture and language while needing to be accepted and supported, and needing to feel at home with significant others.	Being lonely in Australia	Being lonely without friends
		Being separated from family
		Need to share experiences with other OQNs.
	Being understood and welcomed	Being accepted at work
		Being respected at work
		Being supported by staff and senior nurses
		Being understood concerning English problems
	Family and private support	Bringing family to Australia
		Support among OQNs
		Family support/pride and motivation
		Managing carers and ENs
	Working with people	Need for effective communication at work
		Working in multicultural environment
		Working with physicians

7.4. The Fourth Theme: Shared World

Summary of theme 4

The OQNs' lived experience of a shared world is the ongoing process of communicating in an unfamiliar culture and language while needing to be accepted and supported, and needing to feel at home with significant others.

The fourth theme, *Shared World,* is concerned with Heidegger's (1962) notion of 'Being with'. Dreyfus (1991a) explains that Heidegger's Being with is a kind of *Dasein,* a mode of being-in-the-world. We are always and already Being in the world with other people. From this point of view, humans are not born as individuals and later become social; instead, humans are already social from the very beginning.

The theme describes the participants' shared world with other people in Australia. There are four sub-themes that structure the world of the OQNs in relation to their involvement with other people: *Being understood and welcomed, Working with people, Family and private support, Being lonely in Australia*. The first sub-theme, *Being understood and welcomed,* is about the participants' perceived needs for the feelings of being accepted, being respected, being understood, being welcomed and being supported by people at work. The second sub-theme, *Working with people* is largely concerned with the *problems* of working with others and the experience of Australian working culture in relation to inter-personal communication and relationships with other hospital workers. The third sub-theme, *Family and private support,* reflects the OQNs' experiences in bringing family to Australia to start a new life together and the

need to feel a closeness with family in order to have energy to live. The last sub-theme, *Being lonely in Australia*, synthesises the OQNs' feeling of loneliness in being separated from family and close friends.

7.4.1. Sub-Theme 1: Being understood and welcomed

This sub-theme is fundamentally connected to *Theme Two: New Environment* in which the OQNs' felt work place/space was discussed. This sub-theme, *The feeling of being supported*, was also mentioned in Theme Two but here it is interpreted from the perspective of individual inter-personal experience rather than the experiences of organisational culture or working culture, as in Theme Two. In a sense, this is another form of the hermeneutic circle of understanding the phenomena, moving between the context (supportive organisational culture discussed in Theme Two) and the details (the experiences of being supported on an individual level) in this section.

The first sub-theme *Being understood and welcomed*, is formulated from three categories. The first category, *Being respected at work*, is the OQNs' experience of being respected and the need to feel that they are respected by staff or patients. *Being understood concerning English problems* is related to the nurses' need to feel that staff, particularly senior nurses, are sympathetic to their problems with English and the need to feel their willingness to support them. The final category, *Good support from staff and senior nurses*, concerns the perceived support received by each local nurse and the supportive inter-personal relationships experienced on the individual level.

Categories

1. Being respected at work
2. Being understood concerning English problems
3. Good support from staff and senior nurses

1. Being respected at work

The need to be respected at work was another aspect of this sub-theme; the feeling of being respected by people provided a great incentive to work and appeared to increase work-related happiness.

> The best thing is that you feel that you are respected. I feel I am respected by people. I am willing to work. I feel I am working for the hospital and also working for myself. So you feel good…..(Lin, p.6, line28-30)

The feeling of being disrespected by others was experienced when one OQN's roster was changed without seeking her permission. The incident caused her frustration and it had a profound effect in lowering her self-image as an overseas nurse.

> Then the manager was changing my shifts on the printed roster without asking me! You know? I am overseas and weak…I don't get respect. (Anming, p.4, line5-6)

2. Being understood concerning English problems

The OQNs experienced the importance of receiving empathy concerning their English problems from their senior staff and co-workers. The feeling of being supported and encouraged provided the nurses with a great deal of psychological security, confidence, motivation to work and a feeling of being accepted. This category obviously relates to the previous theme, *Living in the English Language*, as well, but it is located in this section in order to emphasise the inter-personal aspect of the phenomena, rather than English language acquisition itself.

> My two current bosses told me that you are doing great. "You are communicating in another language though Japanese is your main language. If I was told to work in Japanese language environment, writing, listening, speaking, I could not do that. You are great." The two bosses have been like that. I feel that they support me (teary)… (Mika, p.3, line50-p.3, line4)

Sakura almost left her job as she was very worried about answering phone calls because of her problems in comprehending English. When one local nurse told Sakura that she could ask for help from the staff if she could not handle the calls herself, she felt reassured that she was understood and was supported by the staff, which provided her with a great sense of security and encouragement to continue working there. It is striking that even small tokens of support and empathy could dramatically alter someone's subjective world to a much more positive one.

> Then one day, I was avoiding the phone ringing. One nurse noticed and told me, "Don't be scared. Just pick up the phone and get somebody for help if you did not understand." It was so nice to hear. The fact she verbally told me that I could ask for a help if I could not handle it myself…It made me feel much easier than before. It is very simple thing but it made my working life much much easier…. (Sakura, p3, line27-34.)

In contrast, Mika felt that her total identity or self was rejected when one job interviewer did not appear to understand the difficulties faced by speakers of first languages other than English.

> …..At the interview, one of my possible future boss asked me "Do you think in English or Japanese?" Did she want to say that my English was not good enough indirectly or was she purely curious to know which language I was thinking in my head?? I interpreted as the first reason……I did not have a job then yet but next day I told them that I already found a job somewhere else….I just thought no way……She pretended to be just…it was no big deal question but she meant it. I could see what she was thinking…..(Mika, p.3, line33-38)

As described in her case analysis, Mika immediately felt accepted when the interviewers at the next job interview told her that her English was good; although probably Mika did not believe that this was so. Instead, she interpreted it as a kindly gesture to show her that the interviewers were willing to welcome her as a member of staff even though Mika obviously required support with the English language.

3. Good support from staff and senior nurses

> I feel really really good about working in Australia. Very supportive and I think all of my feedback is positive about the hospital, patients, doctors, and your work colleagues. I am very happy here…. (Lin, p.3, line39-41)

The feeling of being supported at work was widely reported by the participants and, indeed, it was one of the major aspects of their experience in Australia. Organisational structures such as educational support in everyday work and feelings of appreciation for this from managers or directors were often mentioned by the OQNs.

> I did double shift, overtime, I did a late shift and night shift and then the nurse manager arranged for you to taxi voucher, and then to go back home and come back. Return taxi and I received a letter like director of nursing. She gave me a movie ticket. And also the nurse managers in the ward, they are very considerate. If you request the shift, normally they will give it to you, yeah, and they are very good….. (Lin, p.6, line3-8)

> We have a very good clinical nurse that is a senior nurse in a ward, they teach me a lot. You know? She would teach you, she would tell you what you need to do, yeah, really helpful….. (Yun, p.8, line43-45)

Australian nursing staff in general were repeatedly described as being very supportive and friendly, which provided the OQNs with feelings of happiness and satisfaction to be working in Australia.

> Nurses are very nice. They are very friendly and they are very open. They like to help…"(Caz, p.5, line42-43)

> And I really have to say, Australian nurses are very very helpful. I have had the same situation, it would have been more difficult. Because German people are also nice people but many of them are introvert, very quiet, and Australian nurses, most of them are nice. I have had few difficult ones but most of them are nice. In general I have lots of support…This is the best job I have had. (Char, p.4, line11-17)

7.4.2. Sub-Theme 2: Working with people

This sub-theme is related to some challenges in creating and maintaining a good working relationship with other workers. The first category, Being a hard worker, describes the OQNs' principal strategy to create a positive working relationship with the local staff. The need for effective communication at work deals with the OQNs' discovery that it is crucial to have good communication with other staff and workers in Australian workplace culture. Managing carers and ENs, and Working with physicians describe the nurses' difficult challenges in working with experienced ENs and carers. The last category, Working in a multi-cultural environment, describes the OQNs' experience in working in multi-cultural Australia where there are people from diverse cultural, linguistic and religious backgrounds.

Categories

1. Being a hard worker
2. The need for effective communication at work
3. Managing carers and ENs
4. Working with physicians
5. Working in a multi-cultural environment

1. Being a hard worker

In their daily working environment, the OQNs frequently expressed the need to feel that they were accepted by other staff and, as a consequence, they tried to be accepted by modifying and adjusting their behaviour. Particularly in the initial phase, the participants often felt that it was necessary to work harder than other staff in order to be accepted. Since the OQNs had English problems which required support and assistance from the staff, they felt the need to work harder than others in return, and this often proved to be a successful strategy in developing effective working relationships with others.

> Yes, I think because I usually work very hard. Because we have barrier in English, we have to work hard to overcome the barrier. They think we are working hard, they can help English…. (Pim, p.3, line20-22)

> I think it is all depend on me. Yeah, if I work hard, they want to help me but if I don't work hard, they ignore overseas nurses. I saw some colleagues, they just do like Australian nurses but we have to do more than Australian nurses….yeah…..I cannot say they are lazy but we can't do the same level… (Alice, p.2, line24-29)

> I was always hard worker, you know I was really hard worker and I was always willing to learn. I checked what the others were doing you know?.....That's why it was not very problems. Because of my hard work, people started appreciating…..(Zalka, p.2, line44-p.2, line2)

2. Need for effective communication at work

The need for effective communication at work was often described as a very important part of Australian workplace culture. Particularly in order to avoid making mistakes, the participants felt it absolutely necessary to ask other staff when they were not certain about something. It was often reported that the OQNs in general tended to be introverted and were reluctant to initiate communication with Australian staff but the OQNs needed to do this, otherwise, others would have no idea about the problems which the OQNs were having.

> But you can always ask!!! Also other nurses they don't want you to do something wrong. ASK ASK!!... (Caz, p.4, line42-43)

> Many international nurses don't ask. They are scared to ask. They don't want to make trouble. But don't worry about it. If you don't express your heart, nobody understands you. Be communicative. Talk more…(Fei-Yen, p.6, line44-46)

> I think that the most important thing is ask. Because you need to secure yourself. Don't do anything if you are not sure……. (Char, p.3, line12-12)

The need to be open and communicative was also described as one way of fitting into the Australian work environment. One OQN used to prefer working quietly without distraction and she never reported anything to her senior staff unless she thought it was absolutely necessary. She soon realised that it was part of the Australian working culture that nurses have frequent and close communication with other workers, patients, and senior staff and she felt that she needed to adjust to the Australian way of communication.

> I think maybe I come from overseas, or my English, sometimes I don't want to talk so much at work. You don't like to talk. I just do my job and I don't talk. I am pretty quiet. But I think you need talk a lot. Here the nurses are reporting everything to the manager. I don't like it but I need to talk….here you need to talk with others. (Anming, p.6, line48-51)

3. Managing carers and ENs

The management of other nursing staff, such as carers and ENs, was experienced as one of the major problems at work for the RNs from overseas. How to create a good working relationship with experienced Australian carers and the ENs, while maintaining a good standard of care as leader of the nursing staff, was often a source of great frustration and challenge for the OQNs.

Irisa was the first and only RN from overseas in her work place. She soon understood that it was her responsibility to provide ENs and carers with directions for nursing care. However, they were usually very experienced in the aged care field and they were local native English speakers. When Irisa started working, she felt that she was ignored by them because of her low English proficiency and her insufficient professional knowledge.

> In the morning shift, there is another RN but afternoon, evening, just one RN and just carers. If I am not professional, they didn't respect me, they don't follow me, it is very hard. Yeah…at first time, they were so neglecting me. Even if they did not say so, I could feel… (Irisa, p.1, line39-42)

As quoted in the case analysis and Theme Two, *New Environment*, Irisa patiently waited for 6 months until she was confident enough to feel that she was being accepted by the ENs and the carers.

In the acute care hospital, Fei-Yen also experienced a difficult working relationship with the ENs. In her case, as she had some other inter-personal problems at work, she decided to move to another ward, seeking a better working environment.

> In reality, some ENs are more senior to you and I am new, they have got more experience and they know something particular better than me and in some cases, ENs don't listen to me at all. She thinks she knows everything. So she won't listen to you she just… (Fei-Yen, p.4, line28-29)

Similar problems were experienced by some other RNs from overseas but it seems that there is no simple solution. It certainly requires enough time until the RNs from overseas can feel confident in working with the local ENs and carers.

In the case of another RN, Anming, her manager told her that she was too nice to the ENs and carers and that she had to be firmer in order to provide good quality care for the clients.

> I saw them (carers) doing things wrong but I don't know how to tell them? I think you should be like…. work is work and friend is friend. I still need to tell them…(but it is not easy). You should be strong…..I did not realise there was a problem but the manager told me. (Anming, p.3, line14-16)

Many OQNs reported that general nursing jobs, such as giving medication, are not very difficult but managing ENs and carers is a big challenge.

4. Working with physicians

Working with physicians was frequently discussed as a significant aspect of the OQNs' experiences in working with people. Different nurse/doctor relationships, in terms of relative status, from those in

nurses' countries of origin were often mentioned. Unlike the hierarchical nurse/doctor relationships which most OQNs were used to, the nurses felt that they and doctors could work as team members in Australia, with less deference to relative status, which often provided a sense of satisfaction and motivation to their work.

> Err, in my country, we have to serve everything for doctors. Here, they just come, take notes and see the patients and come back, and ask you things. But not in Slovenia. We have to serve everything until the end. You have to open the book and close the book for them. When they come into office, we have to stand up (laugh). And we have to strictly call them doctor with correct titles…It is not like that here at all!(Zalka, p.2, line22-27)

> Yeah, independent and doctors and nurses work as colleagues, we work as a health care team, we work as a team. But in Thailand, the doctors' position is superior than the nurses…. (Mali, p.3, line43-46)

> Of course we have different doctors like egocentric one, some of them. But we have to work as a team. We know what is going on to the residents. If you give more details, they would listen to you and they give you what you want….. (Sabina, p.2, line10-12)

Several participants described negative experiences with physicians who often upset them.

> That was a doctor. I could see that he was irritated by me somehow like slapping his tongue. He did not say exactly but….so there were the manager and the leader. I burst into tears in front of the two…. (Mika, p.4, line29-35)

Actually, for some nurses, the relationship with physicians appeared to be more troublesome than with other nursing staff. The problem was often triggered by the feeling of being criticised and negatively evaluated because of their poor English proficiency by physicians when communicating about patients' conditions and their treatments.

5. Working in a multicultural environment

Working with people from diverse cultural backgrounds was often described as one significant dimension of work in Australia. Before arriving in Australia, most of the participants had an image of Australia as being populated only with Anglo/European people. However, on arrival, the OQNs soon realised that it was filled with people from more diverse ethno-linguistic backgrounds. In daily nursing practice, the nurses encountered various hospital workers with accents, patients from diverse cultural backgrounds and a wide range of religious groups whom the nurses had to contact in case of the death of patients, depending on each patient's religion. Working in this kind of social and ethnic environment was described in both positive and negative terms depending on the individual circumstances. It could provide a sense of satisfaction and happiness but it could also be extremely challenging.

> …There were….doctors with very strong accent and I can't understand them!. It is very hard to understand their accent…. (Caz, p.5, line28-30)

> No, no, not she was not Australian. I think she is from the Philippine or something. I can't understand. Anyway, I told the senior nurse. She said, Don't worry about that. We can find out (about information she could not understand because of the nurse's unfamiliar accent)….. (Yun, p.3, line48-50)

Maria was amused while describing the long list of religious practice groups which the hospital had prepared in case a patient died.

> Hahahaha. Another thing, people here have so many different religions here. I was working in a medical ward and there was a list you know? If this patient is Jewish, you have to call this number, here this patient is Catholic, Catholic priest, if it is Baha'i. You don't wait until the body is cold. God, I never come across so many religions! I used to call relatives but not this many different religions!…(Maria, p.5, line1-7)

Zalka passionately described how her workplace was taking good care of multicultural residents with their multicultural staff.

> There are 52 residents here. Ukrainians, Croatians, Polish, if we don't find anyone, Australians……Lots of laughing, smiling, joking, people are singing. Probably, different from other nursing homes. We got a few Australians now. They should be very happy. We have got Ukrainian, Polish and Croatian cook here. Food is traditional too. Some Australians look funny sometimes, what's this? You know? Because Ukrainian don't have so much spices, and sausages, which we have not got. We also have Polish, Italian, Croatian. Try to please everyone….. (Zalka,p.3, line27-35)

In a way, her non-mainstream work environment was providing her with a sense of security and belonging.

7.4.3. Sub-Theme 3: Family and private support

This sub-theme is related to the OQNs' experience with family (or close friends) in their migratory move to Australia. The first category, *Bringing family to Australia*, concerns the nurses' experiences in bringing their family from their home country to Australia, such as securing visas for the family and building a new life with their family in Australia. *Proud family* describes the feelings of parents being proud of them and their own pride in their families, especially their children. This was important as a source of motivation for them to live in Australia.

Categories
1. Bringing family to Australia
2. Proud family

1. Bringing family to Australia

Starting with obtaining a valid visa for their family to enter Australia, bringing a family to begin a new life could be very stressful for the OQNs and their families. As in Efia's and Sabina's cases, family adjustment problems concerning their new life were commonly described by the participants. In some cases, the partners' and the children's adjustment were harder than the adjustment of the nurses themselves.

> My daughter is 16….my daughter still does not like here. So I am praying everyday so that she might change her mind like my husband did. Before we came here, my husband did not want to come here because he was thinking about his work. He was working in a scientific laboratory, he was working in a office and what he does here is so different….he can only get construction work…. (Efia, p.7, line33-p.8, line4)

> My daughter was home sick for a while. She liked to be over there. She went three times last 10 years. Because she enjoys life over there. It is different culture…(Sabina, p.2, line6-8)

Indeed, for most of the participants, their most significant experiences in Australia concerned their family and not their work experiences and several OQNs were more focussed on discussing family issues rather than work related issues. This category is also connected to Theme One which discusses the perception of experience and time as temporal being. The interpretation of the present moment changes as more experience is accumulated, as discussed earlier. Work related experience was obviously also important to these nurses but the family challenges which arose in the migratory move of course had more importance in their making sense of their lived world than adjustment to Australian nursing.

2. Proud family

In this category, 'pride' refers to the feelings of the participants' parents as well as their own feelings about their family, especially their children. Working in Australia was often interpreted as a great achievement; it provided the family with a sense of pride and happiness. For the OQNs, such family pride was a common source of motivation and encouragement to work in Australia, particularly for those nurses who had left their parents in their country of origin.

> I think they (family) are very proud of me I think people in China they have the image of …..They would be proud of you if you can like…work overseas…. yeah, become… I mean to the other side. They are very proud of you being independent….. (Lin, p.7, line9-11)

For some OQNs who came to Australia with children, like Sabina's case below, family achievements, particularly the children's successful adjustment to Australian society, provided the OQNs with a great sense of accomplishment and happiness.

> For 6 years, we paid off our house, we bought new boats, and we are building a weekend house. All happened since 1997. It has been 9 years. We have not been ashamed about our job…..We did anything for better life, better future. My daughter is waiting for a place in Flinders she is 19, she would like to study behavioural psychology. She would like any kind of psychology. My son is working in business….. (Sabina, p.4, line5-13)

Sabina was very proud and happy about her children's high English proficiency without any 'foreign' accent.

> Their teacher (her children's teacher) said, nobody would recognise they are not from Australia. People would never say that they are from Europe or some other country because intonation of English is like Aussies. They enjoy, they like here…. (Sabina, p.2, line4-6)

The children's ability to speak English without a foreign accent was a symbol of their 'local Australian' status which would secure them a life as insiders in the mainstream community while Sabina and her husband had to experience difficult years in starting a totally new life as political immigrants without an English speaking background.

7.4.4. Sub-Theme 4: Being lonely In Australia

The last sub-theme, *Being lonely in Australia*, concerns the OQNs' perceived social isolation in Australia. *Being separated from family and friends*, describes their feelings of loneliness from being separated from family and close friends. The second category, *Sharing experiences with other OQNs,* is related to their perceived need to talk with other OQNs who might have similar experiences in working as nurses in Australia.

Categories
1. Being separated from family and friends
2. Sharing experiences with other OQNs

1. Being separated from family and friends

Many participants left their family home in coming to Australia. Some of them were bringing family to Australia to stay together and some were not. Being separated from family and close friends, the OQNs felt that they did not have people who could support them and people who could relate to the kind of communities that they had left behind. They missed familiar people from their own societies and they missed the family/home where they had a shared past with others and could communicate easily.

> I don't have any family member here to support me. I don't have enough to have support my feelings. And I think….I pretend to be strong I am really happy here. Because whenever I feel sad, I can't express my feelings. So it is hard… (Alice, p.2, line47-50)

> Yes, it is OK but I miss my family very much, especially my little girl, and I think she almost forgot about me. I left home more than one year ago. She is nearly 4 years old. When I left her, she was just 2 and half, yeah, so maybe she almost forgot me. Sometimes she spoke to me by telephone several times, but she did not want to talk to me anymore…. (Cindy, p.14, line36-40)

It was commonly reported that it was very hard to make close friends in Australia, which also increased their feeling of loneliness. They made friends at university but many international students tended to return to their home country after graduation. Several participants said it was very difficult to make long term friends.

> I cried when my close friend went back to Thailand last year…..Because she finished her study and she went back to Thailand…She might come back or she might not…. (Pim, p.9, line3-5)

2. Sharing experiences with other OQNs

The need to share experiences with other OQNs was widely described by the participants. They felt that other OQNs would understand what they were also going through in Australia and thought that by sharing experiences together, it would provide them with a sense of belonging and the feeling of being understood by someone. The OQNs did not appear to mean that Australian staff had not been supportive or friendly. No matter how pleasant the Australian staff members were, the OQNs still felt the need to talk with other nurses from overseas who had gone through similar experiences to themselves. Organisational support to

facilitate communication among the OQNs, such as regular group meetings at the hospital, was described as necessary and potentially helpful.

> I don't have anyone to talk about it…I often speak with another nurse from Korea on the phone….(Irisa, p.2, line45-46)

> Another hospital has some community for overseas nurses, so I think it is good. If hospital has lots of overseas nurses, they can share problems and experiences… (Alice, p.4, line45-47)

> At Flinders Medical Centre, they have monthly meeting with overseas staff. They said it is very good and helpful…..sometime it is hard to speak to local people…and there are things we can't say to local people…(Sakura, p.3, line7-9)

> If we had the …overseas nurse association, it might be good. Sometimes it is hard to speak with hospital people, so it might be better to speak with someone outside. If there was a support group for overseas nurses… (Jane, p.4, line26-28)

7.5. Summary

In this chapter, the four themes that describe the *essences* (Van Manen, 1997) of the experiences of the OQNs from NESB working in Australia have been articulated. The experiences of the participants are the basis of these four themes (meanings) as follows: *From the Past to the Future, New Environment, Living in English* and *Shared World.*

The first theme, *From the Past to the Future,* concerns Heidegger's notion of temporality (Lived Time) in order to describe the participants' life history. By elaborating the participants' past experiences and the future visions, their experience in the present moment is highlighted.

The second theme, *New Environment*, is concerned with Heidegger's notion of Lived space/spatiality which is part of the ontological structure of the human being. The theme is further elaborated into three sub-themes. *Fitting into new environment* is about the OQNs' experiences in adjusting to the Australian working environment; *Supportive work environments* is concerned with the participants' felt space in relation to the available support they could receive at work and *Exciting new challenges* describes Australia as a place where the OQNs' could feel a sense of achievement and pride as nurses.

The third theme, *Living in the English language*, is concerned with the phenomenological notion of the lived body in relation to adjusting to life and work in the English language. The theme is elaborated into two sub-themes, *Working in English speaking environment* and *Language and self*. The first sub-theme is related to practical problem-related experiences in English learning. The second sub-theme explores the OQNs experiences in being non-native English speakers in relation to their perceived self-image and identity.

The final theme *Shared World* is about Heidegger's notion of 'being with'. This theme describes the participants' shared world with other people. Four sub-themes are presented to describe the theme-*Being understood and welcomed, Working with people, Family and private support* and *Being lonely in Australia*. The first sub-theme, *Being understood and welcomed*, is about the participants' perceived need for the feeling of being accepted, being respected, being understood, being welcomed and being supported by the people at work. The second sub-theme, *Working with people*, is largely concerned with the *problems* in working with others and their experienced Australian working culture in relation to inter-personal communication and relationships among hospital workers. The third sub-theme, *Family and private support*, is about the OQNs' experiences in bringing family to Australia to start a new life together and the need for a feeling of closeness with family. The last sub-theme, *Being lonely in Australia*, is about the OQNs' feeling of loneliness in being separated from their family and close friends.

These four themes have been articulated as the essences of the experiences of the OQNs from NESB in coming to work in Australia. These themes are not independent of one another; they are inter-connected in an ontological sense and any further attempts to separate them clearly in an objective manner would only distort the essences of the OQNs experiences in their lived world.

In the next chapter, these themes are further elaborated together with the previous chapters in order to produce a local theory that describes the core essence of the OQNs' experiences of living and working in Australia.

Chapter Eight: Further Conceptualisation

This chapter is a theoretical elaboration on the findings from the previous chapter. In order to facilitate the understanding of OQNs from NESB working in Australia, the emergent four themes are conceptualised to articulate a local theory which describes and accounts for the core concept of their lived experience. In contrast with higher level theories, often termed 'grand theories', which attempt to describe and explain the entirety of human activity in the world, local theories describe only one specific group/community of the society (i.e. the group of OQNs from NESB in Australia). Such a local theory is not meant to predict and explain the human world in a causal or relational sense, rather it describes and illuminates the core nature of the phenomena with the goal of facilitating human understanding of everyday subjective life; therefore, it can directly inform the knowledge base of nursing.

Parse's method (Parse, 1981) of phenomenological data synthesis is adopted for the process of conceptualisation/abstraction of the findings. In the following sections a brief summary of Parse's 'Human Becoming Theory' and her approach to theory development are presented in relation to her specific methodical approach to theory development. Then, the emergent four themes from the previous chapter are further conceptualised (abstracted) in terms of the two core concepts. These core concepts are then connected to formulate the local theory which is a crystallised description of the experience of OQNs from NESB working in Australia. Finally, the derived theory statement is further expanded with related literature.

8.1. Parse's Human Becoming Theory

Parse is an American nursing scholar who has developed her Human Becoming Theory, strongly influenced by European (existential) phenomenologists such as Heidegger (although some scholars, such as Dreyfus (1991b) refuse to consider him as an existential phenomenologist such discussion is beyond the scope of this paper), Sartre and Merleau-Ponty, and by the first nursing model developed from the holistic nursing perspective (Tettero, Jackson, & Wilson, 1993), Roger's theory of the unitary person (1970).

Parse sees the prototypical human being as an "……open and unitary being evolving toward greater complexity through continuous transactions with the environment" (Walker, 1996, p. 990). With a strong orientation towards existential phenomenology, Parse also defines humans as freely choosing agents who make their own choices. Parse's three assumptions of human becoming are (Parse, 1995b, p. 6):

> **Assumption 1.** Human Becoming is freely choosing personal meaning in situations in the inter-subjective process of relating value priorities.
>
> **Assumption 2.** Human Becoming is co-creating rhythmical patterns of relating in open process with the universe.
>
> **Assumptions 3.** Human Becoming is co-transcending multi-dimensionally with emerging possibilities.

Together with the philosophy of European phenomenology such as that of Heidegger, Parse's view of human becoming is also consistent with contemporary hermeneutics. Parse (1981) emphasises the inter-subjective involvement of the human and asserts that humans co-author their becoming in mutual process with the universe, co-creating distinguishable patterns which specify the uniqueness of both humans and the universe (Parse, 1995b). As Cody (1995) explains, it is clear that Parse's assumptions above are directly related to Gadamer's (1975) notion of language as the horizon of hermeneutic ontology.

In terms of actual research methodology and method, like many other researchers and thinkers in the phenomenological tradition (existential, hermeneutic and transcendental), Parse criticises the blind adaptation of the traditional totality/scientific paradigm to research activities and theory development in the discipline of nursing (Parse, 1987) which deals with people's everyday world, and which cannot be controlled or measured by statistical analysis. Parse strongly objects to scientific-detached observatory approaches to human experience; she has asserted that inter-subjective participation is the only way in which researchers can understand human becoming (Walker, 1996), and this view is also consistent with Gadamer's dialogical nature of hermeneutic inquiry (Cody, 1995).

Based on such philosophical and theoretical assumptions, Parse has developed her approach to phenomenological research in order to examine the lived experiences of people (Parse, 1987; Parse, 1995a, 1999; Parse, Coyne, & Smith, 1985). The process of her phenomenological method is as follows (Parse, 1995a, p. 153):

1) Dialogical engagement

2) Extraction and synthesis

(1) extracting essences from transcribed descriptions,

(2) synthesising essences,

(3) formulating a proposition,

(4) extracting concepts from the formulated propositions,

(5) synthesising a structure of the lived experience from the extracted concepts: a synthesized structure is a statement conceptualised by the researcher joining the core concepts.

Until stage 2) part (3), Formulating a proposition, Parse's methodical processes are clearly consistent with van Manen's (1997) methodological approach to hermeneutic phenomenology which is utilised in this

study. *Dialogical engagement* refers to the conversational nature of understanding and the theoretical assumption which asserts the appropriateness of the inter-subjective involvement of the researcher with the participants rather than remaining as a detached observer. The second process, *Extraction and synthesis*, is parallel to the thematic analysis method also proposed by van Manen (1997).

What is unique about Parse's research methodology is that she has moved beyond van Manen's descriptive approach and asserts the development of conceptualised statements from the themes (propositions), in order to provide a local theory which can inform the knowledge base of nursing in a more explicit and theoretical approach than a purely descriptive/interpretive approach. She refers to these conceptualised statements as the *structure of the lived experience*, which is "a statement conceptualised by the researcher joining the core-concepts….it answers the (phenomenological) research question" (Parse, 1987, p. 177). In the following section, Parse's process of producing a *structure of the lived experience* is conducted and the derived structure of the lived experience is further discussed and elaborated with related literature.

In addition, the last stage of Parse's research process is Heuristic Interpretation, but this is not adapted to this research. Heuristic Interpretation is the process of logical abstraction which "weaves the structure into theory beyond" (Parse, 1995a, p. 153). The process of Heuristic Interpretation is further abstraction/conceptualisation of the derived core concepts; "Conceptual interpretation" means specifying the structure of the lived experience within the Human Becoming theory, "leading to a specific theoretical structure from the principles" (Parse, 1987, p. 177). This research project is not being conducted fully within Parse's Human Becoming school of thought; therefore, conducting Heuristic Interpretation in this thesis appears to be logically inconsistent. Thus, only her methodical approach to the local theory development (structure of the lived experience) is adopted as a final process of the data analysis. The derived local theory statement is further discussed without using Parse's specific language from her own school of thought.

8.2. Formulating the structure of the lived experience

8.2.1. Extracting Core Concepts

In Parse's approach to data synthesis, the research findings/themes are presented as *propositions* (Parse, 1987). The four themes (propositions) from the previous chapter have been further synthesised into two core concepts.

Table 6. Four Themes from Chapter Seven

Theme 1	From the Past to the Future (Lived Time): the OQNs lived experience of understanding the present moment and their expectations for the future are formulated on the basis of their life history, including personal and professional experiences, while the perceived lived time (present, past and future) changes constantly as more experience is gained.
Theme 2	Living in the English Language (lived Body): the OQNs' lived experience in the English language is a process of formulating a new bodily/conscious identity through the English language while perceived English ability affects self-image and self-confidence.
Theme 3	New environment (Lived Space): the OQNs' lived experience of the new environment is a continuous process of clearing hurdles to fit in to Australian

	nursing practice while receiving organisational, professional and personal support to facilitate adjustment.
Theme 4	Shared World: the OQNs' lived experience of a shared world is the ongoing process of communicating in an unfamiliar culture and language while needing to be accepted and supported, and needing to feel at home with significant others.

Table 7. Core Concepts (Structures) from four themes

Themes	Derived Core Concepts
Theme 1. From the Past to the Future Theme 3. New Environment	➔ Active formulation of reality through interplay with new surroundings
Theme 2. Living in the English Language Theme 4. Shared World	➔ Obtaining new identity in the English language

The derived core concepts from the four themes are as follows:

1. Active formulation of reality through interplay with new surroundings.

2. Obtaining new identity in the English language.

These core concepts are connected in order to formulate *the structure of the lived experience*, based on the Parse's synthesis process discussed earlier.

8.2.2. Structure of the lived experience of the OQNs from NESB

> *"The lived experience of OQNs from NESB working in Australia is the process of obtaining a new identity in the English language, while actively formulating reality through interplay with new surroundings.*

8.3. Core concept 1. Active creation of reality through interplay with new surroundings

The first core concept, *Active creation of reality through interplay with new surroundings*, means that the OQNs from NESB do not passively receive some *given* reality from the new environment; instead, they actively create/construct their perceived reality through dialogue with their surroundings. Reality is not 'out there' to be found but is instead the product of individual interpretation through interplay with both environment and people. This is directly related to Gadamer's notion of understanding as dialogue through horizons (prejudice) (Gadamer, 1975).

People's 'prejudice' gained from previous life experiences plays a significant role in the process of understanding their present experience/reality. Their prejudices or fore-having assumptions are historically situated and embodied in their own contextual backgrounds. Thus, the process of understanding occurs through interplay (dialogue) between their prejudices in the process of relating to their new surroundings.

8.3.1. Actively formulating reality

The OQNs actively formulated their subjective reality on the basis of the past. For the OQNs, their perceived present experience is closely connected to the past in an ontological and fundamental sense. During the interviews, the participants repeatedly made comparisons with their previous experiences in order to articulate their present experiences in Australia. It appeared that it was impossible for the OQNs to describe the present moment while being detached from their earlier biographies. In order to comprehend and to articulate what they were going through in Australia, they firstly needed to articulate what they had gone through before coming to Australia; then the present could be described *in relation to* their past experiences.

In other words, past experience is necessary to facilitate the ongoing-active process of making sense of a new reality. Similarly, their projections of the future were formulated through their present experiences. This is very much consistent with Heidegger's (1962) concept of fore-structure and Gadamer's (1975) prejudice, in the process of understanding.

For the OQNs in the study, the past was largely expressed in the form of reasons for coming to work in Australia. The individual contexts which brought them to Australia, such as professional, social, economical or cultural contexts, including their previously formed value system, were projected as the

core aspects of their belief system/*prejudice*. For instance, for the OQNs who came to Australia as political immigrants, their own adjustment issues to the Australian nursing environment were often not a major concern. Such nurses largely expressed their past experience in terms of leaving unstable social/political conditions in their home countries; in such cases the family experience in re-constructing their new life in Australia was much more important than their work experience as nurses in Australia.

For nurses who were purely seeking good professional opportunities in Australia, their main concern appeared to be clinical and practical nursing matters. In a similar way, as for the OQNs who came to Australia for better financial rewards, their main concern was often financial aspects of work and life in Australia. If working abroad was a common life course in their societal context, coming to work in Australia was often understood as something that routinely happens, without it being seen as a particular hardship or a big challenge.

Ginsburg and Opper (1983) argue for the importance of considering individual belief systems in order to understand, and make sense of, people's reality within their own contexts. They have identified two key factors which formulate this belief system: basic instinctual needs, and the need to understand or the need to make 'meaning' of the existence of things within one's environment. It is also claimed that these two basic motivations initiate the process of the hermeneutical construction of reality and understanding (Ginsburg & Opper, 1983). The need to make sense of existing things within the new environment is inseparable from individual motivation (e.g. history of immigration) which derives from people's previously formulated value and belief systems.

In addition, country of origin is obviously a factor that may influence OQNs' interpretations of their experiences in Australia but this needs careful consideration along with the other contextual situations of the individual, too. For instance, among the OQNs from China, many said that adjusting to work in Australia was hard, largely due to their limited exposure to Western systems. However, one Chinese

nurse who had worked in Singapore prior to Australia viewed her adjustment to work in Australia as very easy and smooth. There was another Chinese nurse who was very young and had worked in China for only half a year prior to coming to Australia; she appeared to be functioning as a staff nurse very well without complicated adjustment problems, as many other Chinese nurses had. What is apparent from these findings is that through a process of active involvement in the new world with an individual's unique belief system/historically situated prejudice , the process of understanding present experience in Australia is constructed. Therefore, the differentiated, complex and multi-dimensional nature of each OQN's context needs to be considered when trying to gain insight into their creation of subjective reality.

8.3.2. Interplay with surroundings

'Surroundings' refers to the environment and to the people to whom the OQNs related and interacted with, in their daily work. These include the general working environment and working conditions, such as the organisational support system for the OQNs, other working conditions in general, difficulties encountered in the work environment, and people they work with. The OQNs make sense of their individual reality through the interaction with the people and environment around them while (previously discussed) historically-situated individual prejudice opens the interactive experience and the formation of subjective reality.

This is Heidegger's notion of *Dasein* and Being-in-the-world. The OQNs' experience is formulated in the ongoing interaction with their surroundings; they are "in-the-world" and "being in the space" and "being with other people" in a "shared environment". The OQNs form representations of reality through communal activity in actual practical aspects of work on the ward, by receiving support from other nurses and senior staff, or receiving a good salary, or feeling satisfied or dissatisfied with the given working conditions. Again, this process of formulating subjective reality is largely based on their previous experiences, motivational factors and other forms of subjective *prejudice*.

In general, the working environment in Australia was evaluated more positively than that in their home countries. Most participants started the interview with something like, "It has been good to work in Australia. I like it." Good support systems available in the workplace were often described with feelings of appreciation. The Australian working culture was widely experienced as being more open and less hierarchical than that of their home countries. In contrast, some aspects of Australian working culture were reported negatively, such as a high level of bureaucracy and related inflexibility compared with their home countries.

All such direct and indirect interactions with the interpersonal environment involve the process of understanding and formulating subjective realities while making constant comparisons with experiences prior to Australia. This finding is consistent with social constructionist theories of human understanding which claim that people do more than just passively accept the knowledge offered by society; they construct their own reality. Gergen (1985) emphasises the active-dialogical nature of people's making sense of reality and claims that knowledge is not what people 'have'; it is what people 'do'. The process of understanding takes place in actual life and this is Heidegger's notion of *Dasein* as lived experience.

Reality then is not some impersonal state of being in a positivistic sense; rather, it is subjectively constructed by each individual. In case of the OQNs, this reality lies in inter-personal relationships with co-workers, senior staff, other health care members including physicians, patients and others, and relates to the environment. Sorajjakool (1999, p. 155) explains, "We start from what we want to believe and then search for the logical explanation to support what we want to believe in the first place. It is not related to how logical the belief system may be. It is related to the perception of the unity between one's existential experience and one's belief system". In a way, the process of understanding is existential (Tillich, 1951) involvement to the world with their own unique belief system.

8.3.3. Temporal reality

The OQNs' formation of reality is not fixed but is temporal in nature; the process of understanding is embodied within a particular historical and cultural setting within a particular period of time. As discussed earlier in this section, past experience works as a significant factor in making sense of the present moment. As experience accumulates, the perception of the past and present appear to change. For instance, some newly arrived OQNs might have expressed their experiences in relation to their past more than the OQNs with longer experience in Australia. As in the case of Maria who had worked in Australia for thirty years, it was clear that OQNs with longer experience of working abroad including Australia, appeared to reflect on their working life in Australia quite separately from their pre-Australian life. The formulation of their reality and making sense of their present time is expressed in a continuous changing process; therefore, it is temporal.

As Sorajjakool (1999) states from a social constructionist perspective, when new knowledge has been added on top of the present cognitive structure, accommodation of the mindset takes place. As the OQNs gained more experience in Australia, their pre-Australian experience became less important and significant in understanding their present moment. Also, as more experience is accumulated, the perception of the past could change because their perception of the past depended on their present experience, and *vice versa*. Therefore, their understanding was fundamentally temporal.

8.4. Core concept 2. Obtaining a new identity in the English language

The lived experience of the OQNs from NESB working in Australia was also *a process of obtaining a new identity in the English language.* 'In the English language' does not simply mean language

learning/acquisition but instead refers to a process of learning to live through the medium of English within a society where English has been historically used.

8.4.1. Language and identity

The vehicle mediating knowledge and information is language, and language is the means of relating individual and surroundings. Ginsberg and Ginsberg (1989, p. 109) explain that "language is one of the most traditional elements of culture and the most resistant to change which explains the great effort it takes immigrants to change their language". As Zajacova claims (2002), language learning for immigrants is to come to know its unwritten rules and social norms, while securing a place for themselves within the newly encountered society.

As discussed in the previous chapter, language learning is strongly linked to the individual's bodily image and identity. For the ethnic feminist scholar Anzaldua (1990), language is what represents herself. What people actually express in language forms the foundation of 'who they are' and 'who they appear to be to other people'. The body is the place where negotiating and mediation occur through language. "One enters into language with a body that is already socially codified and performs in contexts that are already socially determined" (Lim, 2006, p. 61). Language is also strongly linked to one's knowledge of the world, of others, and of oneself, thus providing a basis of support for one's identity (Grinberg & Grinberg, 1989).

For the immigrant from a non-English speaking background, language learning is a process of distorting the earlier established identity and then a gradual formation of a new self-identity in the new language (Foster, 1997). Norton (2000) explains the concept of identity as the desire for recognition, the desire for affiliation and the desire for security and safety. Identity is embodied in one's personal history within a particular societal context. Therefore, it is very difficult to negotiate the modification of this self-construct

(Kastoryano, 2002); in contrast with young children, adult language learners' identities are complex, multi-layered and multi-segmented (Kosworm, 2005).

As soon as OQNs from NESB entered nursing practice in Australia, they found themselves in an unfamiliar English speaking work environment. The experience of the re-formation of their identity in the English language immediately started to take place. It often began from the stage of recognising difficulties in the language specifically being used in clinical settings such as medical terminology, technical jargon and abbreviations. Such language-in-use has been developed and used inside the health care system; people in this community use such socially/professionally constructed language within a specific context. This displays a membership status which sets a barrier between insiders and outsiders even to native English speakers.

8.4.2. Relational Identity

To establish effective communication in the work environment is the absolute fundamental requirement for working in Australia. Nursing is a job which requires accurate and frequent communication with other people at work. To function as nurses in an English speaking environment does not mean to write an essay or to read books or to write a report at a desk. It requires English in bodily action such as good listening, speaking, writing and reading skills with professional language which is used by health care workers, while providing nursing care to the patients (also in the English language). Therefore, English use was strongly linked to the OQNs bodily self-image and identity.

Furthermore, since the nurses in Australia work as team members, it is also essential to be able to create a good working relationship with other workers through communicating with them in the English language. In this study, when the OQNs from NESB experienced problems in English language at work, it always occurred in the form of relational phenomena with other workers. The problems with English at work

were not interpreted as just a matter of simple skill deficiency, rather they were experienced in inter-subjective relations with other workers and patients.

Therefore, English language-based problems appear to have quite a profound and negative affect on the OQNs' psychological and professional well being. For many OQNs, the experience in communicating on the phone was often a large source of stress. Some avoided the phone out of fear of not being able to communicate well or fear of misunderstanding, and some nurses nearly stopped going to work from the stress of answering the phone. In essence, the OQNs did not want to annoy the physicians and did not want to be devalued by physicians or other workers on account of their English problems on the phone. Thus, difficulty was largely experienced as an inter-personal/relational event with people on the other end of the phone rather than a matter of lack of skills.

8.4.3. Outsider Identity

Again, English language learning for the OQNs from NESB was directly connected to re-formation of their self-image because it was connected with relational phenomena within the specific group which holds institutional power with specific language use. Identity is constructed within the play of social relations of power (Wenger, 1998); and the OQNs from NESB are inherently outsiders as they do not share the same language and social norms as native-English speakers. Zajacova (2002, p. 70) explains; "A person coming to another country finds himself in a different reality, and forced to construct a corresponding new identity for himself. Suddenly, one is a member of an ethnic or racial minority, a non-native speaker of a foreign language, often a member of a lower socioeconomic class".

Similarly, Hsieh (2006) reports that in her narrative analysis study with international students in the USA, it became clear that the participants' earlier established identities were challenged by their immigrant experiences and exposure to and interaction with the local environment and local people (Hsieh, 2006).

For instance, when Mika's job interviewer asked her if she was thinking in Japanese or in English in her head, she interpreted the interviewer's intention as devaluing or categorising her as an outsider because of her non-native English speaking background; the OQNs did not perceive it as an issue of some practical skills required for the advertised job. When another interviewer at the next job interview appeared to understand her difficulty in the use of the English language, she interpreted this as willingness to accept her as a member of staff, which provided her with a great sense of security and encouragement to work there.

The fundamental issue here is that her appreciation and recognition of the local nurse's gesture to accept her and to support her appeared to facilitate the formation of a positive new identity and a positive understanding of the new reality.

8.4.4. Active involvement in re-formation of identity

However, the OQNs from NESB did not passively accept how they were defined or categorised in the new environment. They tried to strike a balance between the given identity and their previously formulated identity. Their need to be with significant others such as family and close friends arose not only from a basic human need but appeared to be related more to the need to re-assure themselves as to 'who they think they *really* are' in their safe inter-personal situation with family and close friends. Similarly the OQNs' need to share their experience or problems in Australia with other OQNs seems to come not only from the need to share and exchanging experience, but also from the need for an opportunity to have some sense of control over their perceived identities in the new environment.

In the actual work environment, the OQNs from NESB also purposefully acted to formulate a healthy identity. They developed their own strategies to survive in the English language; at the same time, they

tried to figure out how to be accepted by local staff. For instance, the OQNs found that working harder than other staff was a good way to facilitate good relationships with the staff as the local staff then helped the OQNs with English. The need to be more communicative with staff than they previously had been in their home country was also found to be important when working in Australia. The need to wait for the best moment to ask questions or to ask for help from a staff member were also described as a useful tactic for building a good work relationship. The need to have positive thinking skills and to be strong was also described as necessary. With all these strategies, the OQNs from NESB sought to be accepted by staff; these strategies were directly related to the formation of their positive identity in the new environment.

Similarly, Hsieh (2006) reports that in her study with international students in the USA, it was revealed that the participants did not uncritically conform with the hegemonic expectations of their given identities from the society; instead, they actively constructed their own identity through their new language and new environment. Norton and Toohey (2001, p. 123) also report a similar finding and claim, "….(although they are) socially constructed and constrained, they are embodied, semiotic and emotional persons who identify themselves, resist identifications and act on their social worlds".

8.5. Summary

In this chapter, findings from the previous chapter have been further discussed from a theoretical perspective. Using Parse's theory building approach from her phenomenological research method, the emergent four themes were further conceptualised to form a structure of the lived experience of the OQNs from NESB (local theory) which describes the core essence of the phenomena.

The derived structure of the lived experience is as follows: "The lived experience of OQNs from NESB working in Australia is the process of obtaining a new identity in the English language, while actively formulating reality through interplay with new surroundings".

The OQNs from NESB actively constructed their subjective reality through the process of understanding with the use of their fore-structure/prejudice as a powerful vehicle. At the same time, their previously gained identity became distorted in the process of moving to Australia where English is used, and the formation of a new identity took place as a relational process with new surroundings, including work environment and people.

Chapter Nine: Recommendations and Conclusion

To conclude the thesis, I will revisit the whole research process and argue the significance and contribution for the field of nursing knowledge. Six recommendations for improved supports for OQNs from NESB coming to and working in Australia will be also discussed. Possible limitations of the study and the suggestions for further research are also put forward.

9.1. Overview of the research process

In this section, I will revisit the research process. This thesis has examined the lived experience of OQNs from NESB in Australia. The specific research questions were:

- What are the experiences of individual OQNs of NESB working in nursing practice in Australia?
- Are there common or shared experiences among the participants? If so, what are these common issues?

The study is informed by Hermeneutic Phenomenology, derived mainly from the work of Heidegger and Gadamer, and van Manen's method to guide the research process. Twenty-four nurses from 11 different countries who obtained their original nursing qualification outside Australia and who were from non-English backgrounds voluntarily participated in the study.

The data were mainly collected through individual face-to-dace interviews (including one telephone interview and one interview with a couple) using a semi-structured and conversational style. Two stages of analysis, individual case analysis and thematic analysis, were employed to explore the lived experiences of the participants through a circular process of hermeneutic interpretation.

From the analyses, four dominant themes emerged that structured the experiences of the participants: *From the past to the future, New Environment, Living in the English Language* and *Shared World*. These four themes were then further conceptualised through an adapted form of Parse's phenomenological method. The interpretation process was finalised when the *structure of the lived experience*, which captured the 'core essence' of the phenomena, emerged from the four themes. This is best expressed as: *"The lived experience of OQNs from NESB is the process of obtaining a new identity in the English language, while actively formulating reality through interplay with new surroundings."*

The OQNs' experience in working in Australia illuminated a continuously changing (temporal) process whereby each OQN's historically situated 'prejudice' and new surroundings in Australia were "co-created" through the medium of the English language. 'The surroundings' includes both environmental and human factors; 'environmental' factors refer to the perceived Australian working culture, working conditions, professional opportunities, support systems, and the social environment in Australia in general, while 'human factors' refer to hospital management personnel, senior nurses, nursing staff, staff from other departments, ENs and carers, other health care professionals (particularly physicians), patients, family and the OQNs' family or significant others.

The OQNs' previously formed notions of 'self' as nurses (historically situated prejudices) were constructed from both their taken-for-granted fore-assumptions, such as culturally embedded beliefs and value systems, and professional knowledge as nurses from pre-Australian experiences such as methods of drug administration, handover systems, the measurement systems of various tests, relationships with other workers and patients, and the meaning and status of nursing itself in their home societies.

In essence, there was no indisputable *finding* which was shared by all the participants; instead, I have reported the process of the inter-play of these three major factors: 'environment', 'people' and the OQNs

previously obtained 'prejudice/fore-assumptions' from both professional and personal experiences. These three occurred and influenced one another to create the nurses' perceived experience. At the same time, a present reality was also created in the process of learning to live in the English language which required a radical re-formation of previously constructed identities.

9.2. Significance for nursing knowledge

This thesis presents a broader, and possibly deeper, interpretation of the experiences of OQNs from NESB than has been previously reported. Significant, new insights or perspectives with which to understand OQNs from NESB are discussed, in terms of the following two important points: providing insights into the complex and multi-dimensional nature of the OQNs' lived experiences, and illuminating Australian nursing culture perceived from the OQNs' point of view.

9.2.1. Providing rich insights into the multi-dimensional nature of the OQNs' lived experiences

As mentioned above, the study represents OQNs' everyday experiences in multi-dimensional and multi-layered terms. Until now the OQNs' community has received little attention from nursing scholars, so the significance of this thesis lies in its contribution to providing new knowledge to facilitate the understanding of issues, difficulties and problems that impact upon their life world. With the use of Hermeneutic Phenomenology as its research methodology, the thesis presents a picture which exists beyond the scope of conventional problem-focused approaches. The findings have captured the everyday experiences of the OQNs as perceived and described by the participants rather than applying questions that have been pre-formulated by researchers who do not share the 'outsider' status of the research participants. Insights from the findings can directly inform stakeholders concerned with OQNs, including policy makers, professional bodies, employers, management, staff nurses and individual OQNs.

The thesis also illuminates the OQNs' active creation of a subjective reality with their previously gained fore-structure. In a similar way to many representations of immigrant populations from NESB in the academic literature, the OQNs' group has sometimes been represented as *passive* or *other* or as a *suppressed group* in relation to mainstream discourse. Such a view is valid up to a point and of course racial or linguistic discrimination should be minimised (and I totally agree that the OQNs require fair and equal treatment and job opportunities) but such representations may over-simplify people's experience. There are many other dimensions that require careful investigation in order to understand the lived world of the OQNs. To do so, it is necessary to investigate the disorganised and chaotically articulated representations of their subjectively constructed reality, where the OQNs take a role as main actor/actress, rather than categorising them into a group of overly passive and homogeneous subjects. The use of hermeneutic phenomenology has enabled me to paint a broader and a deeper picture of the OQNs' inner world than has been previously presented.

9.2.2. Illuminating perceived Australian nursing culture

Finally, the study represents Australian nursing culture as experienced by the OQNs. The original intention of the study was to draw a picture of the OQNs' experiences, but as the study progressed, it became clear that I was actually portraying a picture of 'Australian nursing'; in other words, by borrowing the OQNs embodied experiences, a picture of perceived 'Australian nursing culture' emerged that local nurses and researchers do not reflect upon much in their daily practice.

In the study, Australian nursing and health care culture is widely perceived as being very supportive, democratic and friendly. Positive aspects of working conditions in Australia such as paid overtime and holidays, occupational safety, and rich and broad educational opportunities were reported with feelings of satisfaction and appreciation by many participants. Australian nursing was generally reported as being

advanced and of a high standard, empowering many of the nurses and providing them with feelings of achievement and of being proud to work as nurses in Australia. The participants largely shared the view that local Australian nurses were friendly and willing to help the OQNs from NESB – something that has been rarely articulated in nursing literature. Probably, nursing academics and leaders in Australia have been quite modest about positive attributes such as these in Australian nursing culture because most research projects are inevitably problem focused.

However, some aspects of Australian nursing were perceived negatively, such as the rather bureaucratic and inflexible organisational culture, and also perceived levels of 'excessive' individualism. These were sources of feelings of alienation for some OQNs. However, both positive and negative views were not concrete and fixed; another OQN could interpret the same incident from a completely opposite viewpoint. Interpretation apparently depended on the OQNs' perceptions derived from their contextual backgrounds, and environmental factors they encountered in Australia; therefore, their experiences are temporal and should not be understood in a simple good/ bad, or right/ wrong way. As researchers, all we can do is carry out a careful description of the experienced phenomena and provide theoretically based interpretations with as much rigour as possible.

9.3. Recommendations

The following recommendations were derived from the data expressed in the interviews by the participants and the analyses of the data in Chapters Six, Seven and Eight.

Recommendation 1. There should be transparency and fairness in the assessment and recognition system for OQNs' previous work experiences, job opportunities and treatment at work.

The Department of Health, Government of South Australia, has recently formed a working party (Nursing and Midwifery Office, personal communication, 2007) to address the issue of the OQNs' first year employment status and the report will be published in the near future. Though it is crucial to maintain a balance between high standards of health care and the health care budget, fiscal cuts should not be achieved at the expense of immigrant nurses. In reality, some recently registered participants reported that they received incomes at the level of first year nurses while they had to take responsibility in the ward as experienced nurses. Some experienced OQNs had to accept employment contracts as first year nurses because this was the only way in which they could find sponsorship for their visas to work in Australia; in other words, these OQNs were pushed into inferior working conditions without alternative choices (ICN2007). At the same time, the government has a responsibility to protect clients from low quality nursing care by incompetent nurses. Therefore, there is a crucial obligation for policy makers, professional bodies and employers to create transparent and fair assessment procedures concerning the OQNs' previous professional experience and credentials.

Except for OQNs who arrived before the early '90s, there was no obvious dissatisfaction reported by the OQNs regarding their overseas-qualification assessment in obtaining registration. This could be interpreted as a result of the efforts of professional nursing bodies' to establish an objective and fair competency assessment system, as the OQNs who arrived in the early '90s or before, often could not receive satisfactory credit for their educational background and had to alter or modify their career advancement (discussed earlier in section 7.2.1). However, the participants in this study were only those who had successfully obtained their nursing registration. Those OQNs who failed in their application to receive registration in Australia may tell a different story.

Finally, there should be equitable job opportunities and promotion for both local nurses and OQNs and an important step in this direction would be a transparent and fair recognition system for the OQNs' previous work experience. Fair allocation of shifts is important, along with fair management of rosters (particularly in the nursing home sector). OQNs should be clearly told that they do not have to accept sudden shift changes and they have a right to refuse.

Recommendation 2. The OQNs' voices should be reflected in health care policy-making.

In ICN's position statement (2007, p. 1) on ethical nurse recruitment, it is emphasised that "…the nurses should have right to safeguard their rights as health professionals and workers…and right to be represented by a professional association and/or union". Many OQNs from NESB are in a compromised position with regard to their early employment status, as they need to find an employer who is willing to sponsor their visa (section 7.2.1). Some OQNs are pushed into a situation where they only receive payment for first year nurses while they are given responsibilities of experienced nurses.

The Department of Health in South Australia (Chief Nurse, Nursing and Midwifery Office, 2007, personal communication) is developing guidelines concerning the employment conditions of OQNs but currently, there is no professional body or group with a particular responsibility to act in the OQNs' interest about their employment status within the nursing profession. A national body, Australian Ministerial Council of Women, is concerned with the economic independence of women from culturally and linguistically diverse backgrounds. It conducted a research project (Australian Ministerial Council of Women, 2006) to identify barriers to optimal participation in the health workforce by OQNs from diverse backgrounds. However, it failed to address the issue of disadvantaged employment status experienced by OQNs though there is clearly a breach of ethics regarding fair employment conditions.

If the federal government is continuously encouraging OQNs' immigration in order to ease shortages in the nursing workforce, it is necessary to establish formal representatives of OQNs who can act for their benefit and can also provide support in case of possible problems with employers. In addition, many newly arrived OQNs might be less likely to understand what kinds of support are available from unions (Australian Nursing Federation).

Recommendation 3. Existing pre-registration educational programs need to be improved to meet special needs of OQNs from NESB.

Bridging programs should be reviewed to meet the OQNs' special needs. Programs should be evaluated not only by current students but also by students who have graduated from these programs, in order to incorporate insights and feedback from this group of people. Though clinical placement and clinical laboratory classes were largely reported as being useful, in comparison, theoretical subjects were not considered relevant by OQNs. Many OQNs claimed that they did not learn anything significant or new in the theoretical subjects while they found that the clinical placement was very useful for learning about practical nursing in Australia (section 7.2.1).

Similarly, there should be opportunities to learn about the health care system in Australia in relation to OQNs' future nursing practice. Along with gaining a solid theoretical base and practical nursing skills in order to work effectively as registered nurses, OQNs should be given opportunities to gain some understanding of the health care system in Australia in relation to nursing. One example of this is the difference between the public and private sectors, and the practical implications of this for nursing in everyday practice.

The OQNs require opportunities to learn the English which is relevant to clinical settings, including terminology, abbreviations and the format of medical documents. The OQNs require opportunities to learn colloquial English in daily use, such as "white tea". It is also necessary for the OQNs to have opportunities to understand and to practise handover and documentation procedures, and phone conversations in English, prior to clinical placement. These three aspects of English language usage in clinical settings need some level of preparation before OQNs enter practice. These were largely experienced as difficulties and barriers to adjustment to clinical settings in Australia; most participants felt that they did not have any opportunities to prepare for this form of English before registration. Some kind of effective preparation would provide the OQNs with a sense of security and confidence and, in return, the productivity of quality care would probably also be enhanced from a management perspective.

There should be support available for OQNs who are not required to study in the bridging program. OQNs who directly enter practice (without enrolling in the bridging program) require practical information about nursing in Australia. It would facilitate quick and relatively easy adjustment if there were workshops on preparation to enter practice or, at least, information pamphlets to provide helpful practical information.

In addition, the OQNs who applied directly for registration without entering a bridging program sometimes reported lengthy delays in the processing of their registration paper work. One OQN had to wait for four months before she received her registration.

Recommendation 4. A supportive working environment (management and staff) needs to be continuously fostered.

The open and friendly Australian working culture which accepts newcomers should be continuously fostered. Currently provided educational opportunities and working conditions for OQNs should be continued. Current effective professional support such as graduate nurse programs and support from

clinical nurses and senior staff should be continued. Preferably, the preceptor system and formal support groups for OQNs should be organised.

Recommendation 5. Increased awareness and understanding by local workers

Local workers need to understand that English language usage is directly related to people's self identity and initially, using a foreign language in unfamiliar settings is stressful. Only adjustment in the pre-registration and first year periods have been of concern to management and educational bodies but OQNs from NESB do not suddenly become 'Australian' nurses with adequate English language competence from their second year of work. Management and senior RNs should understand this and provide the necessary support for such OQNs. OQNs still require help with the English language from local staff after the 2nd year.

Using gestures aids understanding of English for the OQNs and provides them with a sense of security and a feeling of being accepted (section 7.4.1); verbal encouragement to the OQNs when they appear insecure is also very helpful. For the OQNs, understanding English in less familiar accents is particularly difficult and often requires support from local staff. Help when communicating with physicians and other departments especially on the phone, is often required.

It also needs to be stressed that some OQNs are not used to much interaction with other staff at work, even in their first language, and they may need some adjustment to the more open and communicative Australian working culture. Finally, it should be understood that the OQN community is a collection of nurses from diverse backgrounds. Though these nurses might share some adjustment issues to some degree, it is not appropriate to see all of them in terms of one homogeneous group.

Recommendation 6. OQNs should be informed of the findings of this study.

The findings of this study should be available to OQNs; particularly, the following five practical recommendations would be useful in helping newly arrived nurses to adjust to Australian work environments:

- High proficiency in the English language prior to arrival in Australia is an advantage.
- It is crucial to establish explicit and active communication with other people at work, especially senior nurses. The Australian working culture was frequently reported in this study as being 'open and communicative' (section 7.4.2). It is necessary to have effective communication with other staff especially senior nurses even if there are no obvious and serious problems or issues to discuss. It is important to keep open communication with other workers in order to be accepted and to be understood.
- Asking questions of other staff members is necessary for success in nursing practice. Therefore, OQNs should not hesitate to ask questions if there is anything that is unclear at work but a sense of appropriate timing and communication strategies when approaching staff are also necessary. All OQNs should realise that the local staff cannot appreciate their difficulties unless they are articulated.
- Objectifying their own previously-formed belief system, value system, professional background and other contextual factors that affect interpretations of the present moment will help in understanding their ongoing experience in Australia.
- Establishing an effective private support network with other OQNs in order to share experiences in Australia helps to maintain a good psychological balance in the workplace.

9.4. Study Limitations

Though the design of the study does not allow the participants to be treated as representative of the whole OQNs' community, the 24 participants came from 11 countries of origin, which closely resembles the current newly-arrived OQNs' demographic distribution. In the year 2005-06, the newly registered OQNs in South Australia (NBSA2006) came from 19 different non-English speaking countries (in a total of 34 countries of origin). The sample included in this study was generally representative of the main countries included in the 2005-06 data. The countries not represented in this study had only a very small number of nurses registered in 2005-06, except for Norway, which had seven nurses registered.

The OQNs' experiences explored in this study may appear to be relative in nature, thus failing to provide a solid contribution to the body of nursing knowledge (especially if viewed from positivist or post-positivist paradigms), but actually this is not true. The OQNs' lived world was interpreted as being fundamentally temporal, an ever-changing process, but the findings can provide a solid knowledge base for understanding the OQNs' world in the sense that phenomenological research is like taking a snapshot of a life world. This image can provide the readers with a vivid picture of and a rich insight into the OQNs' experiences and so facilitates *understanding* (*Verstehen*) of such nurses' experiences in Australia.

9.5. Further research

This research was conducted on the assumption that the researcher's background (pre-assumptions) would inevitably influence the research process and findings. Therefore, if another researcher with a different background and training followed the same research project, the findings would probably be different from those of this thesis. Further research on this topic by a different researcher would add greater depth to our understanding of the experiences of the OQNs. However, perhaps it would be more worthwhile to

examine the experiences of the recipient side's dealings with OQNs, such as hospital management personnel, senior nurses and staff, other health care professionals, and patients.

Further examination of possible cases of maltreatment, particularly in the aged care sector, would be useful, particularly in small local nursing homes which might not receive updated educational and management guidance, unlike large teaching hospitals. In addition, the issue of whether immigrants should be accepted or excluded and which immigrant groups should be accepted and on what criteria, is sensitive and political. Nursing cannot exist outside complex international and local politics and history. One point that is very clear is that the goal for the nursing profession is to provide effective nursing services for our community, while individual nurses, including nurses from diverse backgrounds, should have equitable opportunities to advance their professional careers in health care work environments. Debate on these issues should be open to the public and the process of decision-making should be shared by both OQNs and local Australian nurses.

9.6. Summary

To conclude this thesis, this chapter has firstly presented an overview of the research project which examines the lived experience of OQNs from NESB in Australia. Informed by hermeneutic phenomenology, four themes emerged that formulated the OQNs' life world: From the past to the future; New environment; Living in the English language; and Shared world. These themes were further conceptualised to correspond with the core essence of the phenomena which was, *"The lived experience of OQNs from NESB is the process of obtaining a new identity in the English language, while actively formulating reality through interplay with new surroundings."*

Secondly, in terms of significance for nursing knowledge, the findings from the study provide rich insights into the multi-dimensional nature of the OQNs' experience. In contrast to previously portrayed pictures of

a passive and voiceless existence, the OQNs' active participation in the creation of their present reality has been illuminated. Finally, by avoiding simple judgements about good and bad, fair and unfair, or insider and outsider and incorporating the complex nature of the OQNs' experiences, a multi-layered representation of Australian nursing culture has been clearly demonstrated.

The recommendations for improved support for OQNs have been presented in relation to the findings from the study. Limitations of the study have been discussed in relation to potential objections concerning relativism and the interpretive research paradigm. It is recommended that there be further research projects that can investigate the perspective of the recipients and the experiences of local stake holders and local workers.

Finally, just as the OQNs' pre-assumptions work as powerful vehicles to make sense of their present realities, the presentation of the thesis and interpretation of its results were also filtered through my own contextual background as a qualitative researcher. The possibilities for interpretation never seem to end but I would like to close the thesis here. It is for the readers to make sense of my findings with his/her own historically situated prejudice.

Appendices

Appendix I: Searched worldwide websites

Australian nurse regulatory authorities

• Nurses Board of the Australian Capital Territory (ACT). http://www.nursesboard.act.gov.au/

• Nurses and Midwives Board New South Wales (NSW). http://www.nursesreg.nsw.gov.au/

• Nurses Board of Victoria (Vic.). http://www.nbv.org.au/

• Queensland (Qld) Nursing Council. http://www.qnc.qld.gov.au/home/index.aspx

• Northern Territory (NT) Nurses and Midwives. http://www.nt.gov.au/health/nurse_midwife/index.shtml

• Nurses Board of South Australia (SA). http://www.nursesboard.sa.gov.au

• Nurses Board of Tasmania (Tas.). http://www.nursingboardtas.org.au/

• Nurses Board of Western Australia (WA). http://nwa.org.au

Australian nursing federation

• Federal. http://www.anf.org.au/

• ACT. http://www.actanf.org.au

• NSW. http://www.nswnurses.asn.au

• Vic. http://www.anfvic.asn.au

• Qld. http://www.qnu.org.au

• NT. http://www.anfnt.org.au

• SA. http://www.sa.anf.org.au

• Tas. http://www.anftas.org

• WA. http://www.anfwa.asn.au

Nursing organisations

• International Council of Nurses. http://www.icn.ch/

• Australian Nursing and Midwifery Council. http://www.anmc.org.au/

• The Royal College of Nursing Australia. http://www.rcna.org.au/

• Australian College of Midwives. http://www.acmi.org.au/

• The Council of Deans Nursing and Midwifery. http://www.cdnm.edu.au/#

• The College of Nursing. http://www.nursing.aust.edu.au/

• National Nursing Organisations. http://www.anf.org.au/nno/

• Australian Health Care Association. http://www.aushealthcare.com.au/Federal government

• Australian Institute of Health and Welfare. http://www.aihw.gov.au/

• Department of Health and Ageing. http://www.health.gov.au/State governments

ACT

• ACT Government. http://www.act.gov.au/

• ACT Health. http://www.health.act.gov.au/c/health

NSW

• NSW Government. http://www.nsw.gov.au/

• NSW Health Department. http://www.health.nsw.gov.au/

• NSW Department of Ageing, Disability and Home Care. http://www.dadhc.nsw.gov.au/dadhc/

VIC.

• Vic. Government. http://www.vic.gov.au/

• Department of Human Services, State Government of Vic. http://hnp.dhs.vic.gov.au

QLD

• Qld Government. http://www.qld.gov.au/

• Qld Health. http://www.health.qld.gov.au/

NT

• NT Government. http://www.nt.gov.au/

• NT Health Services. http://www.nt.gov.au/health/

SA

• SA Central. http://www.sa.gov.au/site/page.cfm

• SA Department of Health. http://www.health.sa.gov.au/

• SA Department of Families and Communities. http://www.familiesandcommunities.sa.gov.au/

TAS.

• Tas. Online. http://www.tas.gov.au/

• Tas. Department of Health and Human Services. http://www.dhhs.tas.gov.au/

WA

• Government of WA. http://www.wa.gov.au/

• Department of Health. http://www.health.wa.gov.au/

Appendix II: Search strategy

1. CINHAL search strategy

1. exp Australia/or (Australia$).mp

2. exp nurse/or (nurse$).mp

3. (overseas qualified$).mp

4. (migrant nurse$).mp

5. exp foreign nurse/or (foreign nurse$).mp

6. 1 and 2 and 3

7. 1 and 4

8. 1 and 5

9. 6 and 7 and 8

2. Medline search strategy

1. exp Australia/or (Australia$).mp

2. exp nurses/or (nurse$).mp

3. exp emigration and immigration/or (immigration$).mp

4. (overseas qualified$).mp

5. (migrant nurse$).mp

6. (foreign nurse$).mp

7. 1 and 2 and 3

8. 1 and 2 and 4

9. 1 and 5

10. 1 and 6

3. ERIC search strategy

1. Australia*

2. nurse*

3. overseas qualified*

4. immigration* or migration* or immigra* or migra*

5. Foreign nurse*

6. 1 and 2 and 3

7. 1 and 2 and 4

8. 1 and 5

9. 6 and 7 and 8

4. AUSTRUM search strategy

1. Australia/or (Australia$).mp

2. nurse/or (nurse$).mp

3. overseas qualified/or (overseas qualified$).mp

4. migrant nurse/or (migrant nurse$).mp

5. foreign nurse/or (foreign nurse$).mp

6. 1 and 2 and 3

7. 1 and 4

8. 1 and 5

9. 6 and 7 and 8

5. APAIS health search strategy

1. Australia*

2. nurse*

3. overseas qualified*

4. migrant*

5. foreign nurse*

6. 1 and 2 and 3

7. 1 and 2 and 4

8. 1 and 5

9. 6 or 7 or 8

6. Sociological Abstract

1. Australia*

2. nurse*

3. overseas qualified*

4. (migrant* or migration*) or (immigrat* or immigration*)

5. foreign nurse*

6. 1 and 2 and 3

7. 1 and 2 and 4

8. 1 and 5

9. 6 or 7 or 8

7. ProQuest

1. ((Australia*) AND (nurse*)) AND ((immigration*) OR

(migration*) OR (immigra*) OR (migra*))

2. ((Australia*) AND (nurse*)) AND (foreign nurse*)

3. 1 and 2

8. Dissertation Abstract

Australia? AND ((foreign nurse?) or (migrant nurse?) or (overseas qualified nurse?)

Appendix III: Included studies

Qualitative studies

Authors	*Purpose*	*Participants*	*Methods*	*Analysis*
Jackson (1996)	To generate a clear understanding of the lived experiences of nurses from culturally diverse backgrounds as they enter the nursing workforce in Australia	9 nurses from non-English-speaking background (NESB) Overseas qualified nurses	Conversation-style interviews	Phenomenological approach (informed by feminist theory)
Omeri and Atkins (2002)	To explore, describe and analyse the lived experience of the nurses from NESB	5 overseas qualified nurse, born outside Australia, from NESB, experience of work in their home country	Naturalistic, open-ended interview/ conversations	Phenomenological approach
Teschendorff (1993)	To articulate cultural factors that impinge on the success of Philippine nurses seeking registration in Australia	21 overseas nurses from Philippines	Questionnaire and interview	Grounded theory

Descriptive studies

Authors	***Types of study***	***Sample***	***Methods***	***Findings and conclusion***
Pittman and Rogers20	Descriptive study	(1) 1160 overseas qualified nurses working in Victoria (2) 2349 Australian qualified nurses (random samples)	Descriptive statistics and qualitative data analysis Survey questionnaire (demographic data and open ended questions)	• 60% were born in English speaking background • Nurses from Asian region was the second biggest group • Over 60 languages were spoken fluently and certificate qualifications had been obtained in 59 countries • Nurses from NESB often felt that they were not accepted by Australian colleagues
Hawthorne (2000)	Descriptive study	712 survey respondents 33 interviews Overseas qualified nurses	Descriptive statistics and qualitative data analysis Survey questionnaire (demographic data and open-ended questions, interview)	• NESB nurses have received inferior outcomes in registration because of lack of Australian research on the actual calibre of their courses • NESB nurses have much higher failure rate in Occupational English Test than medical doctors

				• Bridging programs lack of national consistency • NESB nurses were found to be clustered in public sector, or to be based in the nursing home sector

Program evaluation

Authors	***Types of study***	***Sample***	***Methods***	***Result and conclusion***
International Institute for Policy and Administrative Studies (1990)	Program evaluation	Single bridging course with 38 students	Questionnaires interview, and visits	• There is a clear need for the bridging program • The course is very cost effective. It costs only 10% the cost of higher education-based course • More involvement of the English language course staff is needed • More emphasis on medical jargon, colloquialism and modern terminology is needed • The duration of supervised

				practice should be more flexible
Palmer (1989)	Program evaluation	Single vocational language course for nurses of NESB	Qualitative case study, Hamilton's illuminative evaluation model: observation, reflective critique and analysis with the participants	• The buddy nurses play roles of facilitator for mediating links across the cultures • Pronunciation was reported to be significant factor in both understanding and being understood between local nurses and overseas nurses • Australian nurses' English was found to be extremely difficult to identify words • Australian nurses use highly complex language in clinical settings
Menon (1992)	Program report	Single bridging course with 7 students Childcare bridging course in South Australia (16 weeks)	Descriptive report	• Language needs must be seen as a first priority in programming, timetabling, staffing and budgeting • It is not possible to 'bridge' both quickly

		and effectively where there are language and cultural differences

Expert opinions

Authors	***Types of study***	***Conclusions***
Groutsis (1999)	Conference proceeding (expert opinion)	• The structure for Australian Nurses Registering Authorities Conference competencies is monocultural and monolingual and does not provide a valid basis for describing and assessing professional competence
Gonda, *et al.* (1995)	Expert opinion	• Staff nurses need to be aware of strategies to help NESB students to understand the English in the clinical settings • The use of preceptors facilitates learning and helps socialising for NESB nurses/students
Teschendorff (1995)	Expert opinion	• The major difficulties experienced by Philippine nurses related to differences in language and culturally derived behaviour that make the learning of new knowledge difficult • Australian pronunciation and accents, fast delivery of speech, idiomatic language, slang, differences in abbreviations and medical terminologies, telephone conversation were source of difficulties for nurses from Philippine
Hawthorne (1997)	Expert opinion	• Even after passing Occupational English Test and clinical placement, many NESB nurses continue to face language challenges • Needs for training in Australian professional terminology and jargon • Need for improved ability to communicate with staff and

	patients • Need for capacity to reproduce the style of Australian nurses' notes, including relevant use of abbreviations • Need for training in the Australian social and medical idiom widely in use

Appendix IV: Excluded studies

1. Alati R, Najman JM, Shuttlewood GJ, Williams GM, Bor W. Changes in mental health status amongst children of migrants to Australia: a longitudinal study. *Sociol Health Illn* 2003; **25:** 866–88. **Reason for exclusion:** Not congruent with review objectives.

2. Alcorso C. Immigrant employees in hotels: segmentation theory revisited. *Labour Employ Gaz* 2003; **14:** 17–40. **Reason for exclusion:** Not congruent with review objectives.

3. Allotey P. Travelling with 'excess baggage': health problems
of refugee women in Western Australia. *Women Health* 1998; **28:** 63. **Reason for exclusion:** Not congruent with review objectives.

4. Anonymous. Confronting the nursing shortage. *Aust Nurs J* 2002; **10:** 22. **Reason for exclusion:** Not congruent with review objectives.

5. Anonymous. Foreign nurses no solution to UK shortages. *Aust Nurs J* 2001; **9:** 16. **Reason for exclusion:** Not congruent with review objectives.

6. Anonymous. Nurse in profile. Nives Houlihan. *Lamp* 1997; **54:** 40. **Reason for exclusion:** Not congruent with review objectives.

7. Anonymous. Overseas qualified nurses. *Nurs Aust* 2001; **2:** 22–3. **Reason for exclusion:** Not congruent with review objectives.

8. Anonymous. Tuberculosis public health; incidence in birth country best predictor of immigrant TB risk. *Tuberc Week, March 31* 2003; **3:** 3. **Reason for exclusion:** Not congruent with review objectives.

9. Blackford J, Street A. Cultural conflict: the impact of western feminism(s) on nurses caring for women of non-English speaking background. *J Clin Nurs* 2002; **11:** 664–71. **Reason for exclusion:** Not congruent with review objectives.

10. Blackford J, Street A, Parsons C. Breaking down language barriers in clinical practice. *Contemp Nurse* 1997; **6:** 15–21. **Reason for exclusion:** Not congruent with inclusion criteria.

11. Blackman IR. Response. Deborah Jackson's article the multicultural workplace: comfort, safety and migrant nurses Vol 5(3). *Contemp Nurse* 1997; 6: 6. **Reason for exclusion:** Not congruent with inclusion criteria.

12. Buchan J. Recruitment. Happy landings? *Health Serv J* 2000; **110** (5719): 24–7. **Reason for exclusion:** Not congruent with review objectives.

13. Buchan J, Seccombe I, Ball J. The international mobility of nurses: a United Kingdom perspective. *Int J Nurs Stud* 1994; **31:** 143–54. **Reason for exclusion:** Not congruent with review objectives.

14. Chan A, Roder D, Macharper T. Obstetric profiles of immigrant women from non-English speaking countries in South Australia, 1981–1983. *Aust N Z J Obstet Gynaecol* 1988; **28:** 905.
Reason for exclusion: Not congruent with review objectives.

15. D'Cruze S, Taylor C. Ask the experts. *Nurs Stand* 2000; **15:** 27. **Reason for exclusion:** Not congruent with review objectives.

16. Eichler M. Women pioneers in Canadian sociology: the effects of a politics of gender and a politics of knowledge. *Can J Sociol/Cahiers canadiens de sociologie* 2001; **26:** 375–403. **Reason for exclusion:** Not congruent with review objectives.

17. Endo F. Fumie's tale. *Int Nurs Link Up* 2001; **20:** 10–11. **Reason for exclusion:** Not congruent with inclusion criteria.

18. Forde P. Sensitive midwifery care. Midwifery 1999; **15:**60–1. **Reason for exclusion:** Not congruent with review
objectives.

19. Gulland A. Record number of nurses seek adventure overseas. *Nurs Times* 2000; **96** (49): 7. **Reason for exclusion:** Not congruent with review objectives.

20. Hager P. *International Mutual Recognition: Progress and Prospects*. Working Paper. 143 Reports: Research; 2001.Report No. Clearinghouse: CE081983. **Reason for exclusion:** Not congruent with review objectives. This paper is about the role of professional competence standards or descriptors in mutual recognition agreement.

21. Hammond S, English D, McLeod J. The age-range of risk of developing multiple sclerosis: evidence from a migrant population in Australia. *Brain* 2000; **123** (Pt5): 968. **Reason for exclusion:** Not congruent with review objectives.

22. Hawthorne L. The globalisation of the nursing workforce: barriers confronting overseas qualified nurses in Australia. *Nurs Inquiry* 2001; **8:** 213–20. **Reason for exclusion:** This paper is from the author's PhD thesis and the thesis is included.

23. Hawthorne L. Qualifications recognition reform for skilled migrants in Australia: applying competency based assessment to overseas-qualified nurses. *Int Migration* 2002; **40:** 55–91. **Reason for exclusion:** This paper is derived from the author's PhD thesis and the thesis is included.

24. Hendry S. Searching for diversity. *Aust Nurs J* 1997; **4:**23–5. **Reason for exclusion:** Not congruent with review objectives.

25. Jackson D. Constructing nursing practice: country of origin, culture and competency. *Int J Nurs Pract* 1995;**1:** 32–6. **Reason for exclusion:** This paper is derived from the larger study published in 1996. The paper being published in 1996 was included for the review.

26. Johnstone C. Shortage? What shortage? *Nurs Times* 2002; **98:** 21. **Reason for exclusion:** Not congruent with review objectives.

27. Josipovic P. Recommendations for culturally sensitive nursing care. *Int J Nurs Pract* 2000; **6:** 146–52. **Reason for exclusion:** Not congruent with review objectives.

28. Kaan A. Update from your correspondent in Canada. *Transpl Nurses' J* 2001; **10:** 22. **Reason for exclusion:** Not congruent with review objectives.

29. Kamalkhani Z. Perceiving and promoting mental health among Muslim refugee women. *Australia and New Zealand College of Mental Health Nursing, 24th Conference*, Perth, Western Australia, 1998, pp. 161–75. **Reason for exclusion:** Not congruent with review objectives.

30. Kenny C. On a fast track from Oz. *Nurs Times* 2002; **98:**12. **Reason for exclusion:** Not congruent with review objectives.

31. Markovic M, Manderson L, Kelaher M. The health of immigrant women: Queensland women from the former Yugoslavia. *J Immigr Health* 2002; **4:** 5. **Reason for exclusion:** Not congruent with review objectives.

32. McKenzie K. Profile. Jenny Pasimanero. *Lamp* 2001; **58:** 25. **Reason for exclusion:** Not congruent with review objectives.

33. Mitchell RJ, Earl L, Williams JW. Two Y-chromosomespecific restriction fragment length polymorphisms (DYS11 and DYZ8) in Italian and Greek migrants to Australia. *Human Biol* 1993; **65:** 387. **Reason for exclusion:** Not congruent with review objectives.

34. Omeri A. Culture care of Iranian immigrants in New South Wales, Australia: sharing transcultural nursing knowledge. *J Transcult Nurs* 1997; **8:** 5–16. **Reason for exclusion:** Not congruent with review objectives.

35. Powles JW, Macaskill G, Hopper JL, Ktenas D. Differences in drinking patterns associated with migration from a Greek Island to Melbourne, Australia: a study of sibships. *J Stud Alcohol* 1991; **52:** 224. **Reason for exclusion:** Not congruent with review objectives.

36. Procter NG. Cultural affirmation and the protection of emotional well-being. *Holist Nurs Pract* 2000; **15:** 5. **Reason for exclusion:** Not congruent with review objectives.

37. Ribeiro JI. A transnational gendered community. Women's mobilities in the Portuguese health sector. *International Sociological Association 2002*, Brisbane, Australia, 2002; 455–475.
Reason for exclusion: Not congruent with review objectives.

38. Rogalla B. Nursing behind razor wire: a question of ethics. *Aust Nurs J* 2001; **8:** 21.
Reason for exclusion: Not congruent with review objectives.

39. Rossiter JC. The effect of a culture-specific education program to promote breastfeeding among Vietnamese women in Sydney. *Int J Nurs Stud* 1994; **31:** 369–79. **Reason for exclusion:**
Not congruent with review objectives.

40. Sanders JM. Ethnic boundaries and identity in plural societies. *Annu Rev Sociol* 2002; **28:** 327–57. **Reason for exclusion:** Not congruent with review objectives.

41. Schneider S. Interest in medical aid nursing brings Australian RN to U.S. *NurseZone* 2002; **1:** 17. **Reason for exclusion:** Not congruent with review objectives.

42. Settles BH. Being at home in a global society: a model for families' mobility and immigration decisions. *J Comp Fam Stud* 2001; **32:** 627–45. **Reason for exclusion:** Not congruent with review objectives.

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Reason for exclusion: Not congruent with inclusion criteria.

Appendix V: Critical Appraisal Instrument for Qualitative Studies

From QARI: Qualitative Assessment and Review Instrument

Assessment for:

Type: Primary/Secondary

User:

Criteria	**Yes**	**No**	**Unclear**
1) There is congruity between the stated philosophical perspective and the research methodology.			
2) There is congruity between the research methodology and the research question or objectives.			
3) There is congruity between the research methodology and the methods used to collect data.			
4) There is congruity between the research methodology and the representation and analysis of data.			
5) There is congruity between the research methodology and the interpretation of results.			
6) There is a statement locating the researcher culturally or theoretically.			
7) The influence of the researcher on the research, and vice versa, is addressed.			
8) Participants, and their voices, are adequately represented.			
9) The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.			
10) Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.			

Include **Yes** **No**

Reason

Appendix VI: QARI: Qualitative Assessment and Review Instrument

Data Extraction Tool

Methodology	
INTERVENTION	
SETTING	
GEOGRAPHICAL	
CULTURAL	
PARTICIPANT	
DATA ANALYSIS	
AUTHORS CONCLUSION	

Findings	Illustration from Publication	Evidence		
		Unequivocal	Credible	Unsupported

Complete YES _ NO _

Appendix VII: Degree of credibility

Unequivocal [E]: evidence beyond reasonable doubt that may include findings that are matter of fact, directly reported/observed and not open to challenge

Credible [C]: evidence that is, although an interpretation, plausible in light of the data and theoretical framework. The interpretations can be logically inferred from the data but, because the findings are essentially interpretive, they can be challenged

Unsupported [S]: when none of the other level descriptors apply and when, most notably, findings are not supported by the data.

These three levels of evidence are incorporated into the System for the Unified Management, Assessment and Review of Information (SUMARI) software. The

Joanna Briggs Institute, Adelaide, 2003. Used with the permission of the Joanna Briggs Institute.

Appendix VIII: Letter to health care institutions

Ms Rie Konno
PhD student
Discipline of Nursing
University of Adelaide;
The Joanna Briggs Institute
Margaret Graham Building
Royal Adelaide Hospital
Ph 83034880 Fax 83034881
Rie.Konno@adelaide.edu.au
00-00-00

Dear Director of Nursing

I am currently enrolled in the PhD program at University of Adelaide. I am conducting my research project and I would like to collect data for my qualitative study from nurses working in Adelaide. I am writing to you to ask for your support in promoting my study to possible research participants.

My thesis topic is "Lived experience of overseas qualified nurses (OQNs) from non-English speaking backgrounds (NESB)". The purpose of the study is to improve understanding of the experience of overseas qualified nurses from non-English speaking backgrounds who come to work in Australian nursing practice. It is hoped that findings from the research will inform nursing educators and nursing managers who work with overseas qualified nurses so that appropriate support(s) for such nurses can be provided.

I would like to interview approximately twenty registered nurses who obtained their first nursing qualifications outside Australia, where English is not the first language. I would be very grateful if you could help me identifying such nurses working in your institution.

Sincerely yours,

RIE KONNO

PhD Candidate

University of Adelaide

Appendix IX: Information sheet

Royal Adelaide Hospital
University of Adelaide
Information Sheet
for persons participating in research projects

Project Title: Lived Experience of Overseas Qualified Nurses of Non-English-Speaking-background, working in Australia

Investigator:
Rie Konno
PhD Student
Discipline of Nursing
University of Adelaide;
The Joanna Briggs Institute
Margaret Graham Building
Royal Adelaide Hospital
Ph: 08 830 34880

Supervisor:
Prof. Alan Pearson
Professor
Discipline of Nursing
University of Adelaide

Executive Director
The Joanna Briggs Institute
Margaret Graham Building
Royal Adelaide Hospital
Ph: 08 830 34193

Associate Supervisor:
Dr Tim Schultz
The Joanna Briggs Institute
Margaret Graham Building
Royal Adelaide Hospital
Ph: 08 830 333091

Information sheet

Thank you very much for expressing your interest in participating in this project. We have contacted you about this project because you responded to an advertisement, calling for overseas-qualified nurses from non-English-speaking-backgrounds to participate in the project.

The aims of the project

The aims of the project are:

- To describe and interpret the lived experience of overseas qualified nurses (OQNs) of non-English-speaking-backgrounds (NESB) to facilitate understanding of such individual nurses;
- To articulate common problematic issues experienced by OQNs of NESB in coming to, and working in Australia;
- To investigate the nature of sub groups of OQNs of NESB in the Australian nursing profession.

What will we ask you to do?

If you agree to participate, you will be asked to contribute by participating in an interview at a time and in a place that is convenient for you. The interview questions will be open-ended in order to develop a deeper understanding of the experience of your work in Australia. We are

interested in what it is like to work in Australia for you and we are also interested in any issues or problems you have been confronted by, while working as a registered nurse in Australia.

The total time commitment required of you would be a maximum of 1 and half hours for one interview. If you agree to have further interview sessions after the first interview, there will be a few more sessions. If you do not agree to further interviews, you can stop after the first interview or at any other time.

With your permission, the interview will be tape-recorded so that we can make sure that we make an accurate record of what you say. When the tape has been transcribed, a copy of the transcript will be provided for you, so that you can check that the information is correct and if necessary, you can request deletions or changes in the transcript.

Any risk of harm or discomfort?

The risk of harm or discomfort which you may experience as a result from participation in the project is extremely low; however, recalling negative experiences in coming to and working in Australia, may cause uncomfortable feelings for you, or it may be a little upsetting. If this is the case, you can stop the interview and re-start when you are ready, or we can arrange some other time or you can withdraw if you wish.

How will your data be used?

The results of this project and the information from the interview will be transferred onto computer. The interview will be tape-recorded and then later typed (transcribed) on to a

computer. This is to enable a comparison of results and make a list of themes emerging from the transcriptions from your interviews.

Protect your privacy

We intend to protect your anonymity and the confidentiality of your responses as much as possible, within the limits of the law. Your name will not be included in the tape recoding or on the transcriptions, although researchers will know who you are during the study. Your name and contact details will be kept in a separate, password-protected computer file from any data that you supply.

In the final report, we may use a different name to refer to you. We will remove any references to personal information that might allow someone to guess your identity, however, you should know that as the number of people we expect to interview is very small, it is possible that someone may still be able to identify you. The data will be kept securely in the School of Nursing for five years from the data of publication, and it will be destroyed.

Access to data and results

Any personal data collected about you during the research is available to you if you request, at any time during the project. A copy of the transcript will be mailed to you for checking, after the interviews, and before the submission of the thesis or publication of reports or papers. The data from this project will not be made available to any other persons and the data will not be kept for further use in another project. No-one apart from Rie Konno, Prof. Alan Pearson from La Trobe

University (and Executive Director of The Joanna Briggs Institute), Dr Tim Schultz from The Joanna Briggs Institute, will have access to the tape recordings and transcriptions.

Once the thesis from this research has been completed, a brief summary of the findings will be available to you via the Royal Adelaide Hospital. It is also possible that the result will be presented at academic conferences. The results will only be made public after you have received feedback from the project.

Benefit to you from the research

You may benefit from participating in the project, in that you will have someone to listen to and read about your individual experience. This research may also benefit other OQNs from NESB coming to work or already working in Australia, as the research will help us to better understand issues or problems they face. The findings will be able to provide useful information to nursing managers, nursing educators, and nursing in Australia, which will gradually improve the professional environment to facilitate your better professional achievement.

Completely voluntary

Your participation in this study is completely voluntary and there are no adverse consequences, disadvantages or penalties even if you refuse to participate or decide to withdraw from the study. You have the right to withdraw from active participation in this project at anytime. You also have the right to demand that data arising from your participation should not be used in the research project, within four weeks of the completion of your participation in the project.

Any questions?

If you have any questions, please contact Rie Konno, Doctor of Philosophy Candidate at The Joanna Briggs Institute on 08 830 34880, or the Supervisor, Prof. Alan Pearson of Executive Director of The Joanna Briggs Institute on 08 830 34193, Associate Supervisor, Dr Tim Schultz, The Joanna Briggs Institute on 08 830 33091.

If you wish to discuss aspects of the study with someone not directly involved, you may contact the Chairman, Research Ethics Committee, Royal Adelaide Hospital on 8222 4139.

Appendix X: Flyer

Calling all Overseas Qualified Nurses from Non-English-Speaking-Backgrounds

Are you a registered nurse from overseas?

Are you currently working as a registered nurse in Australia?

Have you received your basic nursing education outside Australia where English is not the first language?

If you answered 'yes' to all 3 questions above, then you are invited to participate in a research study that aims to understand the experience of overseas qualified nurses from non-English-speaking-backgrounds. The research project is conducted by a PhD student at Adelaide University, and the outcome of the research will form part of her final thesis.

If you agree to participate, you will be asked to commit a maximum of 1 hrs for an interview. If you agree, the interview session may be held up to several times.

If you would like to know more, please contact RIE.

Office 08 83034880 Mobile 0401330250
Email: Rie.Konno@adelaide.edu.au

However, you will be under no obligation to participate if you contact me.

Appendix XI: Personal data sheet

Overseas qualified nurses from non-English speaking background: Personal information

1) Background history

Country of origin: _____ Native language:_____

Religious practice: _____ Age: _____

Reasons for immigration to Australia:

_____

2) Professional history before Australia

Nursing education:

_____
_____

Work experience (kind of wards, position, length of employment):

_____

_____

3) Professional history in Australia

Pre-registration program (Institution, length of study):

_____

First year of registration: _____

Work experience (kind of ward, position, length of employment):

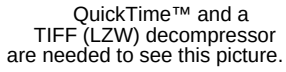
_____

_____

Post-registration program (Bachelor, post-graduate programs):

_____
_____

Appendix XII: Ethics Approval



Appendix XIII: Informed consent form

ROYAL ADELAIDE HOSPITAL
CONSENT FORM

PROTOCOL NAME: Lived experience of overseas qualified nurses from non-English speaking background

INVESTIGATORS: Rie Konno, Prof. Alan Pearson, Dr Tim Schultz

1. The nature and purpose of the research project has been explained to me. I understand it, and agree to take part.

2. I understand that I may not directly benefit from taking part in the trial.

3. I understand that, while information gained during the study may be published, I will not be identified and my personal results will remain confidential.

4. I understand that I can withdraw from the study at any stage and that this will not affect my medical care, now or in the future.

5. I have had the opportunity to discuss taking part in this investigation with a family member or friend.

Name of Subject: _____

Signed:

Dated:

I certify that I have explained the study to the patient/volunteer and consider that he/she understands what is involved.

Signed:_____ Dated:_____
Investigator:

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