The Nature of Learning to Nurse Through Clinical Practice Experience for International Culturally and Linguistically Different Students in Sydney, Australia: An Interpretive Description.

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Certificate of Authorship/Originality

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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The writing of this thesis has been many years in the making. I have watched the flowering cherry outside my study window flower, drop its leaves, and then bloom again for many seasons. I often wondered how many more seasons would it take to complete. During that time I have had the fortune of being supported, encouraged and motivated by my wonderful husband Peter and my two children Matthew and Kaitlyn. Without them taking up the mantle of the everyday, this work would not have eventuated. With all my heart I thank them and love them for that. Today, the flowering cherry is full of leaves and beautifully green.

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I declare that I have received editorial assistance in the preparation of this thesis.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

ABS	Australian Bureau of Statistics
AEI	Australian Education International
AHPRA	Australian Health Practitioners Regulation Agency
AIDS	Acquired Immune Deficiency Syndrome
ANMAC	Australian Nurses and Midwives Accreditation Council
ANMC	Australian Nursing & Midwifery Council
BN	Bachelor of Nursing
CALD	Culturally and Linguistically Different
CINAHL	Cumulative Index to Nursing and Allied Health
CLEI	Clinical Learning Environment Inventory
CRICOS	Commonwealth Register of Institutions and Courses for Overseas Students
DEEWR	Department of Education, Employment & Workplace Relations
ELP	English Language Proficiency
ESL	English as a Second Language
ESOS	Education Services for Over Seas Students
GPA	Grade Point Average
ICALD	International Culturally and Linguistically Different
ICN	International Council of Nursing
ICVF	Integrated Competing Values Framework
IELTS	International English Language Testing System
NHMRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales
NESB	Non English Speaking Background

OECD	Organisation for Economic Co-operation & Development
Son	School of Nursing & Midwifery
STTI	The Sigma Theta Tau International
TALES	Teaching and Learning Enhancement Scheme
TCN	Transcultural Nursing
TEQSA	Tertiary Education Quality and Standards Agency
TOEFL	Test of English as a Foreign Language
UK	United Kingdom
UN	United Nations
USA	United States of America
UTS	University of Technology, Sydney
UWS	University of Western Sydney
VET	Vocational Education and Training
WHO	World Health Organization

Abstract

Nursing in Australia is a practice based discipline that is governed and structured by national authorities that aim to maintain safe, effective and professional standards of care for the population. These standards reflect the notion of care, the role of the nurse, and the language of nursing as it is constructed in the Australian social culture. Undergraduate nursing courses are expected to prepare students to meet the professional and social expectations of the Australian nurse, so that they are prepared for graduate practice. These courses rely on the clinical practice learning experience to socialize students into the profession as well as integrate theory with practice. International culturally and linguistically different students (ICALD) who come to Australia to study nursing have been found to experience difficulty with learning to nurse in the clinical environment.

Through the method of interpretive description, this study presents a comprehensive understanding of learning to nurse in the clinical environments of Sydney, Australia, for international students who come from countries where their language and culture is not western. The findings reveal the complexity of the nature of learning that often remains hidden to clinical educators and facilitators. ICALD students' motivation to learn to nurse is underpinned by cultural pressure and personal circumstance that sustained them for the three years of the degree. The participants in this study came to Australia with very little knowledge of the culture or the population, armed with a learner level of English that was inadequate for full engagement in the clinical environment. Their ideas about nursing were constructed by their own experience and culture and therefore varied from the Australian ideal; therefore having 'to do' nursing as it is constructed here, often placed participants in moral peril and at risk of damaged reputations. The participants also felt that they were different to the Australian nurses they worked with, which affected their socialisation into the role. Despite these issues, the participants took ownership of their clinical learning experience and sought to become Australian nurses.

The doctoral portfolio completing this thesis provides an examination of current and pertinent policy that influences the education of nurses and has informed the actions undertaken to address clinical learning issues. The ICALD student should be seen as a

student of cultural literacy, for the wider Australian society and for the nursing profession, and the clinical learning environment as a space for language learning.

Chapter 1: Introduction to the Study

[1]The face of the Australian nursing student has changed from a homogenous white female group to a heterogeneous male and female cohort from a multitude of cultural backgrounds. The shift of nursing education from hospital based training to the tertiary education sector allowed for increased diversity within student nurse cohorts, and opened the door to international students to come to Australia to study nursing. The push to diversify the cultural backgrounds of Australian nursing students comes from two influential sectors, one from within the profession itself and the other from the tertiary education sector responsible for preregistration nurse education. Firstly, prominent nurse leaders have called for the members of the profession to be more representative of the cultural diversity of the Australian population, a position supported by the National Review of Nursing Education (Australian Department of Health & Ageing, 2002). Secondly, tertiary education institutions are responding to the need for increased financial accountability and profit generation by increasing recruitment of international full fee paying students. As Devos notes '…internationalisation is the means to supplement reduced public expenditure on higher education' (2003, p.161). Further to this, Kilstoff and Baker (2006) suggest that international students may remain in Australia after completing their studies and become welcome additions to the aging and depleted nursing workforce.

The enrolment of international students at Australian universities is not a new phenomenon. International students, mainly from Asia, have been enrolling in undergraduate programs since 1904 (Williams, 1989). A steady flow of students from China, India, The Republic of Korea, Malaysia, members of Asia's 'Tiger' economies has continued (Australian Education International [AEI], 2011; Organisation for Economic Co-operation & Development [OECD], 2011; Khan & Hancok, 2002).

[1] Parts of this section were previously included in a peer reviewed paper published by Dickson, Lock & Carey, (2007). *Appendix B*.

Generally, international students are attracted to Australia to study in a safe and friendly English speaking country, receive a high quality education, and enhance their employment prospects in their country of origin. Since the publication of the Jackson Report (1984), which recommended that Australia could develop education and training as an export, education as a commodity has become Australia's largest export earning $16.3 billion in 2010-11 (Australian Bureau of Statistics [ABS], 2011). Although the economic downturn and the strength of the Australian dollar have decreased international student numbers, the percentage of international students enrolled in Australia's higher education sector continues to be the highest of any OECD country (Economic Analytical Unit, 2011). Marginson (2009) reported that there are several highly regarded universities that obtain more than 20% of their income from international students.

International students enrolling in domestic undergraduate nursing programs are an increasing presence. National data on international enrolment trends in nursing identify that the top three nationalities for international nursing students are Chinese, Indian and Korean (2009). At the university where the research was conducted, the top three world areas that contributed to international nursing student numbers were; South-east Asia, Chinese -Asia Japan & Korea and South -Central Asia, reflecting the trends in national data. In 2007, when this research began, approximately 12% of the first year student nurse cohort comprised international students; by 2011 the numbers have increased to 15% (University of Western Sydney [UWS], student data, 2011; Office of the Academic Registrar, 2006). The net result of international students enrolling in domestic undergraduate nursing programmes is student cohorts that are culturally and linguistically different from the traditional white female, mainstream domestic student (Dunn, 2000; Gerrish, 1997; Yoder, 1997).

From this point in the development of this thesis, the term international culturally and linguistically different (ICALD) student will be utilised to distinguish from domestic culturally and linguistically different (CALD) students. ICALD students possess a student visa where domestic CALD students do not.

Problem Statement

While the clinical learning experience can be stressful and anxiety provoking for any student, anecdotal evidence that led to the development of a doctoral study proposal, suggests that this situation is significantly more complex for ICALD students. International undergraduate nursing students typically arrive to begin their studies at the commencement of semester one, with little time to acculturate to the Australian culture. These students, then lack exposure to the Australian healthcare system and especially to the Australian concept of nursing. Therefore learning and consequently proficiency in the clinical environment may be significantly impeded by the disparity between the ICALD students' own beliefs and values about nursing, and reality in the Australian context. Spradley (1994 as cited in Spradley & McCurdy, 1994) defines culture as '…the acquired knowledge that people use to generate behaviour and interpret experience' (p.14). If this is so, then those international students enrolling in the undergraduate program from cultural backgrounds other than the dominant Australian culture may have different expectations of what nursing is about.

International university students who have English as an acquired language, have been the focus of research in nursing, and in other disciplines, mainly because of their theoretical learning needs and adaptation to student life in a different campus culture. In undergraduate programs, leading to registration as a health professional, especially in nursing, there is an additional factor, the clinical practice experience. This vital aspect of nursing education has been neglected by researchers when it comes to understanding how these international students learn to nurse in the Australian health care context.

Impetus for This Study

Having been involved in nursing education, in both clinical and theoretical settings for approximately 10 years, the researcher came to notice a difference in the success rates on clinical practicum for ICALD students. It has long been acknowledged that students who travelled internationally to study nursing at this university in Sydney Australia, experience classroom related language, communication and learning differences. However, there is possibly more to understand about their clinical learning. At times ICALD students would refuse to carry out certain nursing duties, sit

at the nurses' station and wait for the medication round to begin, or remain focused on the technical equipment rather than the patient. This was despite preparation in nursing laboratories and skill sessions prior to clinical placement; and appeared somehow intrinsically different to local students learning in the clinical environment. Avoidance or selective types of behaviours could constitute a clinical fail for the student and have serious personal and financial repercussions that result in emotionally distraught students pleading for a passing grade. After conversations with clinical educators, it was identified that most often the student did not understand the role of the nurse.

Reflecting on these issues raised certain questions related to cultural understandings including the role of the nurse in the home countries of these students. Hence, an aim of this study was to identify what preconceptions of nursing these students bring with them and how it affected their learning how to nurse in Australia. This issue also raises questions about the universal applicability of nursing theory, since the majority of nursing theory is generated from Anglo-Saxon, Christian, first world countries, and most of the i ICALD students do not come from this heritage.

The main assumption, whether conscious or unconscious, that both clinical educators and clinical staff have about ICALD students is that they will assimilate to the 'way we do things here'; these students are expected to act and respond similarly to domestic students. More importantly clinical educators are expected to assess students on an equal basis, and are encouraged not to identify that the student is international or domestic. Moreover, ethnocentric behaviour and practices from nurse educators and role models in the clinical environment may impede the success of ICALD students on clinical placement.

Student Attitudes and Behaviors Raising Concern

The following student attitudes and behaviours were recalled from personal experience by the researcher. Examples such as these are usually first voiced in the clinical laboratories where encounters with clients are simulated during the students first year of their degree. The students then carry these ideas into the clinical environment where the reality of having to perform the tasks modelled becomes all too apparent.

Performing personal body care. Performing personal body care (PBC) is a fundamental aspect of western nursing practice (Grant, Giddings & Beale 2005). Assisting patients, where necessary, with the activities of daily living (ADL) including personal cleansing (Holland, 2008) would normally be considered part of daily nursing care in Australia. When nurses render assistance to patients in relation to hygiene needs, a situation occurs that has been identified as a therapeutic nursing ritual (Wolf, 1993). This type of care giving enables the nurse to positively influence the patient through touch, massage and in just 'being there' or presencing (Lomborg, Bjorn, Dahl, & Kirkevold, 2005; Wilkin & Slevin, 2004), and can thus be defined as therapeutic. Wolf (1993) proposes that performing PBC conveys the humanistic values of nursing. When international students refuse to perform PBC for their patients on clinical placement, they are in effect interpreted by Australian registered nurses as challenging these values.

It is true that all students of nursing must negotiate their own sociocultural values and beliefs about touch and intimacy (Grant et al. 2005; Lawler, 1991) and go on to perform PBC as part of their care giving. The question that needs to be asked is do ICALD students who assert that nurses in their home country do not perform PBC do so from their cultural group orientation, and if they do perform PBC how do they negotiate this cultural difference?

Authority of doctors over nurses and their practice. Non-western student nurses whose prior experience or understanding of nurses and nursing is informed by a perspective where doctors dominate care and decision making have been noted as possessing a subservient attitude. Nurses who have not been encouraged to critically examine practice or engage in decision-making processes are typically stereotyped as subordinate to doctors and treated as handmaidens (Mannien, 1998). These stereotypical nurses are seen by doctors, as not having a separate nursing knowledge base or autonomy in making nursing care decisions (Darbyshire & Gordon, 2005). For example, Nehring (2003) describes nursing practice in Qatar as being characterized by handmaiden to physician and servant to hospital with care policies written to minimize the nurse's ability to direct care. However, Western nursing students are encouraged to challenge the status quo and develop their critical thinking and reflective skills in order to progress knowledge development within the profession, take a decision making role, and provide high quality care (Parker & Clare, 2004).

Care and western nursing practice. ICALD nursing students have been observed sitting at the nurses' station for extended periods of time, not participating in any of the expected nursing duties other duty than dispensing medications or attending to any associated technology. Students from certain areas of the world have anecdotally explained their behavior as being related to their prior perception of the nurse's involvement in care giving, that any other direct contact care practices were allocated to lesser qualified personnel. To focus upon the task of administering medications or attending to monitors attached to patients, only serves to undermine the humanistic values of nursing as seen from a Western perspective. It is interesting to note that throughout the Western literature, research conducted on patients' understanding of caring demonstrated the importance of nurses; being more interested in listening to the patient than completing tasks, responding and showing concern was comforting and reduced anxiety, and of being near when the patient needed them (Houstutler, Taft, & Snyder, 1999; La Monica, Oberst, Madea, & Wolf, 1986; Reimen, 1986).

Overall Expectations of ICALD Students

From the personal observations made by the researcher, ICALD students are expected to assimilate and accept care giving in the Australian western way like other mainstream domestic students. Whilst there is a focus in the literature on classroom learning and the difficulties these students have in that context, little is known regarding the transference of preconceived ideas about nursing roles and responsibilities, and the meaning of nursing for ICALD students into the clinical environment. At the time of data collection, the ICALD students received no additional support regarding language or adaptation to the Australian nursing environment at the university where this study took place.

International students and adjustment. The development of this research could not adequately progress without acknowledgement and understanding of the extensive body of literature related to the international student experience that has been produced by the disciplines of education and psychology. Where much of the focus has been placed on the classroom learning experience in the discipline of education, there is a branch of knowledge development that is vital to the understanding ICALD nursing students' clinical experience and that relates to student adjustment and moves beyond the classroom.

Studies which analyse the adjustment of international students have proliferated in an attempt to understand their psychological and social adjustment on entering and engaging with a new culture and are of benefit to this study, as all international arrivals undergo a level of learning that results in cross-cultural adjustment. As nursing has a specific culture associated with it as a profession in Australia it is necessary to investigate how adjustment could be understood for ICALD students adapting to the new culture of nursing.

Often in the literature regarding the study abroad experience, international students are referred to as sojourners, akin to other categories of temporary residents in a host country who are there for a specific purpose. The temporariness of this excursion is characterized by the expectation that the sojourners return home at the completion of their duties, for example business people, diplomats, aid workers or missionaries (Gullekson & Vancouver, 2010; Oakman, 2010; Berry, Poortinga, Segall & Dasen, 2002; Hess, 1997; Church, 1982). Because of this state of temporariness Berry et al. (2002) suggest that sojourners, including international students, may not engage with the host society at a depth that might enable full involvement or identification with the new culture. This notion of temporariness, and the resultant effect of a lack of engagement with the host society, is not appropriate for a nursing student's learning, especially in the clinical environment, because the learning of nursing care demands an intimate level of engagement with the client and their culture as well as the work environment and its culture. On the other hand, clinical educators and ward staff may assume that the 'temporariness' of international students means that at the completion of their studies the ICALD student will return home and, therefore, forfeit the time and effort given to helping them learn to nurse.

Ward, Okura, Kennedy and Kojima (1998) identify that there is confusion and difficulty in defining 'adjustment' mainly because most authors fail to distinguish between psychological adjustment and sociocultural adaptation, which Ward et al. (1998) claim are empirically distinct. Psychological adjustment is related to personality, social support and the way life changes that affect the individual; sociocultural adaptation takes into consideration cultural distance, the amount of host culture knowledge and the level of host culture contact by the individual. Basically, intercultural contact affects the individual because they will have to change the way

they think about their interactions and circumstances (adjust), and modify their behaviours when interacting with host nationals (adapt). These are the outcomes of intercultural interaction for the student. In the clinical learning environment, the required adjustments to the ways of Australian nursing are complicated by the intersection of patients, staff and the organisation.

How individuals react, then adapt to a new culture was initially described as culture shock (Oberg, 1960). This concept rested on the belief that entering a new culture provokes personal anxiety due to the loss of all that is familiar (Gullahorn & Gullahorn, 1963; Lysgarrd, 1955). The resultant shock as it was termed came to be known as both natural and necessary in the process of cultural adaptation and adjustment, where the stress or anxiety experienced by the individual, was seen to induce or inspire change. Culture shock is seen by some authors as an equivalent to a medical model where shock is an illness requiring treatment (Heyward, 2002; Bochner, 1989). It could be said of ICALD students entering the clinical environment especially for the first time that their reactions could be equated to a type of culture shock. However, the term culture shock itself suggests undertones of ethnocentrism, and potentially stigmatizes those who do not appear to adjust. Further, contemporary research has since developed and moved away from this basic concept.

How clinical nurse educators and clinical staff might expect an ICALD student to adjust, occurs through a number of empirically identified variables that Yousoff and Cheliah (2010) collectively term determinants of adjustment. These determinants have been examined and encompass: age, the younger the student the faster the adjustment (Sumer, Poyrazli, & Grahame, 2008; Tomich, 2003); gender, female students experience more anxiety than males (Misra, Crist & Burant 2003; Rajapaksa & Dundes, 2003); length of immersion, that the longer the time in the community the better the adjustment (Wilton & Constantine, 2003; Ward & Kennedy, 1992); English proficiency, where the greater the proficiency the better the adjustment (Yu & Shen, 2012; Andrade, 2006; Masgoret & Ward, 2006; Ward & Kennedy, 1993); personality traits, where certain personality types are suggested to aid adjustment better that others, for example openness, extraversion, agreeableness and emotional stability (Bardi & Ryff, 2007; Bakker, van Oudenhoven & van der Zee, 2004; Ward, Leong & Low, 2004); finally the notion of adherence, where an increased level of adherence to the

host culture positively influenced sociocultural adjustment (Zang & Goodson, 2011). The international nursing student must be ready to encounter differences in expectations and values, and be willing to be objective in observing these differences (Hess, 1997). For clinical nurse educators and clinical staff to appropriately support ICALD students in their adjustment process to Australian nursing, they must first unpack individual preconceptions from the beginning of the adjustment period to fully understand the dynamism and unpredictability of adjusting (Brown & Holloway, 2008).

Implications for Nurse Academics

For nurse academics these issues have serious implications. Firstly, nurse academics who are unit coordinators in the BN in conjunction with the Director of Clinical Education are accountable to the School of Nursing for developing competent registered nurses. Secondly, the School of Nursing is held accountable to the professional body responsible for granting registration as a nurse in Australia, for a period of five years once the student has graduated and registered. Thirdly, nurse academics are ethically and morally bound to provide quality undergraduate education and clinical experience that produces safe and competent registered nurses to the community at large. Consequently, nurse academics and clinical learning facilitators need to realise that ICALD students have different needs to mainstream domestic students to ensure success in the clinical environment. ICALD students need to be adequately prepared to enter, and then to adjust, to the Australian clinical environment. To achieve this, clinical educators should be adequately skilled in relation to specific needs of ICALD students that are currently not well understood. It is imperative that research which brings these issues to light is conducted. Therefore, the question guiding this research is: What is the nature of learning to nurse, through clinical practice experience, for culturally and linguistically different students in Sydney, Australia?

Significance

This study is significant for pre-registration undergraduate nursing education on three important levels. Firstly, the Australian nursing student cohort has changed and the methods generally used for teaching and assessing clinical competence have not. Secondly, as socialization into the profession occurs primarily in the clinical

environment, clinicians and clinical learning facilitators are not adequately prepared for students with different cultural backgrounds. Finally, nursing theory that underpins clinical practice and knowledge development is dominated by western nurse academics from nations such as Australia, the United Kingdom and the United States of America, and as such fails to recognize the values and beliefs of novice nurses from other cultures.

International culturally and linguistically different nursing students are expected to have the same cultural literacy as domestic students when it comes to ability to study at university, learn in the clinical environment, and function in Australian society. The preparation of these students, the provision of clinical education, and methods of assessment, impact on the success of the students in the nursing program. Results from the study will be used to improve clinical practice experience planned for other ICALD students who are becoming an increasingly larger group of students within one Australian university.

Structure of the Thesis

This thesis comprises six chapters and a doctoral portfolio completes the final seventh chapter. The first six chapters represent a traditional thesis and format the basis of knowledge development for the portfolio. Chapter two will present the concepts informing the study. Chapter three is a review of pertinent literature, followed by the research design and method in chapter four. The next chapter presents the findings of the analysis and chapter six represents the discussion. The final chapter, number seven, the doctoral portfolio, is the application to practice of the knowledge created from the research. It is informed and influenced by current and relevant policy pertaining to international nursing students. In presenting and applying the knowledge generated from the research it is the remit of the doctoral candidate to also demonstrate academic leadership. Leadership is presented in the portfolio as a reflection of the Integrated Competing Values Framework (Vilkinas, Leask, & Ladyshewsky, 2009).

Chapter Conclusion

Throughout this thesis it has been my intention to influence, motivate, and inspire those involved in clinical education to realise the challenges that ICALD

students have in meeting the expectations of learning to nurse here in Sydney, Australia. Through improving the knowledge of clinical educators, who are the assessors of nursing competency, the clinical learning environment will be seen to be just that, a learning space for all aspects of Australian nursing where ICALD students can develop their nursing cultural literacy.

Chapter 2: Concepts Informing the Study

The purpose of this chapter is to explicate concepts that may lie hidden in the assumptions associated with learning to be a nurse in the clinical environment for ICALD students. By bringing forward certain implicit assumptions this discussion opens the possibility of exploring them further in the data and the ensuing discussion. It is assumed by those teaching and working in the profession of nursing in Australia, that the global construct of nursing is applied without question. However, it would seem that the concept of nursing is socially constructed and such views can be interpreted as ethnocentric. Where nursing is practised and to whom should be central to its understanding. Culture and its influence on nurses' caring practices vary on an individual basis. For students of nursing, the curriculum they study and the application of their new knowledge in the clinical learning environment has a significant impact on their development as Australian nurses.

Nursing and its Practice in Australia

> The International Council of Nurses (n.d) defines nursing as encompassing:
> *Autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.*

Inherent in this definition is that practitioners of nursing across the world share the same understanding of fundamental key points, such as the meaning of care or what constitutes a family. It is the remit of nurse education programmes then, to ensure that these shared understandings are global in nature. The challenge for Australian nurse educators arises when international culturally and linguistically different nursing students enter the study program and begin to question these fundamental key points, or point out to the nurse educators that in their country nurses do not carry out the basic roles and responsibilities that they are expected to perform here in Australia.

Nursing, its education and practice in Australia is framed by the values, beliefs and expectations of a dominant western culture, inclusive of theoretical and practice underpinnings from other, first world, English speaking countries. Australian undergraduate education is pedagogically designed to meet the needs of Australian main stream students (Cioffi, 2000; Dunn, 2000; Fuller, 1997); in addition, clinical practice experience prepares them to function in the Australian health care system. As these culturally derived values and beliefs are the framework within which clinical practice is undertaken, successful completion of the clinical practice experience for ICALD students with minimal understanding of both the tertiary education system and the Australian health care system is difficult. The clinical practice experience is an important compulsory educational requirement for pre-registration nursing students and is graded as satisfactory, unsatisfactory or above average at the university where the research took place. Students must pass the clinical practice component each semester in order to progress through their degree.

As undergraduate degrees in nursing are the entry qualification for registered nurses in Australia, learning outcomes for nursing students are based on the National Competency Standards for the Registered Nurse (Australian Nursing & Midwifery Council [ANMC], 2006). Professional competency standards for registered nurses have been in place as a minimum standard of practice since the early 1990's, and were endorsed as outcome measures for undergraduate nurses in 2002 (Chiarella, 2006). The notion of competency is multifaceted where the learner must demonstrate knowledge, skill, personal qualities, and professional attitudes. For nursing students the ultimate learning outcome, a demonstration of competence, is articulated within this Australian professional context.

Historically, Australian nursing students were homogenous (white), female, heterosexual, Christian, lower middle class and aged under the age of 21 (Allen, 2006; Usher, Lindsay, Miller, & Miller, 2005). If a student was in any way different to the expected, 'she' was identified as a problem. Now as the profession of nursing strives to be truly representative of multicultural Australian society, and the students are no longer homogenous, challenges to the way in which nursing students are educated and socialized into the profession are becoming evident.

The Importance of the Clinical Practice Learning Experience

Application of learning as it is described in this thesis occurs in the clinical setting. Students need to be engaged in the social, cultural and material reality of nursing, which primarily occurs in the acute care setting, with nursing constructed as a profession in Australia.

International consensus exists that the clinical placement experience is an integral part of undergraduate nurse education (Papastavrou, Lambrinou, Tsangari, & Saarikoski, 2010; Sand-Jecklin, 2009; Smedley & Morey, 2009; Chan & Ip, 2007; Midgley, 2005; Papp, Markkanen, & von Bondsdorff, 2003). This view has recently been supported by the World Health Organization (WHO, 2009), where a set of global principles for quality nurse education was endorsed. By participating in clinical practice experiences, nursing students not only have the opportunity to translate theory into practice, they are expected to work towards developing competency in nursing practice (Papp et al. 2003). The total number of clinical experience hours varies between Australian universities conducting undergraduate nursing programs. Currently there is no set requirement of minimum number of clinical experience hours, with cumulative totals across three year programs ranging from 680-1,320 hours (ANMC, 2009). For nursing educators the focus remains the development of a supportive clinical learning environment for all students where hours allow the development of competent practitioners (ANMC, 2009; Clare, Edwards, Brown & White, 2003).

Clinical knowledge is about application of information or skill from the classroom to real life practice, interactions and situations. In order to achieve this complex task, students need to develop their knowledge by utilizing the skills of problem solving, critical thinking and decision-making (Gaberson & Oermann, 1999). Real life clinical practice experience allows for this to occur. Multiple goals for the clinical practice experience can be identified from the literature and include: acquisition of technical skills; development of interpersonal skills, socialization to the informal and formal norms of the profession; familiarization with protocols and expectations of professional practice; exposure to the socio-political health care arena (Jackson & Mannix, 2001; Conway & McMillan, 2000; Chan, 1999). Furthermore, it enables the

students to become proficient in the knowledge, skills, and attributes implicit in the ANMC competencies (Williams, Wellard & Bethune 2001; Napthine, 1996).

Whilst on clinical placement, nursing students are expected to demonstrate the humanistic and ethical values of nursing that are contextually and culturally bound to the Australian health care system. The dynamic clinical environment, the changing face of health care, and current trends in staffing, challenge the way in which these goals are attained for our undergraduate students, especially those who are culturally and linguistically different.

The clinical learning environment. Concerns within the profession have been raised regarding the quality of learning on clinical placement (Henderson, Twentyman, Eaton, Creedy, Stapleton & Lloyd, 2010; Hutchings, Williamson, & Humphreys, 2005). Ever increasing numbers of student nurses in the complex hospital environment have resulted in a clinical milieu into which nursing students are thrust. Given the nature of nursing and this environment, it is difficult, even for students from the dominant culture, to learn effectively.

Research examining the quality of student placements has identified that issues such as, large numbers of students allocated to a ward where they outnumber the registered staff, allocating students to evening shifts, and the general 'busyness' of the ward impacted on the registered nurses ability to provide a quality placement as a learning buddy (Courtney-Pratt, Fitzgerald, Ford, Marsden & Marlow, 2011). Hutchings et al. (2005) study identified that clinical educators had little or no control over the numbers of students allocated to their clinical area, and that changes within the environment had not been taken into consideration when allocating students. Skill mix was an important issue that affected the learning environment, as the divergent needs of new staff, agency staff, and students clashed. When clinical areas were busy, the staff expressed anxiety over the inability to devote time to learners needs or to provide emotional support (Courtney-Pratt et al. 2011).

Eaton, Henderson and Winch (2007) supported by McKenna and Wellard (2004) suggest that the learning environment is affected by the current cultural environment of nursing itself, where students are seen as a burden, and the complex

context of nursing practice is problematic in meeting the learning outcomes for students. These issues are further impacted upon by economic rationalist approaches to health care which often result in a loss of social capital, thereby affecting the quality of clinical education.

When attempting to explore and understand student experiences of the clinical learning environment, the context itself must be examined. It is not new knowledge that the clinical environment is dynamic and demanding in nature. The addition of ICALD students who require extra time to adjust to the culture of nursing, the medical system and the culture of the patient, must impact on the learning experience. Whilst the following discussion does not differentiate between ICALD and domestic students the key points that it raises about the learning environment are pertinent to this thesis.

Students' perceptions of the clinical learning environment have attracted a lot of attention by researchers in the literature, mainly because of its significant influence on learning to be a nurse. The clinical learning environment has been evaluated from the students' perspective in Australia, and internationally, with the Clinical Learning Environment Inventory (CLEI) (Chan, 1999). The CLEI provides data on two significant issues for learning; a comparison between a student's ideal learning environment and the perceived learning environment, and the effectiveness of the clinical teacher. The scales used in the CLEI are based on human factors that are assumed to contribute to the learning environment. A number of these Australian studies concur that a student's ideal clinical placement expectations were not met by the actual experience (Smedley & Morey, 2009; Chan, 1999).

Australian nursing students prefer clinical environments that: recognise their individuality; give some flexibility within the scope of practice, treat them with respect, recognise their knowledge; encourage active participation; clearly explain tasks, and include them as part of the team. In addition, students have been shown to prefer a more personalised approach to their learning needs (Smedley & Morey, 2009; Chan, 1999). Factors that negatively affect students' perception of their placement included: being allocated evening shifts, and being employed for more than 16 hours per week while at the same time having to attend placement (Salamonson, Bourgeois, Everett, Weaver, Peters, & Jackson, 2011).

Nursing students' preference for the type of learning environment, have recently been encapsulated by the notion of belongingness. Belonging brings together the students preferences for being valued, trusted, and connected to nursing and the nursing clinical team (Levett-Jones & Lathlean, 2008). A sense of belonging has been found to encourage, motivate and sustain students in their clinical learning (Levett-Jones & Lathlean, 2008; Levett-Jones, 2007). Even in clinical learning environments that were identified as challenging or busy, nursing staff who developed a supportive relationship with students, and had a positive attitude toward them, enabled learning through the sense of belonging (Levett-Jones, 2007). Clinical learning environments that did not promote a sense of belonging in the students were found to alienate them, and therefore, had a negative impact on learning.

The model of clinical placement has also been shown to influence students' perceptions of the clinical learning environment. Edgecombe and Bowden (2009), and Henderson, Twentyman, Heel and Lloyd (2006), found that students felt more supported in a dedicated clinical education unit than in a 'buddy' or preceptor type model. Further, Edwards, Smith, Courtney, Finlayson & Chapman (2004), reported that students who choose rural placements returned higher scores for competence and confidence than students who chose a metropolitan placement. The authors commented on the socialization that occurred in and around the rural placement where the students were adopted into the community, as a possible influence on the scores.

Ethnocentrism in Nursing

Discourse related to nursing education and practice reveals ethnocentric notions that perpetuate the monocultural ideals of the past that impinge on students who are different in relation to the historical student cohorts once experienced. Examination of the notion of ethnocentrism is fundamental in developing a deeper understanding of the practices within both nursing's theoretical and clinical education. Sutherland (2002, p. 275), defined ethnocentrism as '…. a method of protecting ones cultural identity has transformed over time to mean that one's own culture is superior'. From this perspective, superiority hinders the ability to see or experience other cultural beliefs and values. Value conflicts encourage notions of superiority regarding culture, values,

and beliefs to be elicited. In using model cases, Sutherland (2002) identified that ethnocentrism is a major barrier to cross-cultural understanding in the clinical area.

Nursing in Australia is ethnocentric from the perspective, that the culture and practice of nursing is strongly grounded in western European and American tradition (Cioffi, 2001; Weaver, 2001). There is a growing body of literature that debates the applicability of western Eurocentric and Americancentric perceptions of nursing and nursing theory. The National Review of Nursing Education (Australian Department of Health & Ageing 2002), supports the reappraisal and replacement of texts that reflect the western white Anglo-Saxon principles of nursing and its practice.

The following are examples which highlight the pervasive nature of ethnocentric nursing perspectives. Nursing as a career choice for Islamic students may be influenced by the Christiancentric values that lie in the heritage of nurse education and underpin the health system (Narayanasamy & Andrews, 2000; Rassool, 2000). In China, nursing is seen as a borrowed concept from the west and little research has been conducted to identify how congruent this concept is with cultural health practices, values and beliefs (Pang et al. 2004). Chinese definitions of nursing goals, roles, and activities are informed by the nurse's cultural understandings of health rather than the theoretical foundations of the west. Shin (2001) explicated that the western metaparadigm of nursing, the basis of theory development, is influenced by the culture, philosophy, geography, environment and society from which it came. Shin (2001) points out that in order to apply western nursing theory to practice, Korean nurses had to abandon their traditional values and beliefs incorporating the philosophy of Buddhism, Confucianism and Taoism. This process was described as '….a radical paradigm shift' (Shin, p. 352). It is the goal of nursing in Korea to provide therapeutic interventions to maintain or restore harmony from within the patient and the external environment.

The profession of nursing acknowledges, through theory development that guides practice, the importance of avoiding ethnocentrism in providing care (Purnell, 2005; Campinha-Bacote, 2002; Leininger, 2002; Ramsden, 2002). When applied to nurse education, theory assists the individual nurse in realizing that the self is a cultural bearer influenced by historical, political and social interactions. What remains

unknown is how nurses themselves come to accept and perform culturally appropriate care.

Cultural Frameworks Articulated in Nursing Practice

Culture for nurses, as a significant means of coming to understand another, has long been associated with definitions offered by anthropologists. Indeed, Duffy (2001, p. 488) states that Anthropology is an enduring cultural foundation of nursing. Although many definitions of culture exist, it is true to say that any definition is influenced by the lens of the author from which it is derived. Discussion surrounding theoretical and empirical views of how culture is regarded in nursing practice is essential to any research involving ICALD students. Not only as it reflects the dominant views of the profession to differentness, but it also has implications for clinical education. Spradley (1994 cited in Spradley & McCurdy, p. 14) define culture as '….the acquired knowledge that people use to generate behaviour and interpret experience'. This broad definition may seem simple in its application here as it is context free, yet once applied in the clinical area can cause problems for students who are culturally different.

The context in which the action of nursing takes place, to whom and by whom, is imperative to understanding the appropriateness of the care provided. Implicit in this interaction is the assumption that people use this knowledge to interpret the actions of others. Therefore, the appropriateness of the care provided can be determined by both the recipient and the provider and is dependent upon their knowledge and experience. That is, appropriateness is determined from the culture of each of the individuals involved in the transaction of care. For all nurses to avoid ethnocentric health care, the emphasis on appropriateness should be determined by the recipient of that care. These frameworks are put forward as a professional expectation for all nurses, irrespective of culture, in care transactions with patients who differ from themselves.

The discourse regarding culturally appropriate care in nursing has been stimulated by the development of theories and models that attempt to guide nursing practice in this area. Theories explaining how to care for patients of a culture different to the nurse include Transcultural Nursing (TCN) (Leininger, 2002), The Purnell

Model for Cultural Competence (Purnell, 2005), Cultural Competence (Campinha – Bacote, 2002) and Cultural Safety (Ramsden, 2002).

In particular, TCN has been criticised for defining culture too narrowly, causing nurses to create fact files about patients, and ignoring individuality (Campesino, 2008; Giddings, 2005; Gustafson, 2005; Duffy, 2001; Weaver, 2001; Bruni, 1988). On the other hand, the outcome for nurses using a culturally safe frame work (Ramsden, 2002) is '… the delivery of nursing and health care that maintains a person's identity and ability to be self-determining in the context of health care and power relations' (Richardson & Carryer, 2005, p. 202). From this standpoint Polaschek (1998) equates cultural safety with the ethical standards of the profession.

These frameworks are related to providing nursing care to a patient who is culturally different to the nurse. Whilst some of them advocate a level of reflection on the part of the nurse to identify conflicts between their values and beliefs and those of the patients, there is still the underlying essentialism of western nursing practice that must be resolved in some way. These frameworks relate primarily to a nurse who is confident and competent in their practice with insight into the constructs of nursing practice. For ICALD nursing students learning Australian nursing in a multicultural population, the task of developing cultural competence or safety is complicated by their own differentness and having to adapt to the Australian nursing culture.

The Concept of Learning

Broadly speaking learning is recognized as a complex process which involves the learner being engaged in their social, cultural or material environment where new connections are made and linked to previous knowing. Importantly, the learning process involves aspects of an individual's cognition (knowledge and skills), affect (emotion and motivation) and social domain (communication and co-operation), embedded in the context of learning (Illirus, 2003). These notions are highly relevant to this thesis in that previous knowing about nursing and the role of the nurse may need to be re-learnt because of the change in context from the students' home country and culture to that of the Australian clinical context.

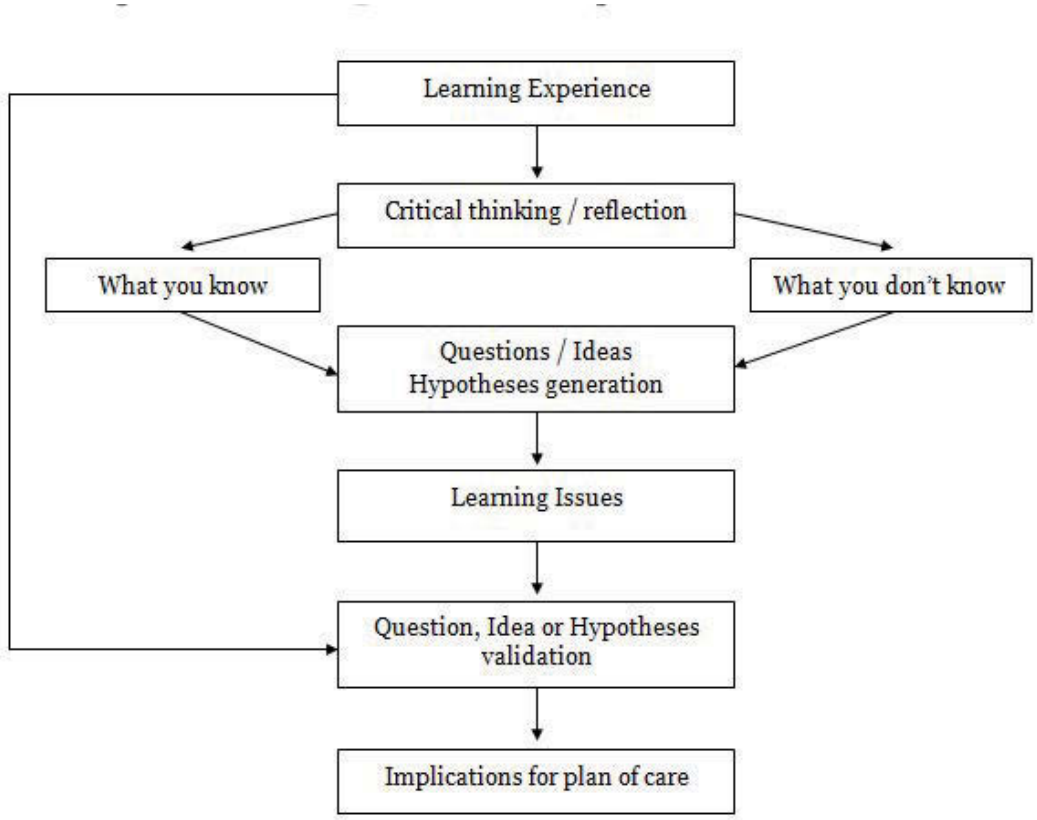
Undergraduate nursing curricula are required under university policy and from professional regulatory bodies to have a theoretical basis for the modes of teaching and learning utilized in their courses. This applied learning theory is meant to serve a dual purpose by describing how students learn, both in the on campus and clinical environments. Once the theory is articulated in the curriculum document its presence underpins and guides the teaching strategies employed to meet the learning outcomes of the course. How learning is then defined is encapsulated in the theory and is particular to that curriculum.

The current curriculum. It is important to acknowledge the learning theory used by the school of nursing that the participants are enrolled in, because of the diverse ways in which knowledge is developed and the learning that supports it. Generally, it is believed that the learning theory associated with a specific discipline, reflects its language, norms and values, to the extent that the learning becomes embedded in the way education is developed across the board (Kolb, Boyatzis, & Mainemelis, 2000; Kolb, 1981). Since nursing is a practice discipline, it is not surprising that learning theories which include an experiential component have become integral to the learning of nursing for many years (Laschinger, 1990). Therefore, students choosing to become nurses enter a learning environment that is highly specialized and therefore requires a specialized adaptation (Kolb, 2000). Articulating learning theory provides a context for learning experiences as they are conceptualized in the curriculum. However, due to the complex interplay of the learner and the learning environment, the theory may not necessarily translate in all learning spaces.

The learning theory underpinning the curriculum in the institution where the participants in this study were recruited was informed by Kolb's Experiential Learning Theory [ELT] (1984). Learning as defined by Kolb (1984) 'is the process whereby knowledge is created through the transformation of experience' (p. 38). Learning experiences, of which clinical learning experiences are one type, serve as the impetus for reflection and observation in Kolb's learning process as learning is not purely experience alone (Kolb, 1984). For students to be able to transform experience into learning they need the ability to see issues from a variety of perspectives, construct observations as theories, and then use the theories in decision making. Figure 1 illustrates the model as conceptualized by the school of nursing in the curriculum

developed for commencement in 2006 (UWS, 2006). The model explicates the processes of Kolb's model by including actual descriptions of the required abilities to complete the learning cycle, thereby turning them into tasks in a linear pattern of learning that presents a rather simplified view of learning to nurse in Australia for ICALD students.

Figure 1. *Student Inquiry and Learning Framework (UWS, 2006)*



Whilst research has been inconclusive about the learning styles of nursing students, they have primarily been categorized as concrete learners, where learning occurs primarily through actual experience (Haure, Straub, & Wolf, 2005; Stutsky & Laschinger, 1995; Laschinger & Boss, 1984; Kolb, 1981). Therefore, the inclusion of the tasks involved in learning assists both students and educators to achieve outcomes,

and reflects students as active participants in their learning (Grealish & Ranse, 2009; Stockhausen, 2005).

Learning to be a nurse requires participation in two very different learning environments on campus in classrooms, and off campus in the professional world of nursing. Learning in the professional world of nursing, the clinical practice experience, is complex in the way that Kolb (1984) explained learning complexity through four modes- affective, perceptual, symbolic and behavioural. For nursing students on clinical placement all of these modes are activated where students are experiencing how to be a professional: collecting patient information and making links to nursing care; solving problems by applying knowledge and enacting the correct procedures for delivering care. Bourgeois, Drayton and Brown (2011) believe that by participating in activities such as these, the student's interest in learning to nurse is energized. The importance of the clinical placement in learning to be a nurse where convergence of these modes occurs cannot be underestimated.

Structure of the clinical learning experience. In the current curriculum, the first clinical placement takes place late in the second semester of the first year of the program. During the preceding semester students have had both theoretical and practical instruction (in simulated hospital environments); regarding the nursing care they will be expected to perform. Typically these include: taking and recording of patients' vital signs (temperature, blood pressure, and pulse); attending to patients' full hygiene needs; applying and demonstrating the principles of aseptic technique in performing a simple dressing on a wound; performing a urinalysis (testing urine), and toileting patients. Professional communication is taught in conjunction with the clinical skills. As the student progresses through the three year course the complexity of knowledge and skill increases, culminating in a five week final placement in preparation for graduate practice.

The dominant model of clinical learning applied by the studied university is the Facilitator Model, where one facilitator is allocated to eight students in a scatter like arrangement over the available wards in the one acute care facility. There is a 'Cluster Model' where up to eight students are placed in the one ward with one facilitator who is a registered nurse employed at that facility. However, this only occurs in one large acute

care facility by special arrangement with the School. Clinical facilitators are employed on a sessional basis by the School of Nursing and Midwifery.

Clinical assessment. Currently in the undergraduate curriculum assessment in the clinical area is carried out by clinical facilitators. Clinical facilitators are accountable to four main stake holders: the university, the student, industry, and ultimately the recipient of care (Harding & Greig, 1994). Clinical facilitators are required to: be current in practice; have the ability to identify appropriate learning opportunities in the clinical environment, and possess the ability to objectively assess student performance. Inclusive in their role is the identification of students at risk of failing and the resultant interventions. Skill and competency assessment is based on the western notions of nursing articulated in the Australian Nursing and Midwifery Council competencies. Currently, clinical facilitators are not offered any additional instruction in dealing with ICALD students.

Chapter Conclusion

All students who enrol in undergraduate nursing courses bring with them a cultural heritage. The concepts presented here reveal that the most widely adopted of the theoretical frameworks related to culturally appropriate nursing care currently used in western nursing is inadequate in its conceptions of culture, and the international definition of nursing lacks cultural relativity. Therefore, alternative understandings of the practice of nursing currently have no place in the Australian clinical practice learning environment. Attitudes such as this can influence the way nursing educators and clinical staff members interact with students who are culturally different. It is also possible that clinical learning for ICALD students may not be as prescribed in the curriculum because of perpetuated ethnocentric constructions of nursing. Whilst undeniably important to competent professional practice, there remains the aspect of how these students reconcile their cultural values and beliefs related to nursing in the Australian context.

Chapter 3: A Review of the Literature

This chapter presents a review of pertinent literature with the aim of identifying what is currently known about ICALD nursing students. However, it was evident from this search that there is a paucity of research relating to this specific topic in the nursing literature. A lack of recognition for the clinical learning issues for ICALD students suggests that those responsible for designing and delivering clinical nurse education are inadequately informed about the clinical learning experience for ICALD students.

A literature search was undertaken using the Cumulative Index to Nursing and Allied Health (CINAHL), EBSCO Host-Education Research Complete, ERIC, Journals @ OVID database and PubMed, for the years 1990-2011. Initial search terms were based on key words/phrases combined with nursing students; international, CALD, foreign, and overseas born. The total number of papers from this round of searching was 455. Papers that were excluded from the review were those that presented data on or discussed the international immersion experience of on campus students, and those papers that related to post graduate nursing students. Papers that reported on international students enrolled in an exchange program of study to complete an undergraduate nursing degree were included. This resulted in 11 papers that were included in the review.

From the initial literature search it was noted that there were papers that included international students defined as English as a Second Language (ESL), or from Non English Speaking Backgrounds (NESB). A second search was completed using the same data bases and a further 71 papers were located. These papers were read and reread carefully to identify the inclusion of international students, key words as identified by authors were also helpful, and nine papers were included in the review.

A total of 20 papers are included in this review. Three themes were developed from the review: international nursing students; clinical communication programs, models, and approaches; finally clinical learning experiences.

International undergraduate nursing students

Whilst there is a wealth of literature related to the international student experience, generally from the education and psychology literature, there is a paucity of it relative to the discipline of nursing. However, it would appear that interest in international students as a particular cohort has been gaining momentum as the numbers of international students are increasing in the domestic nursing programmes of western countries, and as their unique learning needs are explicated. The papers presented in this section are from a range of countries including Australia, New Zealand (NZ), The United States of America (USA), and the United Kingdom representing countries that are currently attractive to international students.

Using a qualitative explorative approach Australian authors Jeong, Hickey, Levett-Jones, Pitt, Hoffman, Norton and Ohr (2011) designed a pilot study for the purpose of exploring issues for culturally and linguistically diverse (CALD) nursing students and their academic and clinical educators. The aim was to use the data generated to design appropriate support strategies. The 11 CALD students who participated in the focus groups were predominantly from China (n=9), although the demographic table accounted for 12 student participants. Three clinical educators and four academic staff were also interviewed. The data were thematically analyzed and four key issues were identified that were common to all three groups; English language competence, feelings of isolation, limited learning opportunities and inadequate university support.

Whilst the students felt that their language was limited and affected communication, both the academic and clinical staff felt that students were admitted to the course with existing poor English communication skills and that put them at a major disadvantage, setting them up to fail. Social isolation was described by participants in the form of rejection and discrimination. During clinical interactions discriminatory behaviour towards students was also noted to occur by academic and clinical staff. Educators reported that domestic students requested not to be teamed with CALD students for group work in the classroom, and they were rude or verbally inappropriate to CALD students in the clinical environment. However, CALD students had identified that they needed to become friends with domestic students to help

overcome feelings of isolation. The length of time that clinical educators needed to work with CALD students was identified as extensive and resulted in participants feeling that they were dismissed by educators claiming to be busy. This avoidance strategy by clinical educators denied CALD students learning opportunities. Academic staff also reported that they did not have the time available to support individual CALD students with their learning needs. The clinical education and academic staff both reported a lack of knowledge about university wide support services for CALD students and a need for personal knowledge about working with CALD students. The authors reported that as a result of the study a number of initiatives have been implemented in the school. These include: a list of support services for CALD students distributed to teaching staff; a mentoring program; and an international liaison officer for CALD students. The paper overall gave a comprehensive account of the issues and contextualized it to the Australian environment and the location of the study.

Mackay, Harding, Jurlina, Scobie & Kahn (2011), present another discussion paper that articulates the 'Hand Model' of cultural safety aimed at 'creating a safe environment for international students' (p. 14) based on the framework of Cultural Safety. The authors suggest that numbers of international full fee paying students are rising in New Zealand partly due to a cut in government funding for tertiary institutions and the need to generate income. The observed increase in international students prompted the need for a structured framework for assisting these nursing students to adjust to the social and learning environment of New Zealand. A literature review conducted by the authors identified three reoccurring themes associated with international students: English language difficulties; difficulty with the educational requirements of the host country, and problems with social integration. The teaching of cultural safety in New Zealand has been embedded in nursing programmes since 2005, being specifically designed to articulate Maori culture within the context of nursing. The five main concepts of cultural safety; awareness, connection, communication, negotiation, and advocacy are represented by the five fingers on the hand with the palm representing shared meaning. The authors suggest that the meeting of different cultures is represented in the meeting of hands. Overall, the application of the model by staff and international students is deemed to be relevant to the local New Zealand nursing context, a notion that is highly relevant given that the meaning of nursing and how it is

enacted varies from culture to culture. One drawback of the paper is that there has not been a follow up publication reporting the implementation of the hand model.

Smith, Naya and Rankin (2011) present suggestions to faculty and host institutions to assist international students adapt and adjust to the practical everyday living requirements of being in Adelaide, South Australia. This paper is presented in an informal conversational format and whilst the title 'Assisting international student's adjustment to a new culture' appears informative there is no discussion to explain the new culture. The authors attempt to address fundamental considerations that should be given to housing and food, followed by transport, social interactions and health care. The paper is lacking formal references to literature and only addresses a select few of the daily living issues experienced by international students. There is a lack of direct links with the specific needs of nursing students even though it is formulated around the international students the School of Nursing hosts. However, as a published article it is useful as a basis for further enquiry.

A mixed methods approach was taken by Junious, Malecha, Tart, and Young (2010) in their study aimed at exploring and describing the essence of stress and perceived faculty support for foreign born nursing students in the USA. Using an interpretive phenomenological design, the qualitative data were collected from focus group discussions and individual interviews, whilst the quantitative data came from the Student Nurse Stress Index (SNSI) and Perceived Faculty Support (PFS) survey instrument. SNSI measures student stress with a 22 item scale, where higher scores indicate greater stress, and PFS measures psychological and functional faculty support on a 24 item scale, where a high score reflects the level of support perceived by the student. The participants were given a $20.00 financial incentive to participate in the focus group, its follow up, and individual interviews.

The overarching theme for the qualitative data was the need for participants to be valued and accepted. This concept was underpinned by 7 themes and 25 sub themes. The highest score for the SNSI was academic load with clinical concerns ranking third after interface worries. Psychological support was identified as more important than functional support in the PFS. The psychological support item that was ranked highest by the participants was encouraging students to ask questions. As with other studies the

authors state their findings are consistent with previous studies such as issues with language, communication, and discrimination. Overall, the authors state that faculty support built into the curriculum for international students is undeniably related to student success.

Pardue and Hass (2003), reported on teaching and learning adjustments to their curriculum for Israeli undergraduate students in a RN to BSN conversion course in the USA. The adjustments were described as a two-phase process where pre-planning was followed by delivery and implementation. The pre-planning phase included an exploration of Israeli culture in relation to nursing education in Israel and nursing practice, teaching and learning structure. Preparation of faculty was noted as being an important factor. Resulting from the exploration adjustments were made to: the material that was presented such as replacing lectures with a video; extensive group work; wording of syllabus to reflect more concrete language structure, and vocabulary lists of local colloquial language. The most significant change was to the structure of the academic program where it was altered to reflect a 'block pattern' of intensive 6 day sessions rather than a standard weekly session. This was done to provide an intensity of exposure to language, context and the tutor.

The second phase of the process was the delivery of the modified program, where it was found that: time taken to accomplish learning goals was more than previously expected; that students spoke in class at the same time as the tutor, and in order to write assignments the Israeli students needed dedicated library time and orientation to technology. Interestingly, some students had never used English language key boards as they speak Hebrew. The authors state that the program required meticulous planning and engagement with course material from the host school of nursing. This paper did not explicate any clinical experience for the students, and was academically focused. However, it provided insight into the extraordinary requirements of adjusting a nursing course to only one group of international nursing students.

Sanner, Wilson and Samson's (2002) qualitative research was conducted using a naturalistic approach where they interviewed a convenience sample of eight Nigerian female students in the United Kingdom. The aim of the research was to describe international nursing students' experiences in their nursing program. With only one

type of participant in this study it would have been beneficial to state in the title the experiences of Nigerian females rather than international students. However, after analysis of the data from the interviews by Nud*ist, three themes were reported: social isolation; resolved attitudes, and persistence despite perceived obstacles. From the discussion it appears that accented speech impacted on the students' feelings of acceptance and that this definitely resulted in the students' lack of verbal communication at times. It was interesting to note that the students felt more accepted in the clinical setting, where they had to work together as a team with other students, than in classroom settings. The participants felt that they had to accept and endure what they perceived as poor attitudes from student peers, a situation in which they already had formed preconceived notions. The participants stated that they thought being persistent was the most important advice to give to incoming international students especially in coping with peer student attitudes, and combining study and clinical placements with working to financially support themselves. Finally the authors make recommendations for the support of international students that appear to be more academically focused, reflecting the point that clinical learning did not seem to be an issue for these Nigerian students. Given this, the recommendations may have been more applicable to supporting the learning of nursing for Nigerian students rather than blanket applications for international students.

Carty, Hale, Carty, Williams, Rigney and Principato (1998) discuss the teaching challenges and resultant strategies developed to address issues presented by 12 male Saudi Arabian students in an American Bachelor of Science Nursing program. The title of this paper also describes the students as international not Saudi Arabian; however the discussion is entirely focused on the students' needs as Saudi nursing students. The challenges presented in the paper can be broadly categorized as cultural, religious and professional. Cultural challenges were then related to relationships between men and women, conceptions of time and the nature of independent living. Religious challenges were related to prayer time and the role of women in Islam. Finally the nursing profession is not seen as an attractive profession for a male as it has lower status to the status of a male doctor and is therefore seen as a challenge. The strategies that were enacted to deal with the identified challenges were highly individualized to the needs of Saudi students and were characterized by efforts from staff that would be unrealistic in a large cohort of international students. For example: satellite conferences were

arranged for the participants to converse with family at home in Saudi Arabia face to face; weekly meetings with the faculty were arranged to discuss clinical and curricular issues; teaching methods were aligned to Saudi expectations; daily quizzes were instigated, and additional learning goals developed for the clinical area to reflect giving personal body care, medication administration and women's health. Interestingly, the English language level of all the students was noted as less than expected, even after close assessment of applications, and required intensive language support. It would seem that the university where the study took place had a reciprocal relationship with the university from where the students were admitted. Therefore, there was an undue pressure on faculty for the students to succeed. Although the authors identified relevant issues in respect to learning to nurse in the USA for Saudi Arabian male students the sustainability of an intensive support program and specific cultural amendments to teaching would be questionable.

Summary

The prevailing issue identified from this theme was the importance of faculty support for the success of international students. This support was most needed in relation to English language proficiency. Without clear speech ICALD students learning to be nurses experienced being ostracised, ridiculed and discriminated against by clinical nurses, peers and patients. It clearly prevented them from entering into learning opportunities especially in the clinical environment, and affected their ability to be socialized into the profession. The importance of clarity in written format for ICALD students is exemplified in the way some universities redesigned curriculum and associated teaching and learning material. However, due to the primary focus on English language proficiency other learning to nurse issues related to culture are beginning to emerge from the selected literature.

Communication Programs, Models, and Approaches

Teaching strategies and approaches related to success in clinical performance predominantly reflect the need for communication proficiency, as previously identified from the literature. Not only is verbal and nonverbal communication important in relating to patients, it is also fundamental to teaching and learning, assessment, and professional relationships (Burnard, 2005). In order to address the complexities of communication where ICALD students are concerned, a number of strategies have

been undertaken by various authors. The following review provides an examination of these and compares and contrasts approaches. The review focuses on the following; The TALES program, Clinically Speaking Program, Communication Learning Support program, Cummins Model of Language Acquisition, and the Bridging Approach.

SanMiguel and Rogan (2009) have been part of an ongoing team associated with the 'Clinically Speaking' program at a Sydney university since 2004. Their paper examines the long term effects of clinically speaking by reinterviewing 10 participants from the original program. Semi-structured interviews were used to gather data to assess whether the program had provided ongoing support in their following clinical placements. In addition, student records were accessed for academic progress and clinical assessment reports as added data. The results clarified that the program offers ESL students an *introduction* to the language of working in the clinical environment, mainly because it is only one factor in clinical learning success. The other factors identified are the registered nurses, the clinical learning facilitators, the patients and the facility it- self in terms of organization. Improvements have been made to the program post student feedback and include running 'Clinically Speaking' before the first clinical placement. Other suggestions from participants to enhance clinical learning included, more orientation time, time to familiarize themselves with their clinical learning facilitator, and repeated placements in the same facility. Finally, the authors suggested professional development for clinical registered nurses and the clinical learning facilitators in regard to teaching and learning of CLAD students in the clinical environment. Whilst this program may begin to address language issues that present themselves in the clinical environment, it only goes half way to addressing the issues. There also needs to be acknowledgement of the differing cultural aspects of nursing to truly meet the needs of CALD students.

Seibold, Rolls and Campbell's (2007) Australian paper presents the results of an evaluation of the TALES (Teaching and Learning Enhancement Scheme) programme designed to support international students enrolled in an accelerated program to adapt and assimilate into the Victorian nursing context. The program consisted of sessions held every two weeks that covered written and spoken English language and focused on clinical communication needs and professional writing. The

authors failed to explain the accelerated course structure and the Victorian nursing context. The data were collected from international students who took part in the program and consisted of three questionnaires and a focus group. Of the 20 possible participants only seven completed all three of the questionnaires, and only nine attended the focus group. There is some confusion in the paper around the actual sample as the authors state that there were 14 completing students of the original sample of 20 and do not go on to explain why the remaining six were not included. Descriptive data analysis of the questionnaires and content analysis of the focus group uncovered findings that reflected the prominent issues identified in the literature: English proficiency; communication difficulties; cultural differences, and lack of knowledge about the Australian health care system. Overall, the students rated the support program positively although the programme was not articulated by the authors in any depth. In addition it would seem that the success of the program was also measured in terms of post-graduation employment and at publication only three of the participants were known to be employed. The Seibold, Rolls and Campbell's (2007) paper also presented positive feedback about the support structure for the international students enrolled at the university where the study was conducted. The structure of the paper was confused by the concurrent aims, a lack of detail about the actual support actioned and the accelerated course structure. Both aims would have been better served in seeprate papers.

An intensive communication program with follow up clinical assessment is the approach of a program for CALD students developed by San Miguel, Rogan, Kilstoff and Brown (2006a). The aim of the program was to assist students in developing competent communication skills that would lead to a satisfactory pass for the clinical practice experience. Fifteen students who were graded as unsatisfactory for communication competency during their first clinical placement were identified and invited to participate in a trial clinical communication program. The students who were from China, Hong Kong, Korea and Vietnam were enrolled in the inaugural week long 'Clinically Speaking' program instead of completing their second clinical placement. During the program, instructors encouraged students to stage interactions with fellow students posing as patients using templates and role-play to reinforce learning. The students were also encouraged to learn medical terminology and every day

conversational language. Positive outcomes for the students included: more confidence in communicating with patient; improved engagement with patients through small talk, and improved understanding of medical terminology. Once clinical practice was reattempted by the attendees, the clinical facilitators noted positive changes in the interpersonal skills of those students. The authors recommend that communication programs such as this are conducted to improve preparation *prior* to clinical placement.

A second paper by Rogan, San Miguel, Brown and Kilstoff (2006b) reported the outcomes of the evaluation of the 'Clinically Speaking' program. Fifteen students who took part in the program attended focus groups and completed questionnaires and the researchers reviewed the student's clinical placement feedback. It would appear that the focus group questions related to how they felt before attending the program and then after the program, although the focus group questions were not explicated. Following an interpretive descriptive analysis of the data, three themes were identified: wanting to belong but feeling excluded; wanting to learn how to, and you find yourself. Overall the paper presented data on how the students felt whilst on clinical and how they had improved after the 'Clinically Speaking' program. Generally all participants felt that clinical placement was difficult, however on completing the program felt that their knowledge and understanding of the expectations around communicating in the Australian clinical environment were improved. The students' perceived improvement was reflected in a more positive learning experience.

Yoder's (2001) American research, describes in detail the 'bridging approach' method of teaching, with a focus on educators broadening their sensitivity to diversity rather than the student conforming. The suggestion of an approach such as this supports the methods for dealing with diversity in the classroom now evident in many Australian tertiary institutions. The aim is to aid students in preserving their cultural identity and to operate biculturally in the nursing environment. Although it does not specifically address the issues CALD students face on clinical practicum, the discussion is easily transferred to the clinical setting. The authors assert that the underlying philosophy of the bridging approach promotes cultural pluralism in the classroom and ethnic sensitivity in the clinical arena. In addition, it highlights the need for diversity in nursing faculties. In-depth interviews of 26 nurse educators and 17 nurses involved in

student nurse education were conducted with the aim of uncovering approaches in education for ethnically diverse students. All participants were identified as having a cultural heritage different to the main stream Anglo-American. The author identified that the teaching process was significantly enhanced by the cultural awareness of the educator. That is, they identified with the students because most of them had similar life experiences. They also understood their students' cultural frames of reference related to nursing concepts. The four major teaching strategies employed by bridging educators are: incorporating the student's cultural knowledge; preserving their cultural or ethnic identity; facilitating and negotiating barriers, and advocating for a system of change. Application of this approach can occur in both the clinical and the academic setting. Outcomes for the students of this approach included: enhanced ethnic identity and self-esteem; validation of their concerns; and a comfortable learning environment. Faculty reported that their teaching effectiveness increased because of the incorporation of students differing worldviews.

Theoretical discussion related to the Cummins Model of Language Acquisition is provided by Abriam-Yago et al. (1999). To meet the learning needs of the increasing numbers of ESL students across American schools of nursing, nursing faculty are urged to re-evaluate their teaching strategies. Abriam-Yago et al. (1999) suggest that by incorporating conceptual frameworks such as Cummins Model of Language Acquisition, faculty can improve their teaching and promote positive ESL student outcomes. The Cummins model is based on two types of language proficiency, basic interpersonal communication skills, and cognitive academic language proficiency. Both types are considered with a strong emphasis on context, and both are required in the clinical learning environment. Educational research stated by Abriam-Yago et al. (1999) suggests that ESL students take up to two years to attain basic interpersonal skills, and five years for cognitive academic language proficiency. These extensive time frames occur due to the higher level of language analysis, synthesis and evaluation required in differing contexts. Time to acquire language proficiency is significant for the nursing profession, given that newly graduated nurses in Australia are expected to 'hit the ground running' at the completion of their three year program. The authors describe and explain how context impacts on the level of language required. For example, the context reduced/cognitively-demanding situation of the class room

environment differs to the context embedded/cognitively-demanding situation of the clinical learning environment. Having faculty who employ teaching strategies such as: modelling the use of texts and resources; preparing individual learning objectives related to communication; providing bilingual and bicultural opportunities, and academic who staff can move between the contexts of the classroom and the clinical learning environment to enhance learning and participation by ESL students. Due to the theoretical nature of this paper, it is less specific in application to the research reported in this thesis.

Hussin's model of learning support (1999), titled 'From Classroom to Clinic' was an Australian study that can be compared with the San Miguel et al. (2006) study. Fifteen volunteer students were involved in the program, however, no other details or demographics are provided. Five levels of support are discussed in the paper: professional development of faculty; workshops for students prior to and following clinical practicum; individual consultation; onsite supervision of 'at risk' students; and online learning materials. All staff was involved in a workshop that addressed culturally based learning styles, attitudes towards authority, respect and the role of the student on clinical practicum. A significant difference from the San Miguel et al. (2006) study was the inclusion of clinical education staff. The students were involved in two workshops which focused on communicating with patients, communicating with staff and debriefing. Methods used included role-play, case scenarios and case studies. Positive evaluation by the students occurred in both papers, although Hussin's (1999) conclusions only highlighted the clinical placement success of one 'at risk' student, and did not elaborate on the other fourteen. Finally, Hussin (1999) makes recommendations for further research to improve clinical practice success for NESB students. Hussin recommends focusing on how implicitness is incorporated in the giving of instructions to students, and an exploration of the interpretation of assertiveness through the power relationships evident in the clinical environment.

The 'Nursing SPEAK' program reported on by Brown, Mannion and Thompson (1999) occurred in an Australian university and was run as a 14 week off campus course aimed at students developing the ability to: identify their own communication problems; improve verbal and non-verbal communication skills, and

improve active listening and improve confidence. The authors assert that broad brush stroke language programs offered by universities only address some of the issues for international students and the need for expressly nursing focused context based communication is essential. Various techniques were employed by the tutors reported in the paper including goal setting, journaling, videotaped interactions, telephone etiquette, working with different cultures, ages and gender, debating and presentations. The authors gave detailed explanations of each week only up to week 7 in the program. The authors acknowledge the commitment of the participants, however it was noted that they had not considered the nursing culture or knowledge of nursing of the participants. Having recognized that the participants were just that, participants, the cultural influence of individual students was not addressed.

McCausland Kurz (1993) pointed out the many issues confronting adult ESL students in the USA in what appears to be a literature review although that intention is not expressively stated in fact, nor is the aim of the paper. The author identified that nursing programmes across the USA are accepting ESL students, who she refers to interchangeably as either non-traditional or minority, because of low domestic enrolments. Teaching strategies such as allowing students to record lectures and handing out printed notes, role playing and review of video interviews with students and lecturers, were suggested for enhancing on campus language learning. Whilst on clinical placement educators were encouraged to pair an ESL student with a domestic student to improve the chance of conversation. Lecturers themselves were urged to familiarize themselves with the diversity of cultures in their classrooms and to use a game called ‘BaFa BaFa’ as a way of simulating cultural experiences. This game is not explicated in any depth. Overall this paper adds little to the literature review as it stands in 2012; however when the paper was written it may have had some influence in directing the language learning experiences for ESL students.

Summary

The literature presented in this theme has identified the need for comprehensive understanding from all involved in clinical communication. Appropriate communication in relation to safe patient care, teaching and learning, assessment, and relationships with clinical staff and facilitators, is of utmost importance. On campus language support needs to be reinforced in the clinical environment by exposure to

medical terminology, and everyday language. It was interesting to note that the papers discussing English language support programs did not present evidence in the form of research or theory from linguistics to support their models. There was no best practice discussed in any of those papers, neither did they include an examination of the structure of the language they were asking students to learn. In addition there was no contextual introduction to the language of nursing relevant to the country in which the students were studying, nor a discussion related to the competency standards expected in relation to the nursing profession. Overall it can be seen that students benefit from additional language support related to clinical nursing however, authors presenting their methods need to contextualize the profession and its language.

Clinical Learning Experiences

Clinical practice experience or the professional practice experience as it is more contemporaneously known, at the undergraduate level is essential for the development of competent Registered Nurses. Exposure to the reality of professional practice, its integration of explicit and tacit knowledge, and a focus on nurse-client interaction is invaluable in producing skilled clinicians. However, learning to be a nurse is context and culture dependant as well as language dependant. The papers below explicate issues relating to learning to nurse for international students in the clinical environments of Wales, Finland, United States of America (USA), and Australia.

De (2010), presented findings from an action research study conducted in Wales with the aim of establishing whether ethnicity was linked to discrimination in the clinical environment. Using focus groups and a questionnaire to collect data from 13 international students and 12 domestic students to compare results, De found that the international students, (Chinese, Nepalese, Indian, Iranian, Nigerian and Trinidadian), reported more incidents of unfair treatment and felt more racially abused when compared to the domestic students (Welsh Caucasian). The international students reported being called foreigners, second class citizens, and poor country folk. One student had a patient refuse care because she was black. Refusals came mostly from older patients. Four of the international students felt racially abused. For the domestic participants unfair treatment was in the form of being punched or sworn at by a patient, however the students did not take the issue personally or describe it as racial abuse. Overall, the author felt that because of these negative instances, care giving by the

international students was affected, as demonstrated by avoiding communication with the patient, and feeling nervous and frightened. The small sample size was a drawback of this study although the findings do alert faculty and clinical educators to the issues for students who do not look like the expected domestic student. The discussion located the findings within the literature about discrimination in the broader National Health System; however it was fairly superficial in its exploration of the racial findings.

African and Asian undergraduate nursing students in Finland were the participants in a qualitative study by Mattila, Pitkajarvi and Eriksson (2010), where the purpose was to describe the students' experiences of clinical practice in the Finnish health care System. A total of 14 students participated in semi structured interviews that were analyzed using inductive content analysis around two themes; positive and negative experiences. Positive experiences were related to the initial orientation to the ward where expectations were clearly explained, staff made the students feel welcome, students were able to use dictionaries, working independently was encouraged, and the students felt accepted as part of the team. Negative experiences included restricted learning opportunities because of language difficulty, students felt they were ignored or left out because they did not understand Finnish, being prevented from higher order roles such as medication administration, and mistrust between staff and students and patients and students. Some students were called names and patients refused to shake hands or be cared for by them. These actions made the students feel scared, stupid, and intimidated and produced poor self-esteem. In response the students gave up engaging or alternatively they became even more determined by developing strategies to overcome the negative experiences. The findings of this study concentrated on the effect of language differences and the effect of student support in the clinical environment. Importantly, no issues around culture or the provision of nursing care that were culturally different or posed challenges to the students were identified. This may be due in part to the type of semi- structured questions that students were asked.

The unique challenges and needs of culturally diverse nursing students in the United States of America (USA) are the focus of the work by Davidhizar and Shearer (2005). Their discussion paper offers an explanation for these challenges in relation to the process of acculturation. Acculturation is defined as the process of adjustment to

living in a dominant culture whilst maintaining cultural identity (Bonvillian, 2006), thus presenting a wider sociological understanding of the student's experience. The authors suggest that the length of time a culturally diverse student has spent in the USA correlates with need for learning support, the longer a student has been resident in USA the fewer are their learning support needs (Davidhizar & Shearer, 2005; Ladyshewsky, 1996). Once again, communication, specifically medical and nursing language, is highlighted as an area that requires positive reinforcement. Culturally specific meanings of time, space, social organization, and environmental control are all identified as factors that impact on clinical performance. Time orientation in cultures such as the USA and Australia refers to clock time, and its interpretation can affect performance such as in timely attendance to class or clinical placement and the submission of assignments 'on time'. Space refers to personal space and varies with each culture. As personal boundaries expand or contract ppersonal space may become an issue on clinical placement in regard to the need for close contact with patients in the provision of nursing care. Social organization includes the process of decision-making in families, attitudes to the opposite sex and values relating to social class. Lastly, environment control involves the extent to which the individual has control over their fate. The personalized approach to addressing these issues requires specific individual interventions and evaluation (Davidhizar & Shearer, 2005). The authors advocate for assessment for culturally unique needs of individual students, and provide a proforma that may be used by faculty to record this data.

Qualitative research conducted in Australia by Shakya and Horsfall (2000) offers some insight into the learning experiences of nine undergraduate nursing students from six non-English-speaking countries, three of which were identified as being international students. Their learning experiences are related to both theoretical and practical components of undergraduate nurse education. The researchers used a qualitative design based on Van Manen's hermeneutic phenomenological framework. The themes constructed were listed under two broad categories challenges and supports. Challenges were identified as being language (specifically technical aspects of language, speaking and listening, and interaction in tutorial groups), perceptions of ethnocentrism and inadequate orientation. Challenges were demonstrated to influence the student's individual confidence, interpersonal communication and academic

success, all of which cause some degree of stress to the student. Support was reported as being found from within the university, peers and family, and personal strengths and strategies. Access to support structures within the university, such as learning support, and counsellors assisted students in resolving academic issues and overcoming personal difficulties. Students also identified the importance of spiritual guidance for inner strength and maintaining motivation. A weakness noted in the paper was that the participants were all female and that all students were classed as international in the discussion.

Shakya and Horsfall's (2000) study provided discussion relating to clinical practicum in the following way. It showed that language is important when establishing a relationship with the clinical facilitator to make the practicum meaningful, and that clinical placements are more difficult for ESL students because of this. Although the impact of values and beliefs regarding nursing for ESL students was briefly mentioned, this was not translated into the clinical environment.

Summary

Clinical learning experiences for international students have been found to be more difficult and stressful, than for domestic students, primarily because of language proficiency. This issue is not solely located within the English speaking countries as demonstrated by the study from Finland. International students have reported instances of discrimination and feelings of low self-esteem that in turn impact on their ability to learn in the clinical environment. So far the ability to carry and use a dictionary is the only language support explicated for use in the clinical environment. However, students feel that extra time to adjust to the clinical environment and a more personalized approach to learning support would be beneficial. A more personalized approach would not only entail a close examination of their language learning needs but also the learning needs relating to the nursing culture relevant to the host country.

Chapter Conclusion

The literature review has made the following salient points. Those students who are different to the mainstream domestic student, experience educational obstacles that impede their success both theoretically and practically. The work presented here has

revealed that much of the current discussion has focused on problems with language and communication. The major issue identified is that international students are not adequately prepared to enter the clinical environment and successfully engage in personal and professional communication. However, many programs and strategies exist with no one of them being identified as superior or adopted as best practice. Theoretical and clinical learning experiences are identified as more difficult for international students because of language, and ethnicity. Of high importance is the impact of the clinical milieu on all undergraduate nursing students' performances. Particularly for those students coming to terms with studying in a different culture, learning to communicate effectively in a different culture, and learning how to nurse in a different culture. Whilst communication and language remains undeniably important for competent professional practice, there remains the aspect of how these students reconcile their cultural values and beliefs related to nursing in the Australian context.

Chapter 4: Research Design and Method

Designing research is an intricate process of locating a research question and aligning it with an appropriate framework to eventually produce a worthy contribution to knowledge within a specific discipline. This chapter presents the research question, describes the research paradigm and the method for the study articulated in this thesis. In providing the decisions undertaken during the research process, it is the intent of the researcher to provide evidence of the auditability of the work (Lincoln & Guba, 2007).

The Research Question

The research question was devised after consideration of the existing literature around the research problem. Thorne (2008) asserts that this is a worthy basis for locating a research question within the existing knowledge. It was found that there was a paucity of literature related to the actual experiences of ICALD students learning to nurse in the clinical environment. The literature review served its purpose to ground the study in the existing knowledge for all students of nursing (Thorne, 2008). The evident knowledge gap prompted the question:

What is the nature of learning to nurse through clinical practice experience for international culturally and linguistically different nursing students in Sydney, Australia?

Explicating the term nature. The construction of the research question needs to reflect the: the aims of the study; the theoretical allegiances, and the method of the study. Strategically in this research '…the nature of a thing is internal to it accounts for its functioning or development '(Maunter, 2000, p. 372). By using the term nature in this way it allows for the researcher to come to an understanding of what is internal and accounts for the development of learning to nurse in the Australian clinical environment for ICALD students.

The overall aim of this study is to come to an understanding of how these ICALD students learn to nurse in the Australian clinical context. This understanding will be facilitated by meeting the following research objectives:

- Explore the meaning of learning to nurse from the perspective of ICALD students.
- Describe the preconceptions ICALD students have about nursing roles and responsibilities.
- Suggest how these preconceptions and meanings affect learning and student performance in the clinical environment.

Qualitative Research Design

To declare a research design 'qualitative' is to essentially inform the reader that the study will focus on *qualitas* or an observation of things in the world (Lapan, Quataroli, & Reimer, 2012). It also serves to inform the reader of the way in which the researcher has chosen to know the world. The qualitative researcher rejects the assumptions that the world is orderly and predictable and therefore controllable, and that there is a clear separation between the knower and the known (Garrick, 1999). In rejecting those assumptions the qualitative researcher accepts that, cause and effect are mutually interdependent, objectivity is clouded by the humanness of participants, and that the world is constructed of multiple complex realities (Garrick, 1999).

Underlying qualitative research is the basic premise that knowledge is developed from an emic view or insider's perspective (Streubert & Carpenter, 2010). From this perspective, the researcher works with participants in order to understand human behaviour within a certain context. Close attention to the life world, or everyday experiences of the participant uncovers the influences that impinge on human thought, speech and action (Angen, 2000). The qualitative researcher undertaking a study interprets individual descriptions of experiences to come to a deeper understanding of the question at hand (Denzin & Lincoln, 2005). Understanding is generated from the interpretive process, as individuals live in constant interaction with people and things (Angen, 2000).

Interpretive Description

Interpretive description was developed by Thorne, Reimer Kirkham and MacDonald-Eams (1997) as a noncategorical qualitative methodology that could provide new knowledge to the discipline of nursing whilst maintaining the necessary rigour to ensure credibility (Oliver, 2011; Hunt, 2009; Thorne, Reimer-Kirkham &

O'Flynn Magee, 2004). The development of interpretive description was necessitated by the perceived 'methodological boundary pushing' of nursing scholars utilizing more traditional research approaches that did not quite fit their research questions (Thorne et al. 2004; Thorne et al. 1997). The rationale for interpretive description as stated by Thorne et al. (2004, p.3) is to '….provide a grounding for the conceptual linkages that become apparent when one attempts to locate the particular within the general, the state within the process and the subjectivity of experience within the commonly understood….'. As such Thorne (2008) asserts that it moves beyond mere descriptive research, and beyond the self-evident.

Moving beyond the established methods of qualitative description is achieved by combining inductive analysis techniques with interpretive perspectives (Thorne, 2008; Thorne et al. 2004), resulting in a research product that consists of an interpretation of themes and patterns within subjective perceptions that is '….believed to characterize the phenomenon….' (Thorne et al. 2004. p.7). These characterisations are then capable of informing practice not as new truths but as a 'tentative truth claim' (Thorne et al. 2004.p.7), articulating and describing individual variations of the experience that can be used to generate understanding.

Interpretive description was chosen as a methodology to inform this professional doctoral study specifically because of its expressed relationship with the clinical environment and the need to apply the findings to the social, political and ideological issues in that context. The doctoral portfolio is designed to '…. shift the angle of vision….' (Thorne, 2004, p.50) about ICALD students learning to nurse in the Australian clinical context.

Scaffolding the Study

Thorne, Joachim, Paterson & Canam (2002) assert that explicating the research frame is vital to comprehending why a study develops in a certain way, and then in ascertaining how it contributes to the field of knowledge. The research frame is termed by Thorne (2008) as 'scaffolding the study'.

The research scaffold used to develop this study supports the notion that all student nurses come to the study of nursing with preconceptions, experiences

and beliefs about the role of the nurse that have been formulated from their own life experiences. Thorne (2008, p. 64) suggests that there are three important elements to the research scaffold:

1. locating theoretical allegiances
2. locating the researcher in the discipline
3. locating the personal ideas the researcher holds.

An overview of these important elements is provided in the following discussion.

Theoretical Allegiances

In developing a study design it is imperative for the researcher to know and understand the research paradigms influencing the construction of the work. The design, implementation, and outcome of the research process are an interaction between the researcher and his/her inquiry paradigms (Denzin & Lincoln, 2005).

The constructivist paradigm. A paradigm is defined by Guba and Lincoln (2000) as the basic belief system or world view that guides the researcher not only in method but in ontological and epistemological ways. Constructivism offers a framework for thinking about the nature of social life and interaction. For constructivists, understanding how things are put together and how they occur are not mere description. The understanding of knowledge from a constructivist perspective is that it is a social construction, and cannot be separated from the knower (Baxter Magolda, 2004; Jacobson, 1998; Denzin & Lincoln, 1994). Further, that meaning is acknowledged as being generated from experience and interaction in a particular culture and is, therefore, context dependant.

The notion of truth for the constructivist lies in the personal perspectives of the participants, from the meaning they attach to their own experiences which are intangible mental constructions. Because of this intangibleness of what is known by the participant, the findings in constructivist informed research are created between the knower and the researcher (Thorne et al. 2004; Thorne et al. 1997). Mills, Bonner, and Francis (2006) describe the interaction between the researcher and the participant as a ‘give and take’ of information that elicits deep, reflexive and ardent knowledge.

Essentially knowledge is constructed not discovered (Finnemore & Sikkink, 2001; Jacobson 1998; Denzin & Lincoln, 2005).

The ultimate aim of research in this paradigm is to understand the constructions of the participants and the associated social, political, cultural, economic, ethnic, and gender influences (Denzin & Lincoln, 2005). The philosophical foundations of the constructivist/naturalistic paradigm are articulated by Thorne et al. (2004) as essential to research designed using interpretive description.

Locating the Researcher in the Discipline

To 'do' interpretive description well the researcher needs to make explicit the disciplinary grounding or frame for the research. This has been established in the previous chapter where nursing was described as being a socially constructed concept. Firstly and importantly, the researcher needs to assert his/her position of influence on the work at hand (Thorne, 2008; Koch, 1999). Further, that the position of the researcher to the question and the investigation needs to be clearly articulated as the interpreter of the work. Koch (1999) suggests that this type of personal scrutiny will heighten the researcher's own self-awareness in the interpretation of the reality of others.

The position of the researcher. Nurses define the profession, its philosophies, and the body of knowledge in regard to the culture in which it is practiced. Having been born and educated as a nurse in Sydney, Australia I consider myself an Australian nurse. In this sense I, as author of this thesis, must position myself as white, female, Anglo-Irish, Christian, heterosexual orientation with a middle class socio-economic background. As such I fit the historical stereotype of the Australian 'nurse'. As such nurses who have different colour skin to me, speak a different language to me, practice different religious beliefs to me, and possess different health care beliefs and practices, are *different* from me. They are the visible change in the face of nursing, and I of course am *different* to them.

Constructs of the researcher. In my role as a university lecturer I present information and stimulate discussion with students about nursing and how it is positioned in Australia both as a caring practice and as a profession. I am also the current Deputy Director of Clinical Education, where I am called upon to advise clinical

educators on the progress of students learning to nurse in the Australian clinical environment. In the dual roles of on-campus educator and clinical advisor, I usually find myself returning to the frameworks for professional practice set down by the professional bodies here in Australia as an explanation or a justification for the many issues that present in the learning of nursing here in Australia. I am constrained by them as outcome measures for students. However, I have little knowledge as to how ICALD students individually negotiate achieving compliance as an Australian nurse.

Method

In order to answer the research question, the following components of a qualitative method were chosen.

Setting. The university from where the participants were recruited is located in the greater western Sydney region and in 2008 when the study began had a student body of approximately 28,600 students cross 4 campuses (Office of the Vice Chancellor, 2011). The School of Nursing and Midwifery at this university is the largest provider of undergraduate pre-registration nurse education in Australia.

Population. At the time of data collection Bachelor of Nursing programs were offered at 3 campuses in western Sydney with in excess of 2500 students enrolled in 2008. International students accounted for approximately 12% of the student cohort at the time the data were collected. The university admitted students wanting to study nursing to two different programs. These programs were, the Bachelor of Nursing, a three year degree and the Bachelor of Nursing Graduate Entry, a compressed 2 year program for students who possessed an undergraduate degree in a health science related field.

Sample selection. A purposive sampling technique was chosen to select participants who had already been exposed to learning in the clinical environment at least once in their study so far (Streubert & Carpenter, 1999). Because the study is about international culturally and linguistically different students studying nursing here in Sydney, Australia it was important to ensure that the students came from an appropriately located university, were international students, and had clinical learning experience in the form of attending at least one clinical placement. International

students hold a student visa and therefore come to Australia for the purpose of study. After their first clinical practice experience students will be able to relate their preconceptions of nursing to the real life expectations of learning to nurse in the Australian context. Therefore the following inclusion criteria were formulated to assist in the purposive sampling:-

- Hold a current student visa and be enrolled in a Bachelor of Nursing Program at the university.
- Have completed as minimum their second or third semester of study, and have completed at least their first clinical practice experience.
- Home country must have an official language other than English and have a culture not dominated by Anglo-Celtic influence, thus eliminating the possibility of prior enculturation.

Choosing participants who had at least one clinical learning experience was essential to meeting the needs of the study even though the extent of their experiences cannot be known until data collection has begun (Thorne et al. 1997). In using a purposive technique, Thorne (2008) asks researchers to be mindful of ensuring that the sample includes appropriate groupings so as to ensure that the data is as complete as possible. At the time of data collection the international student cohort comprised male and female students from the world regions of South & Central Asia, South-East Asia, Chinese-Asia, Japan & Korea. Smaller numbers were identified from Africa, The Middle East and Polynesia. Table 1 provides an overview of participant data that reflects the major areas of the world identified in the overall cohort.

Table 1. *Participant information*

Participant	*Country of Birth*	*Language*	*Age*	*Sex*	*Year*	*Interview*
Felisa	China	Mandarin	23	F	2	81 min
Lyn	Zimbabwe	Shona	23	F	3	46 min
Mi Mi	Poland	Polish	27	F	2	72 min
Angela	China	Mandarin	22	F	3	59 min
Jane	India	Tamil Hindi French	27	F	3	75 min
Cheska	Philippines	Tagalog Mandarin	29	F	2	42 min
Zara	Iran	Persian	40	F	3	39 min
Manoj	India	Punjabi Hindi	27	M	3	44 min
Phoebe	China	Cantonese Mandarin Local Dialect	27	F	3	49 min
James	Butan	Hindi Asanese Maharati Bengali Sherdukpen	31	M	3	70 min
Amy	China	Mandarin	24	F	3	63 min
Jin	China	Mandarin	20	F	2	28 min
Irene	Taiwan	Mandarin	30	F	3	66 min
Milky	China	Mandarin	24	F	3	73 min
Yvonne	Nepal	Nepalese Hindi	27	F	2	37 min
Louisa	Philippines	Tagalog	31	F	2	65 min

Participant recruitment. The 300 international students identified as being enrolled in the two nursing programs were contacted by email sent to their student account and invited to participate in the study. The emails were sent by a member of the university professional staff familiar with the international cohort and not by the researcher so as to keep the students contacted as anonymous as possible.

In a qualitative investigation such as this it is difficult to predict the size of the sample prior to the study. In the initial stages of the study design, data saturation or redundancy was proposed to determine the end of data collection. Originally it was anticipated that the sample required to reach data saturation would be 10-15. However, the process of recruiting participants was long and protracted. Initial emails were sent in April 2008. Responses were slow and a second and third round of emails did not result in data saturation. Snowballing or asking the students to recommend their friends to the study was also ineffective. After the fourth and final round of emails in April 2009, it was decided between the researcher and supervisors that a representative sample of participants, that included students from the main world regions contributing to the international student population would be preferable to data saturation. Thorne (2008) suggests that when using interpretive description that there is no exact number of participants required, that it is up to the researcher to determine that the data formed is coherent, defensible and sufficient in scope to discern commonalities and patterns.

One possible explanation for the students' reluctance to participate in the study could have been their mistrust of the confidentiality of the process. Another reason could be that the participants who did come to be interviewed revealed deep personal information that included feelings and cultural values and beliefs. It could have been that they did not wish it to be known that they had participated, that they wanted to remain anonymous to their group of friends and to the process.

Data collection. Individual semi structured interviews were conducted, by the researcher with each participant to elicit a full and rich description of the meaning of learning to nurse in Australia for these students.

Semi-structured interviews are commonly used in qualitative research designs, and are described as having a sequence of themes to be covered as well as suggested

questions. The interviewers themselves remain open to the possibilities of exploring salient points that are alluded to during the interview (Minichiello et al. 2000; Morse & Field, 1999; Kvale, 1996). It is acknowledged that in conducting a semi-structured interview, the conversation between the interviewer and the participant is an exchange between two people about a subject of interest to both of them, which generates knowledge.

Using an interpretive framework, the semi structured interview offers depth in the data. An interview guide was developed by the researcher to assist with reminding the researcher of what needs to be discussed in the interview. This is what Thorne (2008) describes as having a healthy respect for the context, to not get carried away in the background information, and to know what is data and what is context. The guide included general themes or topics that meet the aims of the study and that are central to the research question, for example:

> What were your ideas about nursing before you began studying here in Australia?
>
> Why did you come to study nursing in Australia?
>
> What is the reason that you think nurses do /don't do that?
>
> How do you learn in the clinical environment?

The interview guide was not followed word for word in each interview as the individual nature of the content of each interview allowed the researcher flexibility to explore different issues. In addition, the interview guide was not shared with the participant to allow for the spontaneity in data generation.

The interviews lasted for an average of 56 minutes. The majority of the participants spoke with heavy accents which meant that the checking of meaning was concurrent with the data collection. This was necessary as the grammar, sentence structure and word choice of participants often made it difficult for the researcher to understand meaning. In addition if the participant became excited or upset during the interview, understanding was also affected.

The participants were asked if they would be available for follow up contact to check their transcripts, all participants were happy with the clarification during the

interview and the summary at the end and did not wish to be sent a transcript. Rather, some suggested that they would wait for a publication. This type of validation, member checking in context , has also been used by Parker (2006) and Milne and Oberle (2005) who suggest along with Sandelowski (2004) that participants can often forget what they have said or the findings become unrecognizable to the participant after analysis so that standard means of validation of the data become problematic. It was also highly unlikely that participants would respond to an email asking for validation of their interview since it was so difficult to recruit in the first instance.

The individual interviews were digitally recorded and transcribed. Verbatim transcription was carried out by the researcher to create a text for analysis. Morse & Field (1999) state that it is imperative that the interview is transcribed word for word and not paraphrased, and all expressions, such as laughter or crying noted in the transcript. During the transcription of the voice files, care needed to be taken as the spell check mechanism on the computer would want to correct the grammar of the response and thereby change meaning. In addition, slowing or speeding the voice file was not beneficial to transcription. The reason for this was mainly because the participants' accents affected the pronunciation of individual words and phrases, and words would become lost or miss-heard. This would essentially change the meaning of the response. The transcript was then checked and rechecked against the recording for correct language and accuracy of transcription.

As an additional source of documentation a journal entry was kept for each interview. These journal notes consist of the experiences, thoughts and reflections of the interviewer on each of the interviews. These notes became important as having digitally recorded the interview; it was not possible to review the context in which the interview had taken place, or to recall observed body language. These written impressions of the interview aided in providing a full and accurate account of each encounter. In addition, the journal entries were used reflect on how the session went and endeavors to improve the questioning technique for the next participant were made.

Typically, questions I asked of the interview process were:

How could that interview have gone better?

How could that question have been phrased better?

Did I use appropriate language for the participant?

What did I learn from that interview that I could take to the next to explore?

This reflection on each interview also allowed for development of the data as the interview process evolved.

During the data collection phase of the study at times I found myself responding as a mentor, an academic or as a concerned friend based on the type of response the participant gave to my question. Thorne (2008) accepts that this type of 'stepping out of role' happens due to the inherent nature of the interview and the relationship between the researcher and the participant. It is the remit of the researcher to then review those parts of the interview and to decide if they are appropriate for use in the study.

Data Analysis

Data analysis in a qualitative study is a 'hands on' process, requiring the researcher to become immersed in the data itself (Streubert & Carpenter, 1999). By explicating the steps taken in the analysis the researcher provides an audit trail that contributes to the credibility of the findings (Thorne, 2008).

A thematic analysis of each transcribed interview was conducted by the researcher. Prior to attempting analysis a significant amount of time was devoted to reading, and re-reading the transcripts to develop a sense of the data. Thematic analysis was informed by the work of Thorne et al. (2004) where the data are not so much coded as they are inquired of. The importance of data analysis in interpretive description is the analytic process rather than the technique.

Step 1. Questioning the data. The first step in the process involved asking four questions of each whole response from a participant. This was the preferred method rather than a line by line, or word by word coding which as suggested by Thorne et al. (2004) can affect the researcher's ability to see broad patterns. Those four questions asked of the data were:

1. What is happening here?
2. Why is this here?
3. Why not something else?
4. What does it mean?

It is suggested by Thorne et al. (2004) that by engaging in the intellectual process of questioning the data the researcher is able to focus on moving among and between the pieces of data, therefore, the contextual nature of the data remains intact.

By inquiring of the data 'What is happening here?' I was searching the response for an overall orientation to meaning. Is it an interaction between student and patient? Is it a description of a misunderstanding? Is it an emotional response?

In progressing to the second question 'Why is this here?' The intent is to question the influences and background on the response.

The third question, 'Why not something else?', consciously engaged and challenged me to think outside the immediately obvious, to examine a contrasting perspective.

The final question necessitated me to combine and examine the results of the other three questions to formulate a meaning unit for that response. My thoughts on each of the questions were noted on the transcript itself so that I could refer to the actual data if required to check my understanding.

By questioning the data, in the way described above, my perspective on the possibilities of meaning broadened. The application of these questions in the analysis enabled a thoughtful and deep engagement with the data and helped to avoid a 'smash and grab' technique of breaking down, analyzing and synthesizing a whole transcript in a short period of time. The eventual outcome was a set of meaning units that presented examples, variations, and contrasts that were used to identify patterns.

To further aid in attending to patterns in the data, or inductive imagining (Thorne, 2008), NVivo software (Bazeley, 2007) was used to store each meaning unit and print out a collection of characteristics that could be visualized and sorted.

Step 2. Deciphering patterns. The next step in the process was to gather all of the meaning units and begin to search for patterns in the data. This stage is what Thorne (2008) called 'from pieces to patterns'. The overall number of meaning units generated was overwhelming because the analysis had generated many complex conceptualizations. Some of these meaning units obscured the specific nature of learning to nurse on clinical in Australia for ICALD participants. In an attempt to provide clarity, it was necessary to separate them to provide a clear understanding. Thorne (2008) refers to this as interrogating the data to decide what best serves the research question and what does not. Consequently, the data were separated into the commonalities of the clinical learning experience noted in the literature for all nursing students, and those that appeared to be specific to the ICALD student. Dividing the data in this way reflected the orientation of triangulation with the existing literature (Anfara, Brown, & Mangione, 2002).

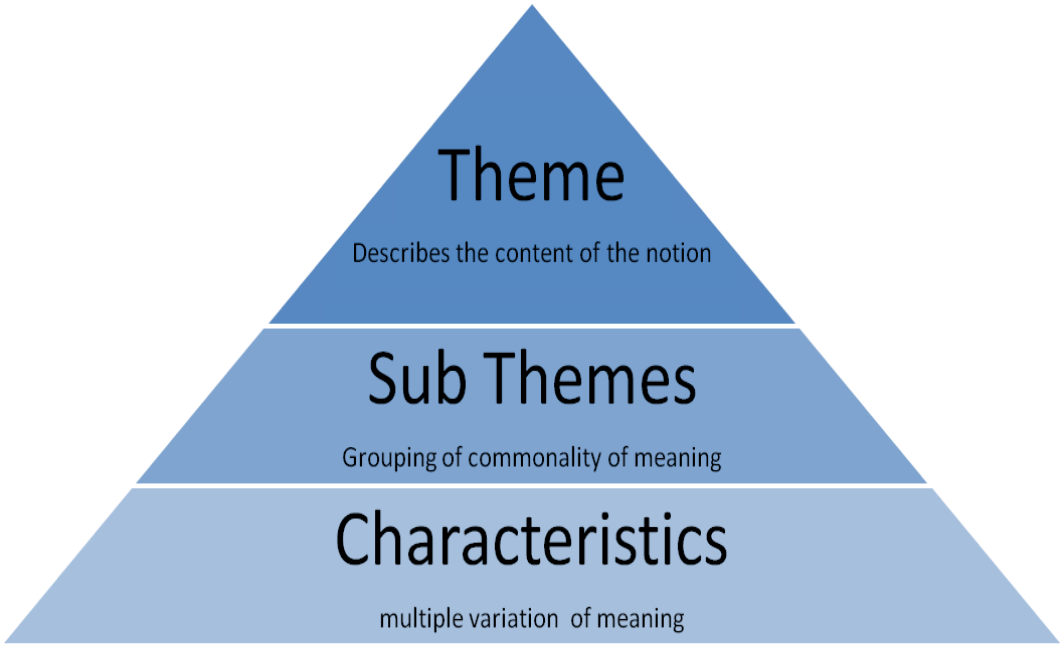
Meaning units were then reviewed multiple times to ensure that they were challenged, tested and refined into relevant common characteristics that represented relationships in the data. Groupings of meaning units are termed characteristics in this thesis. The identification of these characteristics prior to larger conceptualizations allowed me to remain with the data and develop ideas about the relationship of these to each other and common links (Thorne, 2008).

Step 3. Conceptualizing subthemes. The step described above was then taken further by analyzing and synthesizing the characteristics to form sub themes. Subthemes were identified by grouping commonality of meaning. This way of organizing and presenting the data articulates the layers of meaning attributed to each theme; it also demonstrates that meaning is complex, convoluted and moves beyond mere description.

Step 4. Conceptualizing themes. Overarching themes have been described by Thorne (2008) as structures that the underlying characteristics support and therefore they need to be substantial in their meaning. Van Mannen (1990) describes the process

of coming to a theme as insightful invention, discovery and disclosure, where the researcher interprets, contextualizes and then reasserts meaning. Therefore, the wording of a theme also needs to reflect the combined collective meaning from all of the subthemes and characteristics. It is not possible for one singular characteristic to be the one truly representative of meaning; themes must be constructed of multiple varying perspectives (Thorne, 2008; Sandelowski, 1986). Because qualitative inquiry is about understanding; the construction of themes allows the researcher to capture the entire phenomenon; it is a reduction of the main meaning made clear by the subthemes and the characteristics (Van Mannen, 1990). Figure 2 pictorially represents the structure of the findings.

Figure 2. *Construction of Findings*



Establishing the trustworthiness of the study

The literature is replete with discussions and opinions related to the nature of rigor or how 'good' the research is from the qualitative tradition. The intent of research in either the qualitative or quantitative tradition differs; therefore, the determination of rigor differs. Lincoln and Guba (2007) remind researchers that studies conducted in the constructivist paradigm result in: multiple constructed realities; that truth in the study is

bounded by time and context; causality as a state does not exist because actions and beliefs are inversely influenced by contexts; that data is jointly formed by the researcher and the participant and therefore cannot be objective. Thorne (2008) then propounds that searching for the 'holy trinity' or the 'gold standard' of reliability, validity and generalizability in a qualitative study is redundant as these measures serve only the quantitative tradition where verification and objectivity are valued (Sandelowski, 1986). To this end Lincoln and Guba (2005) suggest that the term rigor be replaced with trustworthiness to appropriately reflect the research tradition and paradigm.

Thorne (2008) has nominated a set of four criteria informed by the constructivist tradition that have been accepted as promoting confidence about the researcher's understanding of , and the associated actions on, their qualitative data. Table 2 provides an overview of Thorne's' (2008) perspectives on trustworthiness that have been embedded in this study. When attempting to assert the trustworthiness of a qualitative research study, Sandelowski (1993) maintains that its practices must be visible, making them auditable.

Table 2. *Establishing Trustworthiness*

Criteria	***Strategy***
Epistemological integrity	Research question reflects , design & interpretive strategies Decision making is clear
Representative credibility	Prolonged engagement with the data Triangulation with other sources
Analytic logic	Audit trail Grounded in the data
Interpretive authority	Member checking Reflexivity

(Thorne, 2008)

Epistemological integrity. Throughout this study the alignment of the research with the qualitative tradition and the constructivist paradigm has been explicated. The research question was omnipresent in the analysis and guided the discussion. In constantly returning to the question that was constructed to reflect constructivist values, I was able to construct characteristics, subthemes, and then conceptualize themes that remained true to the context of the data and meaning for the participants. In writing the discussion I was able to ask of the literature: Did these conceptualizations reflect the internal functioning and development of learning to nurse in Australia? The questions asked of the data have also been explicated and reflect the underlying constructivist values of interpretive description as designed by Thorne (2008).Therefore, the epistemology, research question, data collection and analysis are congruent with the research tradition and paradigm.

Representative credibility. The ability to truly engage with the data and then being able to come to an understanding of meaning can best be achieved through prolonged engagement with the data. Because I interviewed the participants, checked the meaning and then transcribed the audio, closeness with the data was established that enabled me to search for similarities within and across meaning units (Thomas & Magilvy, 2011). The process of inquiry and categorizing then deepened that relationship. The data were collected from a representative sample of the major ethnicities of the student cohort and generated individual meaning units that could be grouped together under common themes for international students learning to nurse in Sydney, Australia. These themes were reasonable in their meaning as established with the current literature; typical and atypical meanings were included in the findings. Sandelowski (1986) terms these faithful interpretations where a reader of the study is able to recognize and understand the meaning vicariously from the findings.

Analytic logic. The audit trail of decisions made in relation to the selection of representative data, analysis and formation of themes has been presented as a four step process, with the three levels of findings depicted diagrammatically. It would be possible from the explication of this process for another researcher to replicate this study; therefore, it is accessible (Thorne, 2008). The findings have also been presented using vignettes from the verbatim transcript to demonstrate grounding in the data.

Interpretive authority. The product of interpretive description is to '…go beyond what an individual might "see" in his or her own situation' (Thorne, Reimer Krikham & O'Flynn Magee, 2004. p.17). In this study my ability to move beyond was achieved through constant member checking whilst conducting interviews. It was necessary to develop a skilled approach to verifying statements in my interview style. This skill not only enabled the development of understanding for others but enabled me, as a researcher, to reflect on the words of the participant. That kind of reflection, recorded as field notes, caused me to question my role as data collector and more importantly as co-constructor of the data. Thorne (2008) notes that there are times in the research process that researchers may need to abandon their former selves to be able to interpret participant data with authority. That abandonment was applied when questioning the data during analysis where the focus was on meaning for the participant not for me as a researcher, lecturer and Deputy Director of Clinical Education. Reducing the distance between researcher and participant is necessary to try to maintain subjectivity where engagement is paramount over detachment (Sandelowski, 1986).

Summary

Measures of trustworthiness of any study are not values that can be applied post completion, the quality of the work and its credibility need to be embedded in its totality. The research design, method and final product are required to reflect the underlying theoretical positions that informed the work. For an interpretive descriptive study, readers of the work need to be able to see the constructivist foundations and the interpretive influences throughout the presentation of meaning, and be able to appraise its understanding.

Ethical Considerations

Historically, undergraduate students in many disciplines have been seen as ideal participants in research studies conducted by their lecturers (Clarke & McCann, 2005). The students' time was often rewarded by inducements such as extra marks, or admonishments for non-participation such as a fail grade. Consequently, student participants were not identified as being a vulnerable population, or as lacking autonomy in the researcher/participant relationship. Ethical dilemmas arise in qualitative research designs because the researcher is identified as having a dual role or a position of dual agency (Ferguson, Myrick, & Yonge, 2006; Clarke & McCann,

2005; Edwards & Chalmers, 2002). The ethical dilemmas inherent in this research include unequal power relationships, coercion, informed consent, anonymity, confidentiality and fair treatment (Clarke & McCann, 2005). It is important to consider that in the conduct of any research informing nursing education, involving nursing students as participants is essential (Ferguson et al. 2006).Ethics approval to conduct the study was approved by the Ethics Committee of UTS (Appendix A).

Informed consent. The paramount issue here that required careful consideration was the students' concern of what might happen if they choose to participate or not. First, it is understood that relationships between the researcher and the participant may become more complex in qualitative research because the main aim is to gain a deeper understanding of the experience in question (National Health and Medical Research Council [NHMRC], 2001). In a qualitative study such as this, it is acknowledged that some students may have felt embarrassment or distress related to the nature of the interview in exploring sensitive human experiences. Second, students may have also thought that participation may positively influence their grades. Third, informed consent also relates to the participant giving permission for the data collection interview to be taped and transcribed verbatim. For this study the following strategies were put in place. All potential participants were given: a plain language information email attachment that outlined the potential risks of participating; assurance that participation was voluntary; anonymous and confidential data collection procedures such as removal of all identifying information from interview transcripts, and reassurance that there would be no benefit or repercussion if a student participated or declined to participate.

Confidentiality/anonymity. Qualitative interviews require face to face engagement of researcher with participant. The researcher in this instance fulfils the role of the data collection instrument, creating an environment conducive to providing rich data (Streubert & Carpenter, 1999). Participants in all types of research have the right to assume that they cannot be identified from data collected and that their data will be kept confidential (Burns & Grove, 2005). In this study, anonymity means that participants cannot be identified from the data once it has been recorded and transcribed. Therefore, all references to their names, family members, friends, lecturers, clinical facilitators, places of clinical practicum and the like have been deleted from the data. The anonymity of participants was also protected by the use of pseudonyms that they chose for themselves. Tape recordings of the interview, and the subsequent transcriptions were

labelled with the pseudonym only. Demographic data retained for each participant was kept to a minimum e.g., age, gender, place of birth, languages spoken. Furthermore, as the university used in the study has three campuses, no campus identifier was used. These measures lessen the possibility of data being attributed to any one participant.

Confidentiality has also been preserved by the thoughtful storage of consent to participate being kept separate from any tape recordings or transcriptions. In addition, transcription was carried out by the researcher, thus lessening potential exposure of the data. As suggested by Clarke and McCann (2005), the identity of those students who declined to participate was also protected as the names of these students were not forwarded to the researcher.

Thoughtful storage according to the legal requirements pertaining to data was adhered to. Audio and transcript files and data files were stored in a locked cupboard in the researcher's home.

Freedom from harm/fair treatment. Consideration of freedom from harm is based on the ethical principle of beneficence (Burns & Grove, 2005), and entails protecting students psychologically and emotionally. Participants may have disclosed episodes of prejudice or harassment whilst exploring or describing experiences during the interview process that may have caused them distress. They may have also voiced complaints regarding their clinical experience. Therefore, it was essential that they were reassured that they were free to speak without recrimination. As the students were also asked to describe their preconceptions of nursing prior to experiencing clinical placement they may have also felt embarrassment. The researcher assessed the risk of this as minimal and further, it is noteworthy to mention that Liamputtong and Ezzy (2005) state that sensitively conducted qualitative research does not usually disturb participants to the point that they require counselling.

All participants were given information relating to the free counselling service offered by the university on all campuses. If at any time a participant wished to make a formal complaint regarding any incident in which they felt they had been unfairly or inappropriately treated, they were referred to the equity and diversity department located on all three nursing campuses within the university. This department provides

free advice, consultation and information regarding matters of equity, diversity, discrimination and harassment. If the participant experienced breeches of professional conduct whilst on clinical practice other than explained above, by other students or staff, they were directed to the Clinical Director for advice and support.

Students entering the research did so on a voluntary basis and were free to leave the project if they found the process too disturbing to continue. The voluntary nature of the study and potential for distress are clearly stated in the participant information and consent that was provided prior to entering the project (Appendix A).

The ethical principle of justice was exercised in this study by fair selection of participants and fair treatment of those participants (Burns & Grove, 2005). The participants selected for this study were chosen because of their direct link with the research question, its aims and objectives. They were not chosen because they were conveniently located. Furthermore, the participants were not inconvenienced as the interviews were conducted on their home campus, out of class hours, on a day that they would be normally at university, at an agreed time.

Unequal power relationship/coercion. It was acknowledged by the researcher that there was unequal and dependant relationship in the design of this research. Because of this power differential between student and lecturer, potential participants may have felt the pressure to participate as perceived rather than actual or intended by the researcher (Ferguson et al. 2006). The researcher may potentially be a lecturer/tutor in the future in the course of the participant's 3-year degree. The researcher assesses this risk as minimal. To minimize the risk, if the researcher has cause in the course of her usual employment as a lecturer, to be responsible for providing an assessment of a student's performance in any subject, over the student's enrolment in the Bachelor of Nursing, the researcher will remove herself from the assessment.

Ethical issues related to the researcher. The researcher may be at risk of physical harm when dealing with emotional or distressed students in a confined environment. It is also recognised that the researcher may become distressed by students' disclosures. Prior to conducting any interview, the researcher notified the administrative assistant located near the office used for interviews and asked that any

call from that office be answered as a matter of urgency. The researcher was also aware of the free counselling service offered by the university.

As the researcher was a doctoral student at a university different to the participants, approval to recruit from the university where students were enrolled was sought and gained.

Chapter Conclusion

This chapter has discussed the research design and method utilized in this thesis, and in doing so explicated the steps in the research process so that they are clear and could potentially be used to replicate the study. Moreover it has articulated the theoretical foundations of knowledge development associated with the work that must be understood for the research to be credible. The next chapter will present the findings of the thematic analysis, the interpretive description.

Chapter 5: Findings of the Thematic Analysis

Introduction

The experience common to all nursing students who are learning the ways of the profession is exposure in the clinical practice environment. The findings of the thematic analysis presented here seek to elaborate the variations that International Culturally and Linguistically Different (ICALD) students experience whilst learning to nurse in the clinical environment. To that end the findings reflect the constant connection to the initial research question 'What is the nature of learning to nurse for ICALD students in Sydney, Australia? The word nature has specific relevance to the themes identified where *nature* has been defined as meaning 'where the nature of a thing is internal to it but also accounts for its characteristic functioning or development' (Mautner, 2000.p 372).Therefore the construction of the chapter reflects the internalities of learning to nurse, how learning to nurse functions and how learning is developed, based on the subjective experiences of the 16 participants.

The researcher's role and responsibility in presenting the coconstructed data is to conceptualize thoughtfully and to utilize the information in a strategic manner to authentically communicate that the findings themselves are grounded in the data (Thorne, 2008). The overarching organizational framework of this chapter constitutes three levels of analysis. There are six major themes; each of these has a number of sub-themes and finally a number of related characteristics. The extent of the findings can be found in Table 3. Each major theme is introduced at an abstract level of description followed by the subtheme and associated characteristics that present the original participant data. Verbatim vignettes are presented to demonstrate the authentic basis for the interpretations and to enhance the credibility of the coconstructed findings. The major theme is then bought to a conclusion in the summary.

The 16 participants, who represented the major contributing nations of international student numbers at the time of data collection, gave freely and without reservation, their thoughts and feelings about learning to nurse in Australia. At times emotional responses were induced as the participants recounted experiences. However,

the level of complexity and interconnectedness of their narrative only became apparent through the analysis.

There exists an intricate layering of perceptions, beliefs, expectations, culture and language that remains underestimated by the participants themselves and by academic staff when ICALD students enter the clinical environment. Table 3 provides a structure of the themes developed from the analysis.

Table 3. *Structure of Themes*

MAJOR THEME	SUB THEME	CHARACTERISTIC
Motivation-Binding the personal with the professional	Entanglement of Obedience, Obligations and Opportunity	Vicarious fulfilment
		Securing the future: parental push
		The silent contract we pay you pass
	Control of Destiny	You don't always get what you want
		Get what you want somewhere else
		Escaping the personal
		The unspeakable Nursing a means to an end
Conspicuousness	Looking Different, Sounding Different.	Visage
		Voice
	Consequence of Difference	Warnings
		Dislike for difference
		All about attitude
Cross Cultural Encounters. To Know Australians is to Know The Patients	Australian Archetype	Interim illusiveness
		Australian image
		Mates or stranger danger
		No worries work ethic
	Relationships Australia	Family disconnectedness
		Boys and girls disquiet and dilemmas
		Australian freedoms
Encountering and Engaging With Language in Context	Language Level Readiness	Expectations
		Onshore language background
		Offshore language background
	Australian English and the Vernacular	Australian accent

		Vernacular and understanding
		Unanticipated speed
	Encountering Language in the Clinical Environment	Engaging with ill patients
		Breeding frustration
		Engaging with written language
		Striving for improvement
		Placement for improvement
		Clinical language ability develops over time
Impressions Of Nursing	Nursing, Variations on a Theme	Passion and desire for the care encounter
	Perceptions of the Profession	Globalisation of medical dominance
		Excrement and elitism- Contaminates in the reputation of nursing
	Opinions of and Influences on Nurses' Work	In my country nurses do
		The omission or commission of care
		Primacy of treatment over ethical behaviour
	Female Nurses and Male Patients	Prohibited contact
		Intimate interactions lead to physical reactions
		Compromised reputations
Ownership of the Clinical Placement: Crafting Success	Situating the Self	
	Understanding the Purpose of Clinical Experience	Determination to learn.
	An Authentic Australian Nursing Experience	Trust vs. Mistrust

	Observing Australian Nursing Practice to Learn to Practice Nursing in Australia	Determining the lie of the land
		In the passenger seat
		Unfamiliar territory
		Judging observed behaviours for worthiness
		Putting it into practice -Replicating worthy behaviour
	Managing Clinical to Pass	Premeditated relationship forming
		Developing a communication routine
		Testing the teachers-interviewing for a personal learning assistant
	Focus on the Clinical Summary	The yellow paper.
		Securing a pass by deception

Theme One: Motivation Binding the Personal with the Professional

An understanding of the role that motivation plays in learning behaviour is important for educators. The motivational forces that compel individuals to undertake international travel to study in a foreign country and enable persistence are complex and diverse in nature. Moreover, they are highly individual and integral to the function and development of learning to nurse.

MAJOR THEME	SUBTHEME	CHARACTERISTIC
Motivation. Binding the personal with the professional	Entanglement of obedience, Obligations and Opportunity	Vicarious fulfilment
		Securing the future: parental push
		The silent contract we pay you pass
	Control of Destiny	You don't always get what you want
		Get what you want somewhere else
		Escaping the personal
		The unspeakable Nursing a means to an end

Entanglement of Obedience, Obligations, and Opportunity

The entanglement of obedience, obligation, and opportunity proved to be a complex motivational force that bound the student's to their Australian nursing studies through their families. Whatever the students underlying drive to be successful in their studies, these forces were strong enough to maintain the student's dedication through the ensuing years of their nursing degree.

Vicarious fulfillment. Cheska, a mature age student, who had already achieved a Bachelor's Degree in the Humanities prior to beginning her nursing studies, demonstrated a strong sense of connection to family. Cheska was driven to achieve a dream for her sister who was unable to study nursing in her home country. Because her sister was the sole provider for the family, and nursing as a career was held in low regard in her home country and remunerated accordingly, a reciprocal obligation was evident: I fulfil your dream to be a nurse while you support me financially. Cheska studied nursing to repay her sisters commitment to the family.

But really it is my sister's dream, she did not get to study nursing she had to study something else because she is the breadwinner for the family. In the Philippines nursing is nothing, nothing! (Cheska, p.3).

Cheska did not choose to become a nurse of her own volition; she was driven to be successful in her nursing studies by the obligation to repay a debt to her sister. By being successful in her nursing studies, Cheska hoped to gain access to a well-respected Australian profession and be suitably remunerated. In achieving this, her sister could then vicariously live her dream.

Securing the future: the parental push. In sending their children to Australia to study nursing, parents made their intentions very clear. The opportunity to study nursing in Australia was a way of securing a better financial future for their children.

Philippine student Louisa explained her obedience and consequent obligation to her family, because they finance her tuition. From her response, it is evident that education is highly valued by her family, as a way of ensuring a brighter future.

When my parents tell me "you go to uni", I can't do anything. Whether I like it or not I go there. They pay for my tuition fee and if they say you cannot go out, you do not go out. And what else, but education is number one for, that's generally number one. Only because there is fear for their children's future (Louisa, p.1).

Mi Mi was also supported by her family to study in Australia, with the aim of securing a good education that would potentially enable her to work worldwide and increase her earning capacity. Underlying that intention was the notion that qualifications gained in the home country are not well respected and that nursing as a career in Poland is not well remunerated. However, obedience as a motivator was less obvious than the opportunity of career security for Mi Mi.

My parents told me, we love you, go away but leave Poland and get good education. We will help you so you have good qualifications. So you can work in any normal country, for your job will give you decent money. That's why I'm here (Mi Mi, p. 17).

In career planning for their child, Amy's parents appeared to have considered the financial security of the nursing profession and the benefits of having a nurse in the family as they became older. Although Amy did not mention financial support from her parents, obedience was reflected in that her parents chose the career she should study and the obligation to her parents once her study is completed is clear.

> *Um in China, a my parents choose this one this job for me as a future, because as a nurse they can very easily get a job in China, and because the salary is really good and a the nursing job is like um, people always help the patient yeah? And because if I'm a nurse I want my parents get older and I can help them, so most of the people like nurse, yeah (Amy, p.1).*

Aspirations for their children's financial future were evident as an imperative for parents. Securing good qualifications and in turn a well-paying career appeared to be a significant aim in providing their patronage. In return the participants obeyed their parents' 'directive' and seized the opportunity given. For some, the repayment to parents was simply study success leading to a secure well paid career and for others repayment to family will come in the form of provision of care to elderly parents.

The silent contract: We pay, you pass. Providing patronage for their children to come to study nursing in Australia did not come easily to some parents. To successfully apply for a student visa in Australia, ongoing financial security for the applicant must be demonstrated. International students are required to pay for their units of study at the commencement of each semester, at a rate that is significantly higher than domestic students. These participants were aware of their parents' financial investment and the consequent imperative to pass. Failure meant another unit payment for unsuspecting parents.

Jin was aware that her family worked hard to provide financial support during her studies here in Australia. Jin had spent a total of four years away from her family, initially arriving in Australia to complete her Higher School Certificate. Her obligation to pass the nursing course was clear.

> *Yes, yes I'm serious, because my family not a rich. It's really, really not a rich. But I really think about this one. I really don't want to fail any subject. This is not good to say but I have to say my wish is not big. I just hope pass I don't want*

distinction, high distinction I just want a pass... Yes like me because, they support me, so like ahh, that to. And I'm serious my father he works two jobs just for the school fee just to support me but like, I don't know how to say, he didn't have like superannuation he didn't help himself, if I have, I have to study hard (Jin, p.8).

Felisa also acknowledged the role her family plays in supporting her studies and the sense of responsibility she feels because of it. In this response she implied that she will have to repay her parents by eventually taking responsibility for their care.

Yes because my parents work hard for my study, after I graduate, as long as I have come, it's like my sense to take responsibility for them. So yeah (Felisa, p. 15-16).

Along with the sense of obligation came fear of failure. Failure for an international student means having to repeat the unit of study at some stage of their enrolment. Currently four units of study per semester are considered to be a full time study load. Having to repeat a unit means additional academic study on top of a full time load, and an additional subject fee. As the study of five units in a semester is only undertaken against academic advice, sometimes the student will have only one unit to complete. Having only one subject to study in a semester, does not constitute a full time load and may be in breach of visa conditions. When a situation such as this arises, extensive negotiations occur between the student, the university's international office and the Department of Immigration and Citizenship. Jin voiced the consequences of failing a unit of study in monetary terms and provided insight into the emotional impact of failure.

Oh my Gosh! We will fail! We need to repeat, how high is the school fee for us? You, you know one unit is two thousand, two thousand for us. And we just cry, cry (Jin, p.8).

Mi Mi received a fail grade in a compulsory clinical unit that impeded her progression in the course. She explained here the emotion and impact failure generated on her financial status and on her student visa.

Now I have to repeat that subject and I feel like I am reversing my knowledge! I am having to learn to make beds again! {Sarcastic tone here}. Because the unit requirements are like that... Yes it is not only a waste of my

money it is a waste of my time. Also in my case you have visa. To keep visa you have to be full time student not just one subject, and work the rest of the time. I can't even do two subject I have to do three at least, three or four to be full time student to keep the visa (Mi Mi, p.25).

The dedication of parents in financially supporting their children's study was clear to the participants and had the potential to result in contractual type agreements. Consequently, the need to pass units of study was interpreted as a necessity for participants to discharge their responsibly and meet their obligations to parents. Failing a unit not only had an emotional impact on the participant, it had financial ramifications for the student's family and student visa conditions may be breached. For the international student failing a unit of study has a complex outcome.

Control of One's Destiny

Control over the course of study and career path was straight forward for participants who were told what program to study. Control was taken out of their hands resulting in obedience to complete that program accompanied by an obligation to pass. For others, coming to Australia to study afforded them the opportunity to change the direction of their own, and possibly their families' lives. They were able to change their own destiny and, for some, part of that destiny was the ultimate plan to immigrate to Australia.

You don't always get what you want. Even though sometimes a student's choice to study nursing may have been heavily influenced by the student's family, there was evidence of inflexible governmental control over the allocation of university places in some home countries. It appears that passing a university entrance examination did not guarantee your first choice of a degree course.

Phoebie explained that nursing was not her first choice for study and that she had little or no control over the allocation of her place at university in her home country of China.

At first I not choose to study nursing I choose pharmacy. In China when you take the exam to go to university if you, in the order they will ask you... but you write that down they allocate it to you, you cannot against that (Phoebie, p.7).

In this instance the participant understood that her preference for study was overridden by the government. Nevertheless the decision was accepted without argument, as there appears to be no process of appeal. This then meant that the participant would be locked into one career path for the rest of her life, a concept that was accepted and obeyed by the participant.

Get what you want somewhere else. Lyn was from Zimbabwe and had experienced periods of political unrest. From her experience she believed that the only way of being admitted to a university in Zimbabwe was through nepotistic designs or corrupt methods. Attempts at these methods of securing a place at university failed, so she made her way to Australia.

> *In my country it is hard to get anything um, to go into nursing. Not because of the qualification 'cause you know if you listen to the radio or the TV these days it's all corrupt, and inflation is one hundred, its one hundred thousand precent inflation. So you know it was hard. If you want to get a place there you have to be a relative of the boss or you have to pay. So we try everything to pay to the boss to get a place there but I couldn't (Lyn. p.12).*

In some countries the ability to exert freedom of choice to pursue a chosen field of study was limited by various political forces. Control over participants' own careers was taken out of their hands and given to government officials. For those participants who came from a socialist dominated political system, their field of study was determined by party officials. For those who came from a less stringent and rigorous political system, their field of study may have been determined by illegitimate means. If these illegitimate means were not successful, the participant was forced to find an alternative path and this may mean study overseas.

Escaping the personal. Two participants presented poignant personal reasons for taking the opportunity to come to Australia to study. Zara, a mother of a teenage son and a registered nurse in her home country of Iran explained her situation, escaping from a kind of persecution, to protect her son and take control of her own destiny.

> *Cathy, you know my motivation to come here is different I have to say I came here for my son. I adopt my son and because of religion in my country, if he is not from your blood, after 18 years old there is not heritage for them. All of*

my sisters and brothers, I'm just scared may be they might hurt him. So I decide to move here (Zara, p.3).

Jane was from India and held a master's degree in a science related field. She also felt that by coming to Australia she would escape a personal issue. Even though she did not elaborate on the details, it posed a serious enough threat for her to flee to another country. It would appear that she stumbled upon nursing as a means to permanent residence.

I had some personal issues so I could not stay in India so I had to get out one way or another. And my good friend was here in Australia so, I also found some study for nursing here so it's better to be here. So I decided to settle down over here and let me do nursing (Jane, p.9).

Coming to Australia to study nursing offered some participants an opportunity to avoid personal issues and problems in their home countries. This in turn allowed them the opportunity of beginning a new life for themselves and their families free from the worry they had previously experienced.

The unspeakable ambition: Nursing a means to an end. By choosing to study in Australia, some participants had deliberately planned to migrate permanently and have found that nursing was a targeted profession for migration. So there was a planned approach to gaining permanent residency.

Felisa was quite open and candid about her intention to come to Australia to study. Felisa was a Chinese student with family already established in Australia. She believed that migration was the motivational force behind most international students' reasons for studying in Australia.

Yes, Yes. Like The reason I doing nursing is just to want to migrant here. I believe most international students they doing the nursing because they want, for the same reason. They want to migrant here (Felisa, p.1).

Although Jin was embarrassed to admit it, she did eventually disclose that nursing was generally regarded as good for migration purposes amongst other benefits.

What I guess for international students, the reason they study nursing, um yea, it's the, the first you know why? The good job, and good money and, yea. You can go anywhere and, this one is the most important, I have to say may be its not good, it's embarrassing but it is good for a migrant, immigration (Jin, p.1).

James, a student from Bhutan, possessed a medical degree that he had received in India. These qualifications were not recognised here in Australia. Having completed a master degree in a related field here in Australia, he found it difficult to get employment without being a permanent resident. As someone wanting to apply for permanent residency, James enrolled in the Bachelor of Nursing. Once he has gained Australian permanent residence he is planning to re-enter the medical field. It would appear that studying nursing is a deliberate choice to enable success in obtaining permanent residence, and a job as a doctor in the future.

But what I realised was it was really difficult to get a job if you didn't have a permanent residence to, if you did have a student visa without a PR they are reluctant to give you job. And then after that may be I'll do some other stuff. And may be go for some time um, give exams and try for Dr things. When I talk to other people that is their main reason for coming here (James, p.13).

The chance to steer one's own career was restricted in some cases by the political system of a participant's country of origin. It was difficult for them to realize their own ambitions, which led them to find alternative methods of securing their future. The seeking of international opportunity was not limited to those who wanted a specific career in nursing. It encompassed those who were escaping from personal issues and those who were aspiring to a better life.

Summary

Motivational forces that continually drove international nursing students remained complex and embedded in the personal, and often modified by the political. These forces were strong enough to bind them to the term of the course and pressure them to succeed. In its essence, motivation was fundamental to the function and development of learning. Obligation to family, obedience to parents, state, and

opportunity for financial security through an international qualification represent the many facets of this complexity. By coming to Australia to study nursing, some of the participants were able to take control of their own destiny and reach their goal of living and working here. Therefore, failure at any stage of the program had serious emotional and financial repercussions for participants.

Theme Two: Conspicuousness

To be conspicuous means that someone or something is easily seen or worthy of notice. The generalized notion of the nurse as a blonde haired, blue eyed female, which dominates the Australian image of the profession, automatically denotes those who do not conform to the preconceived image as being different and, therefore, conspicuous. The way that this difference is ultimately interpreted and experienced, impacts on the ability to learn to nurse in the clinical environment.

MAJOR THEME	SUBTHEME	CHARACTERISTIC
Conspicuousness	Looking Different, Sounding Different.	Visage
		Voice
	Consequence of Difference	Warnings
		Dislike for difference
		All about attitude

Looking Different, Sounding Different

The participants were acutely aware of being physically and linguistically different from the two broad groups of people they came into contact with in the clinical environment. These two groups were mainstream Australian society as the inpatient population and the nursing staff. This sense of being different was verbalized by the students in discrete areas. Students identified their obvious facial characteristics, vocal accent, and language ability as areas that rendered them conspicuous. Some participants coped with being conspicuous, for others it provoked emotional responses that had negative consequences.

Face. This characteristic manifested strongly because the students were aware that their facial characteristics differed from the Australian population in general and from the nursing staff in the clinical areas.

James recognized that his physical appearance posed a challenge that he first identified as an on-campus student, which also became evident in the clinical learning environment. From his perspective, James believed that communication was made all that more difficult because of his appearance. He believed that the preconceptions people held in regard to his appearance, impacted on their ability to understand his attempts at communication. James thought that he was communicating clearly, that his language and expression were appropriate. However, despite his attempts the people he interacted with did not comprehend. He surmised that as he looked different and sounded different his appearance therefore posed a barrier to effective communication. There is a sense here that effort expended by the student to communicate had its limit, and equal effort needed to be afforded by the person he was communicating with, to the process of understanding.

> *You have this idea, that foreign face. No matter how many times you see them you have this foreign face. So I think that creates a huge challenge to overcome. They see that you are a different person and they expect not to understand you that's what I've seen {laughing} because I have been speaking properly and they still have not understood me so I was like ok this is not my problem {laughing } (James.p,5).*

Phoebe described her thoughts about assumptions made about her when she sensed her appearance influenced how people acted and interacted around her. Consequently, Phoebe believed that people around her who are local took the liberty of saying what they liked in front of her because she would not understand what they were saying. In this excerpt, she is talking about local Australians with the reference to local language.

> *It's hard to tell but I feel some people look your appearance and oh you are from China, yea, you must not know. I think sometimes they use low words or local words because they don't want you to know they are talking about me, like gospy [gossip] or something like that (Phoebe, p.5).*

Lyn reflected on her first foray into the clinical environment. Her response highlighted the obvious difference in overall physical appearance that was experienced by a person of African descent, including the language component of being different. Lyn voiced concerns about her acceptance by staff and patients which resulted in feelings of worry and nervousness. These feelings were apparently generated mainly because the student did not know what reaction to expect from the patients. In essence, this describes a fear of rejection based on her obvious physical difference.

> *Yes since Sydney it was a different country. I'm black and you're white. I'm really oh it's, worried a bit. Oh and the English part of it! I was really nervous the first day I went to clinical and, I wished this week was over. Because I wasn't used to the environment, the environment, as in the patient. The patient, I don't know if they, if they are gonna take me, take me down. If they say I don't want any black people to take care of me. I wasn't sure (Lyn, p.3).*

Jane also provided insight into how she sensed that she was perceived by the patient and nursing staff. By giving this response Jane verbalized her thoughts on the effect her physical difference may have on patients' feelings.

> *That's why I think they [patients] don't feel comfortable when the nurse are from some other country. The nurses, even they look, I go and stand near them they know I am from some other country (Jane, p.5).*

Zara's thoughts related to Australia having a multicultural population, a societal construct that was known to her prior to arrival. Still there was a sense of being different from the nursing staff whilst out in the clinical environment. Zara identified that although the broader Australian population may be multicultural the nursing staff in a certain hospital, in a particular part of Sydney, did not reflect that population mix. Essentially, Zara sensed that she was different from the majority of the nursing workforce in that particular clinical environment and that may pose certain difficulties for her.

> *You know with multiculturalism, people know I come from overseas and they, so a lot of people know you, and you are new. But some areas are more difficult for me. In [hospital] all of the staff, nearly all of the staff are native and you know, very different (Zara, p. 2).*

Being aware of their facial characteristics caused the participants to think about the effect that looking different had on the perceptions of people they came into contact with and on themselves. In the main the participants identified the people they came into contact with in the clinical environment to be patients and nursing staff. The participants interpreted the effect of looking different on patients and nursing staff as being an immediate barrier. The participants internalised concerns about looking different that resulted in a fear of rejection from both nursing staff and patients and that certain things might be difficult because of the difference between them and the nursing staff in certain facilities. The feelings of fear resulted in worry and nervousness for some of the participants. Looking different had negative connotations for the participants in relation to interacting with patients and staff in the clinical environment.

Voice. Manoj, a native speaker of Punjabi, was aware that he sounded different because of his pronunciation. He freely acknowledged his accent was a problem. Manoj explained that his accent affected the way people heard him. Sounding different, and the way that words are pronounced or ordered in responses can lead to misunderstandings in every day conversations.

> *Sometimes I have pronunciation problem. I do have. Sometime I say some word and the other person he is listening to me and he hears something else. As well we are speaking words with different accent. I can give you an example. I was doing job for an agency and she asked me for my availability. I say I am available and she say what? That is the sort of thing, those things do happen (Manoj, p.6).*

A message sent verbally may not always be interpreted correctly or appropriately by the listener. Complicating any dialogue between two people, when one is not a native Australian English speaker, is the construction of the language and the accent of the speaker. By constructing language in a particular way with a verb at the end of the sentence, the participant confused the person he was speaking to. Awareness of the impact of an accent, and how people may hear someone speaking, is only one aspect of verbal communication. Understanding the message that was sent is further complicated by language construction.

For the participants, awareness of looking different and sounding different from the nursing staff and the patients on clinical placement was inescapable. Looking different impacted on person-to-person communication and interactions because of negative assumptions conceived about the participants. Once the participants engaged in verbal communication, understanding was complicated further by accent and language construction.

Consequence of Difference

Being conspicuous led to a certain level of vulnerability for some of the participants. On one hand there was an expressed fear of being disliked that was interpreted by some participants as acts of discrimination or racism. However other participants believed that if you sought to be treated differently, you would be; a kind of self-fulfilling prophecy.

Warnings. A predeparture warning of the possibility of discrimination turned into reality for Amy, who described the warning given to her by students who had previously travelled to Australia to study. This warning revealed that, to this group of students, discrimination was expected as it was believed to be a social norm here in Australia.

> *Before I come to Australia some other overseas student say to me some Australian people have, there is strong discrimination views about other people (Amy, p.6).*

Irene provided insight into the level of discrimination that could be expected here in Australia after being given a warning by other students. The idea that Australia was populated by white people, who predominantly disliked people from Asian countries, was quite daunting for a newly arrived international student.

> *They when I came here, they say white people they don't like Asians, nine out of ten white people don't like Asians. Because I have never been here I don't know (Irene, p.11).*

The idea clearly expressed here is that Australians do not like people who are different. This idea was perpetuated by students who had previously studied in Australia, and by others onshore. These ideas were given as warnings to potential

international students. Despite the warnings, these participants still travelled to, and remained in Australia to study.

Dislike for difference. The possibility of some level of disapproval of her ethnicity weighed heavily on Jin. She stated that she felt that some people did not like her. However, she linked it to her ethnicity, the thing that is obviously different about her. She expressed her feelings of having to cope with the perception of being disliked.

> *I think this is the biggest one in my mind, well I feel that, I kind of, I don't know how to describe that one. Well I feel that some people just don't like me. They don't like Asian, they don't like such things. OH My God! I don't know what should I do? Just deal with it (Jin, p.2).*

Milky voiced the notion that disdain for Asian students was overtly practised by students from western countries. Milky felt that there was an inherent dislike for Asian students. She implied that the hatred of Asian students was ingrained in Australian culture and reflected in the behaviour of her fellow students whom she identifies as 'western'. This example was overt and led to feelings of paranoia for Milky.

> *I have this experience in my, this clinical and you know the students from western countries they really, I can't say hate, but they don't like students from, especially Asia students, yea. They sort of sit together and critique each other and critique other students as well. Like say something behind each other as well (Milky, p.2).*

Felisa offered a clinical performance example where she believed that the clinical fail grade of one of her friends was motivated by racism. Felisa determined that the facilitator was motivated to fail the student on the basis of racist beliefs. Only the Asian student was given an overall fail for communication even though no student could provide an answer to the facilitator's question.

> *Like I said it could be racism involved. Because one of my friends she, clinical last year. The reason the facilitator fail her, say that she had communication problem. But actually I don't think. Her English is better than mine. The reasons I think the facilitator ask, here the bone here [points to humerus] what's the name? So she couldn't say it said 'I don't know.' Then the*

facilitator ask the Australian students who don't know as well, and the facilitator finally just failed her (Felisa, p.6).

James had previously experienced some level of discrimination in his home country of India so expected that the same would happen to him here in Australia. He believed that if racism exists here in Sydney, Caucasian people don't display it, it is covert. However, other members of the Australian community, whom he identified as non-Caucasian, clearly demonstrate their opinions of people from different ethnic backgrounds. Basically he was saying that there is an identifiable inter group discrimination within immigrant groups.

It was more like, I expected that. Because what I notice is in Australia, even in India, because I only know India, the main part of India, people don't treat me very nicely {laughing} they are a bit racist. They are more racist than others. I took it in my stride. I thought that even if the other Caucasian are racist they don't show it. They might not like you but they don't show it {laughing} But the Indians or the Chinese show it (James, p.12).

The idea of being disliked for their ethnic difference began prior to arrival in Australia for some of the participants. It would appear that the people of Australia have developed an international reputation for antagonism towards people of Asian backgrounds. The participants relayed experiences that exemplified that reputation for them in the major contexts of: the broader Australian community; as part of a student cohort; between student ethnic groups, and as a student nurse being assessed on performance in the clinical environment. These experiences were interpreted as racist by some of the participants, indicating the depth of sentiment attached to them.

It is all about attitude. In contrast to the above experiences and ideas, Lyn had contemplated the possibility of being disliked, for Lyn however, there was no manifestation of dislike towards her as a person of difference.

But I haven't experienced any of that. No. But it was in my mind, Oh; I'm used to my own people. And now I'm here maybe the people doesn't like me. So, but I haven't experienced that (Lyn, p. 3).

Like Lyn, Yvonne had not felt dislike for her personally. Using her insight she identified that the process of victimization can be seen as a self-fulfilling prophesy, that if the ICALD student is looking for a reason to claim discrimination then it will be found. Her sense of relief was palpable.

> *I haven't faced any racism or any differentiation with attitude like with my facilitators or my tutors. I wasn't a victim as people say, a victim 'cause I've heard people say we were victimized blah blah, but I have never had any issues. But I think that has to do with your attitude towards them as well. If you think oh! They're treating me differently then obviously there will be some issues. But I never take things, but I was really glad (Yvonne, p. 5).*

Being out of their familiar surroundings and away from the familiar culture of their own people, caused some participants to worry about how they would be received here in Australia. These two participants Lyn and Yvonne did not expect to be treated differently and, therefore, did not find it.

The perception of being disliked was not common to all participants in the group. However, there was an expectation that this may occur and a sense of relief when it did not. Although the participants saw themselves as different and some expected a level of antagonism due to pre departure warnings, they either braved the odds and arrived onshore or remained in country. The feelings of being disliked by others occurred in various contexts and with various groups. Participants also noticed that antagonism did occur on some level among student groups of differing ethnicity, and within student groups of the same ethnicity. The perception of being discriminated against or disliked because of ethnicity pervaded many aspects of the students' learning experience in the clinical environment from the engagement with patients, to the facilitator who graded their performance, and even extended to student to student interactions.

Summary

The participants identified themselves as different and, therefore, conspicuous across multiple contexts of the experience of learning to nurse in Australia. This conspicuousness was inescapable and instantaneous once they entered into a clinical environment. Looking different and sounding different had wide implications for

ICALD students' learning to nurse in the clinical environment. These responses suggested influences on the perceptions of the participants as individuals shaped the type and outcome of interactions. Because they looked different from the mainstream Australian nursing student, they were perceived as having less knowledge and ability. Possessing certain ethnic characteristics also caused the student to contemplate dislike for them, and to turn to serious accusations of racism or discrimination. Once the participant began to converse with people, assumptions were made that their level of communication was poor due to accent and language construction. Formal and informal English language courses, especially those conducted off shore in American English, are suggested as being inadequate preparation for coming to Australia to study nursing. It would seem that the results from language testing that allowed admission to the course became redundant once studies of nursing began. The effects on the participant of not being able to communicate or understand people they came into contact with, were clearly voiced as anxiety, frustration, self-doubt, bewilderment, and feeling lost. In some instances this led to the participant missing information in conversations, inaction where action was required, or agreeing that they understood when they clearly did not. The notion of being conspicuous was not a revelation to the participants; it was a constant of which they were acutely aware.

Theme Three: Cross Cultural Encounters-Coming to Know Australians

In coming to understand a new culture, there will be some aspects of that experience that may cause consternation. Once immersion into a new culture has begun many issues that may not have been anticipated and existing values and beliefs are challenged. Any challenge may be positive or negative and affect the overall experience of the participant. Coming to an understanding of the Australian culture, population and ways of life is significant for a reason- people populate our hospitals as patients. In turn, these patients are a microcosm of the wider, diverse Australia.

MAJOR THEME	SUBTHEME	CHARACTERISTIC
Cross Cultural Encounters to Know Australians is to Know the Patients	Australian Archetype	Interim illusiveness
		Australian image
		Mates or stranger danger
		No worries work ethic
	Relationships Australia	Family disconnectedness
		Boys and girls disquiet and dilemmas
		Australian freedoms

Australian Archetype

For students who come to Australia to study, preconceptions based on historical information and stereotypical images, seem to form the basis of attempts to define what, or who, is an Australian. The notion of a national culture is difficult to define and that difficulty increases when faced with the complexity of a multicultural society. People from over 200 different countries populate Australia, each bringing with them a cultural heritage. Introductions to an unfamiliar society appear to result in generalizations that reinforce the expectation that members of a society form a homogenous group.

An elusive concept. Felisa presented a poignant explanation for understanding culture. There was no existing formula, or structure to assist her, and that makes identifying the culture of a person difficult. She developed some confusion because the generalizations that she had heard about Australian life style were not proven. Also evident was her increasing awareness of the multicultural mix that added a layer of complexity to attempts to capture what are Australians. A mix of assumptions and reality have contributed to the idea that the Australian culture is difficult to define and hence elusive.

> *.... you know if there is a formula you can learn it, or language have grammar you can learn it, but culture is really, really sometimes hard to say. Like some people say the first day I arrive here you're gonna go wallabies, have a look at it. But when I talk to some Aussie people they say no no, no, I don't like rugbys! So I get confused! I believe that most people here they like rugby, they like some kind of sports, so it's like really hard. Australia is multiculture so it's hard (Felisa, p. 19).*

There were no rules about how or if a person must comply with a national culture. Generalized notions and assumptions about people who belonged to a particular cultural group may result in confusion once immersion into that society begins. The ability to be flexible and adaptable in understanding the meaning of culture was important and a skill developed over time. However, in the meantime, confusion was felt as generalizations were applied to the whole without thought for individual differences.

The Australian image. The extent of Australia's' multicultural population came both as a shock and as a surprise to some of the participants. The notion of what an Australian looks like appeared to be embedded in historical ideas from Australia's colonization by the British more than 200 years ago.

Milky used her historical knowledge of the colonization of Australia to arrive at the conclusion that the Australian population remains Caucasian. In addition, her belief extended the idea that all countries whose people are predominantly Caucasian are Western. The indigenous population remained unrecognized in this description.

> *Why do I think like that? Australia is like a English British federal something? Commonwealth country yeah so and, and umm, like it is true that the Caucasian people are the first generation in Australia and people from other countries they just migrate. May be, like since 19th century the 20th century so I still perceive Australia as a western country (Milky, p.5).*

James was accompanied by his father when he travelled to Australia to begin his studies. James described both their reactions as ***shock*** at seeing so many Asian people on his arrival. In this quote James alluded to the fact that he believed that Australians are not Asian.

> *Actually it was quite funny. Because the first time that I landed at the airport ummmm drove through the town, and I saw so many Asian people. I was like where are all the Aussies gone? {laughing} I was really shocked. My father came with me and even he was a bit shocked it's like OK (James, p.12).*

Although not having previously contemplated the population mix of Australia, its multicultural nature was a pleasant surprise for Yvonne.

> *I never thought that Australia had so many people coming from so many different backgrounds it was really good to see (Yvonne, p.6).*

The positive side of being in a multicultural population was highlighted by Mi Mi who explained the population of her home country is largely perceived by her as homogenous.

> *Because talking to people is interesting especially in Australia, not like Poland where you have mostly Polish people. Here you have different kind of people from every part of the world (Mi Mi, p.10).*

It would appear that the participants had limited understanding of the nature of the Australian population prior to arrival here in Sydney. A lack of knowledge about the multiple ethnicities represented in Australian resulted in reliance on historical data that poorly reflected contemporary Australian society. Further, the use of generalization in descriptions of the typical Australian was suggestive of an early stage immersion experience where confusion leads to understanding after period of time. Despite the lack of knowledge about multicultural Australia, for some participants it provided an environment different to the home experience that was accepted with pleasure.

Mates or stranger danger. In Australia, politeness and friendliness are exhibited in various forms as part of social norms. A simple 'Hi', 'Hello' or a smile exchanged between strangers engaged in a common activity is frequent. Interacting with strangers was an idea that Irene was not accustomed to as she explained that in China, strangers are strangers, and therefore conversation is prohibited.

> *In my country if we are on the road I don't say hi to you, I don't smile to you, we just walk by that's it. I don't know you, but here even if I don't know you, I can smile or say hi. Even if we are waiting for the traffic light and we look each other we can talk making friends. In my country we don't, we just look ahead. Look at your bag waiting for the light and go through (Irene, p.11).*

A little further on in the conversation, Irene explained in some depth the extent of the social distance that is the norm in China. This insight provided information

regarding the way interactions take place between strangers. Exaggerated personal distance, protection of personal information, and subterfuge can be used when interacting with an outsider.

> *I found the people here are more friendly, they are happy to get close to you. But in my country if I don't know you we have a distance. There is definitely a distance between us, maybe we don't sit that close, maybe I sit a little bit far away from you, maybe I little bit defence myself, I might not tell you information about myself that you want, some information I might hide, or I choose some information that I think doesn't really matter to tell you (Irene, p.6).*

Nursing students were expected to develop skills in interacting with people from the wider Australian society, who then become the patients. It would appear that, to some participants this perspective about communication with people who are essentially regarded as strangers, posed a barrier to the exchange of information and the foundation of the nurse-patient relationship. Selective release of information, the act of choosing what information to impart based on personal beliefs, may affect the information transferred in the student's interactions.

'No worries' work ethic. The relaxed way that Australians are perceived to deal with demanding or stressful situations became a source of frustration for Mi Mi. Meeting customer demand and providing a timely service was important to Mi Mi. Eventually she left her employment as tensions followed with the other staff. It appeared that she could not tolerate the difference in expectations, relating to meeting the needs of the customers, that the other staff exhibited.

> *And also in my first job, here in Australia I worked in a café near the Opera House. I love to cook so I loved that job but I quit. I started to have problems with other colleagues because they were so relaxed Australia! "No worries" what you can't do today, you can do it tomorrow! Don't stress; chill out! I was like OH my God! You have people over there who want to eat pasta, how can I relax I have to cook quickly for them? For example, It's ok they can wait.' I was like no they can't! (Mi Mi, p.12).*

The experience of a different work ethic was a difficult concept for this participant. The frustration evident resulted in a clash with co-workers and eventually led to the abandonment of the employment. Underlying this situation was the implication that Mi Mi's co-workers were lazy and non-caring towards their customers. Understanding and adapting to a different way of working was a difficult transition.

Little knowledge of the Australian way of life, population, and work ethic appeared to generate negative outcomes for some participants. Possessing the ability to be flexible with the limited notions they had, was reflective of a beginning immersion experience. For participants from Asian backgrounds, wariness around communication with strangers was salient. The task of ultimately defining an Australian archetype was unachievable.

Relationships Australia

The structure of family and kinship ties varies across cultures as does acceptable social behaviour between men and women. Exposure to the way people in relationships demonstrate care for each other can cause value crossing and result in value judgments when a difference is noted. For some participants certain aspects of the relationship between family members elicited feelings of empathy for elders. For those who observed public displays of affection or different social behaviour related to sex roles, fear of judgment by their own standards was evident.

Family ties, a disconnectedness. From observing family interactions here in Australia, Felisa came to the conclusion that most people live separately from their parents and that visits to close family members only occur on three or four days during the year. She has decided that she will not adopt this custom.

> *No I personal I would not do this thing. I would not live separate to the, from what I know they say there are only three days in the year you will be with your family Christmas eve, Easter and Fathers or Mother Day you must be like there. I think how come only four days like that. Won't be, I don't think I will do this (Felisa, p.15).*

Jin made a similar observation and provided an example from her own experience of working as an assistant in nursing in an aged care facility. She was

saddened by the events she witnessed and came to the conclusion that the reason for the lack of family interest in elderly relatives was culturally based.

> *Normally just like, because like, actually my grand pa is really, really sick but you know every day my mum go to the hospital to see my grand pa and talk to him. Every day, also like all of the family there. Compared to the Australian one. I just, nearly one week, I didn't see relatives come to see him. You know just really sad. Every Saturday and Sunday you know the old people prepare, they shower everything. Then they just wait in their family until, I mean lunch time no one come. Then they just feel very sad, eat and go out and wait again and no one come. I just OH My God! Oh My God! What I think is kind of like culture difference between Asian one and Western one (Jin, p.2).*

Both these comments came from students with an Asian background and clearly projected their dismay at the examples of family connectedness they observed. Living apart from family appeared to translate into disconnectedness for these participants. This disconnectedness not only involved the elderly who are placed in aged care facilities, but also the younger generation who live apart from their parents. Consequently, feelings of empathy and sadness were generated in these participants. It appeared that the participants have noted disconnectedness between close family members that was exacerbated by distance and was something they choose not to replicate.

Boys and girls, disquiet and dilemmas. The physicality of relationships between young men and women here in Australia came as a surprise to some participants. Coming from cultures where open displays of affection are not tolerated, some participants have had to come to terms with this behaviour even though it appears to be the subject of some consternation.

From Amy's perspective holding hands and hugging between male and female is acceptable. However, Amy is particularly affronted by couples kissing in the street and explains that this kind of behaviour only happens behind closed doors in China.

> *You know in the Chinese culture the male and the female umm, before the married they don't touch each other. You know in the, in the Australia we*

can see that they kiss each other in the street but in China you can't see that. Hold hands is common but kissing on the street it. Not saying it's not good to do that, it's just inside at home. We can hug each other you know, you understand me? (Amy, p. 2).

As another cultural perspective related to moral behaviour Jane explained that in rural India, girls who drink or smoke are considered to be promiscuous and that same judgment is passed to girls from developed nations. Jane presented a complicating dilemma, because driving a car is also considered immoral for a woman and now, living in Australia, she needs to get a driver's licence.

Over there if you are from the rural place the girls do not drink or smoke over there it is a big thing. So that they think that the girls are loose and all that. That's what they think about all the developed countries. The boys think that they are good but the girls are being treated like they are loose and they are for anything. Even driving a car, my father never allowed me to drive even now I don't drive. Because if you drive, you are going off to meet guys then you, ah that is a problem. Now I have to go and get a license (Jane part 2, p. 2).

An aspect of socialization in any culture is the relationships between the sexes. Expectations and boundaries relating to this kind of relationship may be governed by the appropriateness of particular behaviours that are observable to others. Observations of how men and women act towards each other in expressing a relationship can be confronting for those not readily exposed to public displays of affection, such as kissing, in their home culture. Further constraints on female activities that may infer clandestine meetings with males, or behaviours such as smoking or drinking, are interpreted as inappropriate and inviting attention. Possessing culture specific beliefs and values about relationships may prompt personal dilemmas and disquiet when adjusting to behaviours observed in Australia.

Cultural expectations of social behaviour in relationships were highlighted by these participants. Challenges to values and beliefs about these relationships produced various effects. Feelings of sadness were generated by the perceived lack of commitment to elderly family members, which, in turn fortified the participants' home

cultural values in this area. Living apart from relatives was interpreted as a disconnectedness that was not in tune with the home experiences of the participants. The appropriateness of relationships between men and women appeared to be dominated by the socio-cultural rejection of certain behaviours, which were observed here in Australia. Observing these behaviours generated internal conflict and dilemmas for some participants. Adjustment to the values and beliefs of another culture appeared to have caused the participants to question their own attitudes towards relationships.

Australian freedoms. The underlying political structure in Australia allowed certain freedoms and entitlements that are not experienced worldwide.

Having been born in Iran, Zara experienced a country governed by a different political system, one based on Islamic Law. She was happy because what she observed in Australia was that people are treated with respect, a value that was of great importance to her.

> *To be honest I am very happy .At my age I try to learn because very different Cathy, I don't know how to explain. People are people and they require respect and government give them. In my country no (Zara, p.5).*

Mi Mi was both relieved and happy to find that in Australia health care was provided free to people without any extra inducement, contrary to her experience in her home country of Poland. Mi Mi suggested that corruption was present in the Polish health care system she had experienced and payment was necessary for the receipt of appropriate care.

> *In Australia, it was like paradise! I was like you can do things without bribing people. You can go to the hospital and deserve proper health care without giving extra money in the envelope. So was like wow that perfect! (Mi Mi, p.14).*

The realization of how a different political system impacted the lives of the people in that country is poignant. Both participants expressed delight and joy at being able to enjoy what Australians consider to be basic rights, respect for all persons and equity in health care provision.

Summary

Little knowledge of Australia, its inhabitants and their way of life generated a number of issues. These issues mainly stemmed from adjusting to a new culture. Assumptions, generalizations with resultant confusion and even conflict were illustrated as some of the experiences that demonstrated a process of cultural adjustment. The act of defining what or who is Australian proved difficult in a multicultural society. However the friendliness of people in that multicultural society came as a shock. Cultural differences were noted mainly around relationships with family members and between men and women. Thus, the sociocultural aspect of adjusting to a new culture was evident. The political aspect of cultural adjustment was not neglected. What this means for learning to nurse is that an understanding of the nurse patient relationship as friendly, interactive and tolerant, is internal to its functioning.

Theme Four: Encountering and Engaging with Language in Context

Interacting and communicating in the clinical environment occurs through a multitude of mediums. Language in the clinical context relates directly to verbal dialogue, reading, and writing and is largely constructed using medical terminology. When language is effectively interpreted, an appropriate response is elicited. To effectively communicate using contextual language is a complex task. Staff and students must be able to use English language (and all its forms), the Australian vernacular, and combine them with medical terminology. This complex task is encountered every day, where staff and students are expected to engage with language, that is, taking it on to perform or enact a response. Those entering the clinical environment are expected to have increasing levels of ability from their first foray into the clinical learning environment.

MAJOR THEME	SUBTHEME	CHARACTERISTIC
Encountering , and Engaging with Language in Context	Language Level Readiness	Expectations
		Onshore language background
		Offshore language background
	Australian English and the Vernacular	Australian accent
		Vernacular and understanding
		Unanticipated speed
	Encountering Language in the Clinical Environment	Engaging with ill patients
		Breeding frustration
		Engaging with written language
		Striving for improvement
		Placement for improvement

Language Level Readiness

Using Australian English as an additional language was an issue for most of the participants. Some participants spoke up to five languages due mainly to the geographical location of their home countries. Because of this, it was inappropriate to classify some participants as having English as a Second Language (ESL). It would appear that on a fundamental level the participants were aware of the need to use the English language to study in Australia. Entry into the Bachelor of Nursing (BN) program requires an IELTS score of 6.5 across all bands. Despite fulfilling that university admission requirement, participants arrived with limited English language background. When participants were confronted with the everyday usage of Australian English, it became clear that they were less than prepared.

Expectations. Louisa held an expectation that she would have some level of difficulty in regard to English language usage as she began her studies. Her apprehension led to anxiety at the beginning of her studies, mainly because the level of language expected was unknown.

Oh, any way I never I ever thought in my mind that is was going to be easy. I have to say there's really a language barrier. I was really anxious before I

started first semester last year. I didn't really know what to expect (Louisa, p. 5).

Onshore language background. Having completed high school here in Australia, some participants were able to gain entry into the BN without providing proof of language ability such as the IELTS.

Felisa benefited from prior language exposure by having completed high school here in Australia. However, she still felt that her English language ability was inadequate compared with local people.

Yes benefits a lot but I can still feel a gap between me and those local peoples (Felisa, p. 4).

Jin had also completed high school here in Australia. However, a registered nurse from the clinical environment doubted her language ability. This interaction caused Jin to justify her language ability. Jin asserted that, compared with other people who are exposed to English from birth, her use of the English language was introduced at a later stage and that the nurse's reaction was essentially unfair. Jin articulated that as Australians we have studied English language from a young age and that she was expected to be at the same level after only a few years of study as an adult.

Then the nurse, how can you graduate high school? How come you get to university? That makes me think that you study English from a little baby and I am getting older. I just think that kind of thing, really bad (Jin, p.9).

On arrival in Australia Amy attended a four-week language course provided by the university. She described her level of ability as being equal to that of a two-year-old child at that time. She was well aware that her language was not of adult standard and deprecated herself as a result.

I have been here about more than one year and a half, and when I came here I begin to speak English I just don't like me. It's just like a one-year two-year-old baby. So my standard is not equal to you (Amy, p.4).

The length of onshore language preparation for a non-native English speaker would seem to have little effect on the participants' self-confidence once they are

immersed in the clinical environment. In comparing themselves with the language ability of the local people the participants were aware that their language level was inadequate. Contributing to this inadequacy were the comments made from staff about the adequacy of the participants school education.

Offshore language background. Yvonne, a Nepalese participant for whom English was her third language, was exposed to English language classes throughout her childhood education in a Catholic convent school. She then furthered her studies at an undergraduate level in the United Kingdom. Even so, the skilful use of English language required for spontaneity and free flow of conversation was not something that came easily to her. The awkwardness related to planning and reaction time required to respond in an appropriate and meaningful way generated feelings of numbness for Yvonne. The requirement for instantaneous and spontaneous conversation rendered her incapacitated in this instance.

> *But for me coming from a different background sometimes I can't even speak properly at times I just get numb, and cracking up jokes and things it's spontaneous, you can't just like think, do it instantly. And with English basically because I don't speak the same language, is not my first language, you know I have to think before I speak, makes things difficult for me. Awkward situations sometimes you want to do something, say something sometimes and it just doesn't come out (Yvonne, p.3).*

Lyn explained that despite a compulsory English language course in Zimbabwe, the use of English in the workplace in the capital city of Harare, and as a common language between multiethnic African peoples, there was some self-doubt about her competency. A lack of confidence to use the English language skills that she possessed became evident for Lyn once she arrived here.

> *Even when I use English back in my country, but when I came here I wasn't confident enough to use it here. Am I good enough? (Lyn, p.23).*

Phoebie described the English language class that she attended in China. She identified the type of English language instruction conducted in Mandarin, a class lasting for one hour per week. Phoebie highlighted that the class is a mixture of

Mandarin and English and that the students were able to converse in Mandarin, not solely in English.

> *I'd study but just may- be one class each week and about one hour, and also in the class, the teacher he will use Mandarin you can talk in Mandarin so (Phoebie, p.4).*

The following comment from Irene highlighted the social and emotional aspects of an everyday occurrence such as answering the telephone to someone with limited language ability. Irene had attended an English language course in her home country prior to coming to study in Australia. This incident is multifaceted and deals with language confidence, comprehension, and articulation. For Irene, the lack of these skills caused feelings of worry and the outcome was avoidance of social interaction. The impact of the experience has left a lasting negative impression.

> *So when I'm at home and the phone rings I don't like to pick up because I worry. I think if I pick up the phone I think I cannot answer, and if they speak and they might give me a lot of things, what can I do? So I just ignore the phone and I don't go out by myself and I told my friend and the clinical staff as well and that time was terrible (Irene, p. 10).*

The level, type, and standard of offshore English language instruction was not made apparent and perhaps irrelevant to university course admission centres. However, what is known, explicated and relevant through admission policy is the level of achievement in the IELTS test required for course admission. From the responses of these participants it is clear that even though admission requirements had been met for English language testing, the participants' confidence and language proficiency remains inadequate. This inadequacy was clearly identified by the participants themselves and resulted in a range of negative emotions.

The participants' language proficiency and confidence was judged by themselves as inadequate once they arrive onshore. It would seem that whatever language preparation they had received, and the consequent testing that allowed admission to the course, became redundant once the student landed in country to begin nursing studies. Once the participant had entered the clinical environment and began

immersion into the language, realization of the level expected and negative comments from nursing staff radically affected the student's confidence.

Australian English and the Vernacular

The participants articulated both formal and informal methods of language preparation that focused on American English usage. Television programmes were the most common form of informal language preparation discussed. Exposure to American English from television drama and from formal methods of language instruction was interpreted as being a satisfactory form of preparation for communication here in Australia. However, once engaged with the Australian community in the clinical setting, some difficulties began to emerge especially with the vernacular or slang language.

Australian accent. Phoebe identified that she has no difficulty understanding dialogue from American television programs. However, despite concentrating, she noticed that information was omitted from her understanding of conversations with older people in the Australian community**.**

> *I find that I, when I watching American drama, I can understand 100% but the Australian accent especially the elderly, I have to concentrate 100% on the conversation but still missing some of the conversation, its hard (Phoebe, p. 4).*

In Taiwan, Irene asserted that American English was the mode for language instruction. However it is not used every day as the Taiwanese have their own language. Learning to use Australian English, the speed of language and the Australian vernacular complicated communication to the point of causing Irene to feel lost.

> *In my country we learn English as well but we do the American way, and we don't use English as much as here because we speak our own language as well. But here you have to speak English. So here you have to speak English even though you pass the exam you fail, because you speak fast and you have an accent, they have slang and you think oh what's that and plus abbreviation. Another question mark over there. You feel lost (Irene, p. 8).*

Informal and formal language preparation methods using American English seem inadequate for engagement and understanding in the Australian context. Coming to know an American language structure, accent and phrasing, led to participants missing parts of the conversation with speakers of Australian English. In addition, communicating in the clinical environment was complicated by; slang; abbreviations; accents, and speed of speech. Language complexity of this kind led to confusion for the participants.

Australian vernacular and understanding. The complexity of communicating in a group where Australian slang is being used was identified as a problem for Milky. She admitted that she was able to understand medical terminology that may be used in a lecture, however at the same time knew that she would be unable to understand a conversation where slang was used.

> *Australian is famous for their slang you know, and I understand the medical terms in the lecture in the uni, but if you put me into a group where they speak like slang I wouldn't have a clue what they are talking about (Milky, p.6).*

Angela provided an example of a typical request that may be used in any context. For example the word *grab* is foreign to her so she would not know what to do if asked to grab something.

> *But if you are local and you know how to say the sentence. Ah, like you ask me to give you a cup, may be if me, I would say can you bring that cup? But you say can you grab that cup? That's different words (Angela, p.8).*

Both Milky and Angela identified words that are unique to Australian English, and can then attribute their lack of understanding to the use of words that they do not know. They were aware that Australians have their own slang language and that it impacted on their ability to comprehend verbal interactions.

Unanticipated speed of spoken language. Lyn explained that there was an additional factor in effective communication, she was unprepared for the speed of language. One consequence of this was that she would pretend that she understood the conversation.

So people say that your, your English, you speak English pretty good! But, I find that I have problem with those who speak quick, and I couldn't catch up with them [Laughter] And I would go OK but I didn't understand (Lyn, p. 7).

Zara also identified that speed of language was an issue for her. In this instance she took the initiative and requested the person to slow their speech down. Zara felt that from a professional perspective she should be able to speak the language appropriately. Not having developed that ability, caused her to feel considerable shame.

Sometimes patient ask me and sometimes I can't explain and sometimes you speak very fast so I ask to please slow down. You know shame on me! I am the professional and I can't speak English {laughing}. It's very, very, big point (Zara, p.4).

Angela took the issue of the rate of speech one-step further and identified that the speed of language appears to increase with the younger generation, increasing the difficulty in understanding them.

I have sometimes, ummm; know especially the local young girls or young boys they speak very fast. I can't understand them (Angela, p.4).

For the participants, full comprehension and understanding of a conversation with a person who uses Australian English, was dependant on the speed of the language. The fast rate of speech led to the participant missing vital parts of the dialogue or feigning understanding. Having to ask somebody to slow down their rate of speech was seen as humiliating for one participant. However, the importance of understanding outweighed that emotion.

The complexity of Australian English language was not understood by the participants until they were immersed in the language onshore. Despite meeting required language levels for university admission participants still struggled with every day Australian English.

Encountering Language in the Clinical Environment

Encountering clinical language began with some participants identifying the importance of language in the clinical setting. Progressively, participants began to

realize that it was not just a command of the English language that was required to communicate effectively in the clinical environment.

Significance of clinical language. Having some home country nursing experience, Irene brought that to the Australian clinical arena. By utilizing this experience, she was able to identify some similarities in practice. However, the language difference was apparent from the beginning.

> *The first time I went to the uni and the first time I went to the clinical here, I'm thinking it's still the same as a nurse you deal with the patients, deal with the doctor, professional team exactly the same , just the language different, um.. (Irene, p.2).*

Felisa identified the importance of learning the English language to practice as a nursing student in Australia. She identified language as the most important factor common to all aspects of learning to nurse in Australia.

> *Yes only I think language is the first of the first, yes the most important. Being an international student living here I'm supposed to learn the language to be able to communicate with other peoples like in hand over and read the language, when I give the medications. I need language, if I have a question, I need language, it is very important (Felisa, p.13).*

However, the seriousness of having the appropriate level of language is made clear by Mi Mi. She contrasted responsibility for language learning when studying nursing to the study of economics, and illustrated that language could mean life or death when it comes to nursing. She pleaded for prospective nursing students to complete a medical language course.

> *You know if I study economics no problems. But nursing and the medical language is different. So whoever wants to study nursing or medical course in Australia please do medical course before. You know it is not a joke. If you make a mistake in economics who cares! In nursing, you kill someone (Mi Mi, p. 26).*

The realization of the importance of language relative to the practice of nursing in Australia was identified by these participants. It was clearly understood that language

related to providing care was different to what had been previously experienced, pervaded all areas of nursing practice and was imperative to the safety of patients.

Contextual language: vocabulary and vernacular. On entering the clinical context, it became apparent to some participants that it was not only a working foundation of English Language that was required but, in addition, it was expected that they learn and understand medical vocabulary and nursing vernacular. Participants referred to these as medical or nursing language. Contextual language learning was an unexpected requirement that compounded language difficulties already known to the participants.

Mi Mi identified that she was not adequately prepared to study what she called medical language in English prior to her arrival as a nursing student.

> *I wasn't prepared to study medical language here in Australia in English (Mi Mi, p.25).*

Angela pointed out that although she had some limited in country medical language experience it was inadequate due to the lack of contextual application in China. Consequently, an extra commitment to improving her medical language proficiency was required.

> *We have a class about medical language we always watch some medical TV in the class but you know it doesn't help because we don't have such an environment to learn English. To use medical language we have to learn, really learn (Angela, p. 9-10).*

The language used in the clinical environment by nurses also has its own vernacular. In this instance, Irene was familiar with the commonly used collective term 'vital signs' for taking a patient's, temperature, blood pressure and pulse. In the clinical environment to term 'obs', short for observations, is used instead. For Irene, her lack of awareness resulted in the negative impression that was given of her as a student.

> *And then she asks me can you do a favour for me? Can you do all the obs? And I thought obs what is obs? {laughs} and I say what do you mean by obs? And she is quite surprised. And I say, excuse me can you explain what you mean by obs?' She 'You don't know? But aren't you a second year*

student?' and I say yes I am and she said' Don't you know how to take a blood pressure?' and I thought oh vital signs! And I said oh yes I just don't know what is obs mean. And I feel very frustrated and she must think that my ability is very terrible, terrible! Because I didn't know (Irene, p 3).

Felisa identified that having to learn a language specific to nursing created an additional hardship.

Like, English for me is already another language, but language in nursing is like another language compared with English, for me is hard (Felisa, p.4).

The contextual language, which prevailed in the clinical environment, was understood by these participants as a complex layering of three language types. Firstly a foundation of English language secondly, a layer of medical vocabulary and finally, nursing vernacular. It appears that the participants were unprepared for the complexity that contextual language presented and that complexity led to the need for additional learning.

Hearing but not understanding: Encountering words with no meaning. Despite on campus preparation for the clinical placement that involved instruction, demonstration, and actual hands on manipulation of various kinds of equipment, some participants experienced an inability to recognize and retrieve a piece of equipment as requested by someone in the clinical environment.

Lyn was unable to retrieve a bedpan as requested by the nurse. She could hear the words but could not associate them with anything that she knew.

Like it happened, like someone say, the nurse say 'go and get a bed pan!' I could hear bedpan, but I couldn't understand what bedpan mean (Lyn, p. 7).

A similar experience was had by Jin where she was asked to retrieve an infusion pump. In her verbal response, Jin was unable to pronounce the name of the equipment properly; she stated *influsion* instead of infusion.

And one nurse came in up and say to me can you get me the influsion (sic) pumper? I, what a pumper? Where can I find it? And the nurse went 'Oh My

Gosh!' Then they wanted to go away and find it herself. I was like Oh. I'm really sorry I don't know what that is (Jin, p.6).

Felisa also experienced a similar episode. She also mispronounced the word syringe, although when she hears '10 mills' she interpreted that as meaning a syringe.

Cause once to me the RN said can you go to the store room and get me a 10 ml springey. Springey (sic) for injection. Yes syringe. But I don't know what a syringe is. I heard 10 ml and just guessed it was a syringe (Felisa, p. 12).

It would appear that recalling the names of commonly used equipment was a difficult task in the clinical environment. Being unable to identify and retrieve requested items could be interpreted as gaps in the participant's knowledge, and be used to form a negative perception of their knowledge base. Mispronunciation by two participants was noted, which possibly could be attributed to their reduced ability to retrieve the equipment. However, the inability to recall and retrieve suggests a level of unfamiliarity with linking words to objects.

Confidence crisis: Searching for familiarity and understanding. Confidence to engage in the use of language was won or lost depending on the people encountered in the clinical area. Confidence was lost when participants felt that they were in the cultural minority or when they met with an unsupportive clinical facilitator. A loss of confidence resulted in varying emotional responses from participants. On the other hand, confidence was increased if the facilitator was also someone with English as a second language as they were perceived as being more sympathetic to the students' struggles engaging with clinical language.

Self-comparison with Australian or local students and their language ability became a matter of concern for Angela. In her third year of study, she logically explained that she could communicate with her patients at home in China very well. However, when placed with local students in the clinical environment, awareness of her deficits was increased.

...and when you have clinical with the Aussie, and you all third year student, so they are better than you. Well, because they can communicate with patient very easily. You know, when I was in China I can communicate with

my Chinese patients very easily. When I was in China I was a very good student but here in Australia I'm not (Angela, p.5).

James looked to the cultural mix of the staff to find some level of comfort, a degree of familiarity that would increase his confidence when communicating in the clinical environment. When placed in a clinical environment which renders him in the cultural minority he becomes less confident.

I think it is the familiarity thing that comes up, for me. I mean, if I see in the same hospital I see lot of Indians , for example [hospital] is full of Indians, the nurses are all Indians and stuff, I would say I'd be more confident in approaching (James, p.6).

Amy received some negative feedback from a clinical facilitator regarding her language ability. Engagement with critical feedback resulted in a withdrawal from using language in the clinical environment and an emotional stress response.

...She said if you want to stay here you should do this, you should do that, you should learn English and things like that. And after that I feel, that I feel really scared when I open my mouth I feel really scared because I feel really scared if make some mistake. Yea so I, so stressed before next clinical. So I cry and I call my mother to go back. I don't want to stay here {Crying} (Amy, p.4).

Angela found that facilitators who were from non-English speaking backgrounds were more understanding of language difficulties than those with English as a first language.

If the facilitators are not from, I mean their mother language is not different from English, they cannot understand you have problem about your communication. My first and second facilitator, they are from Australia so they tell me 'I have problems about your communication'. My third and fourth, one are from the Philippine and Korea and I think they can realise I have problems with communication (Angela, p. 8).

The ability of participants to engage in the use of clinical language appeared to be impaired by a lack of confidence that was generated by comparison with local

students and feelings of being in the minority. A complete withdrawal of engagement was the response when critical feedback was received. However, confidence was bolstered by working with someone who was perceived as being sympathetic to the student's plight, specifically, when that person was identified as also having English as a second language.

Deciphering the written word. Encountering written language is a frequent occurrence in the clinical environment. It is paramount to providing safe and effective patient care. The interpretation of orders from medical staff, understanding patients' notes from the previous shift, are just some examples of written material that needs to be read, understood and acted on.

For Phoebie the task of reading patients' notes was time consuming and difficult as she was unfamiliar with writing styles or language construction.

> *Because also is need to know find time to read the progress notes because the way they write is different and I need to know their style or how they write that (Phoebie, p.3-4).*

Felisa experienced difficulty reading and understanding a hand written medication chart. In this instance a learning opportunity to participate in a medication round was lost. This was due to her inability to interpret the written order, including the names of the drugs, a necessary step to administer medications.

> *Bad experience. Because almost all the drugs. I did not really touch the drugs sort of thing; they let me have a look at the drugs. I just couldn't, just understand anything. I think handwriting may be one of the problem as well (Felisa, p.5).*

Currently, in the clinical environment, many documents are still being hand written despite the introduction of more advanced electronic formats. Therefore, students are expected to be able to read and interpret the handwriting before them. For these participants, deciphering handwritten words and their grammatical construction was required before understanding was reached, and access to participate in the skill of medication administration was granted.

On entering the clinical environment the importance and seriousness of the language that is used to communicate became apparent to the participants. It appeared that some participants were not prepared for the level of proficiency expected of them, nor had they been exposed to different types of clinical language that would result in some familiarity and understanding. Although Australian English is the dominant language used in the clinical setting, it became apparent that medical terminology and nursing vernacular were additional language types that had to be learned, increasing the complexity of clinical language. To feel confident and able to engage with language in the clinical setting, participants searched for other people who had English as a second language, as comparing themselves to the local students only decreased their confidence. A decrease in confidence often resulted in an emotional response described as stress or fear. Hand written language required deciphering as familiarity with language construction and writing style was lacking. Inability to read and interpret these types of documents resulted in restrictions being placed on learning opportunities.

Engaging in Clinical Language

Actual engagement, reading, listening, understanding and responding to the variety of language in the clinical environment is essential to providing safe and effective patient care. Participants were exposed to the general Australian population mix in the clinical context. Thus, the multicultural nature of society was represented as people experiencing episodes of ill health, which posed an impediment to understanding forms of clinical language. In addition, difficulty was also experienced by participants in language construction when creating written documents.

Engaging with diversity. The multicultural nature of the Australian population and the resultant cultural diversity of the inpatient population seemed to have a significant impact on the students' ability to engage with language and provide appropriate nursing care.

Manoj appeared to cope well when engaging with patients from English speaking countries. However, once he encountered patients who spoke English with a discernable accent, problems arose. His difficulty in understanding was further compounded when the patients' language was affected by an emotional episode.

Most of patient are usually from English speaking countries but there are some from countries other parts of the world such as Poland, Dutch, Greece and their way of speaking is altogether different. The Greeks speak English with a different accent and the Polish speak English with a different accent, sometimes it's hard to understand. If you are listening to someone frequently you get used to it, and you can't understand when they are upset. So that type of problem is for me (Manoj, p.5).

Mi Mi presented an issue where she assumed the patient could speak English but refused to do so. This caused frustration for her as it is the common language they are assumed to share. The patient's refusal to speak English impeded the provision of appropriate care for his needs.

I think the language barrier was the biggest thing. Especially with the older people who live long in Australia. For example, a Chinese man I am sure that he can speak English but sometimes he doesn't want to (Mi Mi, p. 5).

Engaging in using language with patients who had an accent, or who refused to speak English, was identified as an obstacle. A lack of experience in listening to accents was identified as the main contributor.

Engaging with ill patients. Engagement with a patient who was suspected of being confused presented a challenge for Milky. Difficulty arose because of a difference in cultural expectations that were related to behaviour. Consequently, she felt unable to determine if the patient's behaviour and verbal responses were normal. Milky found herself abandoning engagement with the patient on any level, due to feeling overwhelmed, and taking refuge in the toilet.

….I don't really possess the ability to assess whether they have dementia whether they are confused or not, because the culture is different. Is the behaviour normal for them? I even don't know how to feed them, how to communicate with them. I just tried to hide in the toilet in that period in my first clinical placement (Milky p.1).

Mi Mi was unable to understand a patient's request for help because the patient did not have his dentures in place. This resulted in the patient experiencing physical

difficulty forming words. Therefore Mi Mi was unable to render him assistance in this instance.

> *...and he's telling something, he doesn't have his teeth and he's asking for help. He wants me to do something for him and I don't understand really (Mi Mi, p.5).*

Milky cared for a patient with a tracheostomy who was unable to communicate verbally. After attempts to interpret what the patient was mouthing to her, she surrendered to her inability to understand and admitted that the best she could do was to guess at what he was trying to say. Guessing was the limit of her ability as she was unfamiliar with words with no sound.

> *You know if you are born here and you grow up here and English is your home language you can sort of guess what they want to say and I have to. And that's really difficult for me. And I got a patient who have spinal cord injury and he has tracheotomy and he mouths words and I cannot read that. I can really guess what he wants to tell me. I just leave it that's all I can do (Milky, p.6).*

Engaging with patients was difficult for these participants if the patients were confused or experiencing physical symptoms that hindered their ability to pronounce or verbally form words. Nurses in the clinical environment are commonly faced with this communication difficulty, however, in these cases the problem was complicated by a level of unfamiliarity with language and behaviour. There were similar outcomes of this type of interaction for both the participants and the patients. For the participants there was an inability to: adequately decide if a patient's language and behaviour is normal; respond appropriately to a patient's request, and a feeling of being overwhelmed so intense that retreat and refuge was sought. For the patients, appropriate care may not have been provided.

Breeding frustration. The need for constant clarification while attempting to understand clinical language was noted by participants as having an effect on those they were engaged with and resulted in episodes of frustration for those engaging with some participants. Frustration was felt by the participants themselves, and was sensed, as a reaction to them from others, including patients.

For Milky, the need for repeated clarification not only resulted in what she perceived, as boredom for the person she was engaging with, it was also embarrassing for her.

> *Yes and I would ask them twice and if I still can't understand then its really embarrassed you know to repeat several times and they would be bored to say several times (Milky, p.6).*

When Angela asked for clarification, she knew that if the person she was engaged with changed a word in the interaction once or twice that could be sufficient for her to gain understanding. However, repeated questioning may result in her being seen as a poor student even though she was trying her best.

> *I always try my best to understand them If they change a word may be once or twice that OK. But if I always ask how is that? How is that? May be they think oh bad student (Angela, p.9).*

Felisa explained that she might be perceived as asking silly questions if she persevered with attempts to clarify understanding past a certain stage in the interaction.

> *Sometimes if I ask the people they might, I sound very annoying. And say 'Why ask these silly questions?' And then feeling like I'm asking silly questions (Felisa, p.13).*

For Angela, an engagement with a patient provided an example of how illness can affect a patient's ability to tolerate constant clarifying.

> *... patient sometimes pain or she worries something, and she is not very patient to you. And when you said, I am sorry can you say that again I didn't hear very clearly? And the patient very, very angry. And he said How can you be a nurse? How can I speak to you three times go! Go! {Motions with hands}. So I think it's better I go, cause I don't want to stay (Angela, p.4).*

Yvonne discussed the need for careful thought when choosing the most appropriate words to use when engaging with patients, especially on a mental health placement. She displayed awareness of a negative impact on the client if she took her time.

You have to think a lot before you speak and which is if you go on clinical and you go and talk to a patient with a mental illness they might think they are judging me. Why is there this awkward silence between? But the other person is thinking what should be the appropriate words because this is not my language. And the patient might think she is treating me so badly (Yvonne, p.3).

The act of constantly clarifying by participants resulted in feelings of frustration in themselves and in those they were interacting with. From these examples there would seem to be a tolerance limit for questioning and after that a negative perception is formed of the participant. The tolerance of ill patients in the clinical environment was tested, which ultimately resulted in a participant being removed from the patient's presence. There was a degree of awareness by participants of the effect they had on people they were interacting with, and a level of consideration for their feelings.

Engaging with written language. Engaging with language in the clinical environment also meant contributing to it. Whilst in the clinical area participants were required to document care given in an appropriate way. For some of them writing and spelling everyday words was difficult.

Lin had difficulty with words that she was not used to. The example here is the word 'distract' which is not usually a medical term. The best that she could do is to guess the spelling. She finally apologizes for her lack of knowledge.

Not even medical words like distract I don't know how to spell it. May be how I can guess but I don't know how to spell it. I'm sorry (Jin, p.9).

For Amy having a clinical facilitator as a collaborator who was available and willing to assist her in formulating her documentation was beneficial. The important benefits identified by Amy were twofold the appropriateness and correctness of the words chosen and the professional level required of documentation.

...she was really wonderful she can remember every students patient and she go with me when I do the handover, write the report and she recognize the things you know? How to use the words to describe this situation. Yea and umm you know sometimes you know it's, you have to write this way not

that way, even they have the same meaning. The little things make it professional (Amy, p.5).

Possessing knowledge of appropriate words, their spelling and meaning all contribute to the formulation of accurate professionally written clinical language in the clinical environment. It is an expectation that those entering the clinical environment possess a basic level of written language. For those who do not, a collaborator appears to be beneficial to eliminate guesswork.

The main forms of language encountered in the clinical environment are verbal and written expression. This expression comprises English language and its construction, Australian vernacular, medical terminology and nursing vernacular. The understanding of language by the participant was greatly affected by the patients' accents, health issues and symptoms or resultant affect. The outcome of engaging with patients who were suffering from an illness or who were unable to communicate via the usual oral means, was that participants became overwhelmed, ignored attempts to communicate requests for assistance or made a guess at what patients were trying to say. This type of behaviour could have serious consequences for the health of a patient. When participants engaged with staff or clinical educators there were instances where clarification was required to aid understanding. It would appear that there is a limit to which repeated requests for clarification would be tolerated and, after reaching that limit, a sense frustration or anger occurred. The resultant frustration was also evident from patients. When written language is encountered, another dimension is added to the ability to comprehend a document. Language construction and handwriting increase the difficulty in reading for some participants. To the credit of the participants, there was an awareness of the effect that their limited language ability had on staff, clinical educators and patients, which led to the development of strategies for improvement.

Striving for improvement. For the participants who acknowledged a need to improve their ability to engage in clinical language, a number of self-help strategies were exemplified. In addition there was some criticism levelled by the participants at the amount of time, and the type of placements allocated, as being inadequate for the development of clinical language skills.

For Phoebie, watching television drama became an improvement strategy. On reflection, they were not of much assistance as they were acted in American English.

> *Um, uh, I think that I will watch some drama and some English shows but I still find difficult cause much of it is American (Phoebie, p.4).*

Angela also believed that her language ability was improved by watching English television and listening to English music.

> *So always watch English TV and listen English songs to improve myself. I think like I should keep confidence (Angela, p.4).*

Mi Mi discussed a number of strategies that she used and her rationale for their selection. She highlighted that she concentrated on the speed of the language used in medical type dramas portrayed on the television because she may be required to react with the same urgency in the clinical environment.

> *With my language for example; movie, the ER, the TV Grey's Anatomy whatever. I tried to follow it not because of the, not because I like it, but this is based in the hospital. They are talking fast, I need to concentrate um How to listen how to understand when they are talking fast about things. The patient has a stroke at the moment so I need to react and do things fast! Watching movies, reading some extra books maybe, a book I got it here from the [name] book shop actually, terminology, that was helpful (Mi Mi, p.24).*

To increase her vocabulary, Angela developed a notebook with essential words that she reviewed in her spare time or took to class.

> *The words we have to learn we write down in a notebook, a small one I mean and when we take class or take train we should read it (Angela, p.10).*

It appears that participants believe listening to the language in movies, music and on television is an appropriate way to improve their own abilities. However, watching television drama may raise questions about its suitability, due to its tenuous link to the reality of practice. This type of language exposure does not require any kind of response from the listener, so actual engagement or practice is limited. Recording new words in a notebook for the purpose of review later may possibly serve to increase

vocabulary and aid in spelling. These strategies required participants to be able to recognize their learning needs in this area and become motivated to improve.

Placement for improvement. The most appropriate place for clinical language improvement may not be the acute care environment.

Lyn provided her perspective on the most appropriate place for learning to engage the use of clinical language especially with patients. Here she has provided a rationale that in the acute care setting the patients are too ill to be engaged in conversation with students who require language practice. On the other hand residents in an aged care setting actually want someone to talk to.

> *The second semester second year we went to the nursing home and the people there are all old and they want someone to talk to! In the hospital people are sick and don't want to talk so you feel ok and leave them alone. But in the nursing home the old ladies there are lovely! {Laughs}(Lyn, p.24).*

Placing students in an aged care setting to engage with the residents would provide access to a number of language learning experiences at a slower pace. Lyn identified that this placement occurred in the second semester of the second year, whereas it may be more beneficial to have this kind of placement earlier in the curriculum for students who require additional language support.

Clinical language ability develops over time. From the responses of participants who are in their final year of the program it appears that it is not only the context of the clinical placement that affects the ability to engage or develop skill in clinical language ability, it is the duration of the placement as well.

Immersion in the clinical environment constantly for one month meant that Phoebie had to force herself to improve her clinical language skills. Having done this she felt that this area of her practice had improved.

> *Yea I think communication skills I feel I improve a lot after one month clinical. You must force yourself to speak English here on clinical 24 hrs. a day (Phoebie, p. 6).*

Now in her final year of the Bachelor of Nursing (graduate entry), Jane recognised the benefits of engaging with patients concerning clinical language. It is clear that in the first year of her program she did not possess the confidence to take on such a language dependant task as an admission assessment. However, after repeated placements in the clinical environment, she had a newfound confidence and is proud of her achievement.

> *Now I can go and you know, just like now how I was in emergency at [hospital] so you get to admit a patient and you've got this form and ask questions and I was the one asking the questions. What happened? Why are you here? Checking to get all the information from the patient and even the nurse was saying, 'oh you are really good asking the patient!' and I say not in the first year I was really Oh! [Shakes head]. Talking to the patient was the best thing I did this year, yeah I was really confident (Jane, part 2 p.2).*

Avoidance behaviour and excuses were once Milky's method of dealing with a lack of confidence in engaging with patients. Now in her final year of the program, she has realised that she is able to talk to her patients and actually finds it enjoyable.

> *.... and recently I just realises that before they would try to talk with me I just told then I was busy and I really have to carry on with my job, and now if they have some social concern and some psychological concern I like to spend time to talk with them and see what I can do for them (Milky, p.5).*

The amount of time spent in the clinical environment and the exposure to clinical language seems to have made an impact on the confidence of these participants. The ability to be immersed in the clinical area for one month provided a focused period of time to develop clinical language skills. Over all, by the time these participants were in their final year of the program, they felt both comfortable and confident to engage in clinical language, especially with patients.

Summary

Correct and appropriate documentation and dialogue in the clinical environment is essential to the provision of safe and effective care. The forms of language encountered in the clinical environment include both written and oral conventions. Within these conventions are language structures that require a certain level of

proficiency. For those who are already struggling with English as a second language these conventions come as an additional language to be learnt. Knowledge of medical terminology and nursing vernacular, need to be understood and applied to the context of care. Understanding a patient's language is important, particularly where a patient may be experiencing a crisis or have an urgent request for assistance that if not understood may be life threatening. It is, therefore, not appropriate that difficult to understand language is abandoned, ignored or left to supposition. Behaviours such as these appear to be attributed to a lack of preparation and confidence, especially when it comes to the effect that illness has on a patient's ability to communicate. Compounding this situation is the addition of a patient who also has English as a second language. The level of tolerance that a person with an illness has to repeat a request over and over to a person struggling to understand is limited, as is the tolerance of staff in the clinical environment, where constant clarification is required to gain understanding. Mispronunciation of certain terms may also contribute to the inability to recognize their meanings, requiring clarification. It is possible that the acute care environment is not the ideal context in which to develop clinical language skills and a less intense and hectic area would possibly serve to ameliorate these issues. Self-directed strategies that are adopted by the learner are reflective of the motivation to succeed and the understanding of the importance of language to patient care, although, some guidance should be sought as to their relevance and appropriateness. However, it is suggested that as the Bachelor of Nursing program comes to an end, a certain level of confidence and understanding has been attained due to repeated exposure and an immersion period that sought to consolidate clinical language competence.

Theme Five: Impressions of Nursing

It is possible that planning to study nursing in Australia meant that some preconceptions of nursing are held by prospective students. These notions are often formulated by experiences or knowledge gained in the prospective students' countries of origin and brought into the clinical learning environment. These impressions can lead to certain expectations related to what nursing means, the role of the nurse, and the status of the profession, which may or may not match the Australian Nursing experience.

MAJOR THEME	SUB THEME	CHARACTERISTIC
Impressions of Nursing	Nursing, Variations on a Theme	Passion and Desire for the care encounter
	Perceptions of the Profession	Globalisation of medical dominance
		Excrement and elitism- Contaminates in the reputation of nursing
	Opinions of and Influences on Nurses' Work	In my country nurses do
		The omission or commission of care
		Primacy of treatment over ethical behaviour
	Female Nurses and Male Patients	Prohibited contact
		Intimate interactions lead to physical reactions
		Compromised reputations

Nursing: Variations on a Theme

In asking the participants if they knew anything about nursing before they came to study here, they articulated some general understanding. The participants brought with them impressions gained from experiences that shaped their overall concept of what nursing is and what work nurses do. Preconceived ideas about the status of the profession, expectations of the role, and cultural influences were identified.

Passion and desire for the care encounter. Passion for performing the role of the nurse in caring for patients was clearly identified from Cheska. She identified that this was the difference between doing a job and personalizing care of an individual.

> *Yes, you know that if you want to be a nurse you have to be a passion for nursing otherwise you are doing your job. You can feed and dress a patient but you need the passion to do a good job (Cheska.p.2).*

Another student who identified passion as an important factor in nursing was Jin. This response portrayed the nurse as a caring humanist whose interactions with patients had a positive and lasting effect.

> *...nurse is not a robot. You know robot does not have kind of feelings, you need to have feelings. To feel about the patient talk to the patient. That is the most thing I have to say. What you have to face is a human being, its not you like a kind of a table that kind of thing. Otherwise some of the patient I have to say they feel hopeless, really, really hopeless. If you didn't have any kind of feeling you just go ahead and then go away, the patient really, really feel bad. So I think, yeah I only have to say you need some feeling about your patient, feeling about your job (Jin, p.12).*

Mi Mi recalled her own experience as a young adult in hospital as the foundation for choosing to study nursing. She conveyed that nurses are present for those in need of care after being injured and that the help that was rendered to her by nurses was memorable.

> *Nursing was always for me caring for sick people. That is the first thing, and why I choose nursing is when I was seventeen, I broke my arm and I spent a long time in the hospital so, and I was watching the nurses and I was really sick and in pain so they were always there for me, when I needed them to help me out. Because I didn't know how to move. I couldn't go to the shower; I couldn't sleep because of the pain. So that was the first thing. To help people (Mi Mi, p.1).*

The desire to help people who are ill translated into a passion for nursing for these participants. This desire was inherently driven by a positive care experience. Whatever the driver, the overall effect of care experience encounter with a nurse who was passionate and helpful was positive and lasting.

Perceptions of the Profession

The acceptance of nursing as a profession in its own right is a concept that Australian nurses have fought long and hard to attain over many decades. Nurses in Australia are regarded as having high status in the community and enjoy the reputation

for being the most trusted profession. However, it would seem that there are some nations where this is not the case, where outmoded ideas perpetuate some derision of nursing.

Globalization of medical dominance. Cheska presented her perspective of the profession of nursing from her home country, the Philippines. She believed that nursing was not considered a profession there because of the perception that they are just assistants to doctors. However, in Australia she has observed that there is a well-developed professional identity to which people are proud to align themselves.

> *This is what I'm going to tell you, the difference between nursing in the Philippines and Australia. They are not really a profession they are just like assistants to the doctor. They don't have their own professional identity, just the assistant to the doctor. Here there is a professional identity, if you are a nurse you are gonna be proud to say I'm a nurse (Cheska, p.3).*

Having been a nurse in Iran prior to coming to Australia, Zara was able to make comparisons; she notes how nurses in this country are autonomous in making nursing decisions. In Iran that was not the case. The doctor's orders were paramount.

> *You now in my country nurses must follow the doctor order you know what I mean? Here nurses can act on their own, give some kind of a medication, you can do of your own decision. In my country never, they can't (Zara, p.3).*

Irene had also worked as a nurse in her country of origin, Taiwan. Her experience was that role distinction and chain of command, between doctor and nurse was unquestionable.

> *I'm the doctor I'm higher than you. You are the nurse lower than me, you have to do what I say! (Irene, p.6).*

The concept of medical dominance was clearly articulated by Manoj. The perceived opinion of superiority of doctors by the doctors, and the perceived inferiority of nurses by the nurses, illustrates the relationship between the two professions. Ultimately, doctors tell nurses what tasks to do.

Oh ahhh! The concept of that medical dominance is there in my country. The doctors think that they are really superior, and the nurses think that they are too much inferior. You do this, you do this, you do this! (Manoj, p.4).

Having been a medical doctor in his country of origin, India, James' perspective contained an element of nurses' dependence on doctors for the allocation of tasks. He explained that the doctor carried the responsibility in the relationship. Therefore, the doctor is able to give orders to nurses even though the process may have been resented.

But there is a distinction between nursing and doctor. So most of the responsibility is with the doctor, and the nurses are not very much comfortable mostly. And um, from like my view as a doctor from when I was working there, my view of nursing it was more of a general thing. Ah like you could say, the profession of nursing depended really on doctors. They tell them what to do and what not to do, it's like a subordinate thing (James.p.1).

The relationship between doctors and nurses took on a different perspective in the following response from Jane. It would appear from her understanding; nurses do a conglomeration of odd jobs, with no real role description or objective. However, the absence of a clear definition of the role, combined with the concept of medical dominance, led some to believe that nurses are at the disposal of doctors, possibly also including sexual relationships, this notion contributed to besmirching the reputation of the nurses.

Well nurses do this and that job, going and cleaning and stuffs like that. And it's been a bad thing between nurses and doctors over there. Nurses, like nurses linking with doctors and being used by doctors, so its always a bad impression that nurses are used for other things like ahh {lowering head, shaking head}(Jane,p.1).

The above concept of medical dominance over nurses and their work appeared to be global in nature, as the participants from India, Iran and the Philippines showed. Participants who have had previous nursing or medical experience in their countries of origin, were able to clearly articulate a situation of medical dominance, and the consequent impact on the status of nursing. This dominance it would seem extended

outside the boundary of the work area, into expectations of a more intimate nature, encompassing both the professional and the personal. The outcome seemed to be that respect for the role of the nurse was very different to what it is here in Australia. Nurses' work was allocated to them by the doctor, rather than nurses' work being determined by nurses. These ideas are brought by participants into a professional culture in the Australian clinical setting where nurses have a more equal relationship with the medical profession.

Excrement and elitism: Contaminates in the reputation of nursing. Participants described the nature of nurse's work in relation to bodily functions, in particular excretion, as decidedly affecting the reputation of the profession. The effect is negative and presents the work of nurses as distasteful and something that does not engender respect.

Cheska explained why nursing is not considered a profession. Clearly this was because of the perceived nature of the work of nurses.

> *The reason they don't have respect is that if you say you are a nurse in the Philippines they just think that you wipe the bum and everything you know? Unlike here the difference is we got EN, AIN and everything who helps. So they think it is dirty job (Cheska ,p.4).*

Yvonne's' country of origin was Nepal and a similar view regarding the nursing profession persisted there. It is not a good job to hold and that people might be treated differently because of the nature of the work.

> *... But my mum's sister was a nurse so we were exposed to nursing pretty early in our life. But then, back home nursing is treated as, a not so good job as, we treat them as someone who wipes some ones bum, like a poo job, not really good (Yvonne,p.1).*

The perceived notions of the nurses' role would seem to contribute to social stigma and it not being considered a profession from Manoj's Indian perspective.

> *Nursing is not a profession in India, it is still socially stigmatized a little bit (Manoj,p.4).*

Professional elitism is the belief that underlies the perspective offered by James, who possesses a Bachelor of Medicine from an Indian University. He alluded to the fact that nursing is a second rate profession and that anyone admitting to being a nurse would be subject to ridicule and afforded a level of sympathy.

> *As a profession it's not very highly respected and valued. It's like, it's like if you can't get into a better profession then you go into nursing.{laughing}.So if you can't get into a different profession engineering or medical or accounting, nurse O.K., O.K. nurse {Screwing up face and hands one level low and one high indicating nursing is lower}. It's that kind, that attitude is there. If you go out in that society and say you are a nurse, oh well, OK. Well ok {laughing}, that thing is there (James, p.2).*

Perceptions of the type of work that nurses are involved in and the status of that work were ever present as the participants' conducted their nursing studies here in Australia. Despite these beliefs having negative connotations for the participants as people and the status of their qualifications, they remained nursing students

Opinions of and Influences on Nurses' Work

The preconceived role of the nurse was presented as a very task orientated, technical skill set by participants. In the clinical area lower level support staff and the family were identified as people who attended the less technical and more personal aspects of patient care.

Nurses in my country do. Mi Mi provided her perspective of the nurses' role in Poland where their time is concentrated on tasks that she identifies as medical things. Staff other than nurses are allocated to attend to a patient's need for assistance with feeding.

> *Nurse's in Poland does medications, injections, very medical things. Umm, they don't feed people they have different staff to look after that part of daily living activities. Ummm nurse does the medical things (Mi Mi, p.8).*

Felisa's comment supported the one offered by Mi Mi where the administration of medications and injections are the nurse's focus and personal hygiene was deferred to the family, or a lower level assistant in China.

Um, like I said I think just like giving medications, injections sort of things. Because the nurses in China, um they do not doing the showering or sponging things, they don't do that, the other people. May be here like the AIN. May be the AIN or the family doing that (Felisa, p.1).

Manoj conveyed that from his understanding, nurses in India take on the tasks that doctors cannot do. In addition to administering medications and injections, he identified that nurses, not doctors, performed dressings.

So they are mostly responsible for the technical things, medications, dressings, injections the things doctors usually cannot do (Manoj, p.1).

Whereas Angela stated, that dressings are not performed by nurses in China, however, in Australia they are.

If you are a nurse in China you can't do dressing. But we can here you can do (Angela, p.1).

Amy provided some insight into the morning routine of a nurse from her experience in China. Identified here is that the nurse's role is to prepare intravenous medications, perform canulation and administer intravenous (IV) medication. Oral medications are not standard practice. Showering and performing dressing changes are not the nurse's role.

After hand over the morning shift will prepare the medication we don't have too many tablets, most of time we have the IV fluid, and uh the nurse should insert the canola into the patient, not the doctor do that. And uh other things yeah and ummm not shower the patient, and umm, not change the dressing the doctor do that especially in the surgical ward (Amy, p.2).

Phoebie provided a simple summary of the nurses' role from her experience in China.

I think that we just focus on the symptom and the interventions and something like that (Phoebie, p.2).

There appears to be some variation within the descriptions of the role of the registered nurse from country to country. However, it is clear that participants referred

to their experience in China, India and Poland, where nurses do not perform personal body care and that the main focus is on technical skill sets.

The omission or commission of care. In the response below Angela explained that from her experience, due to the focus on the technical tasks of the nurse's role in China, there was little time to devote to the psychological aspects of patient care. From her perspective the nurse was too busy attending to tasks to talk with the patients. This is something that she has seen as a difference in expectations of the nurse here in Australia, where it is identified as something that the patients like, and it is interpreted by her as caring.

> *Oh, there is something that is important that is psychological care. When in China you don't have time to do this because you are busy with techn, technology things so you do not have time for the patient. Umm do you need some pain relief? Umm sometime the patient just press the buzzer, well I mean when you work in China you have no time to do that. So In Australia you always chat with the patient, and apparently patients like that you chat with them, a little care (Angela, p.2).*

The experience of having a nurse by the bedside seemed an infrequent experience, as discussed by Irene. Irene had been a nurse in Taiwan, and explained that the nurses and doctors were so busy that there was little time for patient interaction. Irene suggested that the effect of this on the patient was a feeling of coldness. This coldness developed further by the notion that there is no special relationship between a patient and a nurse; they are in effect strangers. Caring seemed to be a notion that is attributed to friendship, not patient care.

> *We just go we don't spend a lot of time in the bedside we just did what we have to do, do some recordings and then just go. Sometimes you feel very cold in the hospital; umm nurses or doctors don't see you very much. It seems like they don't have time to spend with you, it's kind of, they are always rushing. So as a nurse and you see the patient the first time, and the patient does not know you as well, so patient and nurse that are just patient and nurse. They don't have a special relationship, they don't treat each other as a friend (Irene, p.5-6).*

Caring in this instance was interpreted by Manoj as attending to a person's personal need. From his observations of nursing here in Australia, he determined that the concept of nursing was different from what he has experienced in India.

> *What I have found is that nursing over here is altogether different from my country. Nursing here is more about caring to people, but in over there nursing is not responsible for personal care or anything we do here (Manoj, p.1).*

The idea that nursing is a universal concept is challenged by these responses. Nursing in Australia is taught and is enacted as something much more than performing tasks and demonstrating technical skill on a patient. For Australian nurses, the patient as a person at the centre of the caring relationship is an integral concept to the understanding of their role. The mix of ideas about nursing from other countries, implies that this model of caring is not the standard. It would seem from the alternative views presented, that the actual performance of a task on a patient takes priority over the person as patient. From these responses, the understanding of nursing as portrayed here in Australia is an unfamiliar concept to some participants.

Primacy of treatment over ethical behavior. Administering treatments to patients by any means was considered the primary concern for some participants who came from India. Consideration for ethical and moral treatment of the patient as a person appeared to be disregarded. Nurses were believed to be too busy to ponder the significance of patients' rights. Two participants from India, both with experience in the health care industry, were very vocal when it came to discussing the ethical treatment of patients by nurses.

Jane identified the way she perceived nurses interacting with patients in a government hospital. In stating that the nurses are less bothered, and through the example provided, she inferred that the nurses are dismissive of the patient's requests and disrespectful in their manner.

> *In a government hospital about the patients they are less bothered, less bothered. Well like if you were calling in pain the nurses would say like "shut up your mouth!"(Jane, p.3).*

In providing examples that demonstrated harassing, and bullying behaviour by nurses, James tried to justify the behaviour by stating that the nurses had good intentions and that those methods are suited to the culture.

> *Nurses don't ask if they want to take a tablet or not, they just like force treat the patient, 'take it!' It's like sometimes they bully them, and sometimes they blackmail them, like you will be kicked out of the hospital or something {laughing}. But the intention is good. But the whole procedure is, I think suited to the culture as well (James, p.1).*

Jane used her own inpatient experience of a nurse administering an injection to her, to compare the procedure between India and Australia. It can be seen that the value of consent, medication checking and allergy information was an unfamiliar concept to Jane.

> *They don't really explain to the patient educating the patient it is not there. When I went for my own, the nurse don't say anything not even say the name of the injection. So they don't even know what is happening to them. So we have to learn that thing you know checking, so new for me. We don't bother about allergies because the patients don't know what drug they are getting and they don't even know their allergies (Jane, p.4).*

James attempted to justify the lack of consideration for the rights of the patient by describing the patients as illiterate and the nurses as too busy, from his experience in India. Having had that experience, and comparing it to the way medication administration is taught to him as a student, he has developed an awareness and respect for the patient and safe practice. This new awareness has caused worry for him, as a change in his mode of interaction needed to occur.

> *Well back home most of the patients are illiterate and you don't have time to explain to them about the medication and if you do they won't understand it so. The main idea is to get the job done; you just get the job done. Give the medications take this, this, this, this is for your this, this is for your that, and so on the patient go. That in a way made me be short and curt in my patient skills, do this, this, this, that's it end of the story. But here you have to go about it in a whole round bout way, you have to introduce yourself, and of course we introduce yourself as well but not like here. Here*

is more of a social skills have to be really good, and that was what I was really worried about (James, p.4).

It would appear from these participants' responses that nursing in India is dominated by the imperative to complete treatment at all costs, and that created a high workload for the nurses. The characteristics of the population and their rights seem to have had little influence on the way nurses interact with their patients or their methods of treatment. As far as one participant is concerned, learning to be a nurse here in Australia means a change in attitude and behaviour towards the patient.

Female Nurses and Male Patients

In describing the nurses, the participants brought to light some challenges for them in relation performing certain aspects of personal body care. Personal body care is taken seriously within the profession in Australia as a way of connecting to the patient not only to provide hygiene. It is part of the daily patient care requirements and is carried out by all levels of nurses. There were issues for both male and female participants. Some of these issues provoked a physical reaction, others an emotional reaction.

Prohibited contact. Three participants from three different world regions identified that in their country a female nurse would not be expected to provide care for a male patient.

Lyn from Zimbabwe explained the male patients themselves would not allow a woman to touch them without a male chaperone. If there was no male to accompany the nurse care was not given.

...and it was a big issue like, that if we don't have a man in the ward or if the RN is not a man then how can we provide care? 'Cause they don't want us the women to touch. They would not allow women to touch, so you have to take a man with you so that you can take care of them, the male. You have to take a man, man to man, female to female, it was a big issue. With the cultural issue, so even in Zimbabwe to men won't allow women to go in and provide care for them, so it has to be man to man and woman to woman (Lyn, p.16).

Zara identified that because of religious laws in her home country of Iran, male and female must be separated and cared for by the same sex.

> *Yes and in the female wards never any male nurses, can't just do job or anything. Just a specific area for female because of religion in my country. And injection as well, each injection must be done for female by female (Zara, p.5).*

From Amy's Chinese experience there seemed to be some leeway around the age of the male patient. If the patient is considered *old* then the female nurse is able to attend to his personal needs.

> *In China because sometimes in the surgical wards the female, we also have some not so many male nurse but now if we have some, but if the patient is old we can do that. But if they are young, a young man we can't do (Amy, p.2).*

Cultural or religious restrictions around contact between men and women seemed to have an impact on the ability of participants to provide care for patients according to Australian expectations of the nurse's role. For some participants this was an absolute and for others there may be some compromise around the age of the patient.

Intimate interactions lead to physical reactions. The cultural expectation that women would remain virgins and not be exposed to the male body until marriage was an issue for Yvonne. The act of showering a male patient for the first time provoked a violent physical reaction. Having said that, she eventually came to accept this as part of her role as an Australian nurse.

> *Ummm being a female it wasn't any issue to me other than that the first time I showered a male, I threw up and that was not good for a nurse. It was because we are not exposed to it. It's different in western society, like in our culture we have to be virgins before we get married so there is no contact with male. Um, especially seeing his private parts is a total shock to me. But I have overcome (Yvonne, p.2).*

This culturally based issue of working with male patients extended beyond the provision of personal body care, into day to day interactions between patient and nurse. Yvonne seemed to think that the issue would resolve itself over time.

> *Dealing with young male patients, 'cause I still blush I can't face them. I can't ask them questions its too embarrassing for me, and if I get flushed they will get flushed too, they will see it its embarrassing for me. So that is still there, I still haven't got over it. Oh yea eventually I should, eventually, I should (Yvonne, p.3).*

An emotional reaction was experienced by Amy at the completion of her first male patient sponge bath.

> *The first day is really hard and when the first finished, I cried. Because umm, umm. If I look after a male patient, you know I am a young girl an it's very difficult to see their body yeah, sometimes it is hard. Yeah (Amy, p.2).*

Being faced with such a confronting social issue appeared to be something that the participants were unprepared for. The expectation that being a nurse in Australia means providing personal body care to patients of the opposite sex invoked physical and emotional reactions from some participants.

Compromised reputations. Coming from an Arabic background, and having identified herself as a Muslim, Zara's thoughts were immediately directed to her husband's reaction if he was to have found her with a naked man, even though this occurred in the context of her work as a nurse.

> *The first time I went to [hospital] they give me patient and I must shave whole front of body, and that was very interesting for me. I am of Arabic background you know, and I was, had to shave the whole front of his body and he was just naked in front of me and just, I was imagine! If my husband now came here and saw me with this gentleman, and what has happened here? {Laughing} (Zara, p.4).*

Jane's experience of having to touch a man other than from her own family had cultural implications for her. She explained that attending to the personal care of a male patient had an effect on her sense of respectability as judged by her mother. Exposure

to, and physical contact with an unknown male is generally culturally forbidden, leading the necessity of providing justification for her actions.

> *Culturally touching a man is very bad for us. So when I was talking to my mother she asks do you do that for guys to. When I said yes she was very sad about that. Because we don't talk to other guys other than our family, if we do we have to explain to our family. It is just like that (Jane, p.5).*

Jane went on to voice her concern about the reaction she might receive from the patient in performing personal body care for him. She eventually came to the conclusion, and expressed relief, that the patient accepted that activity as part of the nurse's role and that there was nothing to fear.

> *I was worried how the man was going to react to me, whether he was going to be cooperative or was he going to do something to me, how was his reaction, like is he going to be sexually different to me or something like that. And then when I found I did it for the first one, they a cooperating, they can understand what we are doing (Jane, p.9).*

In relation to discussing the role of the nurse with her parents, Felisa explained that she was unable to tell her parents the extent of the activity of sponging or washing a patient due to the socially unacceptable level of intimacy associated with the activity.

> *Normally I just say that I shower people and sponge them but, I never talk about how I washing the private. Yes, they will never ask. Culturally the Chinese people they pretty like, closed thoughts to the private, they do not say that (Felisa, p.2).*

Angela gave some insight into the fortitude that it took to violate her cultural boundary. She had preparative instruction in class, and then just accepted the task without having previous exposure to this type of thing in China. She came to the conclusion that as she is studying nursing here, that this type of activity is ultimately inescapable and resolved to take pride in her achievement.

> *No I just did in class and I learnt to wash a male patient. Maybe you just can't escape from that. {Laughs}Yes well, I just went and did with not too much changes. About this even I did not do that in China. I think I did that very well here in Australia (Angela, p.2).*

Having to participate in the personal body care of male patients appeared to be a very stressful experience for female participants from countries that forbade physical contact with unknown males. Concerns extended partway from the fear of visualising a naked male to the implications for one's reputation either as a single young woman or as a married woman. The stress felt during this activity was unable to be discussed with some participants' family members because of the serious nature of the encounter. For some, this type of stressful experience was overcome by accepting that providing personal body care is part of the role of the Australian nurse.

Summary

Impressions, or the construction of ideas about nursing, are personal and individual. However, these impressions are formulated from personal experiences in and around nursing: as a patient; a related health professional; or from previous nursing experience. In formulating impressions there is an extension into the social and moral boundaries of the person. Nursing cannot escape this, as it is essentially a socially constructed enterprise. It is no surprise then that previously held ideas about nursing accompany students into the clinical environment and serve as the basis for interpreting and reacting to new experiences. These deeply held beliefs serve to influence the functioning and development of learning in the clinical context and need to be made explicit so that certain behaviours may be understood. Exposure to different socially accepted behaviours that directly relate to the role and function of nurses in Australia pose challenges and difficulties to be overcome. Whilst the notion of nursing may seem to be universally accepted, certain cultural boundaries exist that limit its scope in some parts of the world, and differ to Australian standards. The scope of practice may also be limited by the stage of development of the profession it-self and the control exerted over it by other more dominant professions. Certainly, the scope of practice of the registered nurse in Australia extends beyond the ability to perform skills related to the provision of care that has afforded it the status of a profession.

Theme six: Ownership of the Clinical Placement-Crafting Success

Participants chose to come to Australia to study nursing and, therefore, needed to develop an understanding of the profession and its role in health care provision in the Australian context. The clinical learning experience occurs mainly in the hospital

system where students are allocated a clinical facilitator. A clinical facilitator oversees the placement and is responsible for judging students' performances. She/he is a registered nurse usually employed by the university as sessional staff. However, the clinical facilitator is often not the main role model for nursing practice in situ. Registered nurses in the clinical environment are seen as providing role models for clinical practice, not only by students but by the clinical facilitator, and ultimately the university as well. The registered nurse is in this position by default, as nursing students are allocated to them for their learning experience. Students entering the clinical environment have expectations about, them-selves, their learning needs and wants, who will help, and how they will achieve success in the clinical environment.

MAJOR THEME	SUBTHEME	CHARACTERISTIC
Ownership of the Clinical Placement: Crafting Success	Situating the Self	
	Understanding the Purpose of Clinical Experience	Determination to learn.
	An Authentic Australian Nursing Experience	Trust vs. Mistrust
	Observing Australian Nursing Practice to Learn to Practice Nursing In Australia	Determining the lie of the land
		In the passenger seat
		Unfamiliar territory
		Judging observed behaviours for worthiness
		Putting it into practice -Replicating worthy behaviour
	Managing Clinical to Pass	Premeditated relationship forming
		Developing a communication routine
		Testing the teachers-interviewing for a personal learning assistant
	Focus on the Clinical Summary	The yellow paper.
		Securing a pass by deception

Situating the Self

Being an international nursing student entering the Australian Health care system for the first time caused one participant to reflect on her current status and determine her learning needs. The necessity of situating the self in relation to the learning context allows aspirations to be developed that may prove motivational for the participant.

Jane clearly articulated that she felt that she was not yet an Australian nurse. In making this statement, Jane acknowledged that the notion of an Australian nurse exists and that her current inadequacies restrict her claims to that title. However, there is the potential to achieve that status with additional experience.

> *I am not an Australian nurse so maybe I need some more experience (Jane, p.5).*

The identification of a defining cultural aspect to nursing practice by Jane signified that a difference currently exists between her and that designation. By situating herself in this manner, she espoused a willingness to learn and indicated that experience is a transformative process.

Understanding the Purpose of Clinical Experience

One of the main purposes of the clinical practice experience is to expose students to health care contexts in which they apply their skills and knowledge of patient care. There was an understanding of the importance of the clinical placement as personally significant to the development of participants as nurses.

Determination to learn. Jin articulated that as a student the availability of opportunities to showcase both her knowledge and skill were limited by others. Clearly, Jin wished to be able to demonstrate what she knew and was capable of doing. However, her efforts were thwarted by a registered nurse who Jin perceived as someone who cast her unwanted tasks to her.

> *... because like we are student we want to learn, so that's why we are here. But like some nurse she just say 'oh just do the obs.' She didn't let you do anything, just the obs because she didn't want to do, or just clean the patient, wash the patient, wash the body. That kind of nurse, I really don't like*

that kind of thing to happen. We want to learn, we want to be a nurse, if you did not let us do anything how can we do a nurse? We need to practice that's why we are here (Jin, p.10).

Jin had developed definite ideas about the kind of clinical learning experience that would meet her needs to become a nurse. By identifying her own learning needs, and the kind of supportive clinical experience that will engage her, Jin had understood the ultimate purpose of the clinical learning experience.

The act of putting theory into practice was clearly the goal for Mi Mi. She identified that placement in the clinical environment was her time to get as much practice exposure as she could.

... all books I have here at uni, this is my time to gain knowledge over here. It is time to practice based on knowledge....So I want to practice, practice, practice as much as I can (Mi Mi, p. 8).

Milky had a very insightful understanding of herself as a learner, what she needed to accomplish during the placement, and the expectations of her performance.

I really expect myself to learn more in this clinical practicum period because I know what I need to learn, what I need. I know how to learn, so I expect myself to learn more in this week and ... its relative to myself so (Milky, p.10).

These participants clearly understood the purpose of the clinical placement experience. They possessed well-developed ideas about how the experience gained could serve them to develop as nurses. There was an understanding of the limit to learning to be a nurse that could be accomplished through reading. Exposure to and actual participation in all aspects of nursing care was something that was longed for as a way of demonstrating what had been learnt and what was possible to learn through doing. There was a sense of determination to reap the benefits from all experiences.

An Authentic Australian Nursing Experience

By enrolling in an Australian nursing program that ultimately leads to the possibility of national registration, the participants revealed certain underlying assumptions and expectations about their clinical teachers and role models. These

assumptions and expectations reflected culture, skill, language and came to represent a tripartite condition for clinical teachers and role models.

Trust vs. mistrust. Learning to nurse from a trustworthy person appeared to be of high importance. For Jane, the importance of having an Australian facilitator is explained as a cultural issue. She feels that facilitators who are not Australian, or in other words from a non-English speaking background, will teach her their ways of nursing.

> *Another thing for me I really want to have an Australian facilitator. I have had facilitators from non-English speaking, so I want to have an Australian facilitator because she knows more how to deal with the Australian patients over here. Ahh Lebanon, Portuguese, Scotland, I have had one from my own country. I would like to get to know the Australian facilitator. Yes, yea a feeling I should have one at least. I want to have a person who knows about this country, like if I have non English speaking background person they are going to teach about their culture, it is similar to our culture (Jane, p.10).*

Excuses for poor practice from internationally educated nurses highlighted the need for what were termed 'native' facilitators by Zara. Although sympathetic to their possible motivations for coming to Australia, Zara determined that the nurse's background contributed to a lack of adherence to current Australian practice. In determining trustworthiness of the person as a role model, Zara combined the person's current knowledge with background to arrive at the decision that, as a role mode, this person was unsuitable.

> *May be because they are not native and you know Cathy we all come here for a better life. And it's a part of our life; the job is part of our life. And you know there was this one I think she was from Indonesian, and she' we did not change gloves 30 years ago!' (Zara p.2).*

When it came to language, Angela identified that non-Australian nurses spoke a different variety of English to her but still not the local Australian vernacular. However, the language issues of the clinical facilitators seem to be generally tolerated because of the seniority of their position as educators.

May be I speak Chinese English but they speak Korean English, but they are better than me because they are facilitators (Angela, p.8).

The notion of learning to nurse was underpinned by the desire to be taught by clinical teachers and role models who were perceived by the participants as Australian. The epitome of the ideal clinical teacher was characterized as possessing three critical elements - Australian culture, Australian nursing knowledge, and Australian language. If the clinical teacher or role model did not possesses these essential elements then their teaching and practice was met with scepticism from the participants. This scepticism affected the teacher-student relationship and ultimately resulted in what appeared to be mistrust, as confidence in the teacher to impart the true Australian nursing experience was doubted.

Observing Australian Nursing Practice to Learn to Practice Nursing in Australia

Responses from the participants about how they thought they learned to nurse in the clinical environment indicated that the overall underlying strategy was to observe. Observance of nursing practice, behaviour and interactions all formed part of the development of confidence for engaging as a nurse. The participants provided clear insight into their own modes of learning which appeared to be planned and undisclosed to others.

Determining the lie of the land. Entering into an unfamiliar clinical environment such as the Emergency Department (ED), Milky had previously decided that she would spend some time observing before embarking on any form of engagement.

You know that it was my third day in the ED and previous to that I didn't really do much. The ED, I have never been there before it is a new department, as a new learning environment so the previous two days I just observe how they do things and I was planning to do that. I knew for the first two days I would not have clue and [observation] that is my strategy (Milky, p.7).

It would appear that the time spent observing the machinations of an unfamiliar department were an important predetermined period of adjustment. The personal

requirement for a period of adjustment allowed the participant, who acknowledged that they were unaccustomed to the environment, to familiarize herself/himself with its complexities prior to engagement.

In the passenger seat. The pace of a clinical environment and subsequent workload for registered nurses had implications for student learning. Taking that into consideration, Zara decided that observing was the most appropriate way for her to learn. This comment demonstrated that this participant was aware of the impact that students have on the ability of the registered nurse to complete their work, and an understanding of the importance of their work. Seemingly, by just being a bystander, it is possible for a level of learning to occur as participants follow their registered nurse and observe them in their role.

> *The best thing for me is watching, the most important thing for me because they are very busy. Just watching (Zara, p.4).*

In learning to cope with challenging situations that occurred in the clinical environment, particularly interpersonal issues, Milky admitted that as a beginning practitioner she would have no understanding of how to resolve them. So she observed how nurses dealt with difficult situations to learn practice techniques.

> *You know there is always emergencies and there is always difficult patients like, there's always something wrong. Like may be in communicate with the patient or misunderstandings. I would just observe how they deal with it. As a beginner I would not have really umm, I wouldn't come up with any strategies to deal with that (Milky, p.7).*

Yvonne clearly identified her way of learning in the clinical environment that extended beyond pure observation. The combination of observing a demonstration, listening to the explanation and observing the accompanying body language all contributed to her learning.

> *Um, I observe a lot. Um some things and um, like you might be a teacher or an RN might be doing something and explaining things to me as I observe, but I tend to pick things. I look at body language a lot, that's how I learn (Yvonne, p.6).*

Emerging from these excerpts is the identification of observation as a foundation for learning to nurse in the clinical environment. For some participants a deliberate strategy was to observe, for others the dynamic and complex clinical environment dictated that observation was the only learning method available. It was clear that an episode of observation enabled a settling in period, internalization of an understanding of nurses' work, methods of communication and problem resolution.

Judging observed behaviours for worthiness. Once an observation was internalized, the participants appeared to make a judgment about whether the behaviour was acceptable before incorporating it into their own practice repertoire. Negative practice examples were clearly articulated as memorable by the participants as they produced an emotional effect. Identifying unacceptable behaviour, whether it is nurse to student or nurse to patient, was something that impacted on the participants' adoption of certain behaviours.

Being shouted at and treated rudely was a negative experience for James where the interaction affected him personally. He decided to turn the incident into a positive for his development and determined not to replicate that kind of behaviour.

> *...that nurse who was really rude to me shouting at me and I just walked away because I didn't want to be shouted at. But I think in one way its good because it makes me realise that I shouldn't be like them (James, p.12).*

In relaying the following incident Cheska admitted that she became emotionally distressed. As a first year student with no past nursing knowledge she was still able to identify unprofessional and uncaring behaviour that she was adamant she would not emulate in the future.

> *....but she did this cruel thing that I cannot agree with. Like she just wants the patient to stay in bed, which the patient wants to walk around. She is a bit stubborn the patient, and she's old, demented, diabetic and everything. But you know what she did in front of me? She pushed the patient into the bed which is, oh my God! It really hurts me a lot and I am only first year I have no nursing background, but I know what's the meaning of nursing, like looking after the person and doing everything and they might not have family to look after them and understand even if they are annoying you know? And*

that is not good and I even heard her screaming at the patient 'You have to do this!!!' Yes the first clinical, oh my God , but I thought it's a good thing that I witnessed that because I thought right up there, right up there I said, I'm not gonna be like that (Cheska, p.1).

Nurses keeping a patient waiting for assistance became an example of poor practice for Mi Mi. In this instance, the nurses refused to leave their tea break to assist the patient. Having learnt about responding appropriately to requests for assistance from patients from her textbooks and on campus, Mi Mi did not see that translating into the clinical environment. Thus, Mi Mi interpreted the behaviour as bad manners.

So nurses for example, they were sitting in a tearoom for tea break which is 20 minutes. You could see that room 20 was beeping for help. 'That's OK I still have 5 minutes for to finish my tea!' I would drop everything to go and check what is going on. But they don't have time, it's a break time. Terrible, and also most of the things that Umm professors and uni staff teach us at uni and what we can learn from books we can find, that this is applicable in hospital but some of them is not. I was very disappointed with nurses with manners like that (Mi Mi, p.13).

Registered nurses in the clinical environment serve as role models for current professional nursing practice and carry students along with them. Observing or experiencing certain contemptible behaviours by them in the clinical environment resulted in an emotional response from these participants. This emotional response, articulated as disappointment and shock, was then judged as unprofessional or uncaring behaviour. Reprehensible behaviour was easily identified by the participants and ultimately rejected as examples of good practice.

Putting it into practice: Replicating worthy behaviour. On the other hand participants readily adopted behaviours and skills that had positive outcomes for them. Observing behaviour that the participants themselves deemed acceptable and appropriate led to them replicating that behaviour.

A lack of confidence in ability and knowledge resulted in Lyn being unable to demonstrate a specific skill to her clinical facilitator. The facilitator developed a plan

where Lyn would observe the skill as the facilitator performed it, and then go on to perform it herself a day later. That enabled Lyn to perform the skill just as the facilitator had shown her.

> *... I can do it today and you can do it tomorrow. And that way I get to watch and I get to see what she, introduce herself to the patient, and explain what's the injection. So the next day I was doing the same (Lyn, p.6).*

James' confidence was waning until he noticed nurses from different backgrounds working in the clinical environment. He then began to mimic their speech and behaviour. The outcome was a change in his behaviour that led to satisfied patients.

> *And then I looked around and saw nurses from other background and I thought if they can do it, I can do it. So I said alright let's give it a try and I started copying others, the way they spoke, the way they interacted with the patients and everything. So that's basically what I did. And what I have noticed is when I did it that way the patients were happy (James, p.6).*

Observing, adopting, then practising was an effective learning tool for Milky in dealing with unfamiliar situations.

> *I would just, observe how the nurse deals with the situation what would the nurse do and then, when I get the chance I practice and I do practice a lot (Milky, p.7).*

Searching for personal success in the clinical environment led the participants to actively develop a learning process. It would appear that a lack of confidence in their own ability led the participants to search for someone to model behaviours upon. The decision to adopt or reject a certain observed behaviour or skill was based on its ability to engender positive outcomes. The process manifested by the participants was: situating the self in the environment; observing skill and behaviour; judging what was observed; accepting or rejecting it, and then imitating the acceptable skill or behaviour.

Managing Clinical to Pass

In order to demonstrate successful learning in the clinical environment the participants devised a number of strategies. An array of tactics were used to assist them to gain a satisfactory clinical summary, all aimed at passing. The participants thought

about and deliberately strategized a plan of action that would best support their goal of passing the clinical placement

Premeditated relationship forming. Demonstrating competency in certain skill sets related to patient care is one of the aims of the clinical placement. Angela relayed her strategy for ensuring that she has access to a cooperative patient on whom she can practice. Her strategy enhanced acceptance of the student as a learner, and lessened the chance of rejection of the student by the patient.

> *... I am a nursing student, and, if I want to do some dressing or sub cut... then I ask, ask patient their consent and , and if I keep the patient closer with me, and the patient is easy to accept me to do the injection (Angela, p.4).*

Building trust through communication is the strategy Jane uses to encourage the co-operation of the patient. Without talking to a patient a sense of trust cannot be developed. The formation of trust between the student and the patient preceded co-operation, and without the patient's cooperation Jane's learning goals could not be achieved.

> *I have to talk to them because now they say, I can trust them. The patient has to feel trust of us. Otherwise, it is gonna be hard for me to cooperate with whatever I have to do for them (Jane, p.5).*

Developing a communication routine. Communicating with patients is a skill that is required to be demonstrated and competence gained whilst on placement in the clinical learning environment. Greeting patients, explaining procedures, requesting permission to carry out procedures and general conversation assists in forming the nurse-patient relationship.

Composing a routine for use when communicating with patients allows the student to practice and perform language skills in a habitual manner. Angela articulated her greeting routine which she deemed as very simple questions.

> *First I just greeting, how are you feeling to day, do you have some place pain? You can tell me and I can check your medical chart, and I can ask the nurse to get you something for that, and I just ask them. Just very simple questions, like are you comfortable? Do you need pillow behind your back?*

And, if your family coming this morning? And you want some, some water? If you need just call I am your girl today (Angela, p.3).

Felisa explained her way performing both her greeting routine and the routine used for medication administration. Her rationale for performing her routine this way was because she read it in the textbook.

Ok, hard to say just to follow the book. Say ah, good morning patient! I am Felisa your nurse today. Umm like before giving the meds and that sort of thing what is your name, have you any allergy, that sort of thing. Well because the book say that {Laughter} (Felisa, p.11).

Composing and performing a routine appears to offer some form of safety for participants in regard to communication with patients. However, this one-way method of talking at the patient, does serve to demonstrate some form of essential competence required in language ability to patients, staff and the clinical facilitator.

Testing the teachers: Interviewing for a personal learning assistant. Locating the most suitable registered nurse in the clinical environment to answer the student's questions and be a helper in their learning became a seek and find mission. The participants devised small personal tests to ascertain who was the most willing, obliging, and accommodating candidate for a learning helper prior to engagement. Tests ranged from the seemingly simple request for someone just prepared to answer to elaborate multifaceted criteria. If the criteria were not met the candidate was rejected as a helper. Once the participant found the appropriate registered nurse, they then became their personal assistant to learning.

Irene explained her learning interview format here. Receiving a response to what she described as a simple question, she registered that this person was happy to help and so accepted her in the role of learning assistant.

Sometimes I testing first. So I ask a simple question and if this person is happy to help me or willing to tell me more I will come to this person more often and ask more questions (Irene, p.8).

One chance to be judged as helpful was all that Amy was prepared to afford potential personal learning assistants. If the first interview question was brushed off, that reaction was interpreted as unhelpful, and no further questions were posed. That person was essentially rejected as a learning assistant.

> *.... the first time I ask a question they don't answer they say' I am busy' or something. So next time I won't ask (Amy, p.5).*

Manoj developed a complex set of selection criteria that supported his learning needs. He scanned the nursing staff for someone who liked him personally, who can interact with him on his terms, and who did not find him an intrusion. It did not matter to him if this particular person is not the person he was working with, just that they were helpful to him.

> *So you have to decide, this can be the test. I can go up to him and ask these questions. The thing is that when I was on wards. I have to check with everyone, the one who finds me more interesting, the one who finds me, more adjusting, what I will say? One who is not having any problem explaining. Not disturbed by my way if interjecting in his work. I go to that person usually. Even if he is not that RN with whom I am working with (Manoj, p.3).*

One benefit to the participant of engaging a personal learning assistant was that a relationship developed. Mi Mi found that this relationship allowed the student entrée into the clinical team, and the feeling that she and the registered nurse became a team in themselves. Primarily, Mi Mi's learning needs were met.

> *...if you stick with one nurse and that nurse suits you then you become part of the team or a team yourself, so you know that nurse more than others. So I am always looking for that nurse because she knows me I know her so I know that she will answer me, at least she will try (Mi Mi, p.7).*

The seek and find mission to locate the most appropriate candidate for the position of personal learning assistant in the clinical environment was seen by these participants as a worthwhile effort. There was a direct and active process identified that consisted of the formation of a set of criteria specific to the participant, followed by a brief interview and finally a decision to accept or reject the candidate. The engagement

of a personal learning assistant guaranteed that participants' questions would be answered and, therefore, their clinical learning goals met.

Focus on the Clinical Summary

Whilst some participants were focused on learning nursing through the application of theory to practice with the aid of a personal learning assistant, there were others who appeared to be driven solely by the criteria of the clinical summary. A clinical summary is an overall assessment of the students' performance based on the Australian Nursing and Midwifery Competency standards. The assessment is made by the clinical facilitator, and could mean a pass or a fail in the unit of study if the student was graded unsatisfactory. The participants are given a copy of this document and the colour of the paper was yellow.

The yellow paper. A clinical placement occurs within a unit of study and the knowledge and skills aligned to that unit need to be demonstrated for the participant to be graded at a satisfactory level to pass the unit overall. Angela identified that if she was not able to provide answers to questions then there was a fear of being graded as unsatisfactory.

> *I think it is the clinical summary, you know the yellow paper, and I think there must be something about asking questions, if you can't answer the questions very well, maybe you get unsatisfactory level (Angela, p.9).*

The importance of the yellow paper and its meaning has been circulated amongst the students. Felisa explained that even the thought of the clinical summary made her nervous.

> *They [other students] say the clinical, the yellow paper, the yellow paper is really important {Laughter}. Yes that is why every time you go to clinical you are so nervous, so nervous (Felisa, p.6-7).*

James identified the focus to pass in some of his fellow students. He discussed that he has a different perspective to his fellow students.

> *I don't want to be biased or something but what have really observed, most of the students especially the ones I have seen, they want to do it so they can pass. Not because it is a good thing to do or they should do it properly, so as*

long as they pass as long as they get their yellow sheet ticked they are happy (James, p.6).

The focus to gain a satisfactory grade for the clinical placement was a driving force for some of the participants. The importance of a satisfactory grade was so strongly stressed in some student communities so as to cause feelings of anxiety.

Securing a pass by deception. Feigning interest, or to demonstrate interest by way of false enthusiasm, was portrayed as a customary means of securing a satisfactory grade for the clinical placement. In addition, the use of obsequious behaviour was seen to reap positive rewards.

Yvonne identified that deliberately asking questions was a way to show interest. Here she acknowledged firstly that her facilitators like her to ask questions and actively encouraged her to do so, and secondly the purpose of questioning is to gain additional knowledge.

My facilitators like it too, cause they said 'Oh you need to ask more questions!' Which you do because it gives you more knowledge. So I do ask a lot of questions (Yvonne, p.6).

Milky disclosed that she needed to pretend that she was interested in the same subjects as the facilitator to encourage a satisfactory grade. From this explanation it seems that word has been passed through a particular cultural group of students that deception is an acceptable way of securing a pass. The students need to contrive questions for the facilitator and pretend to be eager to bluff him/her into passing them.

And it's common in Chinese students as well, we all think that we will just pass and we pretend that we are interested in case, you know, the facilitator would just prefer us to be interested in this, subject and, I got the tips from other students. You just ask more questions they like you to ask more questions and you just pretend that you really enthusiastic and pretend that you are really eager to learn (Milky, p.3).

Feigning interest can occur not only in regard to the subject matter on clinical placement, but also with the registered nurse the student works alongside. Angela

manipulated this situation to her advantage by being willing to take on extra tasks to free up the registered nurse. By doing that Angela realised that she was pleased and would repay her with learning opportunities. A tactic such as this suggests a dual pathway to creating an environment for learning. The participant must be willing to ingratiate herself to the registered nurse, and in return the registered nurse grants access to learning opportunities.

> *Actually in clinic if you do many more things for your RN she is very easy and a pleasure to teach you something, and allow you to do something (Angela, p.4).*

In attempting to portray oneself as interested and willing to learn, the underlying focus of the clinical placement shifted in the mind of some of the participants, from one of learning to nurse, to performing to secure a pass. It appears that the ability to act like a student nurse carries more weight than actually being a student nurse for some participants. It would appear that for some participant's tactics to pass were more important than tactics to learn.

Summary

Learning to be an Australian nurse in the clinical environment was a complex mix of understanding the self in relation to learning needs, wants and expectations, and the ability to procure learning opportunities. There was a clear understanding of the role of the student in learning and the role of others to support that learning. In order to gain an authentic Australian nursing experience clinical teachers were expected to possess three attributes: cultural background; language, and nursing skill. A clinical teacher who possessed these attributes was suggested as a desirable role model who increased confidence in achieving a successful learning experience. Learning encompassed not only what to do as an Australian nurse, but what not to do. Examples of poor, unethical, and unprofessional practice by registered nurses witnessed in the clinical environment served as exemplars of behaviour unworthy of adoption into a practice repertoire. On the other hand, examples of good practice served as an inspiration and were readily adopted and in fact imitated as a way of emulating appropriate practice. Appropriateness of practice, demonstration of knowledge and communication skill is reflective of the assessment criteria for clinical placement. Specific tactics and strategies were designed and implemented to either learn around these criteria or to pass

these criteria. There appeared to be a shift in focus from learning to nurse to passing, which reflected an undertone of deception. The overarching theme of ownership of the clinical placement was reflected in active engagement that was aimed at being a successful learner in the clinical environment.

Chapter Conclusion

The process of analysis undertaken in this research, allowed for the identification of commonalities within individual perceptions, beliefs, expectations, culture and language about learning to nurse in the Australian clinical environment to be explicated. Whilst the participants came from different world regions and cultural groups, their responses were remarkably similar, and with the further research that is provided in the discussion, a comprehensive understanding of this intricate task will be generated.

Chapter 6: Discussion

Introduction

This discussion chapter brings together the analysis of the comments of the participants to explicate the complex nature of learning to nurse for ICALD students in Sydney, Australia. As explained in the previous chapter the nature of a thing is what is internal to its functioning and development. Therefore, ever-present in the formation of the discussion is what is internal to the functioning and the development of learning to be a nurse for the participants. There are two foundational questions that have been utilized in the formation of this chapter in the attempt to bring clarity, understanding and meaning to the discussion. These questions are based in the interpretive tradition as understood and explicated by Thorne (2008) and are: What are the main messages? What is it that I know now that I did not know before, or know in the same way? To derive the answers to these questions, as much as possible through the experiences of the participants, five guiding elements have been used to construct the discussion: old literature; new literature; explanation or antecedents; interpretation or placing in context; and finally, the new lens. Continual checking to avoid what Thorne calls '….waxing poetical or invoking the heights of passion' (2008, p.181) has been employed to retain the creditability of the discussion.

Motivation – Binding the Personal with the Professional

'To be motivated means to be moved to do something' (Ryan & Deci, 2000, p. 54). The existing literature on international students, as explicated in the literature review, lists a number of reasons why overseas study experiences are valued and these are reflected in the participants in this study. Of the sixteen participants in this study seven were enrolled in the Bachelor of Nursing Graduate Entry (BNGE) programme, a two year compressed course for students with a prior degree in the health sciences. The remaining nine participants were enrolled in the usual three year Bachelor of Nursing degree. Only four participants had a relative residing in Australia, two of these lived with their relative whilst completing their final two years of high school here in Australia. The decision to leave home for a significant period of time, in the case of this participant possibly three years, to study in a foreign country where the culture is relatively unknown, requires a significant degree of motivation.

Being moved to learn to nurse in Australia as discussed by the participants in this study, was embedded in the individual and personal realm, which was broadly influenced by the cultural and political environments of each participant. Therefore motivation needs to be recognized as highly individual and variable or unique, rather than a 'unitary phenomenon' (Ryan & Deci, 2000). Motivation for learning is related to success in that endeavour; therefore, the type of motivation a student possesses is widely regarded as a critical element to success (Rose, 2011; Mitchell, 1972). Motivation is, therefore, internal to the functioning and development of learning to nurse in Australia.

An examination of the current Australian Education International (AEI) (2010) national data as discussed in the literature review notes that Australia is generally chosen by international students as their *host* country for the following reasons: high quality of education; safety and security; a different cultural and lifestyle experience, and the natural and beautiful environment. These attractive qualities are generally referred to as 'pull factors' and are perceived qualities about the intended destination (Mazzarol & Soutar, 2002). What this national data set does not reveal are the more poignant, and personal reasons around what motivates the students, or the 'push factors' (Mazzarol & Soutar, 2002). These are explicated in this study of international nursing students. The motivating push factors could be termed the 'sustaining factors', that is, the underlying beliefs that enabled the students to persevere and complete their nursing studies despite the challenges they faced. As these sustaining factors cannot be observed directly, and it is only through the participants verbalizations as described here, that the clinical educator can come to understand the value of effort, persistence and choices related to learning behaviour (Schunk, 1991) in the clinical environment.

Understanding the push or the pull in sustaining motivation. The concepts of push and pull factors are used both in education abroad literature and migration literature, and, as such, are not new to the academic discussion about nurse migration (Kline, 2004; Kingma, 2001; Mejia, Pizurki & Royston, 1979). Pull factors for registered nurse migration are broadly classified as educational, economic, social and political, and include, professional development not available in the home country, improved wages and working conditions and better personal safety. Push factors are considered as reciprocal to the pull factors and, reflect a lack of professional

development opportunities, poor wages and working conditions and compromised personal safety in the home country.

In broad terms the participants in this study were pushed or even propelled to come to Australia to study nursing by family on a number of varying levels, or by the quest for an improved life circumstance however that was judged by the participant. Their reasons generally reflect the literature on nurse migration at first examination. However there are deeper underlying familial and personal reasons that are driving forces for the participants in this study. As the participants are not a homogenous group, their motivation cannot be assumed to be homogenous. The nature of learning to nurse for these participants cannot be fully understood without understanding the deeper personal level of motivation, as motivation is internal to the functioning of learning.

Family responsibilities and honor. The depth of complexity related to the participant's motivation in this study was not easy to tease out and reflected a number of entangled and interrelated notions. Whilst being propelled to study abroad, some participants displayed obedience to their parents or unquestioning acceptance to the state. For some participants, mainly from Chinese Asia, the decision to study nursing was made by their parents or enforced by the allocation of a place at a nursing school after completing a national university entrance exam. These participants did not begin nursing studies of their own free will or interest in the profession. They did not possess intrinsic motivation which is widely agreed as learning something for the pure pleasure of the act of learning, a natural human propensity (Ryan & Deci, 2000). Simultaneously, they were obligated to their parents or other family members for their patronage, whilst sustaining the belief the final result would be a more secure financial future. In essence this is an extrinsic motivator where learning results in an outcome that can be regarded as a means to an end; it has an instrumental value (Ryan & Deci, 2000). In an attempt to disentangle the complexity that was revealed by the participant's motivations, an explanation of the cultural, economic or political situations pertinent to the participants' responses is required.

One of the main reasons that one of the participants was studying nursing was to fulfil the dream of her sister who had always desired to become a nurse. The action of this particular participant is reflective of the Philippine culture and its strong kinship

values. Elder members of the family, especially parents are revered. It is the duty of the eldest sibling in the family to carry out certain responsibilities that includes caring for parents as they become older. With these responsibilities comes the expectation that younger siblings will defer to the elder, and afford them unconditional respect (Cimmarusti, 1996).

Obligation and duty are also very firmly held beliefs in the Philippine culture. Particularly in this instance, the idea of reciprocity of benevolence may be invoked. As suggested by Cimmarusti (1996) because the elder sibling was at home providing for their elderly parents, and could not realise her life's dream, the participant felt obliged to study nursing so that her sister may live vicariously as a nurse. This could possibly be seen as a debt of gratitude or, as it is expressed in Tagalog, 'Utang na loob' (Cimmarusti, 1996, p.210). Further, because the participant had travelled to Australia in order to seek a well-paid position, she would be obliged to send home money to help support the family still residing in the Philippines (Cimmarusti, 1996).

Information on Philippine nurse migration presented to the International Council of Nurses by Barcelo (2011) stated that Philippine registered nurses did migrate to other countries because the remuneration was better. In recent years there has been significant growth in nursing student numbers enrolled at university in the Philippines because of the potential for working abroad for a higher salary. Currently, in the Philippines there is an oversupply of registered nurses, a result of a deliberate market strategy to produce nurses for deployment overseas (OECD, 2010; Hawthorne, 2001). This oversupply is attributed to increasing difficulty in gaining employment because of the global economy, political unrest in the Middle East (the largest recruiter of Philippine nurses) and changing educational requirements in English speaking countries such as Australia (Barcelo, 2011; Paquiz, 2008). For those who do work overseas, they contribute to sustaining the Philippine economy by sending home remittance payments to their families. The central bank of the Philippines has stated that the total value of remittances to family members from those employed overseas totalled $16.4 billion US which was almost 10% of GDP.

Participants from Chinese Asia, The Philippines and Eastern Europe were sent by parents to study abroad in the hope that gaining a respectable nursing qualification

from Australia would improve their future financial security. Education was seen as the key to this opportunity. Recognition of the state of the nursing profession in the home country, especially in regard to salary, appeared to be the main driver, a form of extrinsic motivation, of this parental push. Financial security through education appeared to be a paramount concern of parents.

In some instances financial security was not obtainable as a nurse in the home country. This was particularly highlighted by the participant from Eastern Europe. The profession of nursing in Poland is currently undergoing major restructuring, both educationally and legally after Poland was liberated from Soviet Russia in 1989 (Marcinowitz, Foley, Zarzycka, Chalibcz, Windak & Buczowski, 2008). In addition there has been an ongoing industrial dispute regarding nurses salaries which was emphasized by a hunger strike in 1999, and a nationwide strike with mass demonstrations in 2007 (Holt, 2010; anonymous Nursing Standard, 1999). Migration of nurses from Poland to Western Europe in search of better wages increased significantly after Poland joined the Economic Union in 2004. For example, nurses state that they can earn up to four times their Polish salary in the United Kingdom (Holt, 2010).

Some participants' study in Australia was financially supported by their parents, others by themselves. The financial cost to an international student in Australia is high, funds of at least $18,000 are required before a student visa is granted (Singh & Carraal, 2010). It appears from these participants that parents, who agreed to financially support their children, value the international learning opportunity and regard it as vital to their child's future financial security. In this study the majority of participants funded by their parents were in the Chinese Asian group and predominantly came from mainland China. This phenomenon has been previously documented in the literature and explained using the collectivist cultural descriptors, where a child's education is seen as an investment in the entire family's social and economic wellbeing (Owens, 2008). Research conducted by Schneider and Lee (1990) found that compared to Anglo parents, Asian parents are five times more willing to sacrifice for their children's education by working long hours and saving diligently. Other researchers have concluded that Chinese parents consider their children 'the hope of their lives' (Chow & Zhao, 1996, p. 44), especially after the introduction of the one child policy in 1979. Tsui and Rich (2002), go as far to say that, through the education of the only child, the

family becomes its own most reliable welfare agency. Therefore investment in education through parental sacrifice is reciprocated by their child's obligation to pass.

An explanation of the underlying beliefs about international education in China is offered by Brzezinski (1994) and supported by Deutsh (2004) where international education is highly valued in Chinese society, so much so in fact, that it is revered over domestic qualifications. Yan and Berliner (2011) explain that in traditional Chinese culture, well-educated scholars are afforded the highest social rank and this recognition bestows great honour on the family. Because of the importance placed on education it has come to be a way of life for the Chinese family (Zhang & Carrasquillo, 1995). In addition, Chinese students themselves believe that their personal potential and value is significantly enhanced by the study abroad experience, the cultural capital it develops and the western knowledge they bring back to China (Brzezinski, 1994). In other words there are benefits for both the Chinese economy and the students themselves. Brzezinski's research revealed that Chinese students believe that their chance of gaining a prominent position and/or promotion was significantly enhanced by gaining a prestigious qualification from a western university (1994).

The obligation to pass was clearly voiced by participants in this study. Passing not only meant pleasing their parents, it meant that extra funds would not be required to repeat the unit of study if they failed. The participants were acutely aware of the sacrifice their parents were making to afford their study abroad. Their obligation can be best explained as filial piety.

'Our body, with hair and skin, is derived from our parents. One should not hurt one's own body in any situation. This is the starting point of filial piety' (Hsaio Ching, chapter 1 : The starting point and the principles as cited in Hwang, 1999). This Confucian belief has been reflected in Chinese families for centuries and demonstrates the notion that children's lives are the continuation of their parent's physical lives; children exist solely because of their parents (Hwang, 1999). Therefore children are expected to respect, obey and are obligated to care for elderly parents (Deutsh, 2006; Shek, 2006). The social relationship structure influenced by Confucianism is hierarchical in nature and is characterized by the subordinate being obedient and loyal

in return for care and responsibility from the superordinate (Deutsh, 2004; Yue & Ng, 1999).

The participants in this study from Chinese Asia were female, and were their parent's only child. Historically under the influence of Confucianism, the Chinese social structure was patriarchal with the strongest bond between father and son (Deutsh, 2006; Shek, 2006; Deutsh, 2004). As daughters were married away from the family home into that of their husbands, their role in caring for their ageing parents was diminished (Bian, Logan & Bian, 1998). However, with the one child policy this situation has taken a dramatic turn and female children are increasingly responsible for the obligations once rendered to the son (Deutsh, 2004 ; Deutsh, 2006). Deutsch's (2006) research found that the concept of filial piety was alive and well in the actions of adult children in contemporary China, despite the move towards a more capitalist market economy and the one child policy where a female child is the only child. The participants in this study reflected filial piety in their verbalized obligation to their parents who patronized their international study program of nursing.

To some extent the notion of filial piety is also found in Southern Asia, where males are expected to support their parents and other extended kin (Singh & Cabraal, 2010). It is not just Chinese families who invest large sums of money in their children's education. Indian families also value overseas education and many take out loans to secure a student visa for their children (Kumar, Sarkar, Sharma, 2008). These loans are made possible by parents mortgaging their ancestral properties, and it is not uncommon for these loans to range from $15,000- $55,000 (Sidhu, 2011; Kumar, Sarkar & Sharma, 2008; Baas, 2006). In addition Sidhu (2011) notes that some female students have successfully negotiated a reduction in dowry payments based on the possibility of better success with a permanent residency application. Usually, for students who come to Australia, the agreement is that permanent residency will be sought at the completion of the study and the loan repaid with ongoing remittance to the extended family. Singh and Cabraal (2010) note that in 2008 US$52 billion was received by Indian families in the form of remittances.

With the obligation to pass their courses of study also comes the fear of failure. Failure is related to shame for an Asian Chinese family. Needless to say that the

pressure to pass is onerous on many complex levels for the participants. However this type of pressure, the defence of family honour, is intrinsic to the understanding of motivation for this group of participants.

New country, new profession, new life. Control over one's destiny offered insight into the poignant and personal plights as to what moved and sustained the students to come to Australia to study nursing. Political unrest and perceived corruption, religious restrictions and sensitive personal issues pushed some participants to take control of their destiny. This notion of control was also explained by some participants. The sole reason for studying nursing was to increase the likelihood of gaining permanent residence in Australia and was identified as a form of control by some participants. These participants made conscious life decisions that potentially altered the course of their lives, in order to seize control from a place where they appeared to have none.

The existing literature on study abroad and migration acknowledges that general reasons for choosing international study include a lack of availability of courses in the home country, and for migration, described as a wish to escape an unpleasant situation (Hugo, 2009). The participants in this study reflected these reasons and offered new and deeper insights that are discussed using relevant literature.

Intrinsic motivation, the desire to learn nursing because of interest and not because of the possibility of migration, was apparent for only one participant. The participant from Zimbabwe explained that because of alleged issues of bribery and corruption she was unable to secure a place at university, despite allegedly having paid bribes to university officials. Whilst bribery has been considered as one of the most common forms of corruption, it adds significant financial cost to education (Wated & Sanchez, 2005). Ebbi (2005) suggests that bribery occurs in African states because of competition for scarce resources such as education. To highlight the current situation in Zimbabwe, The Department of Foreign Affairs and Trading (DFAT, 2011) has issued a travel warning that describes a volatile political and social situation due to tensions between the two main political parties. There is little regard for the law, and the people are experiencing severe economic hardship and desperation that leads to high crime rates. The provision of essential public services is very poor and shortages of food are

common. Research by Maringe and Carter in the UK (2007) found that international students from Zimbabwe were wishing to escape poverty and human degradation. These issues contribute significantly to understanding the motivation to come to study nursing in Australia.

Concern for the future of one's offspring also appears to be an extrinsic motivator to come to Australia, study nursing and eventually reside here. Certain religious laws can and do act as push factors for immigration. For one participant, the mother of an adopted son, her concerns for his future were the sustaining factor. The example presented by a participant in this study reveals that under Islamic law a child cannot legally be adopted, however, it allows for the guardianship of children without parents (Abbasi-Shavazi, Inhorn, Razeghi-Nasrabad, & Toloo, 2008). The status of an adopted child under Islam is that he/she must retain the name of his/her birth father and under inheritance laws is only entitled to one third of their adopted father's estate (International Development Law Organisation, n.d). Even though Iranian Law was changed in 1975 allowing adopted children the right to take on the adoptive surname, change his/her birth certificate, and declare inheritance rights (Inhorn, 2006), Islamic Law forbids it. The fear of retribution from family members propelled this participant to seek a change in destiny for her adopted child and come to study nursing in Australia.

The most controversial motivation for studying nursing in Australia is the issue of gaining permanent residency, an extrinsic motivator in the classic sense. This issue is controversial on two levels. Firstly, it challenges the historical professional attitude that nurses are assumed to be driven to care for others by an innate altruistic passion. Secondly, it highlights the international education industry in Australia and its link to permanent residency. The participants in this study who voiced that their main intention of studying nursing was to gain permanent residency in Australia were mainly from Chinese and Southern Asia, the regions that contribute the highest number of international students to Australia. The literature reflects the notion that many students, especially from Southern Asia enrol in courses at universities in Australia with the view that education was the pathway to immigration, and that immigration was their sole intention (Singh & Cabraal, 2010; Baas, 2006). A review of the Australian nursing and midwifery workforce conducted by Preston (2009) presented data that confirmed that most international nursing students in Australia remain after completing their courses

and become part of the nursing workforce. Australia is not alone in experiencing this phenomenon; literature from the USA also explicates the use of education as a pathway to permanent residency (Hazen & Alberts, 2006; Pang & Appleton, 2004). There is also some agreement that the type of study did not matter to the type of student who held this view, and that their main focus was on gaining enough points to apply for permanent residency (Singh & Cabraal, 2010; Baas, 2006).

Although a number of participants in this study acted in a dual way, as student and intended migrant, they actually did want to practice as nurses in Australia. There was only one student who freely admitted that he was studying nursing to gain permanent residency to enable his return to work as a medical practitioner, not as a nurse.

The recent literature on the motivation for students in general to study nursing, suggests that the traditional altruistic notion of service has been surpassed by the desire to design a career. That career is typically moving away from the clinically based bedside registered nurse although the notion of care is vestigially represented (Gambino, 2010; Solvoll & Heggen, 2009; Rognstat et al. 2004).This too is classed as extrinsic motivation.

The concepts of intrinsic and extrinsic motivation have typically been seen as dichotomous where intrinsic motivational type is seen as producing learning that characterized deep cognitive engagement and extrinsic shallower engagement (Walker, Greene & Mansell, 2005). However, participants in this study, experienced motivation that was more complex and personal than mere extrinsic or a means to an end. It would seem that the relatively simplistic fashion of intrinsic vs. extrinsic motivation does not grasp the full richness of the participant's motivation, simple categorization was, therefore, inadequate.

The belief systems and cultural views around the value and intention of international study for the majority of the participants in this study can be described as complex. The entanglement of obedience, obligation and opportunity and control of one's destiny are all extrinsic motivations. What it offers is a way to understand the

complexity of the participants, their volition and that the strength of the motivation was enough to carry them through their learning experience.

Summary

As learners of nursing in Australia, the depth of motivation and its effect for ICALD students cannot be underestimated. Whilst it is true that most come with the intention to migrate, it needs to be recognized that the sustaining factors underlying this intention are personal, complex and often founded in cultural values. As such motivational factors cannot merely be identified as intrinsic or extrinsic as this belies the personal importance placed on the sustaining factors. Hence, the importance placed on the sustaining factors for any individual student creates added pressure for success.

What this study shows, as explicated for clinical educators, is the critical importance of the notion of filial piety as the main sustaining factor for students from Chinese and Maritime South East Asia, and to some extent those from Southern Asia. Here the obligation to one's parents not only contributes to their wellbeing, it has far reaching fiscal benefits for the region, as remittance payments to parents at home contributed significantly to the GDP of a student's home country. This, of course, is dependent on the student's success.

Motivation as described in this study comprises highly personal details of a participant's life and often revolved around the opportunity for a new beginning in Australia, family obligations or obedience to parents. This complex layer sustained the students for the duration of their studies.

Conspicuousness

On entering particular clinical environments it became apparent, almost immediately to some of the participants, that they looked different and sounded different to the mainstream nurse. Participants who were most attuned to this difference possessed both skin colour and language accents which they themselves noted identified them as different, worthy of notice, and, therefore conspicuous. The participants then positioned themselves as different which caused them to view their identity as a student nurse through a lens of difference. Research conducted in the United States of America (USA) by Purdie-Vaughns, Steele, Davies, Diltman and

Crosby (2008) found that for minority represented groups such as African Americans, a low level of diversity in the workplace led to the perception of threatened social identities and mistrust of the workplace context. The level of conspicuousness felt by the participants in this study resulted in consequences similar to those cited by Purdie-Vaughn et al. (2008) that affected their behaviours and ability to learn in the clinical environment.

For the students to come to the realization that they were indeed different, when they compared themselves to the nurses they came into contact with, and for it to be such a stark a comparison, the ethnic and language diversity within the profession itself appeared to be incongruous with the Australian population. Indeed, by expressing that he had a foreign face one participant was observing the status of diversity within the profession. However on his arrival in Sydney to begin his nursing studies, the same participant wondered where all the 'Aussies' were in regard to the general population. Therefore, a difference still exists between the ethnic diversity of the registered nursing population and the multicultural population of Sydney.

Immediate differentness. For students who were not Caucasian and who spoke with an accent there was an immediate sense of being different. Comments made by the participants that related to the feeling of being conspicuous, due to looking and sounding different, came from participants who were of Indian, Asian and African origin. The simple statement 'I am black and you are white' is powerful in that its effect on perceived notions of the self and the implication within it cannot be underestimated. The literature describes the physical idea of difference as phenotypical where an individual appears different from a majority population because of skin colour, and other physical characteristics (van Riemsdijk, 2010). The notion of looking different and sounding different has also been identified and discussed in the qualitative work of Brown (2005). It is recognized as an important reoccurring issue impacting on clinical learning for international students. It is therefore, necessary to examine the notion of phenotypical difference in regard to the mainstream Australian nurse, in other words what are the antecedents to the notion of difference.

The Nightingale system of nurse training, and the ensuing media that portrayed nurses as blond haired, blue eyed angels, is largely responsible for the lingering image of the nurse (Russell, 1990). The influence of the Nightingale system of training and practice reforms was widely accepted across the globe which ultimately perpetuated the 'angel' image of the nurse internationally. Nurses, who have different skin colour, speak a different language, practice different religious beliefs, and possess different health care beliefs and practices, are *othered* by a white nursing society that was founded on the Nightingale 'angel' image. According to the most current Australian Bureau of Statistics (ABS) census data (2006), of the nursing population in Australia, 7% of nurses were born in England, 2% were born in New Zealand, followed by China only (1%). England and New Zealand also contributed the most to nurse migration followed by the Philippines, South Africa and India. Whilst vestiges of this historical foundation obviously remain, it is possible to reflect on the diversity of the profession in the following way. The effect of globalization and immigration, not to mention calls from within the profession itself to be more representative of the multicultural population, have changed the face of Australian nursing students to some degree. However, it may possibly take some generations for the profession to demonstrate any real observable change in diversity. The participants in this study, who identified that they looked and sounded different and who remarked that they were in the minority, noted that white nurses remain the majority, reflecting the current state of ethnic dominance within the profession.

The notion of *whiteness*, or being phenotypically white, has been explored in nursing in order to determine privilege and power within the profession and to reveal that, being classified as white in nursing creates advantage (van Riemsdijk, 2010). How nurses in Australia define the profession, its philosophies, and its body of knowledge in regard to the dominant culture and the implicit power over persons, who are *different,* can be seen as questionable and exclusionary. Many authors agree that to be white constitutes invisibility (van Riemsdijk, 2010; Allen, 2006; Frankenberg, 1995) in a group of individuals, and those who are not white are conspicuous.

Accents and their influence. Language is understood as a primary resource for enacting social identity, and establishing social groups (Zhou, Windsor, Theobald, & Coyer, 2011). A person's accent is an important part of social identity and imparts a

considerable amount of social information to the listener and has been described as a significant social force (Lippi- Green, 1997; Ryan, 1983). Indeed, accented speech can be used to make evaluative decisions about a person's traits and influence how people act around them (Stewart, Ryan & Giles, 2005). This could ultimately affect their identity development and acceptance into social groups. Research conducted in Australia by Cargile and Bradac (2001) found that listeners evaluated speakers according to their accent and made judgments about their status, intelligence, wealth, competence, friendliness and kindness. Evaluative judgments like this could possibly go some way to explaining why a number of the participants felt uncomfortable in the clinical environment when with groups of Australian nurses. Because the students perceived a sense of difference, it is important to consider the potential impact of such judgments on ICALD students' identity as learners in the clinical environment.

Through the lens of difference, these participants identified that their accented spoken language, combined with their phenotypical characteristics, impacted on their identity as a nursing student. The participants referred to the way their spoken English sounded different to the local Australian English (Derwing & Munro, 2009), which caused them to see themselves, personally, as an immediate barrier to successful communication. This then, in turn, gave others permission to treat them disrespectfully during interactions, or to reject them outright. Viewed in this way by participants, reflects the power that language has over the ability to identify with the social group of local nurses and the inextricable link that language has to the formation of identity and, of course, as a conduit to learning (Harmer, 2001).

One of the main messages to be conveyed via this discussion is that all speakers of English have an accent and to reinforce the idea that language proficiency is not related to accent. A linguistic accent, or phonetic component of language, is immediately audible. It is because of this that Cenoz and Lecumberri (1999) suggest accent is the most salient characteristic of a non-native English speaker. Most adult learners of a second language retain a foreign accent mainly because the sound system of the first language influences the perception and production of the second language (Derwing & Munro, 2009; Flege, 1995). Listeners are particularly sensitive to the presence or absence of a foreign accent. Because of this sensitivity people are particularly good at detecting outsiders on the basis of their speech patterns. An accent

provides clues to a person's geographical or social origin and can be used to reinforce a stereotypical identity that can influence opinions as to the characteristics of the person, including their abilities (Wated, & Sanchez, 2006; Cenoz & Lecumberri, 1999). This was highlighted by one participant who felt that people could see that she was from China, phenotypically, and assumed her knowledge base of the language was poor so they spoke about her in front of her. Accented speech does not mean communication problems are inevitable, or that the speaker has a low English proficiency or, indeed, that they are a poor nursing student. From their research, Derwig and Munro (2009) suggest that intelligibility, or the level of actual comprehension by the listener, is related to pronunciation and that is where most of the issues with accented speech lie. It is possible to have a heavy accent yet be completely intelligible. However, the combination of phenotype and phonotypical characteristics were detrimental to the student's self-concept, and allowed for conspicuousness.

Accent perception is reciprocal. Pronunciation is one of the most difficult areas for English language learners, and can cause different reactions from the listeners. This is especially so when accented speech is accompanied by errors in other linguistic elements such as grammar, that can lead to misunderstandings (Munro, 2009). Where participants in this study believed that they were speaking correctly, and the listener did not understand, attempts at communication may have had a number of confusing elements for the listener. Munro (2009) asserts that it is virtually impossible to completely eradicate an accent, although pronunciation can be modified to increase intelligibility. It is pertinent that role models, clinical teachers and others that the student comes into contact with remember that the perception of accent is reciprocal and, as such, the student is affected in their ability to listen and understand just as they are.

A sense of differentness increases vulnerability. An acute awareness of phenotypical and phonological differences caused some of the participants in this study to feel vulnerable. The expectation of some level of discrimination was reinforced by students who had previously studied in Australia. Because the students live, possibly work, study, and attend clinical practicum in the Australian context, it is then necessary to explore the literature related to discrimination in all of these contexts to appreciate the sense of vulnerability felt by the participants.

From accounts by participants from Chinese Asia, it was apparent that there was some expectation of discrimination in Australia. Some participants had received pre-departure warnings about the level of racism to be expected in Australia. In terms of Australia's reputation as a provider of quality education in a safe environment this type of feedback was not a positive reflection. Research conducted by Dunn (2003) found that there was a substantive degree of racism in Australia. There was strong anti-Muslim sentiment that appeared to be increasing and an ongoing intolerance for Asian, Indigenous and Jewish Australians that has not changed significantly since the 1980's. The people who are most likely to be racist in mainstream Australian society are; older; born in Australia; do not speak a language other than English; are male, and do not have a tertiary qualification. Interestingly 83.1% of the people surveyed identified that racism was a problem in Australia. However 78% of respondents believed that people could be sorted by race and almost 1:10 self-identified themselves as racist (Dunn, 2003). Those respondents who had experienced racism stated that it mostly occurred in the work place followed by educational settings. Those born overseas and those who have English as a second language, experienced the highest rates of workplace racism. Being treated in a disrespectful manner, name calling and lack of trust were described as everyday racism and were found to be the most frequent (Dunn, 2003).

In essence, what this means for ICALD students, is that the likelihood of experiencing discriminatory attitudes from the mainstream population is quite high. The mainstream population, especially those who are older, who are reported as being most likely to hold racist attitudes, are also most likely to form the basis of the inpatient population and to come into contact with ICALD students.

In 2009, the Australia and New Zealand International Race Relations Round Table acknowledged that issues of discrimination and racism existed for international students (Baird, 2010). Research conducted by Graycar (2010) supported the hypothesis that language proficiency, regardless of skin colour, was identified as a risk factor for racism. In a study of Asian students' preferences for place of international study, Mazzarol and Soutar (2002) found that the choice of country took into consideration its reputation for discrimination. The perception of discrimination by students also effected their satisfaction with the course (Perucci & Hu, 1995), and perceived discrimination acted as a stressor resulting in health issues for international students (Kreiger, 1990).

Discrimination, whether it is perceived or real, acts as a stressor and this stress has been shown, through research conducted in the USA by Wadsworth, Hecht and Jung (2008) to lower satisfaction with the learning experience.

Research involving international students in general has highlighted issues of perceived racism or discrimination, and negative stereotypes based on students' ethnicity (Jung, Hect, Wadsworth, 2008; Frey, & Roysircar, 2006; Bonazzo & Wong, 2007). Hanassab (2006) reported that students from the Middle East and Africa, who were studying in the USA, were more likely to experience problems related to discrimination from their peers more so than European international students. In this study a student from Chinese Asia had developed a perception that she was disliked by her peers based on her phenotypical characteristics. Discriminatory treatment has also been experienced by international students from university faculty administration and off campus aggression from members of the public has also been reported (Lee & Rice, 2007). A significant feature of this study is the identification of tensions between different student cultural groups. The students from India and China were considered more overt in their discriminatory attitudes than domestic Australian students. This has implications for learning and behaviour in the clinical environment, because students are randomly assigned to a clinical placement, and tensions between cultural groups could affect the student's capacity to engage in learning.

Polrazli and Lopez (2007) found that international students in general, studying in the USA, are at greater risk of perceiving or experiencing actual instances of discrimination because of their non-American status, accented English, and visible ethnic group. Interestingly, international students who have lived in the USA for longer periods reported a higher perception of discrimination i.e. the longer they stay the more discrimination they perceive. Polrazi and Lopez (2007) proffered the notion that a 'honeymoon stage' of settling in, combined with a lack of language proficiency, may have allowed instances of verbal discrimination to go unnoticed in the early stages of the student's tenure.

European students in this current study reported less discrimination than the ethnic looking students. This finding correlates with research conducted by Hanassab (2006) and Karuppan and Barari (2010). These researchers explained this away by them

looking like an American therefore being afforded the category of white and a level of invisibility.

In research conducted by Hanassab (2006), 21% of students from South East Asia experienced discrimination from their university professors. Examples of discrimination took the form of professors not knowing how to pronounce the student's name, ill consideration of comments made in class, and the formation of a perception that native students' comments were better respected. The instance of perceived discrimination from a participant in the current study, related to an instance where a Chinese Asian student was unable to answer a question posed by her clinical educator, neither were the local students. However, the Asian student was the only one to receive a clinical fail. Here clinical teachers can be likened to professors who have the power to pass or fail students.

Negative stereotypes based on a persons accented speech can be interpreted as a social stigma which can have direct and devastating consequences for those individuals whose identities are devalued (Crocker & Quinn, 2000). Those consequences identified by various studies include stress, devalued self-esteem and feelings of discrimination or prejudice (Wated & Sanchez, 2006; Mackie, Devos & Smith, 2000; Baumeister & Leary, 1995). Further, in research conducted in the area of organizational management, perceived discrimination regarding a person's accent has been found to be detrimental to job satisfaction and organisational commitment (Meyer & Allen, 1997). It is conceivable that this type of reaction could be experienced by ICALD students in the clinical environment, where they could experience less satisfaction with learning, commitment to becoming an Australian nurse and the perception of the work environment. Wated and Sanchez (2006) suggest that individuals who feel that they are stigmatized based on accent, could be experiencing a situation beyond their natural coping skills and, therefore require extra support.

Interactions with others are also affected by the perception of discrimination, which has the ability to impact on engagement with learning. Consequences related to learning for students who perceive that they are discriminated against include feelings of alienation and possible withdrawal from engagement (Beoku-Betts, 2004). This concept was supported by Karuppan and Barari (2010), who found that when students

perceived discrimination based on their language proficiency, they retreated to find refuge in their international peer group. On the other hand, international students who had high language proficiency developed a confidence that they felt protected them from discrimination. Karupan and Barrari (2010) termed this *insulation*. Students who self-rated their English skills as lower felt more discriminated against than students who self-rated their English skills high. Further, the authors assert that English proficiency is the key to successful acculturation, and a way of negating discrimination regardless of ethnicity. English proficiency may be the single most important enabler of positive learning outcomes for international students as it dampens the effect of discrimination on learning engagement (Karuppan & Barari, 2011).

For nursing students in the clinical environment engagement with patients, their families and staff is expected and is also an element of clinical competency assessment. If the ICALD nursing student in the clinical environment exhibits behaviours that are akin to withdrawing from interaction (Wasdworth et al. 2008) and engagement with learning, then one of the possibilities is that they could be sensing a level of discrimination.

The prominent nursing cultural researcher Xu (2008) has suggested that the notion of racism or discrimination in nursing was regarded as an uncomfortable truth for some nurses he came into contact with in the USA. He suggested that the effectiveness of addressing the issues lies in the profession of nursing's ability to be open and honest about discriminatory practices. Further, Di Cicco-Bloom (2004) suggested that the social inequity within the broader society itself permeated into the nursing profession throughout the USA. She suggested that the notion of racism directed toward immigrant nurses of colour, has not received due recognition in the literature. Di Cicco-Bloom (2004) proposed that these nurses experience racism based on their skin colour and place of origin on a daily basis, much like any immigrant to American society. Finally her research suggested that being a woman, non-white and an immigrant marginalizes these nurses even further in the USA (Di Cicco- Bloom, 2004).

A truly multicultural Australian nursing work force. A number of studies conducted in Australia involving international nursing students or nurse immigrants have identified that these groups of nurses have perceived being the victims of

discrimination or racism in the clinical context (Levett-Jones, 2009; Omeri & Atkins, 2002; Larsen, 2007; Alexis & Vydelingum, 2004, & Hagey et al. 2001). However, in bringing together the currently available literature, issues of marginalization, exclusion, and alienation have been a documented experience by international nursing students and immigrant nurses across the globe in their attempts to learn and work in the clinical environment (Mattila, Ptkajarvi, & Eriksson, 2010; Boychuk, Ducher & Cowin, 2004; Nolan, 1998). The participants in this study are not alone in their perceptions. However, nursing is socially constructed and it would be naive to suggest that the profession in Australia is free from the racist influences already present in the community. This serious issue has yet to be explicated at a level that promotes some understanding of the phenomenon so that the issues may be addressed. There is a paucity of studies that clearly set out the notion of racism and its implications for collegial relationships within the Australian nursing profession. As these relationships begin with socialization of the student into the profession it is both relevant and imperative that they are addressed in this study.

The culture of nursing in Australia is not in itself explicitly multicultural in nature; Berry (2003) offers some explanation for the continuing issue of acceptance and integration of the ICALD student into the nursing social structure. Berry (2003) suggests that certain contextual preconditions need to be met, such as a wide spread acceptance of the value of cultural diversity in the profession, relatively low levels of prejudice, ethnocentrism and racism, positive mutual attitudes amongst cultural groups and a sense of attachment to the larger society. In a country where multiculturalism is the guiding social ethos (Human Rights and Equal Opportunity Commission, 2007), in conjunction with the nursing profession's ethics that encompasses the '….commitment to respect, promote, protect, and uphold the fundamental rights of people who are both recipients and providers of health care' (ANMC, 2006), the perception of discrimination still exists and exerts effects on the ability of ICALD students to learn in the clinical environment.

Summary

Being conspicuous in the clinical environment has direct and indirect consequences for the ICALD student, whether it is because they look different to the mainstream Australian nurse or that they sound different to the mainstream Australian

nurse. The ICALD students in this study explained that they immediately stood out from facility staff and immediately knew that they were different. In identifying that there is a mainstream image of the Australian nurse, what is effectively being stated is that the profession remains dominated by the white Anglo/Celtic nurse. From their experiences students who differed from the preferred image of the Australian nurse were perceived to be lacking in intelligence and language capability. Preconceived notions about who is an appropriate Australian nurse, affect ICALD student's ability to learn because of a need to belong to the dominant group. Not being accepted by the dominant group can affect learning in the clinical environment where the student feels alienated and consequently withdraws from learning opportunities.

What is important for clinical educators to be aware of is that ICALD students may already be expecting a level of discrimination from the Australian population, and that extends into the nursing profession. For the Australian nursing profession to become truly multicultural and overcome accusations of discrimination, consideration needs to be given to value of cultural diversity within the profession.

Cross-cultural Encounters- Coming to Know Australians

The results of this study demonstrate that the learning of nursing in Australia for ICALD students does not just mean an adjustment to different academic demands and ways of teaching. This is only one facet of the learning involved. Nursing is a social enterprise and as such demands a level of interaction, connection and understanding of the society in which it takes place. For ICALD students this is primarily gained through the process of culture learning, where actual experience in context is fundamental.

Culture learning, adjusting and adapting. Culture learning is integral to the learning of nursing in multicultural Australia. However, available published literature on international nursing students has largely ignored the primacy of learning about the culture of the host country, despite it having been identified as impacting on professional development (Woodward-Kron, Hamilton & Rishin, 2007). The literature on qualified nurses migrating to a foreign country does, to some extent, identify the importance of the host culture in work place relations and, as the majority of these students identified a wish to immigrate to Australia, it warrants consideration. This

discussion explores the cultural differences that the participants experienced in being ICALD students, which represented what was internal to their functioning and development as nursing students.

It is important to acknowledge the extensive body of literature that exists in relation to adjusting to foreign settings for international students. Mostly this body of knowledge has a long established tradition where adjustment and adaptation are located in the broader realms of the acculturation process (Berry et al. 2002), and is based on a variety of interpretations of the concept of *culture shock* (Oberg, 1960). Culture learning then rests on the belief that the stress or anxiety experienced by the individual induces or inspires change. However, the process of culture learning that results in adaptation or adjustment is still to be clearly articulated.

It has become essential that educators realize that in general, international students experience significant culture learning demands that exceed their existing knowledge, skills and abilities (Toh & Denis, 2007; Black, 1988). The notion that international students experience a more complicated and complex adjustment than domestic students was initially explored by Church (1982) with research by Kaczmarek, Matlock, Merta, Ames and Ross, (1995) who found that their difficulties were different even to domestic students relocating within their own country.

One of the most important tasks, especially for international nursing students, is to learn how to be in Australia. Success in this is achieved, not only by gaining knowledge and skill, but by learning the salient characteristics of the host country (Toh & DeNesi, 2007; Furnham & Bochner, 1983); the end result being that the international nursing student will be able to participate fully as a learner in the necessary contexts (Lave & Wenger, 1991).

It is widely accepted in the business management literature that adjustment is by nature multifaceted (Kraimer, Wayne & Jaworski, 2001; Shaffer, Harrison & Gilley, 1999). Adjustment for expatriate business persons is said to occur in three contexts: the host culture in general; interactions with locals, peers and supervisors and the work arena which is role related (Lueke & Svyantek, 2000; Black, 1988). These three contexts of adjustment have been empirically supported in the literature (Hechanova-

Alampay, Beehr, Christiansen, & Van Horn, 2002; Black & Stephens, 1989). However, for international students there is a fourth level and that is the university, which is a level of investigation in its own right. This area was addressed in the literature review, and is beyond the scope of the current investigation. It would make sense then, to translate these levels of adaptation into a cogent understanding for nursing clinical education because the clinical education context is the world of learning for international student nurses.

The participants who informed the data in this study are noted as being individuals with their own culture, beliefs and values that they use as a foundation for understanding interactions with others, they come with an existing cultural and self-identity. The responses in this theme highlight individual participants cross cultural encounters with Australians living in Sydney, prior to their engagement in the clinical area as student nurses. These encounters indicate that challenges to their ideas about an Australian national identity begin from first contact with nationals. This compares to the first level of the model of adjustment exemplified in the business literature that is host culture adjustment.

Of the sixteen participants in this study, the time spent in Australia prior to beginning nursing studies ranged from none, that is arriving as the day of semester began, to two students who had completed the final 2 years of high school in Australia. Overall, most of the participants had spent one month or more in Australia prior to beginning their studies as demonstrated in Table 4 below.

Table 4 - *Length of time in Australia prior to commencement of nursing studies*

Time in Australia prior to commencing studies	0	1 week	2 weeks	1 month	3 months	6 months	18 months	2 years
Number of participants	1	2	1	4	3	2	1	2

For the students to be effective in functioning as student nurses in Australian society they need to have some level of knowledge of local cultural beliefs and values because even for the prepared international student, the extent and significance of differences can far exceed those that were expected (Hess, 1997). We, as educators, assume that all international students enrolled possess some level of cultural literacy related to Australia. Heyward (2002) defines cultural literacy as 'possessing the understandings, competencies, attitudes, language, proficiencies and identities necessary for successful cross cultural engagement. '….so that they are able to read another culture' (p10). Heyward (2002) means that new comers can interpret its symbols, and negotiate its meanings in a practical day to day context. For the participants in this study having been here for a month or more, gave them the opportunity to begin to look closely at the Australian people through their daily interactions and begin culture learning. The most effective and efficient culture learning takes place through immersion in the culture itself (Hess, 1997).

The international students who participated in this study received an on campus orientation to the university which included the expectations of learners. There was a lack of any preparation from the host university regarding adjusting to Australian culture but, most importantly, no preparation to the profession of nursing as it exists in Australia. Typically students are directed to university websites for international students where they access links to various other web sites such as the New South Wales (NSW) Government site for international students, and The Department of Immigration and Tourism. These sites offer practical tips and tourist level information, insufficient for preparation as a student who will reside here for three or more years. Research has demonstrated that a lack of appropriate and effective preparation for study abroad programs can result in a negative adjustment experience for the students (Sobre-Denton & Hart, 2008; Gill, 2007; Gudykunst, 1995).

The length of time for a foreign person to learn and adapt to a new setting is extremely variable. Evidence from Australian studies of students born overseas suggests that the amount of time spent in the culture is directly related to the amount of Australian culture learning, and those students who identify more with Australia acquire a greater amount of cultural knowledge within a given period of time (Kashima & Suppakitkumjorn, 2004).

Hechanova-Alampay et al. (2002) found that difficulties in adjustment for international students peak at around 3 months. However, in stark contrast, internationally educated nurses from Korea adapting to work in hospitals in the USA, were found to have an initial period of 2-3 years to overcome psychological stress, master the language and adapt to USA nursing practice (Yi & Jezewski, 2000). Jeon and Chenoweth (2007) noted that no such data are available for the adjustment time of overseas qualified nurses to Australian nursing. What this indicates is that for various levels of adjustment for international nursing students, there are variable time periods. That whilst adaptation to learning styles on campus may be shorter, the stress related to adaptation time to learn clinical practice and language may take the whole candidature (a period of two to three years), despite the need for successful demonstration of competence as an indicator of learning to nurse in the clinical environment. Further, Kashima and Suppakitkumjorn (2004) assert that culture learning may extend past one generation for immigrants to a new country as culture is dynamic and ever changing.

What the literature and the findings of this study indicate is that the learning and knowing of culture is dependent on a number of variables, the most important being the length of time spent in that culture. What clinical educators ask of international students is that they launch into a work environment that cares for a diverse population when they have had little time to learn about the dominant culture, a task that may well be unrealistic depending on the time already spent in Australia.

The responses in this theme provided a depth and richness for the first foray into Australian society and culture that can only be gained from the insider's perspective. Australia is a complex society, in which multiple subgroups exist, and as such, Australian culture is shared by many people of diverse backgrounds (Stein- Parbury, 2009). Having previously had little or no experience with Australians, the participants used stereotypes to initially understand people, a strategy also found by McLaughlin (1998) in a Canadian study of nursing students and their perceptions of culture. What is represented now is unpacking how international students of nursing come to develop this cultural competency, portrayed here in the testing of stereotypes and values questioning that can be described as culture learning.

Learning Australian. Initial comments made by the participants on arrival into Sydney suggested that they expected a pervasive national identity. This in turn can be thought of as cultural stereotyping, a form of cognitive categorizing of the traits that are attributed to Australians (Tajfel, Shekh, & Gardner, 1964). Although the use of stereotypes can be helpful in assisting new arrivals to a culture to organize and process information regarding the people they come into contact with, using them as a sole reference can limit culture learning, understanding and sensitivity (Rattani, 1992). This is especially so for nursing students who are expected to engage and develop trusting relationships with all ethnicities.

Through engaging in conversation with local residents in Sydney the stereotype of the rugby fan was activated for one participant. This is a type of cognitive categorization where the participant assumed that this member of the 'Australian' group fitted the stereotype (Quinn & McRae, 2005). This is the typical process of activation and application of a stereotype (Quinn & Macrae, 2005; Kunda & Spencer, 2003). However, this kind of interaction is of vital importance for culture learning. Firstly, the participant was actually engaged in a conversation with a local person, an example of what Berry (1990) would describe as first hand cross cultural contact. When the participant discovered, by applying their stereotype that this person was someone who was not a rugby fan, essentially the participant's expectation was disconfirmed and a level of confusion ensued. This interaction then forced the participant to rethink the stereotype and come to the conclusion that understanding a person's culture is more complex than applying the stereotype rule. A cognitive change was apparent because the participant explained that there were no rules or formula for understanding culture, as her disconfirmed expectancy revealed (Brislin, Worthly & MacNab, 2006; Bhawuk, 1990). This disconfirmed expectancy was the antecedent for a change in the participant's construct of the typical Australian, and hence the participant learned that she could not generalize the same expectation onto everyone.

To understand why the participant stereotyped Australians as rugby fans, Elder (2007) suggests that the link between Australian-ness and sport is intimate, and that marketing of Australian-ness revolves around it. However, there are certain sports that are more representational of a national identity than others. Elder (2007) postulated that cricket and rugby are associated with the Australian national identity because of their

Anglo-Australian heritage, and sports such as soccer are only just gaining such recognition. Further, sporting heroes are related to a masculine, competitive national identity (Tranter & Donoghue, 2007). Elder (2007) suggests that the Australian archetype is still the white Anglo Australian despite claims that Australian society is multicultural. Interestingly, recent empirical evidence exists in the Australian studies literature (Craven & Purdie, 2005; Phillips & Smith, 2000), which confirms the national identity of Australians by Australians has remained relatively unchanged for many years

In relation to culture learning, Heyward's Multidimensional Model for the Development of Intercultural Literacy (2002) identifies the use of stereotypes as a step in the progression of becoming culturally literate. The use of stereotypes is categorized as attempting to understand a culture, and attitudes to a culture, as the learner is unconsciously incompetent. Initially developed as a model for international school students the model offers nursing educators a way of visioning learning as empowering the development of the student across multiple literacies. It is based on the fundamental notion of conscious competence and presents that cultural literacy, inclusive of language, is gained through first hand contact and reflection.

The literature review at the beginning of this study identified three widely used models of transcultural nursing that are included in nursing curricula across the USA, Canada, the United Kingdom and Australia. The authors of these models are Capmhina Bacote (2002), Purnell (2000) and Leininger (1995). Although there are many practice implications for both the qualified nurse and the student, these models appear to be *most* applicable to the nurse who has a high level of dominant language competency. In all of these models the patient is culturally diverse from the nurse, who is assumed to possess the language skill of the dominant group. These models are best used for patient centred care by successfully encultrated nurses, not student centred learning, as they are not appropriate for the support of culturally and linguistically different student groups.

The participants in this study have entered a country that has been described as a '…. democratic multiethnic society with predominantly monoculture legal and political institutions based on Anglo-Celtic traditions' (Hibbins, 2005, p.170). More specifically in regards to the multiethnic nature of the Australian population, the participants in this

study have come to study in Sydney. According to the latest National Regional Profile data (ABS, 2010), 34.4 % of the population of Sydney were born overseas. Residents in Sydney who were born in North-West, Southern and Eastern Europe account for 11.6% of the population, and people born in South-East, North-East and Southern Central Asia total 13.1%. Accordingly, 31.4% of the population of Sydney speak a language other than English at home. It was precisely encounters with this multiethnicity that caused both consternation and delight for the participants in this study.

A white Australia. One participant held onto the belief that due to colonization by the British, Australians were by default white people; and another was shocked to see so many Asian people in Australia; yet another was delighted to see such cultural diversity as at home there was a monoculture. These responses suggest two issues relating to the diversity of the Australian population and the other to the broader understanding of culture and its diverse nature.

Firstly, by expecting Australian inhabitants to be white, and to be shocked at the presence of people of Asian descent in Australia, suggests an undertone of expected cultural homogeneity, perpetuating the image of white Australians. Whilst it is true that Australia was colonized by the British and immigration was dominated by a covert 'White Australia Policy' from Federation up until the 1970's, the traditional land owners are the Aboriginal and Torres Strait Islander peoples who are not white (Department of Immigration & Citizenship, 2009). Interestingly indigenous Australians did not receive acknowledgement as being representative of the Australian image or identity by any participant in this study.

Antecedents to the participants' beliefs about a white Australia could include the impact of the 'White Australia Policy'. Reisinger and Turner (1997) noted that there is wide knowledge of the past existence of the policy in Asian countries. This doctrine reinforced Australia's position as an outpost of the British race (Levey, 2001); confirming that Australia was, and still is a dominion of the British Empire. This then defined Australia's place in the world where Australia was to be a new Britain that espoused a people with'…. a common ancestry, a homogenous culture and unlimited prosperity' (Galligan, Roberts & Triffiletti, 2001, p, 113). Essentially, Australia was a

British settler state, with its economic, educational, legal, and political institutions providing a homogenizing and normalizing effect for its inhabitants (Marginson, 2007).

Therefore, from a historical perspective the participant's beliefs are correct. At the time of Federation in 1901, Australia was represented as being culturally homogenous, and was expected to maintain a high level of cultural exclusivity in relation to immigration (Webber, 2001). Elder (2007) suggests that there are two Australian stories, one that reflects sameness and one that reflects difference, however, the dominant narratives of Australia presume an Australian as someone with a British heritage.

The use of stereotypes and the expected pervasive national identity in trying to find a typical Australian proved elusive for some participants in this study. This elusiveness may best be represented by Kaufman (2002) who asserts that '….in a diverse society there is simply no monolithic national culture' (p. 3).

Polemic of friendliness. Generally, Australians are portrayed in the media as friendly, irreverent, easy going people. Reisinger and Turner (2002) explain that Australians belong to a low uncertainty and informal culture where they have little concern for the rules of social behaviour, which results in verbal and nonverbal expression being unrestrained. However, how those characteristics are perceived by people from other cultures may be quite different; as Craig (1986) suggests that being yourself, open and friendly can be viewed by Eastern societies as a lack of manners, grace and cleverness. This is the second issue highlighted by the participants in this study, understanding the broader application of culture.

By having a stranger (Australian) say 'Hi' and smile at her, one participant was quite disturbed and alarmed. From her cultural background, the rules of social behaviour deem it inappropriate to engage in conversation or even acknowledge a stranger. A similar issue relating to stranger danger was presented from the personal experiences expressed in the discussion paper by Chenge and Garon, (2010). A registered nurse from Kenya working in the United Kingdom (UK) was not used to people unknown to her, smiling at her. The social behavioural norm in local Kenyan

culture that the informant had grown up in had taught her that smiles were untrustworthy and could mean that a favour was expected from you.

In some cultures the subtle messages sent by nonverbal communication such as smiling, are well known only to members of that culture, and provide the standard for evaluating an interaction. Facial expressions can be regarded as evolved social signals and specifically smiles can take different forms representing honesty, dishonesty or ambiguity (Mehu, Little & Dunbar, 2008). How these messages are interpreted is bound to the power, status, position and cultural context that has been described in the work of Hofstede (1980). Certain cultures, for example the Chinese, have been identified as *High Context,* where close attention is given to what is not said, through the observance of body language and noting pauses in conversations, rather than what is said (Hofstede, 1980). Rashotte (2002) presented empirical evidence that nonverbal behaviours affect the perceptions of interactions in important ways, and those interpretations are often developed within the boundaries of cultural norms of behaviour.

The use of a smile in the mainstream Australian culture is regarded as a sign of happiness, warmth, friendliness, recognition and welcoming. When accompanied by 'Hi!' (hello) in the busy work environment it has been interpreted by immigrant nurses as a flippant gesture, lacking real meaning and the cause of emotional pain (Spangler, 1991). In the scenario presented by a participant in this study, the underlying cultural meaning was unknown to her. So in the absence of cultural literacy, she used her own cultural knowledge to interpret that behaviour as possibly threatening to her personal safety, leading to a cultural misunderstanding.

For nurses working in western cultures the action of smiling is important in establishing relationships with patients. Literature across a number of nursing specialities reinforces the positive impression about caring that a smile from a nurse gives to patients. These nursing specialities include, paediatric care (Shin & White Traut, 2005), cancer care (Johnston-Taylor, 2003), Acquired Immune Deficiency Syndrome (AIDS) care (Witt Sherman & Ouellette, 2001), aged care (caris-Verhallen, Kerkstra, van der Heijden & Bensing, 1998), and general hospital care settings (Dyson, 1995). Friendly nurses were found to be related to the perception of patient centred care (McCabe, 2003).

Learning to nurse in Australia requires an understanding of culturally appropriate nonverbal behaviours and the impact that they have on the communication and caring process. Essentially the patients and facility staff will be strangers to the student and so will their clinical educators. Being defensive, withholding or selectively releasing information may have the potential to impact negatively on the perception of the ICALD student by all these categories of people. In relation to developing cultural literacy, there was little understanding of the metaculture of smiling and a naive interpretation of the nonverbal behaviour that did not create an awareness of the significance of the difference, participants could be said to be at the unconscious incompetent stage.

Clash of work values. The phrase 'no worries' seemed to be the catalyst for a value conflict. One participant commented on the relaxed way she found that Australian co- workers deal with stress. The experience she had, appeared to be a value difference in the way responding to clients is perceived in the work environment. 'No worries' is said to typify Australian culture as casually optimistic (Wierzbicka, 1992; Wierzbicka, 1991; Linge, 1991), and has a multitude of meanings such as an apology, 'you're welcome' and 'don't worry about that' (Bowe & Martin, 2006; Partridge, Dalzell & Victor, 2006). Others have interpreted the saying as meaning not to worry about things over which you have little or no control (Bush, 2011). It would appear that the participant took the phrase to mean that her co-workers did not care at all for the timely delivery of food to the customer. However, another interpretation could be that food preparation takes time and will get done so why become stressed? The impact of this confusion was demonstrated by the participant leaving her employment due to unresolved value differences.

Value differences are considered to demonstrate a deep level of subjective dissimilarity that generally only arises once direct contact with another culture has been made (Toh & DeNisi, 2007; Harrison, 1998). Values about work guide perceptions and behaviours in the work place, and, in a multicultural context, have the potential to cause misunderstandings and limit communication (Ravlin, Thomas & Illsev, 2000) as they have in the above example.

Drawing on the work of Hofsteede (2001), an individual's work values are shaped by the immediate family, societal and cultural norms and values and beliefs, which separate one group from another. A relaxed attitude to minor errors made in the clinical context was also identified in a study of foreign nurses in Iceland (Magnusdottir, 2005). Foreign nurses made judgements about the easy going nature of the Icelandic nurses when minor errors were made, and interpreted this as poorer quality care, where the Icelandic nurses saw it as an opportunity for learning and improvement.

It is clear that differing work values have an effect on the foreign person in a host country. The scenarios presented in this part of the discussion could be determined as relatively minor, although they had a major effect on the attributes afforded to the host nationals. Work values have the potential to create negative interpretations and affect the learning experience for international students. According to Heyward's Model of Cultural Literacy (2002), when participation in another culture leads to conflict, understandings are such that the other culture seems irrational or unbelievable, and there is a negative attitude toward the other culture; a person developing cultural literacy could be said to be at the consciously incompetent stage. There is also a clear link here to adjusting to the work environment as suggested by the business literature.

Valuing family. The issue of relationships in Australia, as depicted in this study, concur with Woodward-Kron, Hamilton and Rischin's (2007) qualitative study of nursing, medicine and physiotherapy students. These researchers also found that attitudes towards older family members and open displays of affection were difficult to come to terms with. The participants in this study struggled to come to terms with the difference in cultural values, behaviours and attitudes that they came across in everyday life.

Culture difference around the concept of family was discussed by two participants in the study, both of whom were from Chinese Asia. Each of these participants voiced their dismay at the way they perceived that Australian families treated their elderly members. There was a decided feeling of sadness for the elderly in aged care facilities whose families did not come to visit frequently and only arrived on special occasions, for example Christmas. Asian families are extended and have very

close relationships (Reisinger & Turner, 1998). There is a dependant nature within these families that is not experienced here in Australia (Reisinger & Turner, 2002). Respect and deference is given to the elderly in Asian culture and is related to the concept of filial piety. This cultural concept is pervasive throughout many parts of Asia. Zhou, Windsor, Coyer and Theobald (2010) found that China educated nurses working in Australia suffered an omnipresent sense of guilt at leaving ageing parents behind in China. One of the participants in this study acknowledged that she felt it was a definite difference in culture, placing her at the consciously incompetent stage of cultural literacy.

Previous studies conducted in western countries involving nurses from the Philippines, India and Pakistan (Di Cicco-Bloom, 2004; Allen & Larsen 2003; McGonagle, Halloran & O'Reilly, 2004), have also noted that there was a cultural mismatch when it came to attitudes about caring for elderly family members. This kind of difference in attitudes could lead to conflict in both personal and work related arenas for ICALD students who are developing cultural literacy and are at the level of conscious incompetence, as demonstrated by disbelief that elderly family members could be treated in this manner.

Emotional display rules. Cultural rules about social behaviour in Australia appeared to cause some participants concern, which has been interpreted in this study as disquiet and dilemmas. Mostly, disquiet centred on the open demonstration of emotion between males and females, and dilemmas around the maintenance of a good reputation for females. In coming to understand the responses, the actions that proved most unsettling were: males and females kissing in the street; females drinking (alcohol) and smoking, and females driving cars. For some participants in this study, the freedoms that Australians were perceived to have, were in stark contrast to the strict moral codes enforced by family or religious codes in their home countries.

Rules about displaying emotions are learnt from childhood and mainly govern which emotions are shown and to whom in any given circumstances (Gullekson & Vancouver, 2009). In an extensive worldwide study of university students, Matsumoto et al. (2008) concluded that these rules vary across cultures, between in and out groups within a culture, and within groups within a culture. Having accurate expectations of

host norms is crucial to success in the culture learning process, as misunderstandings and conflict may occur (Gullekson & Vancouver, 2010). Gullekson and Vancouver's study of American graduate students, which included 35% international students in the sample, found that most encountered emotional display rules that they were not accustomed to (2012). In addition, differences in how emotions should be displayed at home and in the work environment were apparent.

Asian cultures in general do not tend to display their feelings in public to avoid offending others. Being self-restrained and reserved Reisinger and Turner (2002) suggests is to demonstrate *face saving* for one self and others. *Saving face* is done by being moral, humble and well-mannered amongst other personal traits (Reisinger & Turner, 1998). The moral code of the Chinese Asian population is reinforced at a national level with continued official restrictions on the sexual content of music, art and literature (Higgins, Zheng, Liu, & Sun, 2002). Reisinger and Turner (2002) suggest that Australians generally are not as concerned about damaging their own or other's reputations and are, therefore, less restrained in displaying emotions.

In a study involving Chinese university students Higgins, Zheng, Liu, and Sun (2007) found that, despite the rapid changes that have taken place in China since the open door policy began in 1980's, results reflected an adherence to traditional values regarding sexual attitudes and behaviours. This suggests that Chinese family morality is resistant to western influence and remains grounded in tradition and culture. Further, the role of women from a traditional Chinese view portrays women as housebound, submissive and second class citizens, with virtue encapsulated in obedience to fathers, husbands and sons. Chinese male students in the Higgins et al. (2007) study more often wished for a wife who was less well educated, chaste, and socially inferior to themselves.

In a very similar traditional view, Joshi (2000) suggests that the notion of Indian womanhood is founded on the virtues of fidelity, honesty and loyalty to her husband. These notions apparently stem from the roles attributed to women in the ancient mythological scripts of the Ramayana and the Maharbharata. In addition, Joshi (2002) suggests that Ghandi further reinforced the characteristics of Indian women, when he payed tribute to Sita the wife of Rama and reified her virtue, innocence, and

selflessness, thus making her a popular role model for Indian women. Alexander, Garda, Kanade, Jejeebhoy and Ganatra (2006) assert that these traditional values continue to exist in contemporary India and are reflected in the discouragement of friendships and romantic relationships between women and men. Those women who choose to do so, if found out, bring dishonour to their family and reduce their marriage potential.

It is an expectation that Indian girls don't have boyfriends as it is not customary for young people to mix either in public or private before marriage (Alexander et al. 2006; De Lepervanche, 1984). Joshi (2000) noted that there are gender differences in expected morality for males and females, to the extent where the double standard is exemplified by:

> *Indian boys are allowed to have girlfriends and explore everything, live life to the fullest….For them reputation is not an issue, they can go out and sow their wild oats and then still do the right thing by the family. While for girls, being outspoken, achieving, dress, manners, the amount of freedom they have are all indicators of morality* (Joshi, 2000.p.53-54).

The cultural difference for a participant from South East Asia extended past the public demonstration of emotion between men and women to encompass something that would be considered part of the daily life for many Australians, driving a car. Driving a car from the participant's family's point of view was to enable clandestine meetings with the opposite sex. It is a vehicle for independence, and distances the girl from parental control. Driving was also noted as an issue in Joshi's (2002) study of first generation Indian daughters in Australia, as it caused ongoing tension between a young woman and her father. For the participant in this study, having to learn to drive and get a licence to enable her to travel to clinical placements and on campus classes, became a dilemma, a conflict between being a good Indian daughter, and a good Australian nursing student.

In learning to nurse in Australia these cultural differences could also be seen to translate into the clinical environment, where the role of the Australian nurse intersects

with the culturally based role of the woman, and is brought to the fore in the ICALD student. For those who came from cultures where the traditional role of the woman was strictly and deeply grounded in their culture, an internal disquiet and serious dilemmas were salient for these participants as they came to develop their cultural literacy from a basis of conscious incompetence.

Summary

Having arrived in Australia with their own presumptions and stereotypes, adjustment as a task was complex and at times confounding for the international students in this study. Their adjustment was compounded by the unanticipated culturally diverse nature of the Australian population. Overall, the responses indicated a lack of knowledge and preparedness for that diversity. A lack of preparation of international nursing students for cultural diversity is a new and important insight that was salient for the participants in this study. A lack of preparation could impede or delay culture learning, adjustment and adaptation. For the Australian nursing context the education of health care professionals with appropriate cultural knowledge is fundamental.

The cultural differences that the participants experienced on initial contact with people in Sydney, unseated them from their cultural comfort zone and launched them into a relatively unknown context. This unknown context was complicated by the diverse nature of the population. Familiarity of life ways and values and beliefs of their own culture became inadequate as a basis for understanding the people in Australia and their behaviour. Armed with little knowledge of the Australian culture, and specifically the cultural mix of the people of Sydney, as demonstrated by participant responses, they came to learn to be a nurse. Essentially, the participants were embarking on field work, their own individual journey to understand the Australian people and then transfer that knowledge into the clinical environment where they encounter Australians as staff and as clients.

For clinical educators the concepts presented in Heyward's model provide a framework for understanding the nature of learning to nurse as complex culture learning. Understanding the culture of Australia and its diversity is only one dimension of the learning experience.

Encountering and Engaging With Language in Context

Nursing is a profession dominated by the use of appropriate and competent language in communication with patients and their families in a multidisciplinary team environment. The language of nursing not only comprises the local language of the people in which nursing is situated, it also encompasses medical and technical language that reflects the context of health care, and therefore, can be considered to be multilayered. To that extent, nursing has its own communicative culture, where members share the same meaning of language and understand the purpose it serves (Liddicoat, 2009; Eisenchlas & Trevaskes, 2003). It is because of this *shared* understanding between nursing professionals, that the values, beliefs and assumptions intrinsic in communication are invisible to those within the culture. However, they become salient when judgements need to be made about competency.

Clinical learning: A language rich experience. The type of communication expected in the clinical environment is at the same time; broad in its nature, complex in its structure, and intercultural in its foundation. To this end the clinical learning experience provides a culturally rich language experience where ICALD students hear and read the languages and have opportunities for interaction (Liddicoat, 2008a; 2008b). For the ICALD student, simply knowing how to create messages using grammatical structures, or the appropriate medical terms may not eventuate in a meaningful message. So, for a culture learner the clinical context provides exposure to the culture of nursing, where this exposure is critical to language development.

All nursing students need to be able to demonstrate effective communication within the culture of nursing to be assessed at a passing grade, and therefore able to function in that context. ICALD students who have primarily studied grammar and vocabulary of English often find that they are not well enough equipped to function in the clinical context because of the lack of awareness of the cultural rules of engagement (Liddicoat, 2008). The participants in this study became acutely aware of their beginning status in learning Australian English and how it affected their ability to communicate from their first foray into the clinical environment. The importance of learning multiple language proficiencies in all aspects of the nurse's role in the clinical environment became increasingly clear.

Underlying the nursing professions focus on English language proficiency (ELP), is the primacy of patient/client safety, where a recipient of nursing care can expect a level of safe nursing practice. A commitment to safety in clinical practice has been made by the Ministry of Health NSW, with a lack of ELP in staff across all health professions noted as a significant clinical risk (NSW Health, 2007; Northern Sydney Central Coast Area Health Service, 2008). Communication problems have been identified as the root cause of serious clinical events involving patient care over a number of years in the NSW public health system (NSW Health, 2005, 2006, 2008). The Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals (Garling, 2008) identified clinical handover as the most significant contribution to patient safety, where the clinical handover of patient care from nurse to nurse and nurse to doctor, has been noted as requiring competent language skills in the giving and receiving of information that is accurate, timely and understandable (Wong & Yee, 2008). In addition, Garling (2008) made numerous recommendations about improvements to the legibility of hand written documentation in relation to patient safety. The level of importance in communication to a nurse's work has also been identified by the work of Xu (2008), and Brush, Sochalski and Berger (2004) where it was identified that international nurses were unable to act as patient advocates and could not communicate effectively with patients and their families.

ICALD nursing students are learning to communicate in the clinical environment and, therefore need to be identified as not only learning to nurse by developing skill and competency, but also learning the languages of the culture of the profession. Feelings of anxiety and crises of confidence surfaced for some participants once they entered the clinical environment. These were characterized initially by apprehension because of the unknown level of language required and compared with the ability of native speakers. Proficiency would, in turn, become more complicated than social English language with the addition of medical terminology, Australian vernacular and accent, speed of speech and client illness, affecting the spoken word and consequently understanding. ESL nursing students in New Zealand were also found to have difficulty in the clinical environment with broad categories of communication such as social conversations with colleagues, social conversation with patients, performing health assessments, working with patients, telephone conversations and reporting or

giving handover (Eyre, 2010), all of which involve the use of nursing language, medical terminology and a variety of local English. However, this study also identified the deeper complexity with patients whose ability to communicate is affected by illness or injury.

Australian English is different. In relation to learning the Australian variety of English as an additional language, Peacock (1999) found that students can underestimate the difficulty of learning a foreign language, and that additional language proficiency was affected by particular beliefs that the student held. The beliefs that language learners hold can affect the language experience and learning actions (Poon, 2006; Tsui & Bunton, 2000). A belief that: language learning was mostly about grammatical rules; mistakes in the beginning of learning a language would be difficult to erase; the student preferred not to say anything until it was perceived to be perfect; or that language learning was memorizing a list of words, affected the students' ability to develop proficiency. In addition, frustration and dissatisfaction can be felt by the English language learner who aspires to perfect the type of English accent they were learning.

When trying to comprehend the language difficulties of ICALD students it is important to understand the learner to gain a full picture of the level of readiness of these students to engage in learning in the clinical area. The participants' responses referred to certain unpreparedness for the difference in native language speakers which were identified in general terms as Australian vernacular, and the speed of Australian speech. This finding has also been corroborated in studies of nursing students (Brown, 2005). However, it can be said that Australia as a multicultural country uses Australian English as a Lingua Franca, that is a language that is used when communication occurs between two people whose first language is not Australian English; many forms of accented Australian English are encountered.

Although linguistic analysis is not within the scope of this study, it would be useful to include some explanation of first languages and how they impact on subsequent language acquisition, especially for the understanding of the student's language level readiness. The two most prevalent language categories spoken by

participants, South Indian language and Chinese language, have been chosen to highlight language differences in this section.

Students with an Indian or Nepalese first language background come from a world region where a total of 16 major languages are spoken. Hindi and Nepalese are derived from ancient Sanskrit. Because of British colonization of South Asia, English has become very well established as a second language, suggesting that even without formal language instruction, some level of general learning is possible. Distinctions in pronunciation or accent for people from this region are related to the production of vowel sounds, pronouncing the voiceless consonants, and a different intonation. Pronunciation can often be directly related to spelling because South Asian scripts are largely phonetic. Asian languages are syllable timed rather than stress timed so intonation, rhythm, and stress cause problems for English speakers from South Asian languages. It is suggested that an emphasis on written work and formal language discipline may make it more difficult for the Indian English language learner to cope with everyday colloquial language usage (Shackle, 2009).

The Chinese language is a collection of numerous dialects, although Mandarin is the most common dialect and has been adopted as the main Chinese language. Multiple dialects contribute to a number of different pronunciation styles of English for the Chinese learner (Poon, 2006). Because English and Chinese come from two different language families, learners of English can expect difficulty across all areas, at all stages of English as second language learning. Chinese language speakers find English hard to pronounce and understand because of the differences in the phonological systems. Words can be left out in communication by learners if they are too difficult to pronounce. Pitch is used to differentiate words that sound the same, not to stress meaning. Basic Chinese is monosyllabic in nature so speakers tend to separate words in a sentence making it sound staccato in nature, or ill flowing. The writing system of Chinese is not alphabetical so students experience difficulty writing English in many ways. There are also differences in sentence structure and discourse patterns that often directly reflect Chinese thought patterns (Poon, 2006). English words take up a lot more space than the Chinese characters therefore, they take a longer time to visualize leading to slow reading speeds compared to overall proficiency in English. Chinese may appear to be abrupt in their requests mainly because they are not used to the polite forms of

conversation used in English. In addition there is no gender distinction in Chinese so confusion with him/her, he/she, and it can occur (Chang, 2009).

It is important for clinical educators to realize and understand the impact of the first language on the construction and production of the second or additional language. The acquisition of English pronunciation is a complex task involving the ability to understand and produce sounds that reflect the phonetic, semantic, syntactic and pragmatic subtleties of the type of English required (Cenoz & Lecumberri, 1999), in this case Australian English. Native proficiency or the notion of 'nativespeakerdom' as identified by Ryan and Viete (2009) is suggested as an unrealistic standard for non-native speakers because of the way that English is learnt by memory and not by natural creative use (Scales, Wennerstrom, Richard, & Wu , 2006).

Developing Australian English language competence takes time. The onshore language background of some participants seemed to have little impact on their ELP. Two participants had completed the senior years of high school here in Australia, and one had lived in Australia for 18 months, and in that time had attended an English language course run by the university they were currently enrolled in. Despite this amount of time in the Australian language context, they still perceived a language gap between themselves and the Australians they came in contact with in the clinical environment.

It is at this juncture in the discussion that consideration needs to be given to the work by Abriam-Yago Yoder, and Kataoka-Yahiro (1999) related to the Cummins Model of language acquisition. The Cummins model is based on two types of language proficiency, basic interpersonal communication skills, and cognitive academic language proficiency. Educational research stated by Abriam-Yago Yoder and Kataoka-Yahiro, suggests that ESL students take up to two years to attain basic interpersonal skills, and five years for cognitive academic language proficiency (1999). Some participants in this study likened their level of proficiency once they entered the clinical environment to an infant learning to talk. This analogy was also explicated in research conducted by Magnusdottir (2005) and Xu (2007), and signifies the contrast between the proficiency level of a native speaker and second (or subsequent) language learner.

Some participants had studied English language in their home country or off shore for many years, and were of the opinion that their standard was acceptable especially after gaining entry to university to study nursing. However, once participants began to realise the language demands of the social, university and particularly the clinical context, it caused them to doubt their ability. It would be reasonable to suggest that the IELTS score gave them some level of security and assurance around language proficiency that turned out to be false.

Following on from attempting to understand the learner it is also important to include their previous language learning experiences. For example, Zhang and Mi (2010) conducted a study of 40 Chinese international students in Australia and found that on average their respondents had been studying English for an average of 9.22 years in their home country. More than half of them had never had an English speaking teacher, the classes were conducted in Chinese, and there was no actual speaking class in the syllabus. Overall, English language teaching in China focused on language knowledge (grammar & vocabulary) not language skills, with classes mainly conducted in the mother tongue, and learning confined to textbooks and grammatical exercises (Hellesten & Prescott, 2004; Hellesten, 2002; Robertson, Line, Jones & Thomas, 2000). What this type of learning did do, however, was give the students good grounding in reading skills. Unfortunately, good reading skills do not necessarily translate into good writing skills. This is because writing requires active knowledge of meaning production through the skills of planning synthesizing, organizing and composing, in essence higher level cognitive functions. To write well in a second language requires an understanding of the literacy culture to achieve competence. Zhang and Mi (2010) contend that this level of development in competence is unlikely to be achieved within a time frame of 2 years. This result concurs with the Cummins model of language acquisition as explicated by Abriam-Yago, Yoder and Kataoka-Yahiro (1999).

Two participants, who were from South Asian language backgrounds, readily associated their prior language learning to a general familiarity with American English standards. These participants had also included watching American television medical drama in their strategies for learning to communicate in the clinical environment, which they thought would be beneficial and transferable to Australian English. However, they still described a level of unpreparedness for Australian English that was expressed as

missing parts of conversation or feeling lost. The American variety of English is becoming dominant because of its wide dissemination in popular culture (Alego, 2007). There are differences in pronunciation related to stress patterns and consonant and vowel articulation and in language structure related to grammar and syntax. Preparing for engagement in the clinical environment language level readiness that focused on the American variety of English made the participant feel unprepared.

Australian English is described in linguistic literature as a regional dialect spoken by those born in Australia or who migrate here at an early age (Cox & Palethorpe, 2007; Delbridge, 1999). Australian English is further broken down into three subgroups Standard Australian English (the most dominant subgroup), Aboriginal English, and Ethnocultrual Australian English varieties (Cox & Palethorpe, 2007), thus establishing that Australian English is not homogeneous. As Bradley (2003) described, there is a regional distribution of the Australian accent based on the historical and social characteristics of settlement, which is further influenced by sociodemographical and stylistic variation. Therefore, there is not just one Australian accented speech that the participants need to be able to comprehend.

The reference to the speed of Australian speech and its effect on comprehension, was made by two participants in this study and by others in prior work (Wang, Singh, Bird & Ives, 2008; Rogan, San Miguel, Brown & Kilstoff, 2006). The participants perceived that the speed of the native Australian speaker was so fast, that it had a negative effect on their ability to hear and understand. The speed of speech is related to the dimension of listening and the ability to listen effectively to understand (Derwing & Munro, 2001). Zhao (1997) contends that individual listeners have individual speech rate preferences so it is difficult to make generalizations. However research in this area has not provided empirical evidence that speaking at a slower rate increases understanding (Derwing & Munro, 2001). What has been supported is the inclusion of a three second pause at changes in significant points in a conversation, which resulted in improved comprehension by the listener (Blau, 1990).

Studies both nationally and internationally, involving ICALD student nurses and immigrant registered nurses, have elucidated the difficulties associated with the everyday use of the native language, and many have highlighted these difficulties as the

primary concern of their participants (Jeong, et al. 2011; Takeno, 2010; Wang, Singh, Bird, Ives, 2008; Jeon & Chenoweth, 2007; Xu, 2007; Magnusdottir, 2005; Alexis & Vydelingum, 2004; Sanner, Wilson & Samson, 2002). These difficulties have been elaborated on to encompass both formal and informal means of communication and their importance in the learning of nursing and the functions of nurses. Research conducted by Levett-Jones (2009) found that difference in the sense of belonging related to language between Australian born students and CALD students, where a positive sense of belonging has almost become synonymous with learning in the clinical environment.

Australian English is polite in its construction. Whether or not the student has achieved the appropriate ELP scores to be admitted into the course, it would seem that the minutia of each utterance made is reliant upon certain cultural norms of speech. Within any given culture, forms of communication have shared meanings and connotations (Liddicoat, 2009). It is not only the Australian accent that affected the participants ability to understand, it is the underlying complexity of the way Australian speech is commonly constructed. Linguists such as Liddicoat (2009) and Wierzbicka (1985) note that cultural norms are reflected in speech and that Australian forms of English speech are characterized by the use of language that reflects the autonomy of the individual and averts intrusion into private affairs. This form is reflected in the request 'Can you get me a bed pan?' It is an indirect speech act, which is mostly understood by native Australian English speakers, as to mean 'get me a bed pan!', and not understood as whether or not the listener possesses the ability to physically get a bed pan. Polite forms of speech vary between cultures and for the ICALD students who are not familiar with this form of request, the most appropriate answer to this question is 'Yes'.

Clinical learning experience: The embedding of language proficiency. The general understanding regarding the term 'English language proficiency' (ELP) in higher education, is that students must be able to successfully use and communicate meaning in spoken and written contexts applicable to their area of study (Hirsch, 2007). Further, the ANMC Professional Practice Framework standard 9.1 (n.d) states that a registered nurse must 'communicate effectively with individuals/groups to facilitate the provision of care', and this is accomplished by using a range of effective

communication techniques and language appropriate to the context (ANMC, 2006). Liddicoat (2008b) suggests that the notion of proficiency is far more than an individual's ability to understand language input and produce a sensible output. It requires an internalized deep understanding of the culture of the language, the relationship between language and identity, related values and emotions, so that the speaker develops language awareness. Only then will the speaker become truly successful in communicating meaning in a given context.

There has been considerable interest in language proficiency and its implications for the practice of international nurses, including students in Australia and overseas, for some time (Jeong et al. 2011; Chenge & Garon, 2010; De, 2010; Salamonson, Everett, Koch, Andrews & Davidson, 2008; Wang, Singh, Bird, & Ives, 2008; Jeon & Chenoweth, 2007; Starr, 2007; Xu, 2007; Amaro, Abriab-Yago & Yoder, 2006; Rogan & San Miguel, 2006; San Miguel, Rogan, Kilstoff & Brown, 2006; Choi, 2005; Magnusdottir, 2005; Alexis & Vydelingum, 2004; Pardue & Haas, 2003; Sanner, Wilson & Samson, 2002; Klisch, 2000; Shakya & Horsfall, 2000; Abriam-Yago, Yoder & Kataoka-Yahiro, 1999; Brown, Manion & Thompson, 1996), and various language support strategies have been enacted. Language proficiency for ICALD nursing students remains an ongoing issue in Australia and other English speaking countries despite the introduction of a minimum English entry standard for university admission and initial and ongoing registration requirements. Further, at a higher level, legislative requirements through the Health Practitioner Regulation Act (Commonwealth Government, 2009) place the onus on registration boards to only register those with demonstrated ELP.

As clinical educators, it is worth knowing that any language proficiency test in its self is not designed to be a predictor of success at the university level (Ingram & Bayliss, 2004) and as the participants in this study identified, although they have demonstrated ELP they continue to have difficulty with the language requirements. This mismatch between demonstrated ELP and performance expectations has also been identified in other studies (O'Neill, 2011; Brown, 2008; Parker, 2006; Feast, 2002). Engaging with language in the Australian clinical environment is complex. Academic success has recently been related to the level of language acculturation in Australian nursing students who have English as a second language (Salamonson, Everett, Koch,

Andrews & Davidson, 2008), and exposure to the Australian teaching and learning macroculture (Kirkpatrick & Mulligan, 2002). It is worth questioning current ELP test standards in relation to their applicability for the study of nursing in the Australian context.

English language testing. Hirsh (2007) points out that neither of the two most recommended tests of ELP the International English Language Testing System (IELTS) and Test of English as a foreign language (TOEFL), are sensitive enough for specialised uses of English language despite being used in a *gate keeping* capacity. Currently, ICALD students must meet the set standard of a score of 6.5 overall with a minimum of 6.0 in each band to be admitted to a nursing course at the University of Western Sydney. It is worth noting that the IELTS organization itself suggests a score of 6.5 as being appropriate for less demanding English language courses such as agriculture and mathematics (IELTS, 2007). As previously established by this research, the study and practice of nursing is linguistically demanding. Indeed, in their analysis of nursing language in Canada, Epp, Stawychny, Bonham and Cumming (2002) identified that the more appropriate ELP levels for the nursing profession reflected vastly different Canadian benchmark scores of listening- 9(advanced), demonstrates a sense of audience and communicate using language features such as appropriate style, register and formality; speaking/reading - 8, and writing - 7(intermediate) ready for post-secondary academic programs.

Nursing is a profession that is highly language dependant. Epp et al. (2002) and similarly Di Salvo, Larsen and Backhaus (1986) identified that the five main language tasks for nurses were: asking for information; explaining, giving instructions; informing; describing and suggesting. The findings indicate the importance of a nurse's clinical language proficiency inclusive of cultural constructs, of language identified by the actions required of them in each interaction.

It is, therefore, deceptive to claim that English language proficiency devoid of cultural embeddedness, is the only language proficiency that nursing students need to demonstrate in the clinical environment, rather the term Nursing Clinical Language Proficiency (NCLP) is proposed. NCLP brings together the culture of nursing and acknowledges the types of languages expected in the clinical environment. This type of

language proficiency development can only begin with the first foray in the clinical context and develops from there during the course of the student's study. Participants in this study identified that their language development related to successful learning and began when they first encountered language in the clinical environment. From there they were able to identify language issues that they had not previously been exposed to, and strive to improve over the course of their studies.

Clinical language complexity. Successful ICALD nursing students then need the ability to synthesize the following; common everyday language or Australian vernacular, nursing language and medical terminology into specific written formats and professional oral forms. This is not a new revelation for nursing education (Shakya & Horsfall, 2000) however it needs to be remembered that these outcomes require complex actions. The complexity is magnified when caring for patients whose communication abilities are impaired by illness and disease, or physical disability, as communicated by the participants in this study. There is an initial assumption by nursing lecturers, clinical educators and nursing students themselves that, because they have been admitted to the nursing course and they have passed the ELP *gate*, that they will be able to meet the demands of both academic and clinical language. However the number of schools of nursing developing strategies to improve communication for ICALD students belies this assumption.

As noted from the findings in this study, participants encountered spoken language by patients with accented speech, difficulty speaking due to illness or physical disability and from various age groups. This difference in the spoken word impeded the participants' ability to listen and then comprehend what patients were saying. In language proficiency tests, listening test takers are exposed to accented speech from the main English speaking countries, Australia, Canada, New Zealand, United Kingdom and the United States of America. However it is not clear whether they are exposed to other English as a second language learners accented speech. They are certainly not exposed to speakers with speech affected by physical disability or illness.

Written language was encountered in the form of medication orders and patients' progress notes, participants had to read and understand these hand written forms of language. In assessing ELP in any test currently available, the tests are printed

and not hand written as is often the case in the clinical environment. University learning guides and other learning materials are printed and students rarely encounter handwriting whilst on campus. Therefore prior exposure to handwritten materials is very limited, and primarily encountered in the clinical environment.

Currently, students are expected to speak and write appropriate responses using clinical languages in the clinical environment explicated in this study without the use of translators, thesaurus or dictionaries, and often without preparation time. Students are not permitted to use mobile phones or other electronic devices whilst on the ward. The spontaneous construction of written communication such as patient progress notes requires knowledge and understanding of the clinical languages for meaning to be conveyed. Most importantly these records are considered to be legal documents that can be accessed for future reference, so the language is expected to be meaningful, correct and sensibly constructed.

The participants also encountered nursing language such as the term *obs* for observations or vital signs, *infusion pump* and *syringe.* These unfamiliar words essentially belong to a nursing occupational language and take time to assimilate from theoretical to practical use (Carlson, Pilhammar & Wann-Hansson, 2010). Hence, students heard the words but did not understand, or mispronounced them and could not locate a meaning. This impacted on their ability to perform at an acceptable level and was often interpreted by clinical educators and staff as a lack of knowledge.

However, in the elucidation of learning the necessary languages of nursing, it is also necessary to acknowledge the academic language learning that occurs for students, as NCLP is only one level of language learning for nursing students. The learning of academic convention requires all students to develop strategies to learn as academic writing convention structures are not naturally acquired (Borland & Pearce, 2002). This may also be true for learning medical terminology and nursing vernacular, particularly when there is no direct translation for some medical terms (Guhde, 2003). Salamonson et al. (2012) demonstrated differences in academic performance between local Australian born students, international, and local overseas born nursing students. They found that the local Australian born students outperformed the other student groups in their grade point average (GPA) after the first year of study, and suggested that this

finding could be related to their level of acculturation to Australian English language. They identified that the transition to university study for domestically educated students is somewhat enhanced by their education in the Australian macro culture, however they still undergo a cross cultural experience when it comes to learning academic conventions. The difference with international students is that they have not had experience of the wider Australian macroculture and their basic language skills lead to significant differences in language level readiness of domestically educated students compared with internationally educated students.

In bringing together the findings about language level readiness from this study with other studies of nursing students and international students in Australia in general, it is possible to say that there is a vast collection of literature that supports the notion that some international students are not adequately prepared for the use of Australian English language at an academic or social level. This section of the discussion has examined the literature around: how the first language impacts on the acquisition of the second language; how learners' beliefs affect their knowledge development about a second language; and how methods of instruction inform their ability to converse in the second language primarily in order to gain understanding of the antecedents to the participants' language behaviours, and their effect on their identity as nursing students in the clinical context.

Summary

Through the encounters and active engagement with language in the clinical environment, it has been identified that language used in this context is complex, broad, and intercultural. ICALD nursing students arrive in Australia having been admitted to the university through a demonstration of adequate ELP from a testing centre. This ELP has been presented as inadequate for appropriate interaction in the clinical environment. Communication in the clinical environment has been shown to be a complex layering of Australian variety English, medical terminology and nursing vernacular, couched in the cultural norms for the profession and the community. This is a level of complexity for which the participants were unprepared but became aware of from their first foray into the clinical environment.

The inadequacies of their clinical language skills were highlighted by the assumption that an adequate score in the ELP testing system would mean that they were adequately prepared. However, a lack of immersion in the Australian variety of English itself, a reliance on American English as learning tools through various media, and a lack of exposure to different accents, caused communication problems. One of the main issues specifically relating to nursing care was that patients who were ill and/or experiencing physical restrictions or disability related to speech, were unable to be understood. Thereby, compromising the provision of safe patient care.

It is important for clinical educators to understand the impact that first languages have on the acquisition of subsequent languages, and that the beliefs that a student holds about learning another language affects their ability. In addition, language is culturally constructed and many of the rules of engagement are not known to ICALD students, and take time to learn. The clinical environment is not only where the student aligns theory with clinical practice, it is also a language learning environment.

Impressions of Nursing

The profession of nursing in Australia has been presented in the literature review as being grounded in Judeo-Christian tradition and western concepts of health and illness. Parker (2004) identified that the learning of nursing in Australia is underpinned by curricula that remains dominated by western biomedical knowledge and ways of developing nursing knowledge are also western. As nursing students enrolled in undergraduate programmes across Australia are prepared to be generalist registered nurses to work in the Australian health care system as it currently exists, this relationship is not unexpected.

Nursing: A global consensus? The definition of nursing as it is currently articulated by the International Council of Nurses (ICN, 2010) provides broad statements about the structure of nursing practice, who nurses work with, what activities nurses are involved in, and the principles of practice that underpin all of the above. How this is actually interpreted as nursing practice that is nurses' roles and functions, is determined by the cultural context. It would also seem, from the responses in this study, that the level of care that can be expected is also open to local interpretation. In making that statement, what this study has found is that nursing students coming from culturally

different backgrounds, have formed individual perceptions of the role of the nurse that have been shaped by beliefs about the role, its professional status, and experiences of care gained from home cultures. These ideas and expectations are then brought into the clinical practice environment, and can often lead to the exhibition of unexpected behaviours when compared to the professional standard of the Australian nurse. These unexpected behaviours relate to the concept of culture learning as it relates to Australian nursing practice.

The Australian Nursing Federation (ANF, 2011) reviewed and endorsed its policy on competency standards for nursing and midwifery where it states that standards relating to professional practice must 'reflect the skills , knowledge, attitudes, values and abilities required in the work place' (p.1). This statement is directly related to Heyward's definition of cultural literacy (Heyward, 2002). In essence, what ICALD students are doing is learning to be literate in the culture of nursing as it occurs in the workplace.

Nursing students' behaviour in the clinical environment is assessed against the fundamental values and standards of the profession of nursing in Australia, which provide the context for assessing learning to nurse in the clinical environment. These values are articulated in the professional practice frameworks that dictate the measure of competence for registered nurses nationally. These national frameworks consist of codes, guidelines and legislation that are used in the school of nursing associated with this study as outcome measures for all students, in order to prepare them for registration as a nurse in Australia. Generally speaking, the frameworks form the levels of responsibility and accountability for providing safe and effective nursing care, a commitment to accept and uphold the rights of the individual and the expected professional conduct of a registered nurse. Registered nurses are legally responsible for the care that they give to their clients, and fundamental to that is safe and effective practice. It goes without saying that these practice frameworks are also grounded in the dominant Anglo Celtic culture of Australia that has shaped and supported their ongoing application. Facilitators of student learning in the clinical environment have voiced a strong belief that their role is to maintain these standards of Australian nursing whilst assessing ICALD students in the clinical environment (Cotton, 1999).

Whilst Burnard (2005, p. 177) makes the statement that ' ....nor, clearly, is it very helpful for an educator to take the view that, in moving to another culture, students must simply "adapt" '. The ICALD student is subject to constant comparison with how the role of the nurse is enacted within the Australian context. This was, and remains, the state of affairs in which ICALD students find themselves.

This section of the discussion is in direct response to the research objective of describing the preconceptions about nursing roles and responsibilities and the way that they affect student performance in the clinical learning environment. One of the anecdotal drivers for this part of the research was that ICALD students were found to be removing themselves from certain care responsibilities or just focusing on certain technical aspects of care. This discussion delves into the cultural meanings and explanations underlying these types of behaviours.

Participants in this study with a background in nursing, and those who had not, possessed opinions about nursing that were prominent and influenced their performance in the clinical environment. There was not a single participant who had no idea about nursing and its professional standing in their home country. These notions of nursing were generally associated with negative opinions of the nature of nurses' work and the resultant social stigma attached to that, relative to their own cultural beliefs. These individual frameworks are the antecedents of the student's beliefs, perceptions and actions in the clinical learning environment.

Most importantly and significantly, there was not a single participant who identified that the profession of nursing in their home country enjoyed the respect and trust it does here in Australia. This aspect of learning to nurse in Australia for ICALD students has not previously been articulated.

Acceptance of the Australian nursing role. The level of socialization into the nursing profession experienced by an individual is dependent upon preconceived notions and expectations of nursing (Price, 2008). Therefore, if a student holds on to their negative beliefs about nursing, then their level of socialization into the profession in Australia will remain at a fundamental level. This idea was also previously posited by Spouse (2000) where she found that students' beliefs impacted on how they engage in

the learning of nursing and that some of these beliefs are very resistant to change. It is necessary to acknowledge ICALD students preconceptions of nursing, the profession and its work, in the context of clinical learning as understanding their interpretive frameworks may assist educators to help develop their cultural literacy. The individual ICALD student is developing the understandings, competencies, attitudes, language, proficiencies and identities necessary for successful cross cultural engagement with Australian nursing practice (Heyward, 2002).

Nursing as it is currently defined in Australia is based on the central value of caring, and the embodiment of that is the importance of human touch (Heath, 2001). However, the concept of touch and its connection to caring is not the same across cultures, and can have negative connotations for nursing as a profession and nurses personally. Heath (2001) states that although most nurses care in idiosyncratic ways, nursing has most meaning when all aspects of a client's health are attended to. Finally, Heath (2001, p.26) asserted that the professionalism of Australian nursing is found in the way nurses care for clients by performing '….intimate tasks for patients that require delicacy, complexity, skill and a salience'. It would seem that the value of human touch and the demonstration of caring through touch is a western nursing construct which poses a great challenge to ICALD students for whom touching is related to different social boundaries and, in some circumstances, results in exclusion (Hsu, 2000).

Explorations of caring as a fundamental concept in the nursing literature are most often published in the United Kingdom (UK) or the USA This has led to a dominance of western ideas where several adjectival descriptions have been used to describe western nursing practice, such as Christo-centric, Euro-centric and Americano-centric (Narayama & Andrews, 2000; Rassool, 2000). This dominance of western ideas about caring, as it is situated in Australian nursing practice, has previously been identified in the literature reviews as ethnocentric. Hand in hand with an ethnocentric view of Australian nursing practice, is that ideas about the expression of caring have been found by authors from non-western countries to be incongruent with cultural and religious values. This incongruence could then represent a radical paradigm shift for those involved in the learning of nursing here in Australia (Pang et al. 2004; Shin, 2001; Narasawmy & Andrews, 2000; Rassool, 2000; Xu, Xu, & Zhang, 2000).

However, the notion of caring as identifying a congruence with Australian standards was most clearly articulated by three participants who were from differing cultural backgrounds, all of whom were in the second year of their studies and did not have previous (in home country) nursing experience. From their responses it was clear that the participants had developed a passion and desire to care for people in a way that meant that nursing was more than doing tasks for people. The essence of humanity was present in the acknowledgement of the recipient of care as; having feelings and needs, as opposed to an inanimate object, and needing care to avoid feelings of hopelessness. The representation of a nurse as a person who recognized the feelings and needs of others and possessed the knowledge to give effective care was also evident. This is in effect concordant with the assertion by Leininger (2002) that innate human caring is a universal phenomenon.

As most of the participants were now in their second or third year of the BN it is possible that their socialization into Australian nursing, had weakened previously held beliefs. Brodie et al. (2004) noted that students' perceptions of nursing in the UK changed significantly as they progressed through their course as a result of both clinical and theoretical experiences. The nursing students' perceptions changed to reflect those of clinical nurses with whom they had worked alongside. Newton, Kelly, Kremser, Jolly and Billet's (2009) study identified that second and third year nursing students at an Australian university also voiced a passion and desire for helping others that correlated with the registered nurses, unit managers and directors of nursing who were working with the students. Although these participants were able to articulate a beginning philosophy of nursing, as it is constructed in the Australian context, there were times when other notions of the role of the nurse overshadowed these noble intentions.

The perceptions of the profession that the participants disclosed in this study were based on the experiences and impressions from their home culture, and varied from other empirical evidence from western countries about descriptions of nursing. Most beginning students in the UK used stereotypical images to describe nursing, and held strong beliefs about the work of nurses that were usually based on representations of nurses found in the media (Spouse, 2000; Keiger, 1993). The ideas about nursing articulated by the participants in this study were quite developed and did not reflect

stereotypical images, but related to the social status of nurses and concentrated on the fundamental tasks of caring. It is important to note that the western stereotypical images of nurses that are commonly referred to may not be explicated or known in the home countries of these participants.

The knowledge of nursing and nurses' roles in many cultures is directly related to those intimate aspects that Heath (2001) identified. Those intimate aspects are deemed as socially inappropriate for many middle class women, therefore nursing has been relegated to women from low status families in countries such as Bangladesh, India, and Pakistan (Hadley et al. 2007; French, Waters & Matthews, 1994).This relegation of nursing reflects a patriarchal social hierarchy and gender based labour segregation that persists in some countries, affecting the professionalization of nursing.

The existence of medical dominance over nurses and their work is an enduring global issue, as identified by the responses of the participants in this study. Their responses relate to the discussion provided by Salvage more than 25 years ago (Salvage, 1985). Although noted by Germov (2009) that the concept of medical dominance itself is less than a century old in western medical history, its existence is heavily influenced by the culture it pervades. The status of women, their disproportionate numbers in nursing, and the low status afforded to the profession all contribute to the continuation of medical superiority.

Pervasiveness of medical dominance. In Australia, the gendered aspect of medical dominance is currently challenged by the increasing numbers of female medical practitioners, the continued professionalization of allied health practitioners (including nurses), and the increasing access to medical knowledge by the general public who are now more critical and less trusting of medical practitioners (Germov, 2009). Nursing remains a female dominated profession in Australia however. As nurse education and regulation of practice is now controlled by nurses, and the development of the nurse practitioner role has evolved along with the changed role of women in society over the last 50 years, nurses have proven to be a significant challenge to medical dominance.

For countries where these significant events related to the female dominated profession of nursing have not taken place, it seems that the view of nursing as a valued profession has not developed and medical dominance prevails. This in turn reinforces the idea that nurses as women are powerless uneducated and consequently, their work is devalued and stigmatized.

Participants from India, Iran, Taiwan and the Philippines, indicated their perceptions that medical dominance still exists and nurses remain submissive to and nursing work dependant on, direction from medical practitioners. A patriarchal social structure with strong views on the role of women and women's work has led to the revering of middle aged male doctors in Iran. Nurses remain subservient to doctors and are regarded by hospitals as loyal employees, rather than being valued as knowledgeable and skilled full members of the health care team in China, India and Iran (Wang, Li, Hu, Chen, Gao, Zhao & Huang, 2011; Shukla, 2009; Nasarabadi, Lipson & Emami, 2004).

Many authors discussing the status of nursing in Southern Asian countries in particular, agree with the views of the participants in that the status of nursing remains influenced to a great extent by the oppressive nature of race, class and gender (Walton-Roberts, 2012; Hadley & Roques, 2007; Dave, 2007; Nair & Healy, 2006). Therefore, educators of nursing students from these regions need to factor in preconceived notions when observing and assessing performance in the clinical environment.

Nursing still seen as dirty work. Participants in this study from the Philippines, Nepal, and India repeatedly referred to the provision of basic nursing care to patients as dirty work and to the areas of the body that were considered to be dirty. It would appear from their understanding, that the poor status of nursing was directly attributed to this dirty work. It is worth noting that all cultures have a concept of what is considered as dirty work, and those that carry out this work are disparaged (Liaschenko, 2002).

The findings discussed here correlate with two Australian studies of NESB and CALD nursing students. Both Gorman (1999) and Brown (2005) found that status of nursing in the student's home country was often related to dirty work. In particular, Brown (2005) highlighted that the students felt pressure from the family to study

another profession that was considered a 'higher status' and that judgements were made on their intellectual ability because they chose to study nursing. Although this kind of pressure was not evident in the current study, certain aspects of the work of nurses caused the students to reflect on the effect that it would have on themselves and the family. Gorman (1999) suggested that the difference in cultural acceptance of nursing as a career has a negative impact on the success of NESB students in the course.

Anecdotal evidence that spurred this study related to the observation of nursing students from Asian countries neglected or refused to participate in direct patient care. It is essential for clinical educators to understand the personal implications of this activity, so that appropriate support may be given to the student. As previously stated, the current role of the registered nurse in Australia requires direct patient care inclusive of personal body care.

For western nursing, the apparent dirty nature of nurses work with human bodies has in the past been described simultaneously as, sacred and profane, or an asset and a liability (Sandelowski, 2002), when it comes to the development of the profession, its knowledge and status. However western nursing has developed over time from what Sandelowski (2002, p.61) identified as concern with the 'object body' of the patient as a physical entity, to incorporate a holistic framework where body work is legitimized as only one aspect of the notion of care (Liaschenko, 2002). However the polemic of body work remains in non-western nursing contexts where social, cultural, and religious practices are associated with status, and dirty work remains seen as only work.

The concepts of status, purity and power in South Asian society are related to what is acceptable for a person to touch, where touch is directly responsible for transmitting pollutants that result in personal defilements (Alex, 2008). The participants in this study were concerned mainly with coming into contact with faeces. Pollutant rules have been ascribed by ancient Hindu texts, and identified as body parts, body substances, or objects that have been touched by someone else of a lower caste. Pollution of the person can occur both directly, as in contact with body fluids, or indirectly through the casting of a shadow of a lower caste person on to a higher caste person (Alex, 2008).

It is through the direct contact with bodies and bodily fluids of strangers and people who are regarded as lower caste, that the reputation of nursing is tainted in the Southern Asian context (Nair & Healey, 2007; Nasarabadi, Lipson & Emami, 2004). Hadley et al. (2007) identified that dirty tasks included cleaning soiled beds of faeces and urine, shaving and washing patients, providing oral care and even extended to the more technical procedures of urinary catheterization, gastric washouts, nasopharyngeal suction, emptying drains and infected wound dressings. The registered nurses in the study conducted by Hadley et al. (2007) devised strategies to avoid what they termed *distasteful* tasks, which included having a patient's family member or an untrained hospital support worker perform the urinary catheterization, and personal body care. Further, Hadley and Roques (2007) determined from a study of registered nurses in a government hospital in Bangladesh that the majority of on duty time (50.1%) was spent unproductively in activities such as chatting, breaks away from the ward or knitting, and the lowest amount of time (5.3%) on direct patient care. More specifically the taking and recording of the patient's temperature was accomplished without using a thermometer or touching a patient, medications were given to the relative to administer to the patient and although intravenous catheters were inserted by the registered nurses, monitoring of the site and the flask was delegated to the relative (Hadley & Roques, 2007).

In comparison, an Australian observational study by Chaboyer et al. (2008) of nurses on a medical ward found that registered nurses engaged in direct patient care 33.2% of their time on duty, and personal time and time away from the ward on errands amounted to 14.3%. There was no observed delegation of nursing roles to family members or to untrained staff in the Australian study. From a western perspective the performance of nursing work or direct patient care, which Liaschenko (2002) described as the relief, containment, or prevention of episodes of ill health, without the element of touch can be interpreted as uncaring. Therein lies the challenge for clinical educators of ICALD students of nursing-the fundamental expression of caring as culturally determined in the Australian context is the performance of dirty work.

Nurses are strangers to patients. The perspective reported by participants from Chinese Asia was that the nurse is viewed by the patient and the relatives as the stranger, as opposed to the South Asian view that the patient is the stranger to the nurse;

because of this, they prefer that personal body care be done by family members. Xu (2007) explained that Asian families view that the provision of personal body care to a family member as a privilege. Asian nurses working in western hospitals are noted as having been appalled that they are expected to provide this kind of care and viewed it as humiliating and demoralizing (Alexis & Vydelingum, 2004).

The Chinese Asian participants in this study did not express the same level of concern as the Southern Asian participants about coming into contact with faeces. This could be explained by the belief that the subject was an inappropriate topic to discuss during data collection as the topic of excrement is culturally inappropriate.

The understanding that nursing is socially constructed is portrayed in the notion that nursing in Australia prescribes certain behaviours that are prohibited in other cultures (Hadley et al. 2007). For ICALD students who come from patriarchal and religious cultures where gender segregation is the norm, the idea of engaging in care activities with the opposite sex has serious consequences.

Gender role, religion, and cultural restrictions impinge on, Australian expectations of nursing care. Brown (2005) also identified that certain types of contact between female nurses and male patients were considered as taboo. The idea of cultural taboo in relation to contact between males and females extended to interactions with male peers and male registered nurses on the ward. The students in her study hid these kinds of relationships from their parents which resulted in feelings of discomfort. Overall, Brown (2005) described this type of cultural influence as causing disharmony, a form of sociocultural discord for the student.

The examination of cultural contexts that the students have come from assists clinical educators in understanding student behaviour in relation to male patient/nurse relationships in the clinical environment. Both male participants in this study came from Southern East Asia and interestingly did not comment on cultural or religious aspects of providing intimate body care to female patients. This concurs with the findings from Brown's (2005) study where no data was evident from male students who experienced difficulties with caring for female patients. One explanation for this could be the

cultural double standard where males are not expected to maintain the same level of purity as females, so the experience for them was not as traumatic.

Not only were cultural beliefs about the touching of body and its excrement presented by participants in this study, there were also definite cultural restrictions on touching between the sexes. Whether these restrictions had a religious or cultural base depended on the region the student was from, and further there were internal variations on what the norms around touching were. Touch between the sexes has different meanings across cultures, but it is often related to the situation, power, age, existing relationships, status and role of the toucher (van Dongen & Elema, 2001).

Touching restriction based on cultural norms was identified by two participants from differing regions of the world, Southern East Africa and Chinese Asia. The participant from Southern Eastern Africa identified that in social contexts touch between men and women was forbidden and that prohibition extended to nursing care especially intimate body care. Culturally appropriate intimate body care in the Southern Eastern African context was to be given by a same sex nurse. The participant went further stating that a male patient would refuse care from a female because of this belief. In the Southern East African Shona culture of Zimbabwe, Kambarami (2006) suggests that the notions of sexuality, femininity and culture are so entwined that they have become inseparable, leading to inequality and a lack of control for women. Moreover custom is based on patriarchal attitudes that are taught to children from an early age which view women as sexual beings (Kambarami, 2006). In saying that, it is necessary to explain that the concept of purity is also predominant, where women are expected to be virgins at the time of marriage. It is not difficult to see that the expectation of providing body care to males in Australian hospitals places the participant in cultural and moral peril.

The Chinese Asian participants explained that there was an age where it was inappropriate for a woman to provide personal care for a man. Generally, it was inappropriate for female nurses to provide intimate body care to young men. However, if it was absolutely necessary it was permissible. It was appropriate to provide body care to elderly male patients. This distinction could relate to the cultural aspect of respect for elderly members of society. Moreover, the Chinese Asian participants stated

that they would not even broach the subject of the work they do in providing personal body care with their parents, as it would be offensive.

Religious constraints on touching and providing body care for the opposite sex were articulated by the participant from the Middle East. More specifically, Iran has been described as a 'family based country with specific ethical values compared to other countries' (Nikbakht-Nasrabadi, Paras-Yekta, Emami & Mada, p. 2. trans 2011). Most importantly there is no separation of church and politics, and Islamic religious leaders serve as the country's politicians (Shahriari, Mohammadi, Abbaszadeh, Bahrami, & Fooladi, 2011). To this end nurses are *instructed* to provide nursing care along gender specific Islamic rules (Fooladi, 2003). Shahriari et al. (2011) describe nurses adhering to gender appropriate care as being religiously observant and accepting of the privacy of the (Islamic) patient, and that giving care in this way builds trust between the patient and the nurse in the Islamic context. Further Shahriari, et al. (2011), explain that Iranian nurses welcome this gendered care mainly because it represents their spiritual and moral values especially when it comes to reward in the afterlife, as nursing is considered a form of prayer. In regard to nursing education female tutors teach female students and male tutors teach male students. In the skill laboratory there may even be a curtain drawn to keep the sexes apart, and in the classroom males sit at the front of the class and females at the back (Fooladi, 2003).

Australian nursing roles challenge purity, virtue and modesty. It is important to note that rules pertaining to chastity in Islam are absolute, which has given rise to modesty rules for both men and women that encompass but are not limited to, clothing and communication (including touching) between the sexes (Wood Boulanouar, 2006; Hifazatullah, Badshah, Farooq & Nasir-ud-Din, 2000).

Cultural and religious absolutes have an impact on the ICALD student learning to nurse in Australia. Whilst some obvious accommodation can be made, for example the inclusion of the head scarf and arm covering in the uniform for observant Muslim women, the avoidance of having to provide care for male patients may not be. Whilst it is true that not all patients require intimate body care, the student is expected to be able to deliver this type of care in the Australian context, for both sexes. It would seem on the outer that the Chinese Asian students have some degree of flexibility in their

cultural absolutes; however it may be that their acquiescence is related more to the cultural concept of saving face. This aspect of learning to nurse in Australia may have other serious consequences that are not immediately apparent to the clinical educator or indeed the school of nursing in which the ICALD student is enrolled.

It has already been established that the concepts of female purity and virtue exist in the South Asian, Middle Eastern and Chinese Asian cultures. So for those female students who are from these regions studying nursing in Australia and performing personal body care puts them at great risk of damaging their reputations, an aspect of being an ICALD student that is not so obvious. Essentially, the professional role expectations of the registered nurse here in Australia have very personal consequences for students from cultures that place a heavy value on purity, virtue and modesty.

Coming face-to-face a with naked man who was a not a family member, and touching him during the course of providing care for a middle eastern participant, immediately caused her to think of what her husband would say. Marriage is viewed in Islam as an act that protects modesty, and the only time intimate contact is sanctioned between a man and a woman is after marriage (Wood Boulanour, 2006). It is no wonder that the participant's thoughts went straight to her husband when she was confronted by a naked strange man.

A traditional women's role in Islamic Iranian society is to be a wife and mother and to remain in the home. The idea of being in the home is to limit a woman's interaction with men who are not family members and to preserve her chastity (Munir, 2003). This concept is further clarified by Hifazatullah '….prohibiting of the promiscuous intermingling of sexes' (2011, p.2). A large responsibility is placed on to Muslim Iranian women to maintain the spiritual and moral standard of the family, which is ultimately determined by their observance. Therefore the moral and religious expectations of an observant Muslim woman are challenged when learning to nurse in Australia. The implications for these participants reach beyond themselves into the family.

It was brought to light from the literature review that the Judeo-Christian foundation of caring in western models may be neglectful of the Islamic spiritual

dimension. Although caring is seen as a concept that is embedded in Islam (Rassool, 2000), the way it is demonstrated across the two cultures is different. To demonstrate care for an Islamic patient, respect is to their need for intimate care to be given by a same sex nurse. The converse also applies in demonstrating care for the nurse her/himself where they are not compromised by being made to provide care for a person of the other sex. Currently caring in the Australian clinical context is noted as being in direct conflict with fundamental Islamic laws that affect women and the role women play in that culture.

In South East Asia generally there is no social engagement in public or private for young men and women and physical intimacy is forbidden (Alexander, Garda, Kanage, Jejeebphoy & Ganatra, 2006). This strictness around relationships with the opposite sex translated into fear of parental disapproval, or a more severe fear of being physically beaten by parents in the Alexander et al. (2006) study.

Because of the intimate aspects of nursing care a number of authors from this region agree that female nurses are treated with suspicion and are regarded across the board as morally corrupt, with many authors suggesting the cultural belief that there is direct correlation between nursing and prostitution (Walton-Roberts, 2012; Percot & Rajan, 2007; Hadley et al. 2006; Nair & Healey, 2006). This belief not only stems from the intimate nature of nurses work with men, it is born out of the cultural role of women where they are expected to be house bound. Nair and Healey (2006) assert that it was natural that suspicion arose about females who were out at night and came into contact with males, in a community where gender segregation was enforced. This cultural belief could in part be responsible for participants in this study being fearful of performing personal body care for male patients, and the possibility that it may be interpreted as a sexual favour.

Marriage prospects for Indian women who are nurses are limited. Poorer marriage prospects can be attributed to the lingering opinion of the pollutant aspects of the role of the nurse (Walton-Roberts, 2012). Arranged marriages remain the norm across India, and the status attributed to a person's profession remains a significant attraction or deterrent. From their study of nurses in Bangladesh, Hadley et al. (2006) describe the nursing profession as reducing a female nurse's value in the bride market.

Although travelling overseas as a single female nurse can have positive benefits to the nurse herself in respect of realizing that nursing is valued differently in terms of status in different cultures, and that her earning capacity is higher than at home, suspicion around her morality can negate any positives.

Literature from both The Middle East and Southern East Asia provide evidence that the nurses' role of performing personal body care has devolved to lesser qualified or untrained support personnel in the hospital setting (Walton-Roberts, 2012; Khomerian, & Deans, 2007; Hadley & Rogues, 2007). This quite possibly has led to the preconception that registered nurses do not perform this task. The personal consequences for ICALD nursing students can have long lasting effects.

It was evident from this study that having to perform personal body care resulted in more than personal sequelae for the ICALD nursing students. Distress in the form of physical or emotional reactions, were identified for some participants and, despite their reactions, there was a belief that over time they would adapt.

Learning to nurse exceeds coping ability. There is a growing body of knowledge related to the levels of stress experienced by nursing students with a general consensus that the first foray into the clinical environment is the most stressful and that anxiety and emotional distress are the most common responses (Jimenez, Navia-Osorio, Diaz, 2010). The clinical environment as a source of stress has been noted in the literature by a number of international authors suggesting that stress for nursing students on clinical placement is a global phenomenon (Jimenez, Navia-Osorio, Diaz, 2010; Burnard et al. 2008; Timmins & Kaliser, 2002; Sheu, Lin, & Hwang, 2002; Rhead, 1995; Lindop, 1991). These studies are quantitative in nature and do not differentiate between domestic and international students and, as such, may not capture the personal detail that is offered by a qualitative study with a focus on culture.

Participants in this study described feelings of confrontation and shock in addition to embarrassment, and extreme physical reactions such as crying and vomiting. A similarity can be drawn from the results of Brown's (2005) grounded theory study where international nursing students also described feelings of embarrassment, awkwardness and uncomfortableness in providing personal care to patients. It is clear

from these findings that there are individual variations to the distress response for ICALD students performing personal body care. These variations in reactions from ICALD nursing students can be attributed to the level of importance placed on the interaction between men and women and the role of women in the society of their home country.

Studies have found that stress responses are related to an individual's assessment of a situation and their ability to cope (Tomaka, Blaskovich & Kelsey 1993; Lazarus & Folkman, 1984). Le Blanc (2009) suggests that any factor that increases the demands of a task, or decreases resources to complete the task, results in a higher risk of distress for the individual. Increased demand in the form of crossing cultural or religious boundaries is evidenced in the situation where a female ICALD student has to perform personal body care for a male patient.

Stressful situations that led to severe distress reactions, such as crying and vomiting, have the potential to impact negatively on clinical learning and performance for the ICALD student. Le Blanc's (2009) critical review of the literature regarding the effects of stress on performance concluded that the performance of tasks that require certain types of attention, recall from memory and decision making, can be affected by elevated stress levels.

Despite the distress of the situation of having to provide intimate body care to male patients, the female students who suffered physical reactions remained resilient and of the opinion that their reactions would eventually pass once they became used to this aspect of the role of the Australian nurse, meaning once they had adapted.

Australian nursing is different. The participants in this study presented very specific details about the roles and responsibilities of nurses in their home countries. The prior discussion focused mainly on what nurses do not do in their home countries where the following focuses on what they do. Some participants recalled experiences of being the recipient of care, others as nurses in their home country, some as medical practitioners in their home countries, some with relatives who were nurses and still others just from supposition. Preconceived ideas about the role of the nurse proved to be

a challenge to overcome or a pleasant surprise depending on the student's ability to be flexible in their opinions.

The participants from Eastern Europe, Chinese Asia, and Southern East Asia all recounted their ideas of the role of the nurse in similar terms where the main focus of care was the ability to carry out technical aspects of care and technical skill sets. Barnard (2002) defined the technology that nurses use as encompassing pharmaceuticals, devices and machinery. This opinion of nurse's work can be interpreted as a focus on the technology/cure aspects, rather than the nursing/care/touch aspects of an episode of ill health (Sandelowski, 1988). Because of the cultural beliefs about dirty work, it would not be unusual to find that students from these regions possess the preconceived idea that nurses just dispense medication, give injections and sometimes do dressings.

To many Australian clinical nurses a focus on the technical or task is seen as a dereliction of nursing's humane moral duty (Sandelowski, 1988). Western nurses prefer to be seen as the nexus between technology and care (Sandelowski, 2002). The use of technology and technological skill is to be seen as an adjunct to nursing care not the focus of it. Macdonald (2008) affirmed that knowing the patient was central to providing quality westernized nursing care and that technology can be used by nurses as an enabler to create time to develop nurse patient relationships, not an excuse for avoiding it.

What the participants in this study defined as care was informed by their cultural understandings of the role of the nurse. Participants from Chinese Asia and Southern East Asia suggested that taking time to talk to patients, or what was termed psychological care by one participant, was not prioritized. Rather the focus remained on the physical tasks of nursing care and the main reason for this was a lack of time. The participants also had come to realize that nursing care in Australia was different to what they know of it in their home cultures because of the importance of the relationship between the patient and the nurse. That relationship was formed through communication and that the expectation was that nurses take time to communicate to their patients as part of a holistic view of care.

What was interesting was that one participant from Chinese Asia likened the relationship that Australian nurses have with their patients as friendship. That communicating with patients equated to friendship, and this was not expected in the Chinese Asian nurse patient relationship. Caring in the context of Australian nursing is not based on a social relationship with the patient. On the contrary nurses are expected to have a working knowledge of the boundaries of professional practice. The meaning of a professional relationship, as opposed to a social relationship, with the patient implies one significant difference that the patient's needs are at the centre of the relationship (Stein-Parbury, 2009). In a study examining the essence of nursing, Pang et al. (2004) found that nurses from mainland China placed the most emphasis on professional competence related to changes and, the provision of health care and, practising with seriousness, prudence and authenticity, over patient centred therapeutic care and considering the patient as a whole.

This difference in the focus of care leaves the patient's experience of ill health secondary to nursing practice, not primary, as is the case in an Australian construction of a caring relationship. Thus the notion of care as expected in the Australian nursing context could be limited by the ICALD student's ability to understand the need for a professional relationship with their patients. Indeed, Swanson (1999) concluded that caring, as a western concept, could not reach its full potential without a commitment from the nurse to connect with patients.

The codes of ethical and professional conduct for registered nurses in Australia reflect global principles from the United Nations (UN) and the World Health Organisation (WHO), which are related to human, political and cultural rights, and are applicable to nurses at all levels in all contexts (ANMC, n.d). These codes, along with legislation and local policy, inform professional standards of nursing practice and are fundamental concepts that are introduced to nursing students at the beginning of their learning experience. Professional standards also protect the public from poor practice and help form the basis of trust in a nurse patient relationship.

Two participants from Southern East Asia who took part in this study explained their understanding of the nurse patient relationship in the public health system. Their accounts came from personal experience as a patient, and as a medical practitioner,

portrayed nurses bullying patients, verbally abusing patients and using force to administer treatment. The basic concepts of informed consent, privacy and respect appeared to be absent or neglected. The justifications offered for this kind of nurse patient relationship was that on the whole, the patients were illiterate, that nurses were time poor and that administering the doctors' orders was paramount. Nurse patient relationships such as this are the antithesis of what is expected from the profession here in Australia.

Patients requiring nursing care are considered to be in a vulnerable position and, in the Australian context, nurses are morally obligated to interact with patients in a certain manner that is guided by ethical principles. The principles of autonomy, non-maleficence, beneficence and justice are considered nationally as the nurses' guide to making sound moral decisions about the care of vulnerable patients (Johnstone, 2003). In practice, these principals inform the actions of all health care professionals. On the other side, the patient places trust in 'the nurse' who is known in Australian society to be a trustworthy health professional. Essentially the patient does not know the nurse as a person and has to place trust in the fact that this unknown person will act in their best interest because they work in an institution that wants to promote health, they operate within the boundaries of their professional practice, and that they have the knowledge and skill to meet their health care needs (Gilson, 2003). This type of trust between the nurse and the patient is generally acknowledged to occur in first world countries, however Jewkes, Abrahams and Mvo (1998), suggest that the same cannot be said for developing nations.

Jewkes et al. (1998) suggest that nurses treat patients without consideration of ethical principals in situations where there is : a marked power differential between the nurse and the patient; a lack of accountability and sanctions for poor practice; nursing identity of elitism and a moral evaluation of patients where their knowledge is devalued or dismissed. The examples of unethical practice given by participants in this study reflect the findings of Jewekes et al. (1998) study of midwives in South Africa, where nursing and midwifery as professions have developed in a context of discriminatory practice.

In a recent paper published in the Nursing Journal of India, Saini, Toppo, and Manavjot (2009), address issues of consumer protection as recipients of nursing care, however the authors fail to adequately address actually who the consumer of health care is and their right to ethical and moral treatment. Instead the article focuses on the failure of technical skills related to patient injury and only mentions patient communication when there is a question regarding medication. This narrow and superficial perspective, acts as a list of what not to do, or how to avoid claims of negligence, and fails to address the underlying cultural view of the patient.

In respect to informed consent for treatment in the Indian context Sanwal, Kumar, Sahini and Nundy (1996) suggest that even for surgery, only cursory attention is given to signing the consent form. Mostly patients do not understand the procedure and sign if they can or place a thumb print on the form. The authors go on to suggest that many patients are poor and illiterate, and place trust in the surgeon as they revere them as godlike. Therefore surgeons, in the absence of explicit requirements to gain informed consent, have adopted a paternalistic attitude. They give informed consent cursory attention as they know best for the patient and having to spend time explaining is a waste of their valuable time (Sanwal, Kumar, Sahini & Nundy, 1996; Sriram, Kumar, Jayaprakash, Sriram & Shanmugham, 1991). However, whether the patient is illiterate or not does not mean that they are unable to understand what is happening to their health. On the contrary, the Sanwar et al. study confirmed that most Indian patients understand their diagnosis, the organ involved and the procedure that they will undergo (1998).

It is acknowledged that caution is needed when applying western ethical concepts to a non-western situation. For all health professionals alike, using the excuse of illiteracy for poor practice does not demonstrate the universal concept of respect for the person.

Developing literacy of the nursing culture in Australia. From the perspective of learning to nurse in Australia, cultural literacy needs to be developed to meet the moral and ethical demands of the profession in the Australian context. Gilson, Palmer and Schneider (2005) claim that past experiences and personal attitudes are amongst the contributing factors to a trusting relationship. Therefore, the ICALD student, to be

successful in the learning of Australian nursing, will be expected to adapt to the moral and ethical standards of the profession and demonstrate these in the clinical arena.

For the learning of Australian nursing, all students at the university that the students were enrolled in are assessed according to the National Australian Nursing and Midwifery Competency standards (ANMC, 2006), which promote a holistic view of nursing care as defined by western standards. As noted by Chiarella (2006) the standard reflects the need for all registered nurses practising in Australia to observe and conform to the domains of practice identified in the document. Chiarella (2006) has also identified that the standard has been used as a reference point in disciplinary panels for nurse misconduct cases, demonstrating the importance placed upon adhering to the national standard.

The ANMC competencies are inclusive of the use of technology; however that is not the whole focus of nursing competency. The actual university assessment, termed the clinical summary, included criterion '*Cares for client according to the model of practice and, consistently demonstrates an understanding of Australian Nursing culture'* (UWS, n.d). This criterion reflects the domains of provision and co-ordination of care and collaborative and therapeutic practice respectively. If the student did not demonstrate the application and use of these standards they were assessed as not competent in these domains and were failed in clinical practice.

Despite on campus learning about the role of the nurse in Australia and the frameworks that inform practice, participants defaulted to their own preconceptions of the role of the nurse and acted accordingly. As one of the main aims of the clinical practice experience is to link theory with practice, and the clinical environment should be classed as a learning space, the ICALD students were expected to demonstrate competency at the same level as the domestic students, with little real working knowledge or experience of the role of the Australian registered nurse.

The ANMC competency standards have been adopted as the outcome measure for all Australian undergraduate applicants for registration and for international applicants for registration in Australia. There is discussion in the literature about the adequacy of the standard to reflect nurses' commitment to working with a culturally

diverse population in need of care (Chenoweth Jeon, Goff & Burke, 2006; Chiarella, 2005; McMurray, 2004; Kanitsaki, 2003). However, the need to support international nursing students to observe and comply is left solely to the clinical practice experience and the theoretical input of on campus learning. There are no additional supports for ICALD students.

Summary

The notion that nursing is socially and culturally constructed is not reflected in the ICN definition of nursing, which presents the notion of nursing as a universal. From the discussion presented here, this is not the case. The impressions of nursing from various world regions reflect patriarchal social hierarchies; gender based labour segregation and cultural restrictions on contact with humans and their detritus. All of this impacts on the perceived role and function of the nurse, and consequently the learning of nursing as it is contextualized in Australia.

The status of the profession of nursing varied greatly from the high status it enjoys here in Australia. The ethical, moral and cultural standards of nursing care as expected here in Australia, were generally unknown. Perceptions of the role of nurses transported into the clinical environment from personal, professional or imagined experience, affected skill development, most often emotionally, where violent physical reactions were experienced to some of the culturally distasteful aspects of the role of the nurse.

As the ICALD students are assessed in the clinical environment for competency according to the ANMC standards as with any other student, it is imperative that an understanding of the cultural aspects that students bring to the clinical environment around the notion of care be explicated.

Ownership of the Clinical Placement: Crafting Success

The learning of nursing occurs in a system where competence is socially and historically defined (Wenger, 2000) by students who are cultural bearers. The participants in this study were learning to nurse in a system where both the learning institution and the clinical environment were founded upon the values, beliefs, attitudes,

interests, skills and knowledge of nursing, essentially its culture as defined in the Australian context. The participants in this study were acutely aware of being different, and the effect that this had on relationships with people they encountered throughout their learning. Once in the clinical environment the students became active participants in their learning. Essentially, they took ownership of their time in the placement to ensure that they had the experience they needed to learn to be an Australian nurse. For some of the participants this experience meant securing a passing grade at the expense of learning.

Becoming an Australian nurse. The learning that occurs within the nursing system also allows for an introduction into the profession, a beginning socialization, (Carlson et al. 2010) as it is defined in Australia for all students. An understanding of the nurses' role in Australia is crucial to effective socialization (Fitzpatrick et al. 1996). The process of socialization requires psychological and socio-cultural adaptations that contribute to behavioural changes (Berry et al. 2003).

One study participant articulated the aspirational notion of an *Australian nurse*. For a participant to present the notion that an *Australian nurse* exists, signified that the person who holds that title is a member of a particular group and performs a particular role, and understanding the role was held not only by nurses, but also by newcomers to the culture. The person who possesses the title holds a known position in society, which is termed identity (Burke & Stets, 2009). If ICALD students realize that there is such a notion as the Australian nurse and compare themselves to that ideal and find themselves wanting, then according to Taffel's Social Identity Theory (1978), they are identifying with a distinct and positive identity, and will actively change themselves.

ICALD students are a sub group of the larger cohort of nursing students who all share the experience of learning to nurse in the clinical environment. Essentially, all students are *socialized* into the profession of Australian nursing, as they have to acquire the norms, values and behaviours of the group. For students whose initial socialization as a child was in Australia, it is assumed that there is congruence with that primary socialization and the values and beliefs of Australian nursing. However, for ICALD students their primary socialization did not occur in the Australian culture. It is, therefore, likely that there are differences between their primary socialization and the

contact with the new culture of Australian nursing. These differences result in a further process of acculturation, a process of change that the individual undergoes following direct and continuous contact with another culture (Berry et al. 2003). For the individual, psychological changes that occur as a consequence of contact with other cultures include influences on identity (Berry et al. 2003).

The way that identity as a registered nurse is formed and developed is through the clinical practice experience where students are exposed to the realities of practice. During these multiple experiences students '…. have opportunities to communicate with patients and their families, observe and learn from role models, and practice their skills under supervision' (Levett-Jones & Lathlean, 2008, p.104). It was clear from the findings that the participants in this study were in no doubt as to the purpose of the clinical practice experience, their roles as students, and the role of the clinical teacher in their learning to be a registered nurse. Active and intentional engagement is a positive attribute, in contrast to the literature that usually focuses on the deficits of international nursing students in the clinical environment.

The participants in this study all displayed the characteristics of adult learners who are capable of taking responsibility for their own learning. Knowles' (1990) seminal work on Andragogy stressed that the psychological definition of 'adult' was more important in the understanding of the adult learner than the legal, social or the biological definitions. Here, the self-concept of being responsible for one's own life and its direction is more relevant to learning than the age at which a person can vote, drink alcohol or reproduce. By demonstrating understanding of the purpose of the clinical practice experience, designing personal learning goals attached to the experience and understanding how best they learn, the characteristics of adult learners were fulfilled by the participants. These qualities are linked to the characteristics of adult learners as described by Knowles (1990) as the need to know why something is important to be learnt before committing to learning it, a clearly defined self-concept as a learner, a readiness to learn, orientation of learning in the real life situation of nursing, and intrinsic motivation. This intrinsic motivation can also be linked as working towards the aforementioned positive identity of the Australian nurse. Furth (1987) asserted that learning was fundamentally a desire-based function. According to the findings of this

study, the international students who expressed the desire to learn to nurse were the embodiment of that assertion.

The importance of role models- an enduring ideal. The clinical role model has the potential to provide learning opportunities for the kind of application analysis and synthesis that gives students an understanding of what nursing is about (Field, 2004). It has been noted in the literature that the understanding of the part a role model has in student learning has been misunderstood in the past, with students' learning experiences limited to the performance of delegated tasks in an unsupervised manner (Spouse, 1998a; Marrow, 1997; Coates & Gormley, 1997). Participants in this study were actively seeking an appropriate role model who met their own learning needs.

An appropriate role model for nursing students has been promoted as someone who possesses certain qualities. Kramer (1974) explained that role models for students were most likely to be nurses who were risk takers, welcomed challenges and engaged with patients and colleagues well. Davies (1993) then added personal characteristics related to caring, compassion, patience, confidence, gentleness calmness, acceptance and flexibility. Further, Bucher and Stelling (1977) identified five types of role models that students select: *partial*-where the person exemplifies a single skill or quality; *charismati*c-where the student becomes inspired; *stage*-where the role model provided inspiration to achieve a certain level; *optional*- this role model provided a vehicle for alternative professional viewpoints and, finally, *negative*-where the role model displayed a variant of all other behaviours, essentially a non-model. In addition to these clearly identified characteristics, some participants in this study were proactive in their desires to secure what they deemed an appropriate role model for their individual learning needs.

Jackson and Mannix (2001) proposed that the full learning benefit of the clinical experience lies in the nature of the interaction between student and registered nurse. The participants in this study formulated a strategy that would best suit their learning goals where they designed characteristics of an ideal role model from whom they could learn to be an Australian nurse. The students were desirous of authentic Australian nursing experience and articulated that the best role model for them was an Australian nurse. The preferred Australian nursing role model was described by participants as

possessing three essential and critical traits*: Australian culture, Australian nursing knowledge and Australian language.* Marsick and Watkins (2001) assert that when people learn in work place settings their interpretations and actions are shaped by the cultural norms of others. The participants deliberately avoided registered nurses from their own backgrounds or those from similar backgrounds as they were thought to role model practice that did not meet participants' understandings of Australian standards.

Certain registered nurses were selected then subjected to scrutiny based on the participant's criteria. This covert process remained unknown to the registered nurse who was essentially being interviewed; however it was undertaken by most participants. The candidate was given one chance only to prove their worthiness as a role model. In addition to the three essential Australian criteria, stated in the previous paragraph, the role model had to be willing, helpful, someone who agreed with their personality and learning style, and someone who did not find the student burdensome. These qualities did not differ greatly from the literature available on nursing students opinions of appropriate role models (Stockhausen, 2005; Gray & Smith, 2000). Once this person was located they became the main role model for the student. Edgecombe and Bowden (2009) interpreted this as the exploitation of the clinical staffs' goodwill and skill base, where students in their study found it to be a necessary action for learning in the clinical environment. Much of the literature around role modelling discusses its purpose however, how students actually come to choose a role model has not been explicated as clearly as it has been in this study.

The main mode of learning from the clinical practice experience, as presented by the participants in the study, was through observation. Reasons cited by participants for using observational learning were to get some idea of the orientation of the ward, the nurses were too busy, and to learn practice techniques. Individual students from all geographical regions articulated that this was their preferred method of learning to nurse and was deliberate in nature. This way of learning clearly is situated in Bandura's Social Learning Theory (1977) where observation of a behavioural demonstration, usually identified as a role model occurs. This observational model has been suggested as most useful for students whose competency or verbal skills are underdeveloped and, as such, has provided the foundation of clinical preceptor development for students with diverse learning needs (Johnson & Mohide, 2009). Price and Price (2009), and

Donaldson and Carter (2005) conclude that simply shadowing or exposing a student to the practice of a registered nurse is not sufficient for learning as it does not logically follow that learning will necessarily occur. For learning to occur the learner must be actively engaged in the learning process. The participants in this study have been shown to be actively engaged in their learning by expressly understanding the purpose of the clinical practice experience, exhibiting characteristics of adult learners, devising an ideal role model and actively searching for that person.

Bandura's Social Learning Theory is particularly relevant to student nurses in the clinical environment for a number of reasons. Firstly, as noted by Roberts (2008), the nature of their clinical placements is somewhat nomadic and it is unlikely that students ever return to the same place twice. Secondly, the time spent in the clinical area is often short requiring the students to settle in each time they enter into a new environment. Placements can be a little as one week. White (2010) noted that short placements do not allow students to perform anything other than that defined by the role of the observer. However, Bandura (1977) argued that observation shortens the acquisition process of a new behaviour because it eliminates the need for trial and error. In particular observation is most appropriate for the clinical environment because mistakes can produce costly or even fatal consequences. Further he asserts that 'The more costly and hazardous the possible mistakes, the heavier are the reliance on observational learning from competent examples' (Bandura, 1977, p.12).

The registered nurse who acts as a role model has long been cited in the literature as the person who could teach nursing students more than any other staff member. As early as 1993, Davies identified that the registered nurse is the primary source of learning from experience. Her position was supported by research conducted by Levett-Jones (2008) more than 15 years later. In general terms the quality of the role model was found to be significantly improved if he/she possessed skills in leadership, caring, teaching, and clinical experience (Udlis, 2006). The registered nurse in the clinical environment is seen as central to the socialization process where he/she set standards and acted as gate keeper for professional values and beliefs (Price & Price 2009; Dotan et al. 1986; Bertz, 1985). Being a participant in the provision of good nursing practice has been shown to positively benefit student competence and confidence (Zilembo, 2007; Spouse 2001). Charters (2000) asserts that role modelling is

a legitimate way of learning for nursing students because it reconciles the art and science of the profession and, sadly, most nurses devalue its importance. However registered nurses in the clinical environment may be unprepared or unwilling to teach students which could render this type of learning difficult to assess (Henderson et al. 2006; Field, 2004; Wyatt, 1978). Spouse (1998a) noted that staff may be unaware that students need to be afforded opportunities to work alongside them in order to develop professional skills. Further, devolving the importance of the registered nurse from role modelling is the belief that clinical facilitators (sessional university staff) have taken on that responsibility (Levett-Jones et al. 2006).

Further work published by Spouse (1998b) suggests that students without dedicated clinical teachers, through the process of legitimate participation, are left to their own devices trying to fill in their time with meaningless tasks and trying to avoid harm to patients. The participants in this study were actively engaged in meeting their own learning goals and found ways that supported their learning as individuals. Although this type of role model/student relationship may not be ideal, in the absence of a structured and supported program such as a clear community of practice that supports legitimate participation, it was the students who devised their own model. Indeed, Marsik and Watson (2001) term this type of learning as informal, where the student is in control and it is not highly structured, as an appropriate form of learning where the environment is identified as being unsupportive of student learning.

According to Bandura (1977), virtually all learning results from observing other peoples' behaviour and the consequences of that behaviour. Throughout this study the students demonstrated concern for the consequences that patients experienced as well. This concern often resulted in emotional responses from the students. Consequences for good or bad behaviour not only affected the student and the nurse but the person at the centre of the relationship, the patient.

Incidents of role modelling can be interpreted by students as both positive and negative, and further that if imitated, negative behaviours can be difficult to redress. All the participants in this study, whether they had previous nursing background or not, were able to differentiate appropriate behaviour from inappropriate and only added the appropriate behaviour to their practice repertoire. The ability to judge whether the

behaviour of the nurse was desirable or not, is assumed to be a reflection of the transference of theoretical input related to caring practices, ethical and professional codes of conduct etc. that the students received on campus prior to attending their placement. Undesirable behaviours exhibited by registered nurses, as noted by the students, included: rudeness to students and patients; shouting, cruel and unethical treatment of patients; bad manners, and keeping patients waiting for nursing assistance. Desirable behaviours included, technical skill, successfully dealing with difficult situations and interestingly, successful acculturation to the Australian nursing profession by registered nurses from the students own background. This ability reflects one of Bandura's key concepts in that people are able to '…. select, organize and transform the stimuli that impinge upon them' (1977, p. vii). In performing in that way the students have become '….agents of their own change' (1977, p. vii). The process articulated by the students also reinforced the process of observational learning where the student observes the model with particular attention to significant features of the behaviour, retains it in a way that is particular to them, and then is able to enact the behaviour. Finally the student is motivated by the consequences of the observed behaviour in order to either add it to the learning repertoire or discard it.

For students who are unfamiliar with the Australian health system and its structure, taking time to assess the context of the clinical placement was a valuable strategy. Although Mannix, Faga, Beale and Jackson (2006) contend that learning time is wasted when students have to orientate themselves for each placement. However, for students in this study it was a worthwhile exercise. This time was seen as a precursor to engagement by a nursing student learning to be an Australian nurse.

Assessment drives behavior. Learning to be a nurse in the clinical environment is linked with an overall competence assessment of the student, the nature of which has previously been discussed, and the participants in this study were conscious of being assessed. A certain level of concern by students about clinical assessment is not a new phenomenon. Research by Tiwari, Lam, Yuen, Chan, Fung, and Chan (2005), and Cowman (1998) found that learning in the clinical environment was dominated by the assessment tasks associated with the placement. Students in this study not only wanted to be seen as capable, they wanted to be recognized as Australian nurses. Competence is greatly valued in society and is essential to safe nursing practice. Jones (1989) suggests

that people will go to any lengths to influence the perception of others as to their skill level, especially when the assessment is carried out by clinical teachers already successfully socialized into the Australian nursing culture (Cushner, 1990).

All participants in this study were noted as being proactive in organizing independent learning experiences and the most appropriate people to support their learning of how to be an Australian nurse. The most prominent reason for this self-identified level of management was to protect them from failure. The fear of failure was clearly demonstrated by the focus of students on the clinical summary or 'the yellow paper' and the lengths that were taken to avoid failure. In fact there was a type of 'warning' circulated through a particular cohort of students where a pass on this paper was seen as imperative. For participants who had identified that they were seen as different, and with some expecting some form of rejection either by staff or patients (or both), a proactive stance in their ability to display competence provided some form of security. Students from Asia were most proactive in this area, with their tactics attracting criticism from other participants who were disapproving and thus interpreted their actions as superficial learning. Interestingly though, comments of this type were made by participants who freely admitted that they were studying nursing for the purpose of immigration, where immigration has been noted as a driving force in the process of acculturation (Ang & Liamputtong, 2007). As such there was a split in the participants where some students seriously committed to learning to nurse and some students who performed to pass.

Failure, shame and repercussions. Although this study did not specifically research the beliefs of the participants regarding failure, it was identified as a strong influence in learning on clinical placement and was seen by them as a motivator. Essentially, the protective behaviours exhibited by the students are reflective of beliefs related to failure. Therefore, it would be appropriate to discuss pertinent notions related to the fear of failure.

Fear of failure as a concept is described by McGregor and Elliott (2004) as 'a self-evaluative framework in which failure is construed as an indicator of global incompetence that puts the self at risk of rejection and abandonment by significant others' (p.220). Significant others in the context of this study can be the participants'

parents, student group, or teachers. McGregor and Elliott (2004) assert that a fear of failure is something that an individual is socialized into; where the possibility of failure exists there are consequences for failure based on relationships and there is pressure to perform beyond an individual's capacity. As such, failure is an unacceptable event that has strong consequences related to self-worth, which leads to avoiding failure in situations where achievement is required. Being assessed in the clinical environment is an achievement situation. For individuals who have a high fear of failure being assessed in the clinical environment and receiving negative feedback is not seen as an opportunity for improvement or to learn from the experience. It is interpreted as a threatening, judgment oriented experience and, as such, is potentially shame producing (McGregor & Elliott, 2004). Therefore, failure is about identity, where identity is situated in a social, cultural and political context (Zembylas, 2008), and directly relates to the self as a son or daughter, as an international student, or as an aspiring Australian nurse in the clinical environment.

In respect to students from Asian cultures, failures and achievements are directly related to the honour and reputation of one's family. Further, failure is linked to the emotion of shame, interpreted by most Asian cultures as 'loosing face', where disgrace is cast on all family members, the living and the dead (Colosimo & Xu, 2006). Shame is described as a pervasive negative emotion that serves to describe the self as globally defective (McGregor & Elliott, 2004; Niedental, Tangey, & Gavanski, 1994; Lewis, 1992), which often results in social disconnection. Given that every person fears social disconnection (Lewis, 1971); it is understandable that the participants strove to develop the identity of the Australian nurse through orchestrating the demonstration of socially acceptable behaviours in the clinical environment.

Some participants endeavoured to create positive relationships through behaviours that they found reaped personal benefits. Learning to be a nurse cannot occur without the patient, so there was a primary focus on developing a relationship with their patients. This relationship would allow them to demonstrate their skills to their clinical teacher or registered nurse buddy. As previously identified the student is present in the clinical area for a short time only, and therefore, needs to develop a relationship quickly so that clinical skills can be performed; essentially nursing is done to the patient to show proficiency. Morse (1991) described this type of nurse-patient

relationship as ‘clinical’ where the interaction between the nurse and the patient is superficial and conducted by rote. This description ties in with attempts by some students at communication with patients where they developed a communication routine, a dialogue that they composed following the text book, and performed for their patients. For participants who struggled with verbal communication this was seen as an adequate way of demonstrating their English language skills. Carson and Langer (2006) contend that following a script, rather than genuine dialogue, may be used when people feel that they could be judged negatively. However, this way of communicating may be disadvantageous as it may not appear appropriate or genuine and as a result, render the students to be judged negatively.

The same participants also endeavoured to develop a relationship with their registered nurse buddy and clinical teacher who were responsible for assessing the students. Indeed, the professional socialization of the student is reliant on the relationship between the student and the clinical registered nurse (Bond, 2009). So, attempting to maintain that relationship at all costs, sometimes led to the participants pleasing the teacher by deceptive means, rather than demonstrating their learnt knowledge and skill. McGregor and Elliott (2005) described pretending to be what the teacher expects as a survival strategy for students who fear failure. This kind of survival strategy was noted as far back as 1977 by Lacy who termed it ‘Strategic Compliance’, where students presented what the social system demanded.

Demands in the clinical environment include students demonstrating clinical competence and an ability to provide evidence of the underlying theoretical principles. Research by Jootun and McGhee (2007), also found that their students became what they termed skilful actors and where they played certain roles in the clinical environment The most prominent role was that of the ‘willing worker’, that in some respects was represented in this study by the student being willing to do things for their buddy. Another iteration of this theme was found by MacGregor (2007) where students put on a *chameleon coat* to become what the teachers wanted in terms of a good student.

Some participants in this study went further than acting, or ingratiating themselves to their registered nurse, they actually planned and carried out a strategy

based on deception. Deception by the students involved deliberately asking questions of the clinical teachers, pretending to be interested in matters that the clinical teacher wanted to discuss and pretending to be eager and willing to learn. Pretending was the actual word used by the participants themselves to describe their actions. Schlenker (1984 in Tyler & Feldman, 2004) suggests that the effort people exert to create a desired impression of the self is related to the importance of a certain social interaction. Obtaining a pass by presenting the self as a willing and eager student to the assessors was obviously an important interaction deemed worthy of management by pretence. In managing the impression we make on others we can hope to reduce negative feedback and protect our self-concept (Roth, Snyder, & Pace, 1986).

People pretend for two main reasons. Roth, Snyder and Pace (1986) found that pretenders hope to avoid criticism and prevent loss of self-esteem. Conversely, De Paulo (1998) found that pretending can be done to win praise and increase self-esteem. Further, Hussain and Langer (2003) suggest that pretenders can hope to achieve both simultaneously. Hussain and Langer (2003) suggest from their research that people make calculated risks in their pretending and if the cost to them-selves is severe, they instigate pretence to mitigate that risk. Failure of a clinical placement which is linked to a unit of study could mean a failure in that unit overall; therefore the risk is great, personally and financially to the international student. The danger of pretending in learning to be a nurse is that pretenders do not display their true selves, therefore any positive praise is directed at who they are not, not actually who they really are. Hussain and Langer (2003) concluded that even the smallest pretence is disadvantageous for the actor whereby low self-confidence is reinforced.

Summary

It has already been established in the literature that a registered nurse is the main form of role model for student learning in the clinical environment. However, what this discussion has explicated are the strategies that ICALD students undertook to secure themselves a role model who met their learning needs. They clearly understood the need to learn to be a nurse in the Australian context and were proactive in seeking out an Australian nurse role model. Through various means of testing, a role model was found who would understand and support their learning, and be deemed fit for purpose. Social Learning Theory was found to be the dominant way of learning for these

students, who mainly observed then enacted what they accepted as appropriate nurse behaviours. It was through having the appropriate role model to observe and mimic that the student could hope to gain a satisfactory grade on the clinical summary. However, the focus on the clinical summary and its importance to success led some to pretend to meet the learning requirements, a deception of the true self in the process of learning to be an Australian nurse.

Concluding Remarks by the Researcher

At the completion of any research it is prudent for the researcher to return to the research question and theoretical assumptions that informed the study.

For this particular study the research question that was posed was; what is the nature of learning to nurse through clinical practice experience for international culturally and linguistically different nursing students in Sydney, Australia? The method to answer the question was undertaken in a constructivist paradigm, where the overall aim of the work was to present an understanding of the constructions of the participants related to the associated social, political, economic, ethnic, gender and linguistic influences. From an interpretive descriptive perspective that understanding then, is able to inform current practice.

The findings and the ensuing discussion presented in this thesis went beyond the initial three aims of the research to provide the reader with a comprehensive understanding of the nature of learning to nurse for ICALD students that addressed all of the influences that were encompassed by the constructivist paradigm. The research aims to understand the meaning of learning to nurse. Participants' preconceptions about the role of the nurse and how they impact on learning in the clinical environment were all addressed in the way the researcher engaged with the student and co-constructed meaning. However, the research also raised questions that remain unresolved.

Meaning and Understanding. The beginning of this research was stimulated by international students and their verbalization of how the role of the nurse in Australia was different to that in their home countries. I often wondered what that meant and how that played out in the clinical learning environment. I now know that there is a deeper

meaning that is complex and significant for each individual student, it is not just about the 'doing of nursing'.

Questions answered. In setting out to understand the meaning of learning to nurse for the participants in this study I came to realize that the concept of nursing is socially and culturally constructed and most often revolved around the tasks a nurse performs. There were a few participants who spoke about the passion and desire to become a nurse but for most participants it was about tasks. This could possibly be related to the low status nursing has been afforded in the countries the students came from where tasks were the focus. Having to talk to patients and actually engage with them, an expectation for Australian nurses, was something that most of the participants were not expecting and found very difficult, not just because of their English language proficiency, but because nurses did not do that in their home countries. To learn to nurse in Australia the participants needed to understand the Australian population, its customs and values. Developing this knowledge was an unexpected learning challenge. Learning in the clinical environment was hampered by the students' perceptions that their ability was negatively judged because of their physical appearance. I came to understand that the social and cultural preparation of ICALD students to study nursing in Australia was limited.

Preconceptions of nursing were informed by the cultural social, political, and gender constructions of a participant's home country. The participants were coming to study a profession that is culturally and socially highly regarded in Australia because of its human caring focus. The Australian construction of nursing influenced the doing of nursing to the extent that participants were asked to perform tasks that often violated their cultural values and beliefs; sometimes this meant asking them to sacrifice their reputations and, for some, these stressors could not even be discussed even with his/her own family. In coming to an understanding of this through the discussion, I was able to see that the doing of nursing Australian style caused great consternation and stress for ICALD students. The insights into the personal effects of having to conform to Australian standards went much deeper than being seen to get on with it; the associated stress affected their ability to learn. To use a metaphor, they were much like swans on a lake looking serene to the eye but underneath the water they were paddling furiously to keep afloat.

Where the learning of nursing in the clinical environment is underpinned by exposure to clinical practice, and the expectations of that type of learning are many and well documented, the experience can vary in quality. In addition, and importantly, I have come to understand the clinical learning environment is also a language learning environment.

Because of variation in the quality of learning, the underlying determination of the participants in this study became focused on achieving the right types of experiences to learn to be an Australian nurse. However, the focus for students was once again on the tasks of nursing and then on crafting ways to ensure their success, sometimes resorting to deception, so great was the pressure to pass. The registered nurse buddy and the clinical facilitator are the most important influences regarding practice and assessment respectively. Language issues in the clinical environment are reinforced by the entry level standard for students with English as an acquired language. The students' language preparation was inadequate for clinical nursing, this came to the fore in the clinical setting.

Unresolved issues. Due to the vastly different notions about nursing, and what nurses do, it became increasingly clear to me that the ICN definition of nursing was incomplete and inadequate. That nursing and its performance is directly influenced by the culture in which it is situated and therefore, some of the aims in the definition are unobtainable for some nurses. It became clear that nursing is still influenced by oppressive styles of medical dominance, or performed in areas of the world where there are restrictions on engaging with certain patients, or culturally bound to care in certain ways. The ICN definition of nursing can only be seen as a western concept and may be an irrelevant ideal for other cultures.

English language proficiency (ELP) as a demonstration of a student's ability to study a particular course has been controversial. For nursing, the discussions about the benefit of raising entry level requirements have been inconclusive. What remains certain is that, for those students with English as an acquired language, there needs to be significant and ongoing support for the duration of the course. As the language of

nursing is complex and the linguistic demands are high I would suspect that raising the ELP would do little to reduce the demand for language learning support.

Being an international student at university is classified as personal information and is legislated under Australian law. As such a student's enrolment status is not disclosed to any person without permission from the student, unless it is required by law. A person directly asking a student if they are an international student can be seen as discrimination and is also legislated under Australian law. That is to say that a clinical educator, facilitator, or registered nurse buddy cannot directly ask a student if they are an international student. In light of the findings of this study it appears that being an international student of nursing is a significant event that requires additional learning, emotional, and language support. It seems that the benefits to the student of identifying as an international student in the clinical area might outweigh the harm.

Significance for Clinical Educators. The introduction to this thesis identified that methods of clinical teaching and assessment have not evolved to reflect the diversity in nursing student cohorts. Perhaps this is not where the change needs to be. As the curriculum and assessment of nursing students is linked to the Australian professional expectations, it is more about engendering an understanding of the issues for ICALD students and providing appropriate learning support in the clinical environment. In supporting ICALD students appropriately and adequately their socialization into the Australian nursing profession will be facilitated.

The ethnocentricity of nursing theory and knowledge development has, and continues to be, critically discussed in the nursing literature. Whilst there are moves to address the lack of cultural recognition for those from other than western cultures it remains beyond the remit of this study to address these issues. However, for those involved in the clinical education of ICALD students there are opportunities to explore their preconceptions of nurses and nursing so that critical discussion can assist learning.

Limitations of the Research

The limitations of this research relate to the particular cohort and to the researcher. In particular, the insights and understandings generated from the coconstructions of the data are bounded by the participants experience and the stance of the researcher. However, what can be said of the data and its interpretation is that it reflects the issues previously published in the literature, and moves further to new knowledge relating to the reasonableness of the truth claims.

Chapter Conclusion: Final Word on the Research

The conduct of this research has exceeded the initial expectations of the understanding it would generate. Disseminating that understanding is the final step in the Professional Doctorate process and remains true to the interpretive description method. The next chapter consists of the portfolio of evidence that demonstrates the intersection of leadership and policy in supporting ICALD students to learn to nurse in Sydney, Australia.

Chapter 7: Portfolio Component-Leadership, Policy and Change

Introduction

The primary reason for undertaking this work has been to generate a deeper understanding of ICALD nursing students that can be utilised to improve learning support for them in the clinical environment. Therefore, the context has always been about the learning of nursing in the clinical environment**,** whilst being mindful that nursing students and their teachers are bound by and to, the expectations of the university and the profession. This work then is significant on a number of levels, not only to the individual ICALD students who come to university to study nursing in Sydney Australia, its significance extends to the reputation of the profession and ultimately to the safety of patients.

The Portfolio and its Contents

This chapter presents a portfolio of work that has been undertaken to integrate new knowledge and make a contribution to clinical education practice development. This knowledge has also been shaped by who I am and what I do essentially, the personal stance of the work, where I am an Australian nurse of Anglo/ Celtic heritage, a lecturer, and the Deputy Director of Clinical Education Services at a large School of Nursing. These elements influence the leadership that I bring to the work and the responsibility that I have regarding the dissemination of the findings in regard to policy, in the context of the university setting. Further, the extent of professional experience that I, as a researcher bring to the work positioned me within the research and in turn, recognized the validity of that professional experience. Indeed the research was triggered by experiences as a clinical teacher, and led to the creation a portfolio of work that was clinical learning centred and driven.

Professional doctorate programs are structured to encourage the direct application of knowledge produced to be used at the time it is developed. Thus avoiding an application to professional practice lag time (Spear, 2002), and a providing a clear articulation of the nexus between research, theory and practice (McKenna, 2006; Ellis & Lee, 2005). Dissemination of professional doctoral research outcomes demands that

there is a level of pragmatics associated with the application of knowledge to practice, and for this particular doctoral programme pragmatics are framed by the concepts of application to policy and leadership.

For doctoral candidates it is important to demonstrate the capacity to facilitate application to practice for different audiences through various media. These applications then, constitute the doctoral portfolio section of the work. How the research is transferred back to the workplace, within the given contexts of leadership and policy, depends on the texts and materials that are produced during the research process. The way in which the research was circulated and the audience that it reached was strategically chosen to demonstrate the broader professional outcomes for the work. The dissemination of this work flowed correspondingly from new knowledge development and is captured in Table 4.

Table 4. *Linking knowledge development with informing practice*

Date	Level of Knowledge Development	Medium	Audience
Nov 2007	Literature review	Presentation & peer reviewed Conference paper	International academics & staff all sectors of education
Title: "In My Country Nurses Don't…" Dickson, Lock & Carey, 2007.			
2010	Interview data Development &	Presentation of work shop using critical incident technique	Clinical facilitators University of Western Sydney
Title: Working With ICALD Students in the Clinical Environment			
April 2010	Leadership pragmatics	Invited speaker Presentation STTI Leadership Summit Atlanta,Georgia,USA	International nursing Leaders delegation
tle: The Doctoral Nursing Student: A Unique Opportunity for Leadership Development			
2011	Interview data analysis	Invited Presentation of workshop using critical incident technique	Clinical facilitators University of Technology Sydney
Title: Working With ICALD Students in the Clinical Environment			
Nov, 2011	Discussion	Invited presentation. Academic staff Nursing Faculty workshop day	University of Technology, Sydney. Academic staff Nursing Faculty workshop day.
Title: I Want to be an Australian Nurse: Clinical Learning Challenges for the International CALD student			

The dissemination of the work has spanned the time of candidature and reached a wide range of audiences associated with the clinical education of ICALD nursing students.

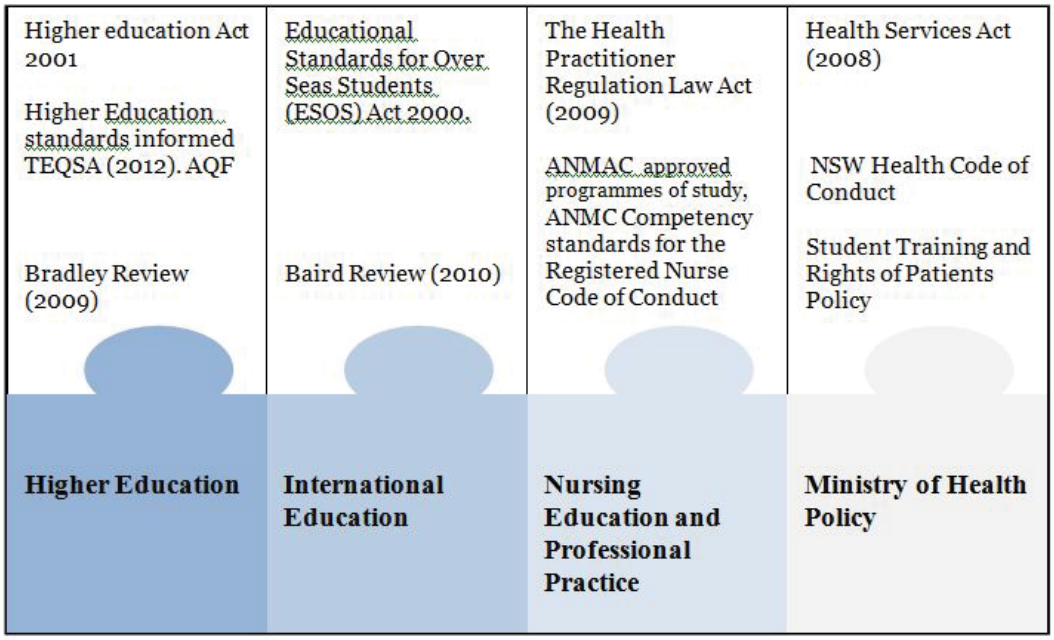
Policy & Leadership Frameworks

This section will explain the policy and leadership frameworks that have significance to the work and its findings. Firstly an overview of each of the policy frameworks will be given, followed by the conceptualization of leadership as portrayed

in the dissemination of the work. Finally, a demonstration of leadership in dissemination of the knowledge developed during the study, inclusive of the key points of the policy frameworks.

Policy related to the work. Learning to be a registered nurse in Sydney, Australia occurs in the higher education setting as the required level of education to apply to register is a Bachelor of Nursing. There is an intricate process of approvals of course structure and content both at the university level and the professional level that is underpinned by legislation and policy guidelines. Moreover, because the majority of clinical placements take place in the public health system there are also requirements to adhere to policy directives from the Ministry of Health. Directly related to this study is the legislation around international students at universities who admit international students, with which universities are required to comply. These interlocking policy frameworks influencing nursing education for international students have been depicted in Figure 3.

Figure 3. *Interlocking Policy Sectors Influencing Nursing Education for ICALD Students*



This section will briefly explain each of the policy sectors, their relevance to the work and the key points gleaned from the policies that have informed the work. Although each sector is relevant and important in its own way, the sectors most relevant to this work are those related to international education and nursing education and professional practice and have a greater emphasis and importance to the work.

The Higher Education Sector Policy Frameworks

Universities in Australia are generally established under state legislation. The Higher Education Act (2001) makes provision for the registration of universities in NSW, accreditation of their courses and approval to provide education to overseas students. The approval to provide education to overseas students, whether onshore or offshore requires universities to be compliant with the national code. The Higher Education Act is the legal framework for the operation of universities in NSW and is legally binding in its content. Once a university has been established under the Act they become self-governing in relation to their own policy (Australian Government, 2003). The performance and quality of education provided by universities is monitored through various data collection methods and standards review agencies, for example the Graduate Destination Survey and the Tertiary Education Quality and Standards Agency (TEQSA). However, the federal government may institute independent reviews of the sector, especially when formulating new education policy. Such a review was commissioned by the then Deputy Prime Minister and Minister for Education, The Hon Julia Gillard in 2008, which led to the federal government's plan Transforming Australia's Higher Education System (Australian Government, 2009).

Recent Higher Education Review: The Bradley Review. A review of higher education was undertaken in 2008 to examine the ability of the higher education sector at the time to meet the future needs of education, workforce and economic considerations to the year 2020. There were 46 reform recommendations made by Bradley for the higher education sector that, broadly themed, included: comparative goals for higher education performance; a greater student focus related to funding studies and funding for more places so that a broader range of potential students have access to higher education; distribution of higher education funds will be relative to goal attainment; a greater allocation of funding for research and for facility improvement; amendments to the ability to offer research degrees and the Australian Government to

play a greater role in monitoring performance of the sector, and to assume the role of allocation funds (now state level responsibility). Two new independent authorities were to be created, one monitor university quality and to develop the Australian Qualification Framework (now TESQA), and one to monitor Education Services for Over Seas Students (ESOS) compliance. Overall it was put forward that these reforms would allow the Higher Education sector to '… create an outstanding, internationally competitive tertiary education system to meet Australia's future needs …' (Bradley, Noonan, Nugent, & Scales, 2008. p.xi)

Amongst the recommendations were some related to the structures around the functions of the body Australian Education International, which is responsible for managing the international education policy throughout Australia. There would be more incentives for international higher research degree students, and that international students' spouses and children would be better supported. Although not directly related to this work the changes are noteworthy as improvements to support structures for international students.

Further, nursing was one of two professions targeted for extended domestic student tuition support because of deficits in workforce projections. Although the recruitment of international students into nursing degrees was not specified, it was made clear that international students were important to the nation's export industry as a whole and have the potential to address workforce shortages. Bradley discussed the responsibility that higher education providers have in relation to preparing international students for the Australian workplace, with specific mention of language proficiency and teaching staff preparedness (2008). These points directly reflect the purpose and the goal for dissemination of the work from this study.

Local University admission policy and nursing students. As previously stated, once a university is commissioned under the Higher Education Act it is self-governing and, therefore, develops its own policies. Universities running ANMAC and NMBA approved programs of study for nursing have a responsibility, not only to run their courses as per the approved curriculum, but also to operate within the broader policies that frame higher education and university policy at the local level.

The general admission policy of the university where the participants for this study were enrolled stated that applicants for admission were selected on the basis of academic merit or the ability to study at the tertiary level. Further, international or overseas students had additional requirements related to ELP, a demonstrated financial ability to pay course fees and support themselves whilst studying and as they are student visa holders, they must study full time according to their student visa (UWS, 2012). The English language requirements as of 2012 posted on the universities international page are

> *For all undergraduate courses except B Medicine/B Surgery:*
> *IELTS (Academic) -6.5 overall score with a minimum 6.0 in each subtest*
> *TOEFL - 575 (minimum 4.5 in TWE)*
> *TOEFL computer based test - 232 (minimum 4.5 in essay writing)*
> *TOEFL Internet based test - 89 (writing = 21 and all subtests = 18)*
> *Cambridge Certificate in Advanced English - (CAE).Grade = B*
> *Cambridge Certificate of Proficiency in English. Grade = C.* (UWS, 2012)

With an additional comment regarding the application for registration

> *Please note: from 1 July 2010 practitioners applying for registration as a nurse or midwife for the first time in Australia are required to demonstrate English language proficiency as specified by the Nursing and Midwifery Board of Australia (NMBA*) (UWS, 2012).

This admission policy and consequent registration policy demonstrates that students who have had to gain an IELTS score of 6.5 overall for admission must be able to show improvement over the course of their studies to a score of 7.0 overall.

When the data were collected for this study there was no discipline specific literacy support structures in place for students of nursing, in particular international students. Over the duration of this research, issues surrounding ELP and the need for academic literacy have become increasingly evident due, in part, to the dissemination of the findings of this research and my associated leadership skills.

In regard to clinical learning, the primacy of patient safety and the need for students to demonstrate competency drove the School of Nursing and Midwifery to

develop strategies to support and encourage ELP for international students. Language issue data from this study were incorporated with The Good Practice Principles for English Language Proficiency for International Students in Australia (Department of Education, Employment & Workplace Relations [DEEWR], 2007) which led to the development of a communication programme for students identified at risk. This programme is headed by TESOL qualified academic staff and is ongoing in its development and scope. Whilst a university Academic English Literacy Strategy does exist, to date there is no designated English language support policy identified in the existing university documents.

Key points taken from the policy.

- International nursing students are potential workforce here in Australia.
- Discipline specific language support is now considered part of learning.
- International students must show evidence of significant improvement in language skills to become registered nurses in Australia.
- Clinical facilitators require additional education as to the language and work culture learning support for international learners of nursing in Australia.

International education – The ESOS Act.

International students who come to study in Australia can only enrol in courses that are registered with the Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS). The Education Services for Overseas Students Act 2000 (ESOS Act) regulates the standard of education provided to overseas students in Australia in all education sectors and provides that overseas students are protected in regard to financial and tuition assurance, that the course they paid for is the course they receive. In addition it also protects Australia's reputation as a global education provider and allows for the monitoring of students on student visas in relation to relevant migration laws (ESOS Act, 2000). As this is an act of Parliament, any offences related to, or breeches of the Act are punishable under the Criminal Code (ESOS Act, 2000). To assist education providers in maintaining their compliance with the ESOS Act, the National Code of Practice for Registration Authorities and Providers of Education and Training to Overseas Students was developed in 2007 (Australian Government, 2007). The National Code (2007) is the legislative instrument of the ESOS Act. There are 15 standards that constitute the National Code, that cover five broad themes: pre-enrolment of students; care for and services to students; students as consumers; the student visa program; and staff education, resources and premises (DEEWR, 2007).

The university where the participants were enrolled is a self-accrediting provider which submits a report annually related to compliance with the Code, and is required, every five years, to submit an audit conducted by an independent body. These assessments take a university wide approach and, as such, do not take into consideration individual courses and their discipline requirements. Because of this broad approach to National Code Compliance, a comparison was undertaken by me of each requirement in regard to international nursing students. It was found that there were some standards where compliance could be improved upon.

For instance *Standard 2 – Student engagement before enrolment*. The hand book summary for the Bachelor of Nursing (BN) provides information to all prospective students, is general in nature about the nursing course, and is mainly related to theoretical learning. There is no real information provided to students about the

construction of nursing as it relates to Australian Society, or the expected role of the nurse. Below is the handbook description of the BN.

> *This course prepares graduates for eligibility to apply for registration throughout Australia as beginning professional generalist registered nurses. The focus of the course is on inquiry-based learning, critical thinking and reflective practice in relation to the theory and practice of nursing in health and health breakdown across the lifespan. Students study application of physical and behavioural sciences to nursing; inquiry and evidence-based practice principles and utilisation within nursing; nursing care of individuals, families and groups from diverse backgrounds across the lifespan. The acquisition of nursing knowledge and skills occurs initially in campus-based simulated clinical practice settings and consolidation occurs as students undertake clinical placements in a variety of health care settings. Prospective students should be aware that full disclosure of any issues of impairment or misconduct is a declaration requirement when applying for registration as a registered nurse* (UWS, 2012).

Following on and directly related to studying nursing in a different culture is *Standard 6 Student support services*, *section 6.1* where the registered provider must assist students' adjustment to study and life in Australia. Further information about competency standards related to nursing in Australia, could be provided to introduce the students to the expectations of the profession rather than waiting until the first semester of study and the reality of the clinical placement that occurs in the second semester.

However most importantly it was found that the School of Nursing and Midwifery did not comply *with Standard 6-Student support services section 6.7* that requires all staff interacting with international students to be aware of their obligations under the ESOS Act (2000), especially in relation to clinical education staff. These results went on to inform how the dissemination of the work could be formulated to meet these standards.

Recent and relevant amendments to the ESOS Act- The Baird Review. The ESOS Act was reviewed in 2009 by Baird as a recommendation following the Bradley

Review of Australian Higher Education Report. The Baird review (2010) made 19 recommendations for changes to the current legislation that revolved around broad outcomes: a well-informed student; an engaging study experience; a rewarding life experience, and a future with potential for international students. These were underpinned by the principal objectives of ESOS to provide financial and tuition assurance, protect Australia's reputation as a quality education provider, and to complement Australia's migration law by monitoring student visa standards.

Baird (2009) requested input from a number of stakeholders in international education that included students and providers' of education to international students, at all levels, peak bodies, federal government ministers and departments, state and territory governmental departments, diplomatic missions and agents. Public submissions were also called for, which resulted in contributions from 18 universities, 2 medical schools, one law institute and one council of medical deans. Surprisingly, no submissions were recorded from the ANZ Council of the Deans of Nursing or from the university where the participants from this study were enrolled. The following represent recommendations from the review that are pertinent to the work.

Baird's recommendations called for providers to refocus on providing a quality experience rather than a focus on the income that international students generate as an export industry (2009, p.2.) Students are to be seen, according to Baird, as investors in their own education, rather than contributors to facilities' coffers. By thinking that international students are primarily money spinners for education providers, Baird asserted that the student has been left out of the education picture (2009, p. 6).

In correlation with the findings of this study, language competency was presented as an issue that required increased clarification for both international students and course providers. Baird received submissions from students voicing their concerns of the ELP of their peers that caused them to question the quality of the course they were enrolled in. Other students stated that they were denied opportunities to develop their English language skills. It was acknowledged that the IELTS was both widely used and recognised, however there was a lack of consideration for the ELP required for particular courses. Recommendations were made that ELP support be provided at an

appropriate level for the course and where relevant professional outcomes are expected, such as in nursing (2009, p. 11).

The recommendation related to accurate course information and ethical recruitment, obliges universities to provide information to international students related to the: history, scope and nature of the provider; other students studying the same course, course content and level of the course; professional accreditation and any other requirements that may be needed to obtain this, the type of support that they can expect from the provider. In regard to nursing and the findings of this study it is pertinent that international students be given information about the type of learning that is expected and the level of participation in the clinical environment, especially in light of the cultural and social differences that have been highlighted in this study. It was also recommended that pre-departure and post-arrival sessions for ICALD students be designed to reflect the actual student experience in the courses, and the adjustment to life in Australia. In fact the issue of culture shock was addressed in the report where Baird acknowledged that it could not be addressed '…. simply by the provision of a pamphlet, a website or a brief lecture' (2009, p.37).

Key points taken from the Act. Certain key points identified from the policy were chosen to be addressed. These key points could inform and structure the dissemination of the findings of the work in a pragmatic way.

- All clinical education staff interacting with international students to be aware of their obligations under the ESOS Act (2000).
- A refocus on quality student experience for clinical learning.
- ELP discipline specific support.
- Culture shock related to the role expectations of the nurse in the clinical environment needs adequate understanding and appropriate support.

Nursing - The Frameworks for Education.

Registration of nurses in Australia is framed by the Health Practitioner Regulation Law Act (Queensland Government, 2009) [the national law], which is enacted by the Australian Health Practitioners Regulation Agency (AHPRA). Implicit in the name of this regulator is the understanding that applicants for registration will be able to demonstrate competence in Australian Nursing and Midwifery Council Competency Standards. Further, to meet national law requirements AHPRA now requires nursing students to be registered. The registration of nursing students was undertaken in the interests of public safety where a student can be notified to AHPRA for broad categories of issues related to illness or criminal conviction (AHPRA, 2012). Students who have completed an approved program of study are eligible to apply to be registered; registration is not automatic at the completion of studies.

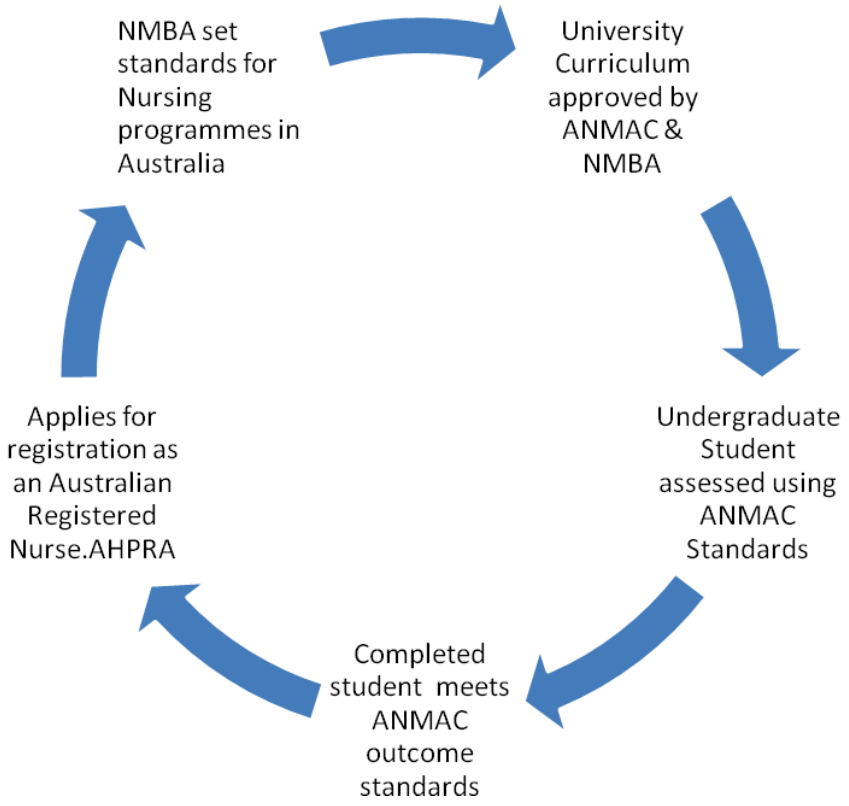
An under graduate nursing degree is awarded by universities in NSW to students who have successfully met the requirements of the programme. Undergraduate nursing education is similar to other health professions where the Bachelor of Nursing qualification allows the graduand to apply to be registered as a nurse to practice in Australia. Across Australia, all curricula implemented by universities for the study of nursing must first be accredited by the Australian Nurses and Midwives Accreditation Council (ANMAC) before final approval by the Nurses and Midwives Board of Australia (NMBA). The six stage accreditation process for nursing curricula is rigorous, lengthy and costly. In order for a BN programme to be approved the curriculum must clearly articulate the course design and teaching methods used to support the Australian Nursing and Midwifery Council Competency standards for the registered nurse (Preston, 2009). The ANMC competency standards are commonly used as outcome measures for nursing students learning in both the theoretical and clinical environment, and are informed by safe practice principles and the social and cultural expectations of the role of the nurse. In meeting the requirements of their programmes, students are deemed eligible to apply to be registered as a nurse, that is, they have met the standards that are set in Australia for the practice of nursing and, therefore, are presumed to be safe and competent practitioners.

Safe and competent practice is inclusive of ELP where applicants for registration must prove language proficiency. To that end applicants who have not had the equivalent of five years full time study, where teaching and assessment was in English, must demonstrate ELP. This ELP can be demonstrated by an IELTS or OET taken within 2 years of applying to register and meeting the standard expressed by the NMBA (NMBA, 2011).

Significance of this professional structure. All students studying nursing in Australia are expected to comply with the Australian standards of nursing care. This is clearly articulated in the criteria for student assessment, stated in the standards and criteria for curricula, where it is written that 'Assessment in the professional experience context to establish the combination of skills, knowledge, attitudes , values and abilities that underpin quality outcomes of performance' (Preston, 2009. p. 16).

Students studying nursing in Australia then, attend a program approved by Australian nurses, need to meet standards set by nurses in Australia and apply to register through the NMBA. How the nursing profession influences and shapes nursing education in Australia is outlined in Figure 4. Further, universities are explicitly encouraged by the ANMC to enrol students from what are termed '…. under-represented groups especially those from culturally and linguistic diverse groups…' (Preston, 2009. p. 9), and state that appropriate support needs to be afforded to them so they are not disadvantaged in developing the ANMC standards. However, what this support might look like that assists these under-represented groups to become Australian nurses, or how it is designed and implemented, is not articulated by the ANMC, it is just presumed to occur through the learning process.

Figure 4. *How nursing profession influences and shapes nursing education in Australia*



Further, the findings of this study explicate that the process of becoming an Australian nurse is a complicated, individual journey that requires specific understanding and attention to detail especially where the values, culture and role of the nurse intersect with the personal for ICALD students in the clinical environment. Pertinent to this, the ANMAC explicitly state that staff involved in clinical practicum '… must be appropriately qualified and orientated to their role…' (ANMAC, 2009. p. 10). This is interpreted to mean that clinical education staff should be aware of the factors associated with being an ICALD student and the impact these have on their learning in the clinical environment.

Key points taken from the framework.

- Support for ICALD students in the clinical environment related to skills, knowledge, attitudes, values and abilities related to the role of the Australian nurse.
- Clinical education staff must be provided with education to alert them to the adjustment process for ICALD students so that they can be supportive as the students learn to be Australian nurses.

NSW Ministry of Health Policy

The governing legal regulation framework for health services in NSW is the Health Services Act (1997). Under this Act provision is set out for the effective and efficient management of health services in NSW related to organizational structure, management, funding agreements under Medicare and broad issues related to staffing (mainly medical practitioners and their employment as Visiting Medical Officers); it also includes the NSW Ambulance service. Employment, initial and ongoing, of registered nurses by the NSW public hospital system is managed in respect to the standards of the Health Services Act. However, professional accountability relies on the individual nurse's demonstration of the AHPRA registration standards inclusive of the ANMC Competency Standards, The Code of Ethics, and the Code of Conduct in their daily work the registered nurses' professional accountability with AHPRA and the Health Practitioners Regulation Law Act (2009) are concurrent.

Recent and relevant reports: The Garling Report 2008. In 2008 the Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, commonly known as the Garling Report, was released. This inquiry was undertaken due to a number of factors, not the least of which was data presented from the Clinical Excellence Commission that reported over 500,000 incident reports were made in the calendar year 2007-2008 (NSW Clinical Excellence Commission, 2008). Public interest in these adverse events was highlighted when an inquest into the death of a young patient at a large Sydney hospital, criticized its care processes for paediatric patients. This resulted in general concern about the quality and safety of care in the public hospital system (NSW Parliament Hansard 28/11/08, p.13, 096; Garling, 2009).

In order to improve care quality and patient safety Garling proposed changes to the way in which care is delivered (2008). Fundamentally he called for a move towards a patient centred multidisciplinary team model of care that needed to be introduced in undergraduate education and early career development of health care providers. To manage the change required, Garling proposed four pillars of reform, the Clinical Innovation and Enhancement Agency, The Clinical Excellence Commission, the Clinical Education and Training Institute and the Bureau of Health Information. The NSW government responded by releasing the Caring Together: The Health Action Plan for NSW (NSW Department of Health, 2009). Underpinning all of these reforms and of significance to this study was the need to improve communication between the members of the multidisciplinary teams, within the teams, and with patients and their careers.

Local NSW Health Policy Directive related to students. Through regulation and registration of health professionals the public are protected to some degree against unethical and incompetent practitioners. Employees of NSW Health are required to demonstrate their practicing certificates on an annual basis; however the situation is somewhat different for nursing students placed in NSW health facilities. Whilst AHPRA have introduced registration for nursing students, students are still required at a local level to sign student declarations in agreement with the code of conduct. Student Training and the Rights of Patients is a NSW Health (2005) policy directive that underpins local policy related to students on clinical placements in the NSW health system. Broadly speaking the nine statements reflect the need for protection of patients' dignity, rights and wellbeing, and expressly state the need for students to understand their role as a learner and scope of practice.

Key points taken from the policy.

- The ANMC standards for the Registered Nurse, Code of Conduct and Code of Ethics underpin professional nursing practice and the expectation of nursing student practice in NSW health.
- Communication through all media is essential for effective multidisciplinary patient centred care.
- Nursing students need to understand and reflect the rights of the patient whilst giving care.

- Nursing students need to know and understand their role as a learner and their scope of practice

Summary

The study of nursing at university in NSW is an intricate process that occurs around a series of interlocking policy frameworks. These frameworks not only provide direction for the education of nursing students and their clinical learning, they explicate the legal obligations related to higher education and the profession overall. It is necessary to include relevant and recent reviews and reports that make significant changes to existing policy so that contemporary nurse education reflects important issues that impact on ICALD students. It is through academic leadership that the policy frameworks can be articulated and enacted to provide appropriate care to patients, and at the same time support ICALD students.

The Concept of Leadership as Represented in the Work

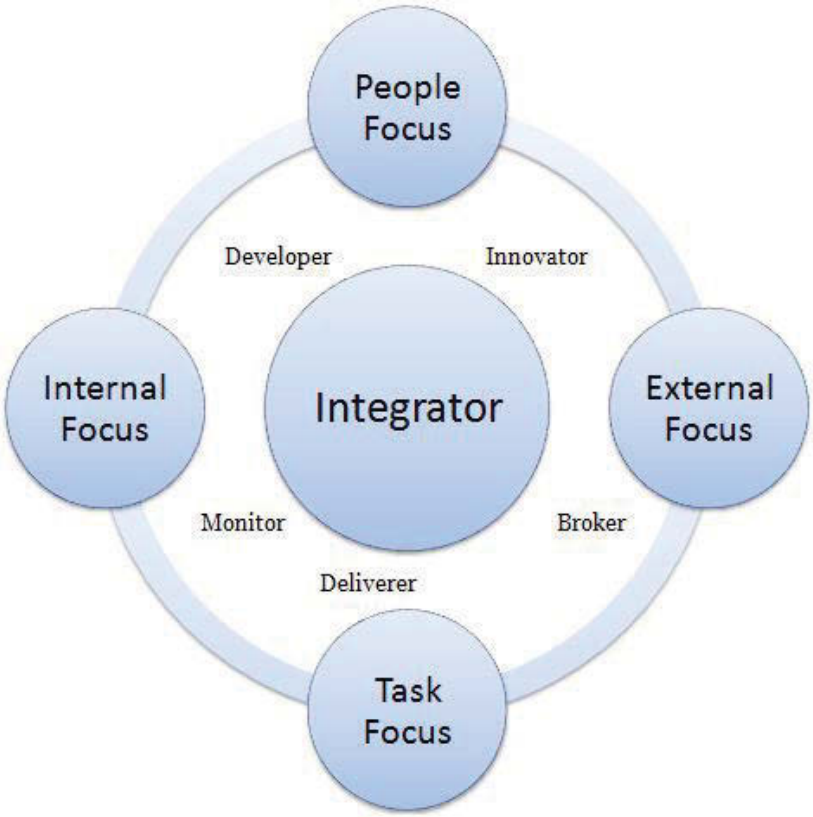
As a lecturer in nursing at a university with a large cohort of nursing students, 12% of whom at the time of the research were holders of an international student visa, I came to realize my role is, what is termed, a linking pin (Likert, 1961) between the students and their clinical educators and the policies around their learning. I began to search for what academic leadership looked like in practice, and how those aspects of leadership could most effectively facilitate the dissemination of the work. Leadership in this portfolio is, therefore, informed by the context that it occurs in, the academy.

The search for a leadership framework. The notion of academic leadership seems to be complicated and elusive (Scott, Coates & Anderson, 2008), however, despite this elusiveness Martin, Trigwell, Prosser, and Ramsden (2003) note that positive links have been made between the quality of academic leadership and the effectiveness of higher education. The notion of leadership in the context of academia is impacted upon by a number of factors which include: the speed, direction and pressure of knowledge growth; the declining respect for academic work, and the way people work together in a higher education environment (Ramsden, 1998). Further, Scott et al. (2007) have identified the four greatest challenges facing higher education today as 'student engagement, institutional accountability, revenue generation and globalization' (p. 1-2). It is evident that academic leadership is complex and influenced by internal and

external factors. However, it is clear that quality leadership supported well and implemented with vision has positive outcomes for teaching and learning. As an academic leader it is my responsibility to ensure program outcomes and quality for clinical education of ICALD students.

Vilkinas, Leask and Ladyshewsky (2009), identify that academic leaders need to be able to influence, motivate, and inspire others. To this end they have identified a set of behaviours that allow for the development of an effective academic leader that culminate in the Integrated Competing Values framework (ICVF) (Vilkinas & Cartan, 2006). This behaviourally based leadership approach portrays what academic leadership looks like in practice (Vilkinas & Ladyshewsky, 2012). The five leadership behaviours, developer, innovator, monitor, deliverer and broker are activated in relation to the focus of the situation in need of leadership, either people focus or tasks focus. The main goal is for an academic leader to integrate all of these behaviours as depicted in Figure 5 (Vilkinas, Leask & Ladyshewsky, 2009).

Figure 5. *Integrated Competing Values Framework (ICVF).*



Leadership development utilizing the roles of the innovator and broker. From the inception of this work I was mindful of creating awareness at various levels to various audiences within the university setting of the international nursing students' unique challenges of studying here in Sydney, Australia. From the early stages of the work I increasingly became aware of the significant cultural and linguistic differences that ICALD students faced, and the lack of attention given to them by clinical education staff and university staff overall. I saw my leadership as encompassing the role of the innovator and the broker. The role of the innovator within the ICTV is to identify changes that are needed, to think creatively and to see the need for new approaches to the delivery of information to those who need it. When combined with the role of the broker, where building relationships, gaining the support of and influencing others is key, the following endeavours provided a unique opportunity to disseminate knowledge at each stage of the work to inspire change (Vilkinas, Leask & Ladyshewsky, 2009).

Making the Links with Policy and Leadership - Dissemination of the Work

This section of the portfolio presents how leadership was demonstrated in the dissemination of the understandings from the research. It will begin with the literature review and conclude with the final workshop presentation.

The literature review and dissemination of knowledge.

Nov 2007	Literature review	Presentation & peer reviewed conference paper	International academics & staff all sectors of education
Title: "In My Country Nurses Don't…" Dickson, Lock & Carey, 2007.			

The literature review conducted in the initial stages of the research informed the understanding of the social and cultural construction of nursing, and influenced the research question. The role of the clinical educator or facilitator is more than just observing skills and documenting a level of competency, it is about understanding the ICALD student and remembering that they are learning to be Australian nurses. The

literature review revealed a strong focus on classroom learning and language issues for the ICALD student; however clinical learning issues were neglected. It was important to begin to disseminate a point of view that focused on nursing as it is constructed in the culture in which it is practised and that international students may have a differing perspective about what nursing is and what nurses do because of a cultural differences. The evidence from the literature review combined with anecdotal evidence from my firsthand experience that led to my interest in researching this issue. This beginning part of the work related to all the interlocking key areas of policy related to learning to be a nurse in Sydney.

The literature review from the study informed a peer reviewed paper and presentation delivered at the ISANA International Conference 'Student Success in International Education' 27-30, November 2007, Glenelg South Australia. In addition, as chief author and presenter of the peer reviewed paper, I was the recipient of a competitive bursary that provided financial support to attend the conference. Receiving this bursary indicated the importance of the paper to the conference theme of student success in international education. The paper was titled, "In my country nurses don't…" The full paper and presentation can be found in *Appendix B*.

This international conference was attended by more than 250 delegates from all education sectors that provided study pathways for international students including higher education, vocational education and training (VET), English Language Intensive courses for Overseas Students (ELICOS) and schools. Attendees were not only academics, but were representatives from all departments of the above sectors. Presenting at this conference provided a broad audience with whom I could begin to address the issues that underpinned the research work.

The data analysis and dissemination of knowledge.

2010	Interview data analysis	Presentation of work shop using critical incident technique	Clinical facilitators University of Western Sydney
Title: Working With ICALD Students in the Clinical Environment			

2011	Interview data And analysis	Invited presentation of workshop using critical incident technique	Clinical facilitators University of Technology Sydney
Title: Working With ICALD Students in the Clinical Environment			

As work continued on the research, moving away from the literature to the collection of data and analysis, it was becoming clear that the clinical facilitator has a significant influence on clinical placement outcomes for ICALD students, particularly as a nexus of understanding between the student and the facility staff. Outcomes included learning about Australian nursing in regard to discipline language, competency and the role of the nurse, and most importantly the patient. It was also evident that students' preconceptions about nurses and their role played an important part in their learning. In relation to policy, the analysis of the ESOS Act and the issues that presented themselves related to nursing education the NSW Ministry of Health could not be ignored when it came to ensuring compliance. Leadership is inherent in my role as Deputy Director of Clinical Education Services, so the decision was made to develop a workshop that combined the emerging data and the need to demonstrate compliance with the relevant policies.

Prior to the development and implementation of the workshop, the School of Nursing & Midwifery (SoNM) had not provided any form of training to assist clinical educators in understanding the learning behaviour of ICALD students in the clinical environment or compliance with the ESOS Act in particular. This type of support for clinical educators can also be directly linked to the university's' responsibilities to provide quality education to international students under the ESOS Act (2000). The research data from this study indicated that clinical educators are required to make changes regarding their understanding of and learning support for, international students in the clinical environment. The issues identified relating to clinical educators included the following:

- Lack of targeted information for clinical educators about the complexities of working with international students.
- Lack of awareness of the legislative requirements when providing educational services for international students.

- Lack of understanding of the Australian Quality Framework in relation to educational services for all students.
- Professional development for clinical educators needed to be structured appropriately to encourage a change in behaviour that will support the learning needs of international students.

In explicating these issues it was clear that there was a direct link with the thematic findings of the research. Consequently, a workshop idea was developed in order to assist clinical educators to:

- Develop a greater understanding of ICALD students.
- Decrease the use of stereotypes about ICALD students.
- Develop of complex thinking about ICALD students, which replaces the oversimplified explanations that students react negatively to.
- Increase enjoyment of working with ICALD students.
- Improve adjustment to the stress of working with ICALD students.
- Create better job performance.

(Brislin & Yoshida, 1994; Brislin, Cushner, Cherrie & Yong 1986)

The workshop was designed using the Critical Incident Technique (CIT) which is the most researched method of cross-cultural training (Bhawuk, 2001). Originally developed in 1971 by Fiedler, Mitchell, and Triandis (Brislin, Cushner, Cherrie & Yong, 1986), it uses real life scenarios to identify potential areas of misunderstanding and intrapersonal conflict. Learning about the reasons for the behaviour depicted in the incidents, workshop attendees have the opportunity to address how they view the behaviour and consequently the ICALD student, leading to a more understanding approach to learning to be a nurse in the clinical environment.

The format of the workshop using critical incidents was based on the model outlined by Brislin et al. (1986) and involved developing the following:

- Self-assessment exercise to determine the facilitators' general knowledge about international students.
- Short presentation on international students to clarify some of the misconceptions and myths, and to provide factual information.

- Case studies or the critical incidents were presented to the group. Here the participants had to choose a possible explanation for the student's behaviour.
- Discussion session about the choices and the most feasible explanation for the student's behaviour.
- Evaluation of the session.

Extensive research and preparation went into designing the general information session, choosing the appropriate case studies from qualitative data generated by the doctoral work, and meeting the specific requirements of the model to make this an authentic critical incident session. The PowerPoint slides from the UWS session are available in *Appendix C.*

The workshop was developed and implemented on the 22 January 2010, and consequently I was invited to present to the clinical facilitators employed by the Faculty of Nursing, Midwifery and Health at the University of Technology Sydney (UTS), 29th April 2011. The PowerPoint slides from the UTS session are available in *Appendix D.*

As change has been identified as a *process* it would be unrealistic to expect that clinical educators attending the workshop session would respond immediately. It is also recognized that the motivation to engage with, and respond to, change requires commitment at both a rational and emotional level (Scott, 2004). Momentum for the adoption of a different way of understanding international students' behaviour in the clinical learning environment will be modelled by the members of the Directorate who deal with clinical educators on an almost daily basis, offering learning support and educational strategies. Modelling the desired behaviour has been shown as a fundamental factor in change management (Scott, 2004).

Leadership pragmatics and dissemination of knowledge.

April 2010	Leadership pragmatics	Invited Speaker Presentation STTI Leadership Summit Atlanta,Georgia,USA	International nursing Leaders delegation
Title: The Doctoral Nursing Student: A Unique Opportunity for Leadership Development			

The use of the ICTV caused me to reflect on my concurrent roles as Deputy Director of Clinical Education, lecturer and researcher. The process of reflection is integral to the development of a leader and is identified by Vilkinas Leask and Ladyshewsky (2009) as necessary for a competent integrator. I began to ponder what had I learnt from these roles that could best communicate the doctoral work at another level. The Sigma Theta Tau International (STTI) Leadership Conference in Atlanta, USA (2010) was an opportunity to disseminate the opportunity that a professional Doctorate student has in regard to leadership. The objectives for the leadership summit were:

- Identify strategies and resources for leading the delivery of quality nursing care/education, specifically in times of economic challenge.
- Describe knowledge and best practices regarding chapter operations.
- Name two actions that will promote exchange of ideas and collaboration with other chapter leaders.
- Identify strategies and resources for developing a personal leadership journey (STTI, 2010).

Whilst two of the objectives were not directly related to the work, two were. Firstly identifying strategies for quality nursing education and secondly, strategies and resources for a personal leadership journey. The PowerPoint slides for the presentation can be found in *Appendix E*.

The discussion presented at the summit reflected the work and its application inclusive of policy frameworks, its primary focus was on the leadership development of the researcher as a doctoral student.

Discussion and dissemination of knowledge.

Nov, 2011	Discussion	Invited presentation	University of Technology, Sydney. Academic staff Nursing Faculty workshop day.
Title: I Want to be an Australian Nurse: Clinical Learning Challenges for the International CALD student			

The discussion section of the work provided a unique opportunity to present the knowledge gained from the work in a well-rounded and informed way. The purpose of a discussion chapter is to examine, interpret and qualify the findings. This was then portrayed to the lecturers at the faculty of Nursing and Midwifery at UTS with application to practice. The PowerPoint slides from the presentation can be viewed in *Appendix F*. This final presentation of the work was the culmination of the leadership and policy frameworks applied over the duration of the study

Summary

This chapter has presented a portfolio of work that has been undertaken to disseminate new knowledge and make a contribution to clinical education practice development. By incorporating the key points from policy relevant to nursing education, the dissemination of knowledge becomes applied in the current context. Through the deliberate targeting of the presentations at the clinical education facilitators, who have control over students' clinical assessment, and who are the face of the university in the clinical environment, understanding of the ICALD student learning experience can be dispersed. The leadership demonstrated by the dissemination of the work embodied the roles of the innovator and the broker, where the research identified the need for change and the presentations inspired it.

Concluding Remarks

As previously described, a doctoral program is designed to be a significant contribution to knowledge and practice in the professional context**.** The significant contributions that this study has made in relation to learning for ICALD nursing students have: redefined the clinical environment as a language learning space, and the students as learners of culture. It has become clear that it is only through a meaningful explanation of the construction of Australian nursing that international students can be

seen as individuals having to adapt to a profession which is culturally and linguistically different to them. In doing so the command of new specialist knowledge, expertise and competence has been taken forward within the frameworks of leadership and policy.

Appendix A: Ethics Approval, Participant Information and Consent

28 November 2007

Associate Professor Linette Lock
KG05.02.03
Faculty of Nursing Midwifery and Health
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Linette,

UTS HREC REF NO 2007-173 – LOCK, Associate Professor Linette, CAREY, Dr Michael (for DICKSON, Ms Cathy DCN student) - "Learning to nurse on clinical practicum in Sydney, Australia for international culturally and linguistically different undergraduate students"

Thank you for your response to my email dated 20 November 2007. Your response satisfactorily addresses the concerns and questions raised by the Committee, and I am pleased to inform you that ethics clearance is now granted.

Your clearance number is UTS HREC REF NO. 2007-173A

Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Innovation Office, on 02 9514 9615.

Yours sincerely,

Professor Jane Stein-Parbury
Chairperson
UTS Human Research Ethics Committee

Cathy Dickson
Professional Doctorate student
Faculty of Nursing, Midwifery & Health
Kuring-gai
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Lindfield, NSW 2070
Australia
Cathy.L.Dickson @uts.edu.au
www.uts.edu.au

UTS CRICOS PROVIDER CODE 00099F

Dear (student name)……..

RE: PROJECT TITLE: Learning to nurse on clinical practicum in Sydney, Australia for international culturally and linguistically different undergraduate students.

My name is Cathy Dickson and I am a Doctoral student at the University of Technology, Sydney.

I am conducting research into the clinical learning experience for international culturally and linguistically different nursing students in Sydney, Australia and would welcome your assistance. The research would involve a one on one face-to-face interview on your home campus and should take no more than 45-60 minutes of your time.

If you are interested in participating, I would be glad if you would contact me via email Cathy.L.Dickson@student.uts.edu.au *or* telephone on [redacted]. You are under no obligation to participate in this research.

Yours sincerely,

Cathy Dickson

(UTS HREC approval reference number 2007-173A)

UNIVERSITY OF TECHNOLOGY, SYDNEY

I _____ agree to participate in the research project **Learning to nurse on clinical practicum in Sydney, Australia for international culturally and linguistically different undergraduate students (***UTS HREC approval reference number 2007-173A)* being conducted by Cathy Dickson, of the University of Technology, Sydney for her degree Doctor of Nursing.

I understand that the purpose of this study is to uncover the meaning of learning to nurse in Sydney, Australia from an international student's perspective. In doing this research, I will be able to make recommendations that will have a positive effect on undergraduate clinical education for all involved.

I understand that my participation in this research will involve a recorded (audio) face-to-face individual interview that will last between 45-60 minutes. The interview will take place on my home campus in a private unshared office, on a day that I am usually attending classes. I will also be asked some basic information such as; my country of birth, language(s) spoken, age, sex, length of time in Australia. There are very few if any risks because the research has been carefully designed. However, it is possible that during the interview I may uncover some feelings that I need to talk to someone else about, and I will be referred to the student counsellor on my home campus.

I am aware that I can contact Cathy Dickson or her supervisor(s) Assoc. Prof. Linette Lock (Telephone 02 95145153 or email lin.lock@uts.edu.au) or Dr. Michael Carey (telephone 02 95145138 or email Michael.carey@uts.edu.au) if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason. I understand that participation is in no way linked to my grades or progress in the Bachelor of Nursing at the University of Western Sydney. Whether I participate or not my relationship with the university will in no way change.
I agree that Cathy Dickson has answered all my questions fully and clearly.
I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

Signature (participant) _____Date_____

Signature (researcher or delegate) _____ Date_____

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph.: 02 9514 9615, Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome

Appendix B: Presentation & Peer Reviewed Conference Paper

GOANA confirmation 2007

"In my country nurses don't..."Australian undergraduate nurse education and the international culturally and linguistically different student.

Presented by: Cathy Dickson

Supervisors: Assoc. Prof. Linette Lock.

Dr. Michael Carey.

Introduction

- The changed face of the Australian nursing student.
- The increasing presence of international culturally and linguistically different students in schools of nursing.
- The clinical learning experience.

Nurse education in Australia

- Values & beliefs of a dominant western culture.
- International Council of Nurses (ICN) definition of nursing.
- Underlying assumptions.
- The importance of cultural theory to nurse education.

The importance of clinical practice experience

- Exposure to the reality of practice.
- Integration of explicit & tacit knowledge.
- Develops problem solving, critical thinking & decision making skills.
- Develops proficiency in the Australian Nursing & Midwifery Council (ANMC) core competencies.

What the Literature reveals

- Language & communication issues.
  - I. Communicating with patients
  - II. Understanding instructions
  - III. Using medical terminology
  - iv. Giving patient handover
  - v. Engaging with other team members
- Directly relates to the need for safe patient care.
- Level of communication skill is related to clinical learning, teaching and assessment.

What is missing in nursing literature?

- How do ICALD students reconcile their cultural values & beliefs to enable them to learn to nurse in the Australian clinical environment?

Preparation for clinical practice experience.

- Theoretical input and practical instruction.
- Simulation of
  - I. Vital signs monitoring
  - II. Full hygiene needs including toileting
  - III. Principles of aseptic technique (wound dressing)
  - Iv. Urinalysis

Student anxieties

- *In my country….nurses don't*
  - *I. Wash people*
  - *II. Need to think they just do what the doctor tells them*
- *In my country… nurses just*
  - *I. Give medications or attend the machines.*

Meaning for nurse academics

- Clinical performance.
- Student preparation.
- Overall expectations of ICALD students.
- Implications for clinical learning.

The proposed Doctoral research project

- Overall aim.
- Research objectives.
- Research question

What is the nature of learning to nurse through clinical practice experience for international culturally and linguistically different nursing students in Sydney, Australia?

- Significance.

Thank you & Questions

- I would like to thank ISANA for the opportunity to present my preliminary Doctoral work, and for the generous bursary awarded to me which made attendance at the conference possible.

Dhanyavad, namastay.

2007 ISANA International Conference "Student success in international education", 27-30 November, Stamford Grand, Glenelg, Adelaide, Australia

"In my country nurses don't..." Australian undergraduate nurse education and the international culturally and linguistically different student.

Cathy Dickson

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Abstract

International students enrolling in undergraduate nursing courses in Australian universities are an increasing presence. The literature in regard to enhancing international student success has concentrated on theoretical, or class room learning. For nursing, and other practice based disciplines success is also required in the practical learning experience. Clinical practice experience is recognised within the profession worldwide as an essential element of nurse education, for the development of competent and skilled registered nurses For those international culturally and linguistically different students entering Australian programmes this requirement is often difficult and challenging This paper will discuss Australian nurse education which is grounded in western values and beliefs regarding health and illness and the role of the nurse, and highlight the student anecdotes that lead to the development of a Doctoral research proposal asking the question what is the nature of learning to nurse in Australia for international culturally and linguistically different students?

Keywords

Nursing, cultural preconceptions, values and beliefs, clinical learning success.

Introduction

The face of the Australian nursing student has changed. Two underlying imperatives are driving this change, one from within the profession it self and the other from the tertiary education sector responsible for pre- registration nurse education. Firstly, prominent nurse leaders have called for the members of the profession to be more representative of the cultural diversity of the Australian population, a position supported by the National Review of Nursing Education (Commonwealth of Australia, 2001). Secondly, tertiary education institutions are responding to the need for increased financial accountability and profit generation by increasing recruitment of international full fee paying students. As Devos (2003) notes '…internationalisation is the means to supplement reduced public expenditure on higher education' (p.161). Further to this, Kilstoff and Baker (2006) suggest that international students may remain in Australia after completing their studies and become a welcome addition to the aging and depleted nursing workforce.

International culturally and linguistically different (ICALD) students enrolling in domestic undergraduate nursing programs are an increasing presence. Australia wide data on international nursing student enrolment for the years 2005 and 2006 shows strong growth at 42.3% and 35.4% respectively over the previous year's figures (Australian Education International [AEI],2007). In 2006, at one large Sydney university, approximately 12% of the first year student nurse cohort was comprised of international students. These students came from twenty two different countries where English was not the official language, and their birth culture not predominantly western (Office of the Academic Registrar 2006). The net result is student cohorts that are increasingly culturally and linguistically different from the traditional white female, mainstream domestic student (Dunn, 2000; Gerrish 1997; Yoder1997).

Whilst the literature identifies that the clinical learning experience can be stressful and anxiety provoking for any student, anecdotal evidence that led to the development of a doctoral study proposal, suggests that this situation is significantly more complex for ICALD students. International undergraduate nursing students typically arrive to begin their studies at the commencement of semester one. With little time to acculturate to the Australian culture. These students then, lack exposure to the Australian health care system and especially, the Australian concept of nursing. Therefore, learning and consequently proficiency in the clinical environment may be significantly impeded by disparity between the ICALD students' own beliefs and values about nursing, and reality in the Australian context. Spradley (1994 as cited in Spradley & McCurdy, 1994) defines culture as '…the acquired knowledge that people use to generate behaviour and interpret experience' (p. 14). If this is so, then those international students enrolling in the undergraduate program from cultural backgrounds other than the dominant Australian culture may have different expectations of what nursing is.

Nursing education in Australia

Nursing in education and practice in Australia is framed by the values, beliefs and expectations of a dominant western culture, inclusive of theoretical and practice underpinnings from other first world English speaking countries. Australian undergraduate education is pedagogically designed to meet the needs of Australian main stream students (Dunn 2000; Fuller 1997) and in addition, clinical practice experience prepares them to function in the Australian health care system. As these culturally derived values and beliefs are the frame - work within which clinical practice is undertaken, successful completion of the clinical practice experience for ICALD students with minimal understanding of both the tertiary education system and the Australian health care system is difficult. The clinical practice experience is an important compulsory educational requirement for pre-registration nursing students and is graded as satisfactory, unsatisfactory or above average at the university where the research will take place. Students must pass the clinical practice component each semester in order to progress through their degree.

The International Council of Nurses (n.d) defines nursing as encompassing

> Autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Inherent in this definition is that all practitioners of nursing world- wide share the same understanding of fundamental key points, such as the meaning of care or what constitutes a family. It is the remit of nurse education programmes, then to ensure that these shared understandings are global in nature. The challenge for Australian nurse educators arises when international culturally and linguistically different nursing students enter the study program and begin to question these fundamental key points ,or point out to the nurse educators that in their country nurses do not carry out basic roles and responsibilities as they are expected to perform here in Australia.

The profession of nursing acknowledges, through theory development that guides practice, the importance of avoiding ethnocentrism in providing care (Campinha-Bacote 2002; Leininger 2002; Ramsden 2002; Purnell 2005). When applied to nurse education theory assists the individual nurse in realizing that the self is a cultural bearer that has been influenced by historical, political and social interactions. What remains unknown is how nurses themselves come to accept and perform culturally appropriate care.

The importance of the clinical practice learning experience

Clinical practice experience at the undergraduate level is essential for the development of competent Registered Nurses. Exposure to the reality of professional practice and its integration of explicit and tacit knowledge is invaluable in producing skilled clinicians. By participating in clinical practice experiences, nursing students have the opportunity to translate theory into practice. Although the duration of clinical experience placements vary between universities conducting undergraduate nursing programs, the main focus remains the development of a supportive clinical learning environment for *all* students (Clare, Edwards, Brown & White 2003).

Clinical knowledge is about application of information or skill from the classrooms to real life practice interactions and situations. In order to achieve this complex task, students need to develop their knowledge by utilizing the skills of problem solving, critical thinking and decision-making (Gaberson & Oermann 1999). Real life clinical practice experience allows for this to occur. Multiple goals for the clinical practice experience can be identified from the literature and include; technical skill acquisition, development of interpersonal skills, socialisation to the informal and formal norms of the profession, familiarization with protocol and expectation of professional practice, and exposure to the socio-political health care arena (Chan 1999; Conway & McMillan 2000; Jackson & Mannix 2001). Furthermore, it enables the students to become proficient in the knowledge, skills, and attributes implicit in the Australian Nursing and Midwifery Council (ANMC) competencies (Napthine 1996; Williams, Wellard & Bethune 2001).

Whilst on clinical placement, nursing students are expected to demonstrate the humanistic and ethical values of nursing that are contextually and culturally bound within the Australian health care system. The dynamic clinical environment, the changing face of health care, and current trends in staffing challenge the way in which these goals are attained for our undergraduate students, especially those who are culturally and linguistically different.

What doe the literature reveal about the CALD student experience

International university students, who have English as an acquired language, have been the focus of research in nursing and other disciplines mainly because of their theoretical learning needs and adaptation to student life in a different campus culture. Currently, many documents identified in the literature do not distinguish between domestic and international CALD students. Therefore the assumption is made that CALD is an inclusive term in which international students remain hidden.

Whilst the emphasis on achievement of integrating theoretical knowledge with clinical skill remains undeniable for all student nurses, those who are not from the dominant culture have been identified as having difficulty with some aspects of the clinical learning experience. CALD student groups have been identified in the literature as having the most difficulty with language and communication (Abriam-Yago, Yoder & Kataoka-Yahiro 1999; Amaro, Abriab-Yago & Yoder 2006; Choi 2005; Dunn 2000; Shakya & Horsfall 2000). Language, the primary human communication medium, is a learned cultural behavior that is used to generate and interpret speech (Bonvillain 2006; Keesing 1964; Spradley & McCurdy 1994). It entails not only the spoken word but also written and nonverbal communication. Communication in nursing and the health care professions is complicated by the use of medical language, terminology and taxonomy, in which professionals must be conversant. This issue has great implications for success at all levels of the tertiary learning experience. For example CALD students on clinical practicum in Australia were noted as having difficulty with spending enough time communicating with patients, understanding instructions, using medical terminology, giving handover, and

engaging with other team members (Hussin 1999). Adverse effects of being unable to communicate effectively are reflected in poorer academic success and clinical performance than mainstream students and in more difficult social interactions with other students. Not only is verbal and nonverbal communication important in relating to patients, it is also fundamental to teaching and learning, assessment, and professional relationships (Burnard 2005).

The main issue pursued in the literature is that ICALD students are not adequately prepared to successfully engage in personal and professional communication. Because of this many programs and strategies exist dealing with communication issues, yet no single program has been identified or adopted as best practice. Theoretical and clinical learning experiences are identified as difficult for ICALD students from other health care professions besides nursing. Major health care professions have recognised the extent to which culture has on student's ability to reflect on learning, meet national competency standards and advocate for themselves. Of high importance is the impact of the clinical milieu on all undergraduate nursing students' performance, particularly for those students coming to terms with learning how to nurse in a different culture. Whilst communication and language remains undeniably important for competent professional practice, there remains the aspect of *how* these students reconcile their cultural values and beliefs related to nursing in the Australian context in order that they have an equal opportunity to succeed.

Preparation for the clinical experience

In the current curriculum, the first clinical placement takes place late in the second semester of the first year of the program. During the preceding semesters students have had both theoretical and practical instruction (in simulated hospital environments), regarding the nursing care they will be expected to perform. Typically these include; taking and recording of patients vital signs (temperature, blood pressure, and pulse), attend to patients full hygiene needs, apply and demonstrate the principles of aseptic technique in performing a simple dressing on a wound, perform a urinalysis (testing urine), and toileting patients. Reality shock of the first clinical placement is a recognized phenomenon in the literature for nursing students generally (Astin, Newton, McKenna, & Moore-Coulson 2005; Mitchell 2002). Concerns have arisen from both personal experience and anecdotal accounts that, often it is not until the international student has entered the clinical environment that difficulties become apparent that places them at risk of clinical failure.

Student anecdotes raising concern.

The following anecdotes were collected from personal experience by the author and from discussions with other colleagues, academic and clinical. Statements such as these were usually first voiced in the clinical laboratories where encounters with clients are simulated during the students first year of their degree. The students then carry these ideas into the clinical environment where the reality of having to perform these tasks becomes all too apparent.

In my country..... nurses don't wash people!!
Performing personal body care (PBC) is a fundamental aspect of western nursing practice (Grant, Giddings & Beale 2005). Assisting patients where necessary, with the activates of daily living (ADL) which includes personal cleansing (Holland 2004) would normally be considered part of daily nursing care in Australia. When nurses render assistance to patients in relation to hygiene needs, a situation occurs that has been identified as a therapeutic nursing ritual (Wolf 1993). This type of care giving enables the nurse to positively influence the patient through touch, massage and in just ' being there' or presenting (Lomborg, Bjorn, Dahl & Kirkevold 2005; Wilkin & Slevin 2004), and can thus be defined as therapeutic. Wolf (1993) proposes that performing PBC conveys the humanistic values of nursing. When international students refuse to perform PBC for their patients on clinical placement, they are in effect interpreted by Australian registered nurses as challenging these values.

It is true that all students of nursing must negotiate their own sociocultural values and beliefs about touch and intimacy (Grant et al 2005; Lawler 1991) and do go on to perform PBC as part of their care giving. The question that needs to be asked is do international students who make these types of statements do so from their cultural group orientation? And how do they negotiate this cultural difference?

In my country.... nurses don't need to think, they just do what the doctor tells them.
This type of comment is frequently heard when dealing with non-western students whose prior experience or understanding of nurses and nursing is informed by the medical dominance perspective. Nurses who have not

been encouraged to critically examine practice or engage with decision making processes are typically stereotyped as subordinate to doctors treated as handmaidens (Mannien 1998). These nurses are seen as not having a separate nursing knowledge base or autonomy in making nursing care decisions (Darbyshire & Gordon 2005).For example Nehring (2003) describes nursing practice in Qatar as being characterized by handmaiden to physician and servant to hospital with care policies written to minimize nurse's decision making. Western nursing students are encouraged to challenge the status quo and develop their critical thinking and reflective skills in order to progress knowledge development within the profession and provide high quality care (Parker & Clare 2004)

In my country nurses just give medications or attend the machines.

In relation to this account, a student was observed sitting at the nurses' station for extended periods of time, not participating in any of the expected nursing duties for the morning. When approached by the clinical facilitator and asked for an explanation the student explained that in his country of origin nurses did not perform any other duty than dispensing medications or attending to the associated technology. That all other duties were allocated to lesser qualified personnel. To focus upon the task of administering medications or attending to monitors attached to patients, only serves to undermine the humanistic values of nursing. It is interesting to note that throughout the western literature, research conducted on patients understanding of caring demonstrated the importance of nurses; being more interested in listening to the patient than completing tasks, responding and showing concern was comforting and reduced anxiety, and being near when the patient needed them (LaMonica, Oberst, Madea &Wolf 1986; Riemen 1986; Houstutler, Taft, & Snyder 1999).

Meaning for nurse academics

Clinical performance

Currently in the undergraduate curriculum offered at the University of Western Sydney, assessment in the clinical area is carried out by clinicians who are responsible for both the facilitation of learning and student assessment. These clinicians are employed on a seasonal basis by the university through industry partners who provide placements for students. Usually, facilitators are allocated to students on a 1:8 ratio. Individual students are then 'buddied' with a member of staff whom they work together in providing care to patients. These clinicians are accountable to four main stake holders, the university, the student, industry, and ultimately the recipient of care (Harding & Greig 1994).Clinical learning facilitators are required to; be current in practice; have the ability to identity appropriate learning opportunities in the clinical environment and possess the ability to objectively assess student performance. Inclusive in their role is the identification of students at risk of failing and the resultant interventions. Skill and competency assessment is based on the western notions of nursing articulated in the Australian Nursing and Midwifery Council competencies. Clinical facilitators are not offered any additional instruction in dealing with ICALD students.

Student preparation

International students, who enrol in the undergraduate nursing program at this university, are not offered additional cultural instruction prior to attending clinical placement within the health care system.

Overall expectations of ICALD students

From the personal observations made by the researcher the ICALD students are expected to assimilate and accept care giving the Australian western way like other mainstream domestic students. Whilst the literature has focused on classroom learning and the difficulties these student have in that context little is known regarding their transference into the clinical environment.

Implications

For nurse academics, these issues have serious implications. Firstly, nurse academics who are unit coordinators in the BN in conjunction with the Director of Clinical Education are accountable to the School of Nursing for developing competent registered nurses. Secondly, the School of Nursing is held accountable for clinical performance to the NSW Nurses and Midwives Board (the professional body responsible for granting registration as a nurse in NSW) for a period of five years once the student has graduated and registered. Thirdly, nurse academics are ethically and morally bound to provide quality undergraduate education and clinical experience that produces safe and competent Registered Nurses to the community at large. Consequently, nurse academics and clinical facilitators need to realise that ICALD students have different needs to mainstream domestic students to ensure success in the clinical environment. ICALD students need to be adequately prepared to enter the Australian clinical environment, and clinical facilitator should be adequately skilled in relation to specific needs of ICALD students. Therefore, it is imperative that research which brings these issues to light is conducted.

The proposed Doctoral research project

The overall aim of this study is to come to an understanding of how ICALD students learn to nurse in the Australian clinical context. This understanding will be facilitated by meeting the following research objectives;

- Describe the preconceptions ICALD students have about nursing roles and responsibilities.
- Explore the meaning of 'nursing' from the perspective of ICALD students.
- Suggest how these preconceptions and meanings affect learning and student performance in the clinical environment.

These objectives will be met by answering the research question - What is the nature of learning to nurse through clinical practice experience for international culturally and linguistically different nursing students in Sydney, Australia?

This study is significant for pre-registration undergraduate nursing education on three important levels. Firstly, the Australian nursing student cohort has changed and the methods generally used for teaching and assessing clinical competence have not. Secondly, as socialisation into the profession occurs primarily in the clinical environment, clinicians are not adequately prepared for students with different cultural backgrounds. Finally, nursing theory that underpins clinical practice and knowledge development is dominated by western nurse academics from nations such as Australia, the United Kingdom and the United States of America, and as such fails to recognise the values and beliefs of novice nurses from other cultures.

The preparation of these students, the provision of clinical education and methods of assessment will be examined in light of the findings of the proposed project. Results from the study will be used to improve clinical practice experience and enhance opportunities for learning for other ICALD students who are becoming an increasingly bigger group of students within one Australian university.

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Appendix C: UWS Workshop PowerPoint Slides

Clinical Facilitators Workshop

2010 The International Year of the Nurse

Welcome

- Dr.Christine Taylor –Acting Director of Clinical Education
- Cathy Dickson-Deputy Director of Clinical Education

Program for Today

- Cultural Awareness Workshop-Cathy Dickson
- Guest Speaker-Stephen Teo
- Morning tea
- Facilitator & Student Practices
- Lunch
- Unit Requirements & Content by Unit Coordinators 2010

Session 1-Cathy Dickson

- Working with iCALD students in the clinical learning environment

Objectives

- Greater understanding of students as judged by the students themselves
- A decrease in use of stereotypes
- Development of complex thinking about the students, which replaces the oversimplified explanations that students react negatively to
- Greater enjoyment of working with international students
- Better adjustment to the stress of working with international students
- Better job performance

Format

- Self assessment exercise
- Short presentation on international students
- Case studies
- Discussion
- Evaluation

Self Assessment Exercise

- Using the sheet of questions that you have been given, grade the ***level*** of the response you think you would be able to write.
- A for a comprehensive, accurate, excellent answer, B- good answer, C -adequate answer, D- inadequate answer, to E you would not know where to start (Brislin & Yoshida, 1994).

International Students- Australia Wide

(Export income top 4,AEI 2009.)

Nationality	2006-07	2007-08	2008-09
China	2,506	3,059	3,787
India	1,298	1,971	2,819
Republic of Korea	903	1,019	1,107
Malaysia	643	711	808

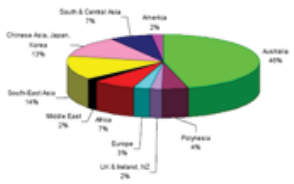
International Student Enrolment Trends in Nursing 2006-7(AEI,2009)

Table 1. Nursing enrolments YTD June 2006 and YTD June 2007 by Top 10 nationalities

Nationality	YTD June 2006	YTD June 2007	Growth
China	1,163	1,446	24.3%
India	288	772	168.1%
Republic of Korea	479	705	47.2%
Nepal	81	345	325.9%
Hong Kong	294	313	6.5%
Japan	222	245	10.4%
Malaysia	198	226	14.1%
Philippines	131	160	22.1%
Indonesia	142	159	12.0%
Zimbabwe	77	145	88.3%
Other nationalities	1,175	1,378	17.3%
Total (All nationalities)	**4,250**	**5,894**	**38.7%**

UWS SoNM Student Data

(BN 4642, May 2009).



All students: country of birth (N = 919)

Frameworks to Support International Students

- AQF
- ESOS- ***LEGISLATION MEANS THAT THIS IS LEGALY BINDING FOR INSTITUTIONS WHO ENROL INTERNATIONAL STUDENTS.***

Use of University Health and Counselling Services

International Student Adjustment

- Academic
- Psychological
- Social

So What About Nursing Students and Clinical?

Increasing International Students Ability to Cope

- Promote connectedness
- Encourage a balanced approach to study
- Faculties as the locus of contact
- Encourage the use of services

Why this model of intercultural interaction?

What is a Critical Incident?

- Incident- *any observable human activity that is sufficently complete in itself to permit inferences and predictions to be made about the person performing the act,* (Flanagan, 1954,p. 357).
- Critical- *the incident must occur n a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficently definite to leave little doubt concerning its effects* (Flanagan, 1954,p. 357).

Consider Critical Incident 1

You chose response 1- *Lin does not want to leave what she is doing as she finds it interesting.* Although plausable,this is not the best explaination for Lins behaviour.Please choose again.

You chose response 2- *Lin does not believe that it is her job to get the patient a bed pan.* Although plausable as in many cultures intimit personal care and toileting are carried out by the family, this is ot the best response her as it simplifies and ignores relevant factors.Please choose again

You chose response 3- *Lin does not know what the word bed pan means so to save embarrassment replies "OK".* This is the best answer.This task involves hearing the spoken word, interpreting it and performing an action.Visualising the bed pan in a text book and then hearing the word in the clinical area and making sense of the request can be stressful.Rather than make a mistake and bring the incorrect item Lin does not do anything to save embarassment.

You chose response 4- *Lin cannot understand your accent.* Once again this response has to do with language, but ignores the personal aspect of embarassment.

Critical Incident 1 Data

Lyn,23 from Zimbabwe 3rd year BN student

- "And then I just say ok and I went back to her …she said to me what did you say? And I ,and I, didn't know what the bed pan mean. I said what did you say? So she said to me again go and get me a bed pan OK? And I said can you come and show me what a bed pan mean?"

Consider Critical Incident 2

You chose response 1- *MMdoes not like being told where do.*
This is not the best explaination for MMs behaviour it is too simplistic and does not take into account other relevant factors.

You chose response 2- *MMis finding nursing different from what she expected.*This is the correct response.MMI has come from a country where the Registered Nurses' role takes a more medical focus and fundamental nursing care is undertaken by assistants.

You chose response 3- *MMdoes not like working with older patients.*Once again this response is too simplistic and does not take into account MMs age or possible cutural value of the elder in the community. PLease choose again.

You chose response 4- *The patient reminds MMof her grandmother in Poland* and this upsets her.This is a *good answer.Whilst many International students suffer* from home sickness this regonse ignores relvant information. Please choose again.

Critical Incident 2 Data

MI MI 27 years old from Poland.

- and I was on my clinical ok, 2 weeks ok, go to the shower and help people, that old lady dress up or something and I was like ummm ..Ok ok. [Looking down shaking head], what about the ? .....I was so interested in getting knowledge about new medications that I don't know, about syringes, why is there big? Why is there small? Why should I use that for? What kind of thing do I need to give that medication to that lady that sort of stuff? I thought while I'm in the hospital I will do more professional things.

The main aim of the Critical incidents?

- "If I had been raised in that culture and had had the kinds of experiences that she [sic] has had I would do exactly what she [sic] did" (Brislin, Bochner & Lonner, 1975,p.41)

Please redo your self assessment.

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CLINICAL FACILITATOR WORKSHOP MARCH 2011

UNIVERSITY TECHNOLOGY SYDNEY
FACULTY OF NURSING & MIDWIFERY
PROFESSIONAL DOCTORATE STUDENT CATHY DICKSON

Intercultural Interactions :Supporting ICALD Nursing Students in the Clinical learning Environment.

"You are welcome not to know." (MiMi, Polish, 27)

Working with critical incidents

Critical incidents potential areas of misunderstanding and intrapersonal conflict. Learning about the reasons for the behavior depicted in the incidents, facilitators have the opportunity to address how they view the behavior and gain the following benefits:-

1. Greater understanding of students judged by the students themselves
2. A decrease in use of stereotypes
3. Development of complex thinking about the students, which replaces the over simplified explanations that students react negatively to
4. Greater enjoyment of working with international students
5. Better adjustment to the stress of working with international students
6. Better job performance (Brislin et al.1986,p.24)

How well can you answer these 6 questions?

*How many international students are there in Australia and what are the 4 largest contributing countries?

A B C D E

*Why do international students come to Australia to study?

A B C D E

*What are the frameworks that support international students in Australia?

A B C D E

*What are the three most frequently used areas to describe the dynamics of a international students adjustment or accommodation?

A B C D E

*What are 2 or 3 reasons why an international student may *not* seek counselling?

A B C D E

*What are the characteristics most likely to determine an international students ability to cope?

A B C D E

Format

- **Self Assessment exercise**
- **Short presentation on international students**
- **Critical incidents**
- **Discussion**
- **Evaluation**

Be nice to me I want to learn
(Felisa, Chinese, 23)

"I am not an Australian nurse so may be I need some more experience " (Jane,27 India)

Critical incident 1

Lyn is a 20 year old first year student from Zimbabwe. This is her first clinical placement. You ask her to get you a bed pan for MR. Jenkins the patient in bed 3.Lin replies "OK" to you and just stands there. You say "What did you say?" and she replies again "OK". You repeat the request "Can you get me a bed pan please?" Lin still does not leave to get the bed pan.

Choose a response that explains this behaviour from the following:

1.Lin does not want to leave what she is doing as she finds it interesting.

2.Lin does not believe that it is her job to get the patient a bed pan.

3.Lin does not know what the word *bed pan* means so to save embarrassment replies OK

4.Lin cannot understand your accent

Critical incident 2

MiMi is 27 year old from Poland, is on a second year clinical placement and has become distracted from assisting her elderly patient to dress following a shower. You find her in the treatment room examining the various sizes of syringes, needles and vials of medication. You ask her to return to her patient to complete dressing and she does not appear impressed with your request.

Choose a response that explains this behaviour from the following:

1.MiMi does not like being told what to do.

2.MiMi is finding nursing different from what she expected.

3.MiMi does not like working with older patients.

4.The patient reminds Mi Mi of her grandmother in Poland and this upsets her.

•"If I had been raised in that culture and had had the kinds of experiences that she [sic] has had I would do exactly what she [sic] did" (Brislin, Bochner & Lonner, 1975,p.41)

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Appendix D: STTI Leadership Summit, Atlanta, Georgia, USA- PowerPoint Slides

The Doctoral Student:A unique opportunity for leadership development

Cathy Dickson R.N.R.M

- If I have the belief that I can do it, I will surely acquire the capacity to do it, even if I may not have it at the beginning

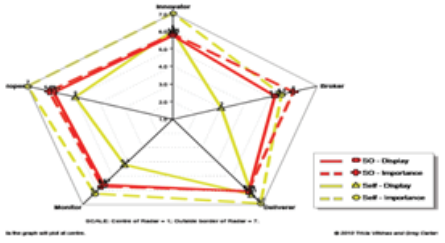
  - Mahatma Gandhi

Leadership Context

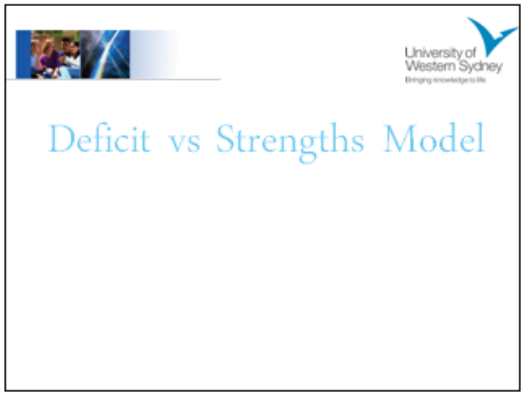
Leadership Model

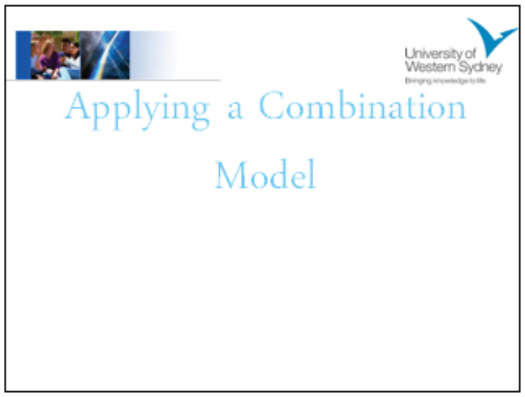
©T. Vilkinas, B. Leask and R. Ladyshewsky 2009

360 Feedback

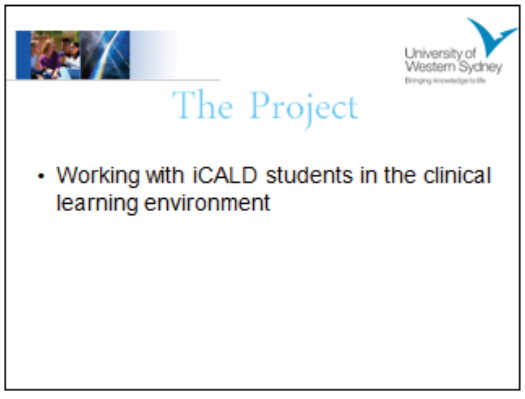



University of Western Sydney
Reflection


University of Western Sydney
Deficit vs Strengths Model


University of Western Sydney
Applying a Combination Model


University of Western Sydney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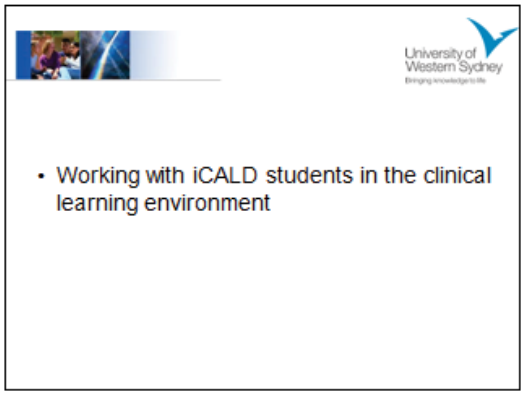
The Project
• Working with iCALD students in the clinical learning environment


University of Western Sydney
• Working with iCALD students in the clinical learning environment

Objectives

- Greater understanding of students as judged by the students themselves
- A decrease in use of stereotypes
- Development of complex thinking about the students, which replaces the oversimplified explainaitions that students react negatively to
- Greater enjoyment of working with international students
- Better adjustment to the stress of working with international students
- Better job performance

Format

- Self assessment exercise
- Short presentation on international students
- Case studies
- Discussion
- Evaluation

Self Assessment Exercise

- Using the sheet of questions that you have been given, grade the ***level*** of the response you think you would be able to write.
- A for a comprehensive, accurate, excellent answer, B- good answer, C -adequate answer, D- inadequate answer, to E you would not know where to start (Brislin & Yoshida, 1994).

International Students- Australia Wide

(Export income top 4,AEI 2009.)

Nationality	2006-07	2007-08	2008-09
China	2,506	3,059	3,787
India	1,298	1,971	2,819
Republic of Korea	903	1,019	1,107
Malaysia	643	711	808

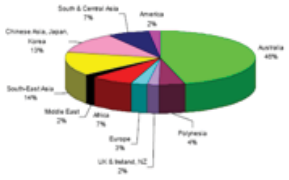
International Student Enrolment Trends in Nursing 2006-7(AEI,2009)

Table 1. Nursing enrolments YTD June 2006 and YTD June 2007 by Top 10 nationalities

Nationality	YTD June 2006	YTD June 2007	Growth
China	1,163	1,440	24.3%
India	286	772	168.1%
Republic of Korea	479	705	47.2%
Nepal	81	345	325.9%
Hong Kong	294	313	6.5%
Japan	222	245	10.4%
Malaysia	198	226	14.1%
Philippines	131	160	22.1%
Indonesia	142	159	12.0%
Zimbabwe	77	145	88.3%
Other nationalities	1,175	1,378	17.3%
Total (All nationalities)	4,250	5,894	38.7%

UWS SoNM Student Data

(BN 4642, May 2009).



All students: country of birth (*N* = 919)

Frameworks to Support International Students

- AQF
- ESOS- ***LEGISLATION M EANS THAT THIS IS LEGAL Y BINDING FOR INSTITUTIONS WHO ENROL INTERNATIONAL STUDENTS.***

Use of University Health and Counselling Services

International Student Adjustment

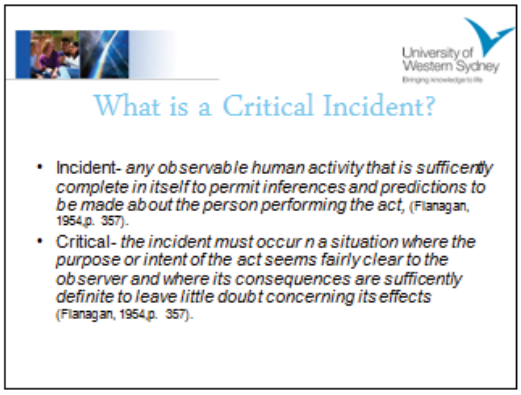
- Academic
- Psychological
- Social

So What About Nursing Students and Clinical?

Increasing International Students Ability to Cope

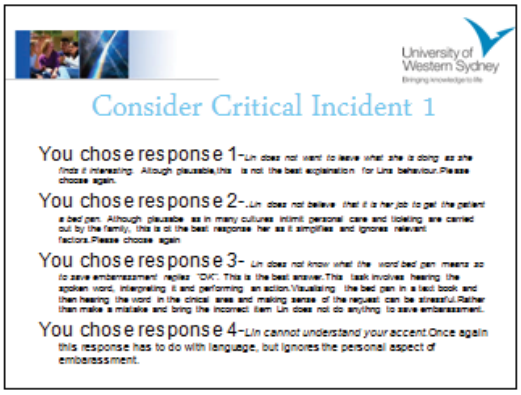
- Promote connectedness
- Encourage a balanced approach to study
- Faculties as the locus of contact
- Encourage the use of services

Why this model of intercultural interaction?



What is a Critical Incident?

- Incident- *any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act,* (Flanagan, 1954,p. 357).
- Critical- *the incident must occur n a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects* (Flanagan, 1954,p. 357).



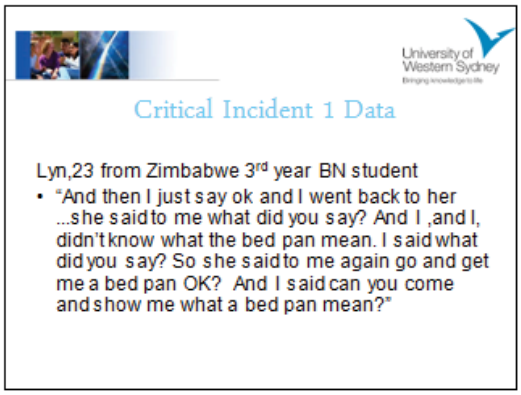
Consider Critical Incident 1

You chose response 1-*Lin does not want to leave what she is doing as she finds it interesting.* Although plausible,this is not the best explanation for Lins behaviour.Please choose again.

You chose response 2-*Lin does not believe that it is her job to get the patient a bed pan.* Although plausible as in many cultures intimit personal care and toileting are carried out by the family, this is of the best response her as it simplifies and ignores relevant factors.Please choose again

You chose response 3- *Lin does not know what the word bed pan means so to save embarrassment replies "OK". This is the best answer.This task involves hearing the spoken word, interpreting it and performing an action.Visualising the bed pan in a text book and then hearing the word in the clinical area and making sense of the request can be stressful.Rather than make a mistake and bring the incorrect item Lin does not do anything to save embarrassment.*

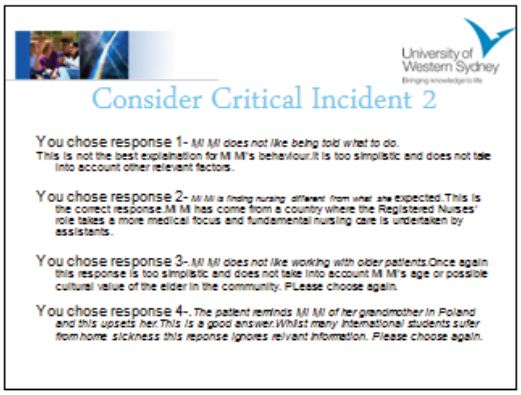
You chose response 4-*Lin cannot understand your accent.*Once again this response has to do with language, but ignores the personal aspect of embarassment.



Critical Incident 1 Data

Lyn,23 from Zimbabwe 3rd year BN student

- "And then I just say ok and I went back to her ...she said to me what did you say? And I ,and I, didn't know what the bed pan mean. I said what did you say? So she said to me again go and get me a bed pan OK? And I said can you come and show me what a bed pan mean?"



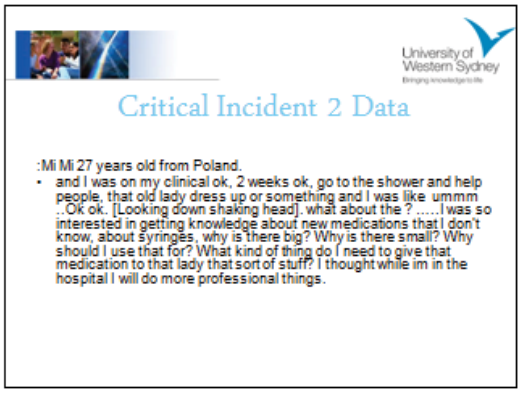
Consider Critical Incident 2

You chose response 1- *Mi Mi does not like being told what to do.* This is not the best explaination for Mi Mi's behaviour.It is too simplistic and does not take into account other relevant factors.

You chose response 2- *Mi Mi is finding nursing different from what she expected.*This is the correct response.Mi Mi has come from a country where the Registered Nurses' role takes a more medical focus and fundamental nursing care is undertaken by assistants.

You chose response 3- *Mi Mi does not like working with older patients.*Once again this response is too simplistic and does not take into account Mi Mi's age or possible cultural value of the elder in the community. PLease choose again.

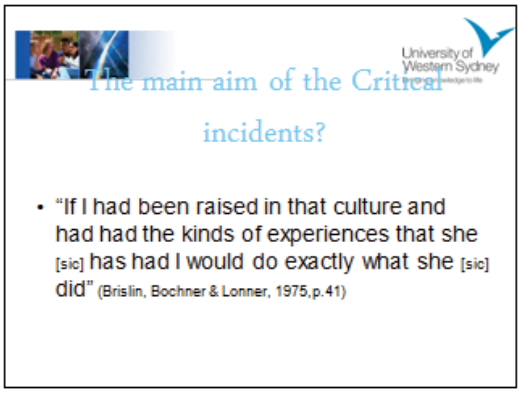
You chose response 4- *The patient reminds Mi Mi of her grandmother in Poland and this upsets her.This is a good answer.Whilst many international students suffer from home sickness this reponse ignores relvant information. Please choose again.*



Critical Incident 2 Data

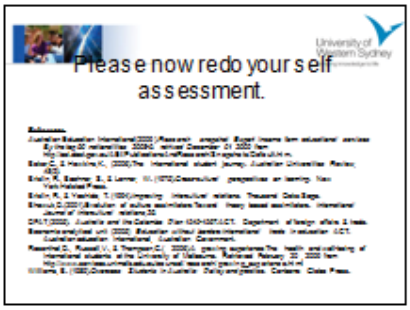
:Mi Mi 27 years old from Poland.

- and I was on my clinical ok, 2 weeks ok, go to the shower and help people, that old lady dress up or something and I was like ummm ..Ok ok. [Looking down shaking head]. what about the ? .....I was so interested in getting knowledge about new medications that I don't know, about syringes, why is there big? Why is there small? Why should I use that for? What kind of thing do I need to give that medication to that lady that sort of stuff? I thought while im in the hospital I will do more professional things.



The main aim of the Critical incidents?

- "If I had been raised in that culture and had had the kinds of experiences that she [sic] has had I would do exactly what she [sic] did" (Brislin, Bochner & Lonner, 1975,p.41)


Please now redo your self assessment.

Appendix E: Nursing Faculty Workshop UTS. PowerPoint Slides.

ARRIVALS
TIME TO TRAVEL

I want to be an Australian nurse

Clinical Learning Challenges for the International CALD Student

WWW.ARRIVALS.COM

ARRIVALS

What is Australian?

ARRIVALS

- respect for equal worth, dignity and freedom of the individual
- freedom of speech and association
- freedom of religion and a secular government
- support for parliamentary democracy and the rule of law
- equality under the law
- equality of men and women
- equality of opportunity
- peacefulness
- a spirit of egalitarianism that embraces tolerance, mutual respect, and compassion for those in need. Australia also holds firmly to the belief that no one should be disadvantaged on the basis of their country of birth, cultural heritage, language, gender or religious belief.

Who are Australians? Preliminary findings.

The students perspective

- Diversity of Australian population not expected
- Mates
- No worries
- The personal
- Family
- Boys and girls

They when I came here, they say white people they don't like Asians, nine out of ten white people don't like Asians. Because I have never been here I don't know. (Irene, p.11.)

Actually it was quite funny. Because the first time that I landed at the airport ummmm drove through the town, and I saw so many Asian people. I was like where are all the Aussies gone ? (laughing) I was really shocked. My father came with me and even he was a bit shocked it's like OK. (James p.12)

Why Do Students Come to Study in Australia?

- Australian education providers offer a high quality of education.
- It is a safe and secure place to live.
- It offers the experience of a new culture and lifestyle.
- It is possible to live close to a beautiful natural environment.

Why do students come to Australia study nursing? Preliminary findings.

Motivation

- Poor reputation of and remuneration for nurses in their home country
- Full filling obligations to family
- Chance for a new life
- Permanent residency

My parents told me, we love you go away but leave Poland and get good education. We will help you so you have good qualifications. So you can work in any normal country, for your job will give you decent money. That's why I'm here. (Mi Mi, p. 17)

What is Nursing?

ARRIVALS

Definition of Nursing ICN 2010

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

Students Beliefs About Nursing Preliminary findings

- *..um but my mums sister was a nurse so we were exposed to nursing pretty early in our life. But then, back home nursing is treated as, a not so good job as, we treat them as someone who wipes some ones bum, like a poo job, not really good(Yvonne,p.1).*
- *Oh ahhh the concept of that medical dominance is there in my country. The doctors think that they are really superior, and the nurses think that they are too much inferior. You do this, you do this, you do this! (Manoj,p.4).*
- *Um.... like I said I think just like giving medications, injections sort of things. Because the nurses in China, um they do not doing the showering or sponging things, they don't do that, the other people. May be here like the AIN. May be the AIN or the family doing that (Felisa,p.1).*

Entering the Clinical Environment

Preconceptions come alive

- In my country... nurses don't wash people!! Why?
- In my country... nurses don't need to think, they just do what the doctor tells them. Why?
- In my country... nurses just give medications or attend the machines. Why?
- All of these issues are very complex and are bound in the students individual cultural beliefs and values.

What is Know n by the Students About the Clinical Environment?

- Students typically arrive the day before or once first semester has commenced.
- Little or no knowledge of the Australian Health system
- Roles, responsibility and hierarchy remain relatively unknown until the first experience
- *You know that it was my 3rd day in the ED and previous to that I didn't really do much the ED.. I have never been there before it is a new department, as a new learning environment so the previous 2 days I just observe how they do things and I was planning to do that.. I knew for the first 2 days I would not have clue and that is my strategy (Milkyp.7).*

Functioning in the Clinical Environment

- The nature of nurses work comes as a shock to some, as liberation for others
- Cross check with Aussie students
- Task focused to pass
- Language issues- Australian English- Slang- ill patients- accent- age

... well back home most of the patients are illiterate and you don't have time to explain to them about the medication and if you do they wont understand it ..So the main idea is to get the job done, you just get the job done. Give the medications take this, this, this, this is for your this, this is for your that and so on the patient go. That in a way made me be short and curt in my patients skills, do this this this that's it and of the story . But here you have to go about it in a whole round bout way, you have to introduce your self, and of course we introduce yourself as well but not like here. Here is more of a social skills have to be really good, and that was what I was really worried about. (James,p.4)

IELTS Scores

ARRIVALS

What do they describe?

IELTS Band Scores	
9	Expert user
8	Very good user
7	Good user
6	Competent user
5	Modest user
4	Limited user
3	Extremely limited user
2	Intermittent user
1	Non user
0	Did not attempt the test

IELTS Bands

ARRIVALS

Where does nursing fit?

Band	Linguistically demanding academic courses e.g. Medicine, Law, Linguistics, Journalism	Linguistically less demanding academic courses e.g. Agriculture, Pure Mathematics, Technology, IT and Telecommunications	Linguistically demanding training courses e.g. Air Traffic Control, Engineering, Pure/Applied Sciences, Industrial Safety	Linguistically less demanding training courses e.g. Catering, Fire Services
7.5 – 9.0	Acceptable	Acceptable	Acceptable	Acceptable
7.0	Probably acceptable	Acceptable	Acceptable	Acceptable
6.5	English study needed	Probably acceptable	Acceptable	Acceptable
6.0	English study needed	English study needed	Probably acceptable	Acceptable
5.5	English study needed	English study needed	English study needed	Probably acceptable

Learning to be an Australian Nurse in the Clinical Environment

- Seek and find
- Acute observation
- Playing it safe

- *Another thing for me I really want to have an Australian facilitator. I have had facilitators from non English speaking, so I want to have an Australian facilitator because she knows more how to deal with the Australian patients over here. Ahh Lebanon, Portuguese, Scotland, I have had one from my own country. I would like to get to know the Australian facilitator. Yes, yea a feeling I should have one at least. I want to have a person who knows about this country, like if I have another non English speaking background person they are going to teach about their culture, it is similar to our culture (Jane, p.10).*

So What Are The Implications For Teaching?

- Understanding and Cognizance
- Preparation & Support for students
- Appropriate Preparation & Support for Facilitators, clinical team staff
- Legal responsibilities - ESOS Act

One Method Currently Used to Support Clinical Teaching Staff

Critical Incident Technique

- Greater understanding of students as judged by the students themselves
- A decrease in use of stereotypes
- Development of complex thinking about the students, which replaces the oversimplified explanations that students react negatively to
- Greater enjoyment of working with international CALD students
- Better adjustment to the stress of working with international CALD students
- Better job performance

Critical Incident 1 Example

- Lyn is a 20 year old first year student from Zimbabwe. This is her first clinical placement. You ask her to get you a bed pan for MR. Jenkins the patient in bed 3.Lin replies "OK" to you and just stands there. You say "What did you say?" and she replies again "OK". You repeat the request "Can you get me a bed pan please?" Lin still does not leave to get the bed pan.

Choose a response that explains this behaviour from the following:

1. Lin does not want to leave what she is doing as she finds it interesting.
2. Lin does not believe that it is her job to get the patient a bed pan.
3. Lin does not know what the word *bed pan* means so to save embarrassment replies OK
4. Lin cannot understand your accent.

Responses for Critical Incident 1

You chose response 1- *Lyn does not want to leave what she is doing as she finds it interesting.* Although plausable,this is not the best explanation for Lins behaviour.Please choose again.

You chose response 2- *Lyn does not believe that it is her job to get the patient a bed pan.* Although plausable as in many cultures intimate personal care and toileting are carried out by the family, this is as the best response her as it simplifies and ignores relevant factors.Please choose again

You chose response 3- *Lyn does not know what the word bed pan meansso to save embarrassment replied "OK".* This is the best answer.This task involves hearing the spoken word, interpreting it and performing an action.Visualising the bed pan in a text book and then hearing the word in the clinical area and making sense of the request can be stressful.Rather than make a mistake and bring the incorrect item Lin does not do anything to save embarassment.

You chose response 4- *Lyn cannot understand your accent.*Once again this response has to do with language, but ignores the personal aspect of embarassment.

Critical Incident 1 data

Lyn,23 from Zimbabwe 3rd year BN student

- "And then I just say ok and I went back to her ...she said to me what did you say? And I ,and I, didn't know what the bed pan mean. I said what did you say? So she said to me again go and get me a bed pan OK? And I said can you come and show me what a bed pan mean?"

Critical Incident 2 example

- MiMi is 27 year old from Poland, is on a second year clinical placement and has become distracted from assisting her elderly patient to dress following a shower. You find her in the treatment room examining the various sizes of syringes, needles and vials of medication. You ask her to return to her patient to complete dressing and she does not appear impressed with your request.

Choose a response that explains this behaviour from the following:

1. MiMi does not like being told what to do.
2. MiMi is finding nursing different from what she expected.
3. MiMi does not like working with older patients.
4. The patient reminds Mi Mi of her grandmother in Poland and this upsets her.

Critical Incident 2 Responses

You chose response 1- *Mi Mi does not like being told what to do.*
This is not the best explanation for Mi Mi's behaviourIt is too simplistic and does not take into account other relevant factors.

You chose response 2- *Mi Mi is finding nursing different from what she expected.*This is the correct response.Mi Mi has come from a country where the Registered Nurses' role takes a more medical focus and fundamental nursing care is undertaken by assistants.

You chose response 3- *Mi Mi does not like working with older patients.*Once again this response is too simplistic and does not take into account Mi Mi's age or possible cultural value of the older in the community. Please choose again.

You chose response 4-.*The patient reminds Mi Mi of her grandmother in Poland and this upsets her.*This is a good answer.Whilst many international students suffer from home sickness this response ignores relevant information. Please choose again.

Critical Incident 2 data

Mi Mi 27 years old from Poland.

- and I was on my clinical ok, 2 weeks ok, go to the shower and help people, that old lady dress up or something and I was like ummm ..Ok ok. [Looking down shaking head]. what about the ? ....I was so interested in getting knowledge about new medications that I don't know, about syringes, why is there big? Why is there small? Why should I use that for? What kind of thing do I need to give that medication to that lady that sort of stuff? I thought while I'm in the hospital I will do more professional things.

Main Aim of the Critical Incident Technique

- "If I had been raised in that culture and had had the kinds of experiences that she [sic] has had I would do exactly what she [sic] did (Brislin, Bochner & Lonner, 1975,p.41)."

- Questions??

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Appendix F: UTS Clinical Facilitators Workshop Briefing Day

Intercultural Interactions:Supporting ICALD Nursing Students in the Clinical Learning Environment

Cathy Dickson

Objectives

- Greater understanding of students as judged by the students themselves
- A decrease in use of stereotypes
- Development of complex thinking about the students, which replaces the oversimplified explanations that students react negatively to
- Greater enjoyment of working with international students
- Better adjustment to the stress of working with international students
- Better job performance

Format

- Self assessment exercise
- Short presentation on international students
- Case studies
- Discussion
- Evaluation

Self Assessment Exercise

- Using the sheet of questions that you have been given, grade the *level* of the response you think you would be able to write.
- A for a comprehensive, accurate, excellent answer, B- good answer, C - adequate answer, D- inadequate answer, to E you would not know where to start (Gibbs & Yoshida, 1994).

Short Presentation on International Students

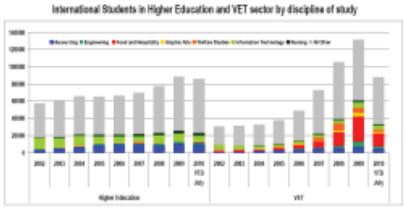
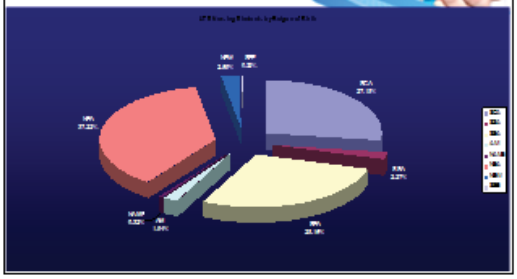


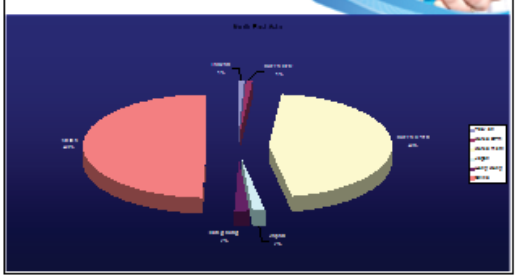
Table 9b: Higher Education Year To Date Commencements by Top 10 Nationalities by State/Territory for December 2010

Nationality	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
China	17,292	11,721	5,666	3,207	2,427	555	48	1,955	42,871
Malaysia	832	2,412	862	728	1,143	243	21	186	6,597
India	1,677	2,456	568	203	426	31	28	107	5,666
Viet Nam	1,344	1,028	993	203	276	37	4	145	4,730
Korea, Republic of (South)	1,558	913	872	172	159	61	2	82	3,896
Indonesia	1,102	1,552	229	121	466	4	13	89	3,946
Singapore	497	682	359	155	873	78	0	118	3,202
Saudi Arabia	873	894	594	219	331	73	0	122	2,928
Nepal	2,226	191	192	45	92	9	16	10	2,568
Thailand	724	919	245	45	104	29	2	41	1,883
Other nationalities	7,295	9,855	8,158	1,004	2,932	173	158	795	24,986
Total	36,640	29,671	17,888	6,424	8,548	1,295	240	3,271	102,536

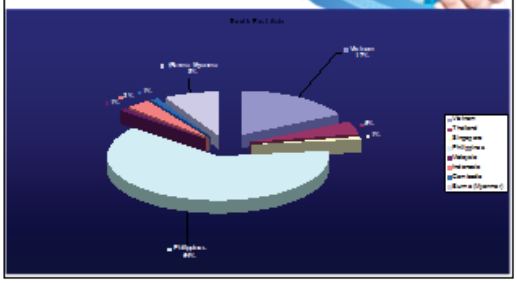
UTS International Nursing Students 2011



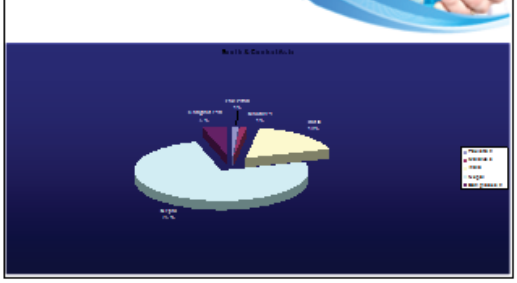
North East Asian Contributing Countries



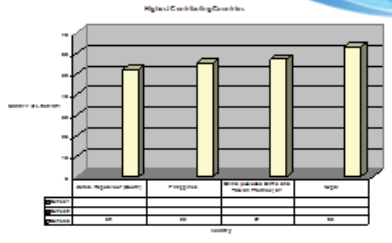
South East Asia Contributing Countries



South & Central Asia Contributing Countries



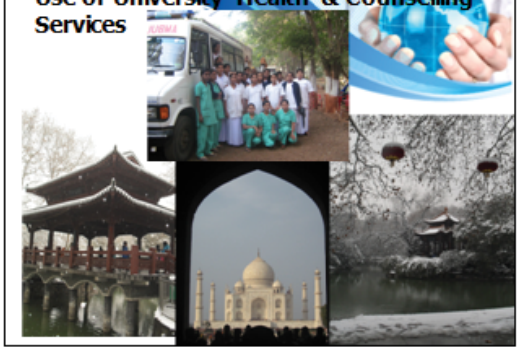
UTS Student Body



Frameworks to Support International Students

- AQF
- ESOS- *LEGISLATION MEANS THAT THIS IS LEGALY BINDING FOR INSTITUTIONS WHO ENROL INTERNATIONAL STUDENTS*

Use of University Health & Counselling Services



International Student Adjustment

- Academic
- Psychological
- Social

- So, What About Nursing Students on Clinical?

Increasing International students Ability to Cope

- Promote connectedness
- Encourage a balanced approach to study
- Faculties as the locus of contact
- Encourage the use of services

Case Studies Using the Critical Incident Approach

- Why this model of intercultural interaction?

What is a Critical Incident?

- Incident- *any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act,* (Flanagan, 1954,p. 357).
- Critical- *the incident must occur n a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects* (Flanagan, 1954,p. 357).

Take some time to consider critical incident 1

You chose response 1- *Lyn does not want to leave what she is doing so she finds it interesting.* Although plausible,this is not the best explaination for Lins behaviour.Please choose again.

You chose response 2- *Lyn does not believe that it is her job to get the patient a bed pan.* Although plausible as in many cultures intimit personal care and toileting are carried out by the family, this is ot the best response her ault simplifies and ignores relevant factors.Please choose again

You chose response 3- *Lyn does not know what the word bed pan means so to save embarrassment replies "OK".* This is the best answer.This task involves hearing the spoken word, interpreting it and performing an action.Visualising the bed pan in a text book and then hearing the word in the clinical area and making sense of the request can be stressful.Rather than make a mistake and bring the incorrect item Lin does not do anything to save embarrassment.

You chose response 4- *Lyn cannot understand your accent.*Once again this response has to do with language, but ignores the personal aspect of embarassment.

Critical Incident 1 Data

Lyn,23 from Zimbabwe 3rd year BN student

- "And then I just say ok and I went back to her ...she said to me what did you say? And I ,and I, didn't know what the bed pan mean. I said what did you say? So she said to me again go and get me a bed pan OK? And I said can you come and show me what a bed pan mean?"

Take some time to consider critical incident 2

You chose response 1- *Mi Mi does not like being told what to do*
This is not the best explaination for Mi Mi's behaviour.It is too simplistic and does not take into account other relevant factors.

You chose response 2- *Mi Mi finding nursing different from what she expected.* This is the correct response.Mi Mi has come from a country where the Registered Nurses' role takes a more medical focus and fundamental nursing care is undertaken by assistants.

You chose response 3- *Mi Mi does not like working with older patients.*Once again this response is too simplistic and does not take into account Mi Mi's age or possible cultural value of the older in the community. Please choose again.

You chose response 4- *The patient reminds Mi Mi of her grandmother in Poland and this upsets her.*This is a good answer.Whilst many international students suffer from home sickness this reponse ignores relvant information. Please choose again.

Critical Incident 2 Data

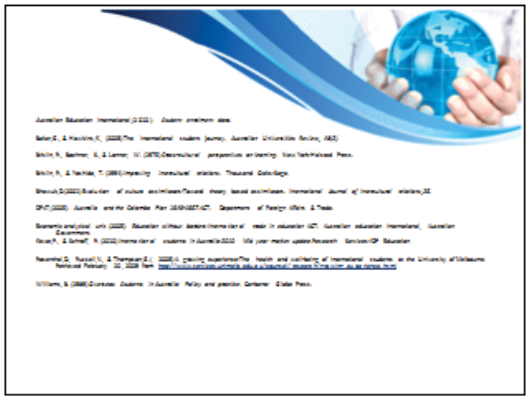
Mi Mi 27 years old from Poland.

- and I was on my clinical ok, 2 weeks ok, go to the shower and help people, that old lady dress up or something and I was like ummm ..Ok ok. [Looking down shaking head]. what about the ? ....I was so interested in getting knowledge about new medications that I don't know, about syringes, why is there big? Why is there small? Why should I use that for? What kind of thing do I need to give that medication to that lady that sort of stuff? I thought while I'm in the hospital I will do more professional things.

What is the Main Aim of the Critical Incident Technique?

- If I had been raised in that culture and had had the kinds of experiences that she (sic) has had I would do exactly what she (sic) did" (Gelin, Bochner & Lonner 1975,p.41)

- Please now redo your self assessment



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