THE LIVED EXPERIENCES OF

INDIAN NURSES WORKING IN THE UNITED STATES:

PERCEPTIONS AND ATTITUDES TOWARDS

NURSE-PHYSICIAN COLLABORATION

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ABSTRACT

Robyn Kathleen Hale

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Nurse-physician collaboration has received much attention over the past decade in the USA. The release of three reports from the Institute of Medicine implicated poor communication and collaboration among nurses and physicians as a major contributing factor to the incidence of sentinel events and medical errors.

Despite the growing awareness of the imperative related to collaboration between nurses and physicians to ensure patient safety, the problem of poor nurse-physician collaboration remains endemic throughout the country.

Indian nurses, along with many other internationally educated nurses, comprise 12-15.2% of the nursing workforce in the USA. Little is known about how Indian nurses culture potentially influences their ability to effectively collaborate with physicians to ensure patient safety.

The purpose of this study is to understand Indian nurses' attitudes and perceptions about nurse-physician collaboration.

Hermeneutic interpretive phenomenology as influenced by the work of Martin Heidegger guided this study through the use of interviews via Skype.

The overall experience of the Indian nurses was of one experiencing a dramatic positive change in nurse-physician collaboration in the USA as compared to India. Four themes emerged describing this phenomenon: Respect/feeling heard, Being Trusted, Assurance of Accountability, and Finding Freedom.

Indian nurses practicing in the USA find a freedom that empowers them to collaborate with physicians for patient safety. They, as all nurses may, benefit from continuing educational opportunities that demonstrate ways to collaborate more fully.

Mary L. Fisher, PhD, RN, Chair

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Chapter One: Background

Nurse-physician collaboration has received much attention over the past decade in the United States (U.S.) with the release of three reports from the Institute of Medicine implicating poor communication and collaboration among nurses and physicians to be a major contributing factor to the incidence of sentinel events and medical errors (IOM 2000, 2001, and 2003). The IOM (2000, *To Err is Human: Building a Safer Health System*) reporting their landmark findings, estimated that up to 98,000 Americans died annually in hospitals as a result of preventable medical errors. However, these numbers do not reflect the number of individuals who survive and are inflicted with a serious illness or disability as a result of preventable medical error. As a result of these findings, the IOM investigated multiple factors that contribute to preventable medical errors, such as, equipment failure, environmental factors, and human error. These findings provided the impetus for the IOM to conclude and subsequently mandate that all healthcare systems incorporate a new design for care delivery processes and practices that facilitates a safer environment for the prevention of future errors. In addition, the IOM recommended that healthcare organizations provide training programs that promote interdisciplinary teamwork and collaborative practices among all healthcare providers with the goal of ensuring patient safety.

The IOM's second report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2000), included core recommendations including the mandate for all health care professionals to be actively involved in programs focused on the development and proficiency of effectively working in interdisciplinary teams. In addition, the 2000 report outlined the imperative nature and importance of collaboration for the successful

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functioning of health care teams in the provision of improved patient care quality and safety. Additionally, the IOM (2000) instigated a major national effort to reduce medical errors by 50%. However, by 2005, the goal was far from being reached (Kwaan, 2006; Pronovost and et al., 2006; AHRQ, 2004).

The IOM's third report (2003), *Keeping Patients Safe: Transforming the Work Environment of Nurses,* revealed the risks to patient safety in the absence of adequate Registered Nurse (RN) staff, limited decision-making of nurses, inadequate work environments, and lack of collaboration among nurses and other health care professionals.

The findings in all the three IOM reports support the importance and serious need for healthcare organizations to cultivate a culture of interdisciplinary collaboration. In addition, these reports provide the significant benefits of interdisciplinary collaboration and teamwork for healthcare organizations that include: 1.) improved coordination and continuity of patient care, 2.) decreased lengths of stay and associated costs, and 3.) improved patient and clinical staff satisfaction. In spite of these findings and the benefits noted by the IOM. In addition, the findings in the research studies related to Magnet hospitals that will be discussed later. Many authors writing and studying nurse-physician collaboration assert that there still remains a lack of true interdisciplinary collaboration in most healthcare organizations. In addition, Burns and Thompson (2005), cite a "root cause analysis" conducted by the Joint Commission on Accreditation of Hospitals (JACHO) that identified communication as being the leading cause in nearly 70% of sentinel events (p. 257). According to the Joint Commission, a sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the

risk thereof. As a result of these staggering numbers of medical errors and sentinel events, the Joint Commission on Hospital Accreditation along with the IOM have mandated that healthcare organizations validate that they have systems in place in order to promote positive nurse-physician collaboration and to ensure patient safety. Despite this mandate, there still remains the problem of positive nurse-physician collaboration and the issue of patient safety (retrieved from www.jointcommission.org/sentinelevents).

In an attempt to understand the problem of nurse-physician collaboration, Hall (2005) points out that both physicians and nurses are limited in their exposure to interactions across disciplines and that both maintain a focus on interactions from the perspective of their respective roles with patients and families. Additional challenges in the study of nurse-physician collaboration have resulted from the differing disciplinary perspectives and differences in medical and nursing knowledge. For example, nurses' understandings of clinical situations tend to be predominantly founded on the relationship and knowledge that is discovered throughout the continuum in which they care for their patients. However, physicians tend to be more interested in measurable and factual understandings to determine appropriate medical diagnoses (Stein-Parbury and Liashchenko, 2007). This is evident in the differing models of practice between nurses and physicians with nurses focusing on "caring" and physicians focusing on "curing." Physicians tend to rely on biomedical knowledge, but nurses most often rely on knowledge of the patient. These differences of knowledge between nurses and physicians have been attributed to potential barriers to collaboration (Lopez and Keenan, 2011). A compounding factor is that nurses are taught to collaborate with other professions during their training, but physicians typically are not (Ashworth, 2000). This fact is validated in

the findings from a recent study by Weinberg and colleagues (2009) in which 20 medical and surgical residents were interviewed on their perceptions of collaboration with nurses. The authors state the resident's comments suggest that nurses don't need them to discuss patient's conditions with them, since they are there to merely follow their orders. Consequently, these residents have missed out on understanding the importance of collaborating with nurses as it has been found to dramatically improve the quality of patient care and to prevent medical errors and sentinel events as evidenced in the literature.

Significance of the Study

My own nursing observations related to collaboration with physicians, both in the U.S. and in India, led to exploring the literature for implications of one's culture on the ability to collaborate effectively to ensure patient safety. The topic of one's culture and its effect on collaboration among nurses and physicians was also of particular interest, since I had witnessed many encounters of nurse-physician collaboration in India in which "culture" appeared to play a significant role in the interactions that took place. The specific cultural factors that were noted included, issues related to hierarchy (physicians having societal status above nurses), and the concepts of saving face, gender, and power. As I considered the potential negative and/or positive effects that culture might play in nurse-physician collaborative relationships, I began to search the literature for studies that investigated the role of a healthcare provider's personal culture and its potential effect in securing collaborative relationships.

There are a plethora of studies that emphasize the importance of cultural sensitivity and competency for healthcare providers relating to patients in order to ensure

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patient safety (Schyve, 2007). These studies have led to the development of standards and position statements that promote cultural competence by the American Nurses Association (ANA), the American Medical Association (AMA), and many health care regulatory agencies (Engebretson, et al., 2008). Consequently, the focus is on provider to patient understanding, and little attention is given to considering one's culture as a potential barrier in provider-to-provider collaboration and interactions.

Fewster-Thuente and Velsor-Friedrich (2008) examined the factors that potentially enhance or inhibit nurse-physician collaboration, which may in turn affect patient and nursing outcomes. They identified such factors as gender, age, culture, and level of education of nurses and physicians that can directly affect the perceived level of collaboration (Baggs et al., 1997; Hojat et al., 2001 and 2003; Wear and Keck-McNulty, 2004). Despite this claim, rigorous studies still need to be done to provide empirical evidence of the importance of considering such factors for nurses and physicians in their interactions to ensure patient safety.

This inquiry could be of utmost importance, since it has been proven in the literature that a poor understanding of culture can negatively affect the provider to patient interaction (Majumbar et al., 2004; Johnstone and Kanitsaki, 2007; Schyve, 2007; Walker et al., 2010). How much more is the importance of understanding one's culture and its effect on the collaborative interactions of nurses and physicians to ensure patient safety? This is a critical gap that must be addressed in the future research of nurse-physician-collaboration.

The airline industry has long been working to understand the factors of "culture" that can prove to be barriers when there are pilots from differing cultures that are

collaborating during flights in order to ensure safety of their passengers. This research

has resulted due to the fact that the kinds of errors that cause plane crashes can be

attributed to errors of teamwork and communication (Gladwell, 2008). A significant

example is noted by Malcolm Gladwell (2008) in his book, *Outliers: The Story of*

Success. Gladwell explains the problem of "loss rate" that Korean Air faced between the

years of 1988 to 1998 that was seventeen times higher than any other airline in the world.

The problem with Korean Air became so dire that in April of 1999, Delta Airlines and

Air France suspended their flying partnership with Korean Air. In addition, the U.S.

Army forbade its personnel from flying with the airline. This was an especially

significant event for the airline, since the U.S. maintains troops in South Korea.

Gladwell goes on to describe events that facilitated the rebuilding of the

credibility of Korean Air with the world and the U.S. Federal Aviation Authority. It was

in 2000, that David Greenberg, an employee of Delta Airlines, was brought in by Korean

Air to run their flight operations. Greenberg's first step was to breakdown the deeply

imbedded roots of Korean hierarchy found in the Korean language resulting in mandating

that every pilot speak fluent English. He took this step to help the pilots break free of the

roles that had been dictated to them by the heavy weight of their cultural legacy that was

inculcated into their Korean language (Gladwell, 2008).

By 2000, Greenberg had successfully helped Korean Air to obtain a perfect safety

record and to achieve the designation by aviation experts to be as safe as any airline in

the world. Why was Greenberg successful in helping Korean Air to redeem itself? He

helped them to understand the role of culture and its ability to be a barrier or facilitator of

excellent communication and teamwork that ultimately affected the safety of airline passengers.

Pilot Study

In an attempt to gain greater insight into one's culture and its effect on nurse-physician collaboration, a pilot study was conducted. The Jefferson Scale of Attitudes toward Physician-Nurse Collaboration (JSANPC) (Hojat, 1999) tool was used with nurses and physicians from two different rural mission hospitals in northern India. Interestingly, the results were different from other studies published about nurse-physician collaboration. The nurses were found to have a significantly lower mean score, indicating more negative attitudes and perceptions towards nurse-physician collaboration compared to the physicians. This result was the impetus for the proposed research study. In addition, the United States Department of Labor (USDL) statistics projects a need for a 30 percent growth in the number of RN's by the year 2014 to ensure quality patient care and to meet population needs (Trossman, 2002; U.S. Bureau of Labor Statistics, 2006). Consequently, based on the current enrollments in nursing schools across the U.S., there will be a 17 percent shortfall in the needed RN's. Therefore, the recruitment efforts for foreign born RN's to be retained for the U.S. nursing workforce will continue and most likely increase rapidly by the year 2020 to meet the growing RN shortage (Davis and Nichols, 2002). Current statistics also reveal that the majority of IEN's working in the USA were recruited from the Philippines, India, Nigeria, Canada, Korea, the United Kingdom and the Commonwealth of States (formerly the U.S.S.R.; Trossman, 2002).

Purpose of the Study

The purpose of this study was to understand Indian nurses' attitudes and perceptions about nurse-physician collaboration in the USA due to the ever-growing population of Indian nurses trained in India, but working in the USA.

Aims

1. Describe the attitudes and perceptions of Indian nurses trained in India and now practicing in the U.S. towards nurse-physician collaboration in the USA.

2. Explore the perceptions of the participants' collaboration experiences and its effect on patient safety.

Definition of Terms

There are several terms that need defining for this study due to the complexity of the topic and when conducting research involving nurses and their experiences. The following conceptual definitions were used for the purpose of this study: Collaboration between nurses and physicians is a process of interactions that evidence a respect of another's knowledge and cultural background, effective communication, shared responsibility for problem solving, and a commitment to quality patient care.

Communication: Communication is a continuous process by which one person interacts with another through written or oral language, space, or other symbols (Giger and Davidhizar, 2004). Communication is the means by which culture is transmitted and preserved (Xu, Davidhizar, and Giger, 2005, p. 7).

Culture: The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (Office of Minority Health, 2001, p. 131). Culture is learned in that people learn the ways to see their environment—that is,

they learn from the environment how to see and interpret what they see (Spector, 2004, p. 10).

Internationally Educated Nurses (IEN's): Registered Nurses who were educated in a country outside of the U.S.A, but are practicing as RN's in the USA.

Contributions to Nursing Science

This study has strong implications for many areas of nursing that include practice, education, and the science of nursing. It is clear from the current statistics on IENs already present in the USA nursing workforce and future projections for more to be recruited that nursing leaders must be equipped with an understanding and knowledge of how to best assist IEN's in collaborating effectively with physicians. This can be accomplished through gaining a better understanding of the experiences, attitudes, and perceptions of nurses from India toward US nurse-physician collaboration to ensure patient safety.

Chapter Two: Review of the Literature

Evolution of the Study of Nurse-Physician Collaboration

Understanding the history of nurse-physician relationships helps to bring clarity to the reasons behind the slow process of developing positive communication systems and collaborative relationships among nurses and physicians. The nurse-physician relationship has evolved over time from a relationship that once entailed the nurse's role to serve as the physician's handmaiden to the current scenario of the nurse possessing knowledge to assess patient needs and to provide appropriate nursing care (Greenfield, 1999). As the nurse-physician relationship has evolved over time, there has been a lack of sufficient time provided in busy health care cultures for team building, professional socialization, and understanding of the other's role (Rafferty, Ball, and Aiken, 2001). Reese and Sontag (2001) assert that the underlying reason for a lack of positive collaboration models is due to physician education being focused on action and outcome and less on relationships. In contrast, nursing education tends to have a high level of focus on building relationships with patients and the members of the healthcare team. Leipzig and colleagues (2002) confirmed the negative effect of a lack of interprofessional training in their survey of 2nd year medical students, nurse practitioners, and graduate social work students. The 2nd year medical students as compared to the nurse practitioners and social work students were found to be much less positively inclined to accept their role as a team member and believed that they had the final say in patient care and at any time could change the plan of patient care without the consent of the team. These behaviors obviously negatively influence the development of positive nurse-physician collaboration.

Vazirani and colleagues (2005) assert that nurses' and physicians' differing

definitions and perceptions of collaboration may also be related to the lack of a truly

collaborative relationship in today's healthcare setting. Henneman, Lee, and Cohen

(1995) assert that the term "collaboration" has been noted by researchers to be difficult to

define due to its complex nature and varying definitions given to the concept. In addition,

they assert that researchers must adopt a clear and measurable definition of collaboration

in order to bring clarity to the practice setting and to provide a greater understanding for

future research.

Defining Collaboration

Merriam Webster's Collegiate Dictionary (2003) defines collaborate as "to labor

together" which is derived from the Latin word, collaborate. Additional definitions

include:

> to work jointly with others or together especially in an intellectual
> endeavor, to cooperate with or willingly assist an enemy of one's country
> and especially occupying force, and to cooperate with an agency or
> instrumentality with which one is not immediately connected.

Common interactional determinants mentioned in the literature associated with the

concept of collaboration related to nurses and physicians include: respect, interpersonal

trust, and open communication (San Martin-Rodriguez et. al, 2005). The American

Association of Critical Care Nurses emphasize in their standards for establishing and

sustaining healthy work environments "true collaboration is a process not an event"

(2005, p. 190). Henneman, Lee, and Cohen (1995) emphasize the fact that collaboration

is often associated with a bond, union, or partnership and is characterized by mutual goals

and commitments. In addition, critical attributes related to collaboration include: willing

participation, team approach, contribution of expertise, non-hierarchical relationship, and

power sharing based on knowledge and expertise versus role or title. Stein-Parburry and Liaschenko (2007) assert that collaboration involves direct and open communication, respect for different points of view, and mutual responsibility for problem solving. Traditionally, in healthcare, collaboration has been understood as the way in which nurses and physicians interact with one another when making clinical decisions (Baggs and et. al, 1993; Shortell and et al., 1994).

The American Nurses Association (1980) provides the following definition for collaboration: "Collaboration is a true partnership, in which power on both sides is valued by both, with recognition and acceptance of separate and combined spheres of activity and responsibility, mutual safeguarding of the legitimate interests of each party, and a commonality of goals that is recognized by both parties" (p. 7). In addition, the American Nurses Association, in its Code of Ethics for nurses (2001), provides the following standard for nurses and their relationships with colleagues and others: " the nurse values the distinctive contribution of individuals or groups, and collaborates to meet the shared goal of providing quality health services" (p. 9). The American Medical Association provides a similar standard in point two of its policy on *The Growing Nursing Shortage in the United States* which states that the AMA: "encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients." (retrieved from www.ama-asson.org). The only similarity in these definitions appears to be in the ultimate goal of nurses and physicians to provide quality patient care. However, they do not provide a clear understanding of how nurses and physicians actually achieve collaboration in order to provide quality patient care. In order to provide a frame of

reference, the definition of collaboration as defined by the American Nurses Association was used for this study.

Petri (2010) provides a significant contribution to defining the concept of collaboration as it relates to the interdisciplinary team in health care through her concept analysis of interdisciplinary collaboration. Petri brings to light that there remains to be a wide variation in the qualities that are held to make-up interdisciplinary collaboration. Consequently, this fact prohibits the comprehensive implementation of effective collaboration in health care. Adding to this problem, there are issues related to inconsistencies in the terms used to describe the concept, which may contribute to the numerous articles that address interdisciplinary collaboration without giving a formal definition for the concept.

Petri (2010) asserts that the antecedents that must be in place before interdisciplinary collaboration can be successful include interprofessional education, role awareness, interpersonal relationship skills, deliberate action, and support. The consequences of interdisciplinary collaboration include the benefits to the patient, the organization, and the healthcare provider. Petri (2010) also points out the three attributes of interdisciplinary collaboration noted throughout the nursing, medicine, and social work literature to include a problem-focused process, sharing, and working together.

Petri (2010) brings to light that there still remains a need for rigorous development of valid measures that will accurately evaluate interdisciplinary collaboration in health care. However, the definition of collaboration must be more clearly defined in order to be able to adequately evaluate interdisciplinary collaboration.

Intercultural Communication Link to Nurse-Physician Collaboration

There is a plethora of research studies that have been conducted to explore and facilitate positive nurse-to-patient and physician-to-patient communication through cultural sensitivity training programs (Majumbar and et. al, 2004). However, there is a lack of studies that explore the effect of one's cultural background/ethnicity and its effect on positive nurse-physician collaboration.

Majumbar (1999) found that those who had received cultural sensitivity training were more open, resilient, had increased self-confidence and tolerance, were nonjudgmental, able to deal with ambiguity, and capable of better understanding others. In addition, they also had improved skills in assessing verbal and nonverbal cues communicated to them by people who were from different backgrounds than themselves (p. 162).

Tjia et. al (2009), assert from their study on nurse-physician communication in the long-term care setting that language and/or accent was found to be a barrier to effective nurse-physician communication.

Porter O'Grady and Malloch (2007) point to the need for deliberate consideration of culture and its effect on effective communication. "Our deeply held internal images of how the world works have a powerful effect on how we listen and react to information. Putting aside our perceptions of power, money, gender, culture, physical appearance, and so on is simply impossible" (p. 187). This statement has merit in reinforcing the fact that more must be done to improve nurse-physician communication and collaboration through exploring the effect of specific role factors such as culture and its ultimate effect on patient outcomes.

Many studies over the past decade have predominantly been conducted in western countries and have measured the perceptions and attitudes of nurses and physicians toward collaboration. The findings have shown a correlation between nurse-physician collaboration and positive patient, fiscal, and staff satisfaction outcomes (Doughtery and Larson, 2005; Tschannen and Kalisch, 2008). Additional findings have shown that nurses and physicians do not share the same definition of collaboration which may be attributed to the historical pattern of nurse-physician relationships being one of "command and obey," along with issues that arise related to gender differences (Brimblecombe, 2005).

Theoretical Perspectives

Role theory has been the predominantly cited theoretical framework for studies on nurse-physician collaboration (Hojat and et. al, 2001 and 2003; Miller, 2004; McGarvey, Chambers, and Boore, 2004). However, these articles provide limited explanations about how role theory was used as a theoretical framework.

Role Theory Defined

Biddle (1979) provides the basis of role theory as an explanation of one's role by presuming that persons are members of social positions and hold expectations for their own behaviors and those of other persons based on those roles. In addition, he describes five propositions of role theory that include: 1.) Behaviors are patterned and are characteristic of people within contexts, 2.) Roles are associated with sets of people who share a common identity, 3) People often aware of roles and to some extent are governed by the fact of their awareness, 4.) Roles persist, in part, because of their consequences and embedment within larger social systems, 5.) People must be taught roles and may find either joy or sorrow in the performance (p. 8). These propositions are foundational to

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Role theory. Hardy and Conway (1988) in their book, *Role Theory: Perspectives for Health Professionals,* assert that role theory is derived from a compilation of works related to roles and is a viable framework for health care research. Miller (2004) states that role theory is pertinent to studying collaboration and quotes Hardy and Conway to validate this claim (p. 134). In addition to role theory, relationship-centered care has recently been cited as a theoretical framework. However, this framework is not considered to be theoretical but rather an ideology, nor is it solely centered on nurses and physicians, but rather the relationships among nurses/physicians with patients (Suchman, 2006). Relationship-centered care is defined as care in which all participants appreciate the importance of their relationships with one another (Beach and Inui, 2005). The conceptual map in Figure 1 was developed to provide a synthesis from the literature about the relationship of nurse-physician roles and their effect on collaboration and quality patient care.

Influence of Magnet Nursing on Nurse-Physician Collaboration

The concept of magnet was coined as a result of studies that were conducted in the 1980's during a significant nursing shortage in the USA. The studies that were conducted by nursing faculty and the American Academy of Nurses across the US focused on hospitals that were able to retain their nurses that acted like a magnet and hospitals that were not retaining their nurses. As a result of the studies in these hospitals, it was found that the hospitals that were able to retain their nurses had a culture that supported nurse autonomy, nurse control over practice, and positive nurse-physician collaboration.

Twenty years later, the American Nursing Credentialing Center (ANCC) (branch of the American Nurses Association) developed the Magnet accreditation process for hospitals to recognize excellence in their nursing practice and those hospitals that embodied a culture that reflected the 3 core values of nurse autonomy, nurse control over practice, and positive nurse-physician collaboration. Since that time, the ANCC has expanded the requirements for hospitals to achieve 14 standards, but still having the original 3 core values embedded in the requirements for hospitals to achieve Magnet designation.

Aiken and Havens (2000) assert that the Magnet model of nursing has been influential in facilitating a professional practice of nursing which include three core characteristics that include: 1) professional autonomy over practice, 2) nursing control over the practice environment, and 3) effective communication between nurses, physicians, and administrators. Hospitals that have successfully incorporated the Magnet Model of nursing and have received the prestigious Magnet designation by the ANCC, achieve significantly improved patient outcomes and demonstrate a culture committed to patient safety (Aiken, Sloane and Sochalski, 1998; Laschinger, Shamian and Thomson, 2001). The ANCC's Magnet program advocates for collaborative relationships among nurses and physicians in Force No. 13 of its 14 Forces of Magnetism, which is focused on Interdisciplinary Relationships and includes the following: 1) collaborative working relationships within and among the disciplines are valued, 2) mutual respect is based on the premise that all members of the healthcare team make essential and meaningful contributions in the achievement of clinical outcomes, and 3) conflict management

strategies are in place and are used effectively, when indicated"

(www.nursecredentialing.org/magnet).

Aiken and colleagues found in separate studies in 2000 and 2001 that hospitals

that possessed the Magnet core values, had nurses that experienced lower burnout and job

dissatisfaction, and higher levels of perceived quality of patient care. Therefore, these

studies validate multiple positive influences of hospitals that incorporated the Magnet

core values into their organizational culture.

More recent studies (Kramer, Maguire, and Brewer, 2011; Purdy et. al, 2010),

found that nurse work environments that foster collaboration and empowerment are

associated with positive effects on nurse assessed quality of care and positive nurse

perceived healthy work environments. Kramer and colleagues (2010) found in their study

with nurses from Magnet facilities that when there are structures in place that promote

interdisciplinary and intradisciplinary collaboration and decision-making there are

positive effects on nurses' perception of their work environment.

Empirical Developments with Nurse-Physician Collaboration

The state of the empirical research that is focused on nurse-physician

collaboration reflects the predominant theme of determining the attitudes and perceptions

of nurses and physicians towards collaboration and not on determining how to achieve or

evaluate the effectiveness of collaboration (Hojat et al., 2001 and 2003; Dechario et. al,

2001;Chaboyer and Patterson, 2001; Miller, 2001; Hansen et al., 1999). However, as

already mentioned, there have been significant findings in earlier research that has been

conducted in much of the magnet literature. Hospitals with magnet recognition have

demonstrated cultures that inculcate quality relationships between nurses and physicians,

and as a result have a high level of nurse job satisfaction and retention that have been

linked to improved patient outcomes, such as safe patient care (Aiken, Sloane and

Sochalski, 1998; Laschinger, Shamian and Thomson, 2001).

Doughtery and Larson (2005) reported, in their review of instruments measuring

nurse-physician collaboration, that it has been predominantly nurses who have done most

of the research in relation to collaboration. In earlier years, this fact was also true and

Fagin (1992) attributes this to physicians in general having a minimal interest in inter-

professional relationships due to a lack of education in interdisciplinary experiences in

communication, planning, and decision-making. Hall (2005) points out that not only

physicians but also nurses are limited in their exposure to interactions across disciplines,

and that both maintain a focus on interactions from the perspective of their respective

roles with patients and families. Additional challenges in the study of nurse/physician

collaboration have resulted from the differing disciplinary perspectives that include

nurses understanding of clinical situations to be predominantly founded on relational

understandings of patients. However, physicians tend to be more interested in measurable

and factual understandings (Stein-Parbury and Liashchenko, 2007). Ashworth (2000)

goes as far to say that nurses and physicians have not been socialized to collaborate with

one another, and as result do not consider that they should.

Much of the nurse-physician collaboration research conducted by nurses has been

based in Intensive Care Units (ICU) (Doughtery and Larson, 2005), and only recently

have there been studies conducted outside of the ICU, in Medical/Surgical and

Intrapartum areas (Thomson, 2007; Sleutel, Schultz, and Wyble, 2007; Simpson, James,

and Knox, 2006). Knaus (1986) asserts that nurse-physician collaboration originated in

the ICU's due to the higher acuity level of patients and the necessity to have on-going communication due to the constant changing status of patients in these units.

The predominant design over the past 10 years for much of the research conducted on nurse-physician collaboration has been non-experimental, descriptive studies. In addition, most studies were conducted by nurses or physicians and not both nurses and physicians together (Boyle, 2004; Hojat, 2001, 2003; Manojlovich and DeCicco, 2007). Zwarenstein and Bryant (2008), in their review of interventional studies of nurse-physician collaboration, found that only two studies qualified as randomized controlled trials (Curley, McEachern and Speroff, 1998; Jitapunkul et al., 1995).

Zwarenstein and Reeves (2006) go as far as to claim that few studies have demonstrated significantly improved nurse-physician collaboration after an intervention designed to increase the quality of patient care. However, Stein-Parbury and Liaschenko (2007) point out that collaboration between nurses and physicians is linked to positive patient outcomes. This conflicting fact provides valuable information when designing interventions to promote nurse-physician collaboration. There is much consideration that must be given to the factors that may or may not influence an intervention to promote nurse-physician collaboration, such as cultural background, gender, age, and educational background.

Several studies have linked collaboration with job satisfaction of not only nurses, but also physicians, as well as the retention of nurses (Baggs and Schmitt, 1997; Kramer, Maguire, and Brewer, 2011; Purdy, Laschinger, Finegan, Kerr, and Olivera, 2010). Studies that have focused on outcomes of nurse-physician collaboration have typically found that nurses tend to rate collaboration as more important than physicians' ratings

and have a higher positive attitude towards collaboration than physicians report (Hojat et al., 2001, 2003; Hamric and Blackwell, 2007).

Most studies conducted on nurse-physician collaboration, are limited to the USA and do not account for one's culture as an influencing factor of nurse-physician collaboration. However, there are several studies that use the Jefferson Scale of Attitudes toward Physician-Nurse collaboration (JSAPNC) (Hojat et al., 2001 and 2003; Aysegul et al., 2004; Garber et al., 2009). The JSAPNC tool (Hojat, 1999) was developed to determine if there was a link between one's culture, age, and level of education and one's attitude and perception toward nurse-physician collaboration. The tool is a 15-item survey, measured on a 4-point Likert-type scale with options including Strongly Disagree, Disagree, Agree, and Strongly Agree. The higher the mean score, the more positive is the individual's attitude and perception of nurse-physician collaboration. Psychometric testing of the tool demonstrated content and construct validity with a Cronbach's alpha of 0.85. In 2001 and 2003, Hojat and colleagues found in comparisons of different cultures such as Italy, Mexico, U.S., and Israel that there were differences by country in the attitudes and perceptions of nurses and physicians toward collaboration. However, in both studies, the nurses had more positive (higher mean scores) attitudes and perceptions of nurse-physician collaboration compared to the physicians from their respective countries.

Nurse-Physician Relationships in India

The nurse-physician relationship in India and its effect on patient care has received little attention in the literature, unlike the attention the topic has received in recent years in western countries. However, the role and history of nursing in patient care

in India provides a point of understanding into the challenges that nurses and physicians encounter in relation to the collaborative process required to ensure quality patient care.

Florence Nightingale played a significant role in elevating the once strongly negative status of nurses in India. In addition, Nightingale was responsible for bringing "modern" nursing to India during the time of the Crimean War (1853-1856). At the time Nightingale began work in India, nursing was viewed as a menial job and belonged to the lowest classes of society including Anglo-Indians and Indian Christians whose communities did not restrict them from taking up nursing as a profession (Raghavachari, 1990). Gradually over the years, especially after post-independence, women of higher classes who were once limited to work in the home, gained more independence and began to join the profession of nursing (Mohan, 1985). Verma (2007) found after interviewing a nurse in the major metropolitan city of New Delhi that physicians still are viewed as having a more prestigious profession compared to nurses and are seen to be much more competent in the eyes of Indian society. She goes as far as to point out that the press coverage of Indian nurses is often negative and provides the impression that nurses are uncaring. In addition, she goes on to say that, Indian society finds it necessary to have relatives present in the hospital to ensure that patients receive the care necessary to improve their health condition.

Despite the current day negative views of nursing in India that Verma brings to light, nursing has gained greater respect in society over the years. This is especially evident when considering the state of nursing before Florence Nightingale made her mark on nursing in India. However, many challenges remain for nurses, especially in their relationship with physicians. The relationship between the doctor and the nurse is

traditionally defined in terms of the authoritarian dependence syndrome. For example, the

doctor orders and the nurse obeys without questioning even if the patient may be harmed

(Raghavachari, 1990). This may be attributed to the concept of "saving face," which is a

cultural norm in Asian cultures such as India.

Scollon and Scollon (2001) define saving face as the negotiated public image,

mutually granted each other by participants in a communicative event (p. 45). Xu,

Davidhizar and Giger (2005) describe an example of saving face to include an Asian

nursing student answering yes when asked if she understood her professor's lectures.

However, she proved she had a significant misunderstanding and lack of knowledge as

evidenced by her poor grade received in the nursing course. The student's cultural

background led her to conceal her difficulties with understanding her professor, which

then most probably led her to believe that she would be showing a lack of respect and

appear to be rude to her professor if she did reveal that she was struggling to understand

the professor's lectures. In addition, the desire to maintain a harmonious relationship with

the professor outweighed the decision to confront a potential conflict that may arise if the

student discussed her problem with the professor. In the student's own cultural context,

she was able to save face and maintain what she perceived to be a harmonious

relationship with her professor.

In healthcare, the concept of saving face has the potential to be dangerous and to

impede patient safety. For example, if a nurse receives a medication order from a

physician in which she knows the medication is contraindicated with her patient's current

medications, but she does not question the physician and knowingly gives the wrong

medication, a negative patient outcome could result. When the nurse is confronted about

giving the contraindicated medication, she absolves herself of any blame without taking

responsibility of knowing that she gave a wrong medication and holds to her position that

she was right for following the physician's order.

This situation could also be attributed to the view of hierarchy in Indian culture.

Kakar and Kakar (2007) explain in their book, *The Indians: Portrait of a People*, the

internalization of hierarchy coincides with the acquisition of language. Children must

learn at an early age to identify with the position in which they are placed within the

family hierarchy. It is within an Indian's relative position within the family hierarchy that

his or her obligations to those above him and his or her expectations of those below him

or her influence how they relate to individuals for a lifetime. Despite any personal

achievements, talents, or changes in the circumstances of his or her own or in the lives of

others, the views, and responses to hierarchy are difficult to change. Consequently, there

is an automatic reverence for superiors from an early age that is a widespread

psychological fact for Indians. Since Indian institutions are markedly hierarchical,

collaborative teamwork across levels of status and power proves to be difficult (Kakar

and Kakar, 2007, p. 19).

My own experience of working with nurses and physicians in India has provided

me with some understanding to the cultural factors that may influence nurse-physician

collaboration. In addition, the pilot study that was conducted in India (the impetus for the

current study) with nurses and physicians using the JSAPNC tool provided some

significant results leading to the current study. Interestingly, the physicians in both

hospitals that were used in the pilot study were unlike many of the physicians with which

I have previously worked in India. The difference in these physicians was that they were

very keen to empower their nurses to think critically in solving clinical problems through

collaborating with them without shaming or scolding the nurses for what they would

deem as a wrong answer or improper way of carrying out their physician orders. Despite

this fact, the nurses from their hospitals in the study still had a lower positive attitude

toward collaboration, which was not what I had expected to find from this sample nor is

it congruent with findings from other studies using the JSAPNC tool in countries other

than the USA. This has led me to believe that there are certain cultural factors that are

embedded within the culture of India that cannot be denied that have an effect on how

nurses in this culture view collaboration with physicians. Such cultural factors that I have

observed that potentially effect nurse's views of collaboration with physicians include:

1. *India's collective culture as opposed to an individualistic culture*-Nurses differ to
   physician's opinions related to care of the patient instead of asserting their own
   opinion.

2. *Hierarchical structure within the culture*-physicians are seen to be in a higher
   class compared to nurses. Thus, inhibiting nurses from questioning a doctor, since
   this would be seen as disrespectful.

3. *The value society places on physicians compared to nurses*-physicians are much
   more highly valued than nurses are. This can be attributed to beliefs held within
   the predominant religion of Hinduism in India as a major influence in the
   beginnings of nursing in India. Hinduism beliefs include the view that to touch
   body fluids is to pollute one self. Consequently, it was the lowest caste of people
   that began in nursing and then later the Christian community, because they did not

hold to the Hindu negative view of touching body fluids, which is common in the practice of nursing.

4. *Lack of empowerment* of nurses to practice nursing due to the cultural constraints placed on nurses in India. This lack of empowerment is a consequence of the negative view of nurses and hierarchical structure of Indian culture that elevates the physician over the nurse, so much that society has a poor view of nurses.

5. The *role of women in society*-higher value is placed on men. This is seen even today with the high rate of abortion when it is determined that a woman is pregnant with a female child. In addition, in the rural areas, many girl children are left to die in the rice fields. A girl child is very costly to a family, because of the dowry (i.e. money, cattle, etc.) that must be given to the husband's family when she marries.

These cultural factors add to the many complexities of the culture of India. A few of these complexities include the differences found in Christianity and Hinduism and the influence of these religious beliefs on the culture of individuals in India. Christians have their roots in the southern state of Kerala where it is believed that St. Thomas of Syria, an apostle of Jesus, came and converted many to Christianity. As a result, these converts began the long history of Christians standing up against social injustices, setting up hospitals and homes for lepers. In contrast, individuals of the Hindu faith have been known for being very religious, but at the same time participants of the most immoral of religions (Kolanad, 2008).

Internationally Educated Nurses Practicing in the USA

The USA is again faced with another nursing shortage as evidenced by the US Labor of Statistics report of the need of 30% more nurses by 2014. Unfortunately, based on the current enrollment rates of nursing schools across the nation, the country will only be producing enough nurses to fill 17% of the needed 30% of nurses for the US nursing workforce (US Labor of Statistics, 2006). Consequently, there will be a 13% deficiency of nurses across the USA. This leads to the fact that many more nurses will be recruited from abroad to fill this gap. Currently, India is one of the top countries from which America recruits nurses, along with the Philippines and the UK (Kingma, 2007). IEN's make up a significant amount of the nursing workforce in the USA and comprise up to 12-15% (325,500-410,625) of nurses practicing in the USA (Aiken, 2007)

Much of the literature on IEN's practicing in the USA has focused on the nurse's acculturation process and have included issues with communication, understanding American culture, and the American way of nursing as the predominant struggle for these nurses. The practice of nursing is universal. However, how nursing is carried out is dependent upon the cultural context of the practice setting. (Bola, et al., 2003)

Gerrish and Griffith (2004) point out the fact that IEN's from developing countries have a major adjustment to differences in professional practice, since nursing practice is typically task oriented and controlled by physicians in these countries. In addition, IEN's have a lack of knowledge of cultural competency for the diverse cultural populations of the USA. This compounds with their own struggle to assimilate into American culture (Lin, 2009).

Sherman and Eggenberger (2008), in their qualitative study with Asian nurses and their acculturation to practicing nursing in the USA, included the following themes from the interviews with the nurses from India in their study:

1. Nurses in the USA have much more power than in India.
2. Nurses are more task-oriented in India than in the USA.
3. Nurses are expected to do physical assessments on patients in USA. However, even though it is taught in India, nurses do not routinely do them in India.
4. Nurses are responsible for more decision-making related to patient care in the USA.

Lopez (1990) asserts that the cultural factors of nurses from a collective culture have an effect on nurse-autonomy, ability to participate effectively in shared decision-making, and nurse-physician collaboration. Lin (2009) found similar findings in her synthesis of the literature on the acculturation of Asian nurses working in the US.

In 2003, the American Organization of Nurse Executives (AONE) issued a policy statement to nursing leaders in the USA urging health care organizations to create culturally sensitive and supportive environments for IEN's who are assimilating into the nursing workforce.

Sherman and Eggenberger (2008) found in their qualitative study interviewing nursing leaders that cultural differences of IEN's were a major theme. These differences included: lack of experience with nurse autonomy, accountability for patient assessment, technology, and assertiveness with supervisors and/or physicians. They also noted that the nurse leaders had significant appreciation for the IEN's as many of them explained that the IEN's added to the richness of diversity of their institution. In addition, on the whole, the IEN's had a very high retention rate compared to the U.S. nurses. Nursing leaders are further admonished to recognize IEN's for their significant and priceless

contribution to the U.S. nursing workforce. They bring their cultural uniqueness and wealth of knowledge that provides a broad perspective on communication, social organization, environmental control, and biological differences (Giger, Davidhizar, and Fordham, 2006).

Qualitative Research Methods

The qualitative research method weights its emphasis on understanding the human experience as it is lived. The data are typically gathered through the careful collection and analysis of qualitative materials that are narrative and subjective (Polit and Beck, 2004). My own experience in reading separate qualitative and quantitative research studies on a particular topic, has provided a greater understanding of statistical findings in quantitative studies through the findings presented in qualitative studies. For example, quantitative studies provide data in the form of numbers and statistics. However, qualitative studies are descriptive and provide meaning and understanding that is gained through words or pictures (Merriam, 1988). Thus, qualitative studies help to provide meaning and understanding to statistical data.

Creswell (1994) defines qualitative and quantitative research as the following: "A qualitative study is defined as an inquiry process of understanding, a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting. Alternatively, a quantitative study, consistent with the quantitative paradigm, is an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analyzed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true (p. 1-2)."

Qualitative research cannot by quantified. However, this fact does not make it any less valuable than quantitative research. On the contrary, it provides a window of understanding into lives and meanings that could not be captured using conventional testing measures that are used in quantitative research. It is more holistic and flexible than quantitative research methods. It allows for a deeper understanding of the subject matter and its effect on the lives of the persons in the population being studied (Farley and McLafferty, 2003).

Denzin and Lincoln (2005) explain qualitative research: Qualitative research involves the studied use and collection of a variety empirical materials—case study; personal experience; introspection; life story; interview; artifacts; cultural texts and productions; observational, historical, interactional, and visual texts—that describes routine and problematic moments and meanings individuals' lives (p. 3-4).

Qualitative inquiry was appropriate to studying nurses who trained in India and are now practicing in the USA, with the aim of discovering their perceptions of nurse-physician collaboration, since little is currently known about their experiences. I was not seeking to derive a theory about Indian nurses practicing in the USA. However, I was interested to discover the description of theses nurses' experiences with nurse-physician collaboration. Consequently, I used a phenomenological framework and methodology as a basis for understanding the experiences of Indian nurses with nurse-physician collaboration. "As a qualitative method, phenomenological analysis seeks to grasp holistically the 'lived experience' and the life worlds of study participants who share a particular experience in common" (Padgett, 2008, p.486).

Phenomenology

Phenomenology is complex related to the fact that it refers to a philosophical tradition as well as a research methodology (Jones, Torres, and Arminio, 2006; Speziale and Carpenter, 2007). "In its broadest sense, phenomenology refers to a person's construction of the meaning of a phenomenon, as opposed to the phenomenon as it exists external to the person. The phenomenon experienced and/or studied may be an event, a relationship, an emotion, or even an educational program" (Leedy, 1997, p. 161). "Phenomenological researchers particularly those of a descriptive bent, focus on what an experience means for persons who have had the experience and are able to provide a comprehensive description of it" (Schram, 2006, p. 98). The underlying assumption is that through conversation and reflection with persons who have had a particular experience, the researcher is able to glean the essence or fundamental meaning of an experience regardless of which "specific individual has had that experience" (Schram, p. 99). The goal of phenomenology is to describe lived experience" (Speziale and Carpenter, 2007, p. 77).

> Schram (2006) identifies five basic assumptions of phenomenologists:
>
> 1) Human behavior occurs and is understandable only in the context of relationships to things, people, events, and situations.
>
> 2) Perceptions present us with evidence of the world, not as the world is thought to be but as it is lived. Thus, understanding the everyday life of a group of people is a matter of understanding how those people perceive and act upon shared objects of experience.
>
> 3) The reality of anything is not "out there" in an objective or detached sense but is inextricably tied to one's consciousness of it. Phenomenologists discuss this idea in terms of the intentionality of consciousness. Accordingly, you cannot develop an understanding of a phenomenon apart from understanding people's experience of or with that phenomenon.

4) Language is the central medium through which meaning is constructed and conveyed. Thus, the meaning of a particular aspect of experience can be revealed through dialogue and reflection.

5) It is possible to understand and convey the essence, or central underlying meaning, of a particular concept or phenomenon as experienced by a number of individuals. This premise is associated primarily with descriptive phenomenology, an approach that rests on the thesis that essential structures constitute any human experience. (p. 99)

Hermeneutic interpretative phenomenology that is based on the philosophy of Martin Heidegger (1962) is a qualitative research methodology in which the meanings of the phenomenon in question are explained through gaining an understanding of the human experience (Diekelman and Ironside, 1998; Benner, 1994). It is through the application of hermeneutic interpretive phenomenology that narratives (interviews and observations) are employed to discover meanings behind practical acts of living (Crist and Tanner, 2003). Dreyfus (1991) explains that this type of methodology increases humans' way of being-in-the-world, as opposed to providing a theory for generalization or prediction of a phenomenon.

The Philosophy of Heidegger

Martin Heidegger, a 20th century German philosopher, attempted to move the focus of phenomenology to an ontological standpoint (how individuals interpret the world) instead of an epistemological viewpoint (why we know what we know) (Leonard, 1994).

Leonard (1994) provides an excellent framework for understanding Heidegger's concept of the person of which there are five key facets including:

1) Persons as having a world.
2) The person as a being for whom things have significance and value.
3) The person as self-interpreting.

4) The person as embodied.
5) The person in time. (Leonard, 1994, p. 46-54)

Persons as having a world:

"Researchers engaging in Heideggerian hermeneutic inquiry assume that human communities share an understanding of their lived experiences that is shaped by culture, language, and other social practices. This is not simply to imply that all persons hold the same understandings, but to indicate that understandings are shaped by experiences in particular worlds". (Baker, Norton, Young, and Ward, 1998, p. 549)

For example, nurses share a common understanding regarding the standards of practice of nursing, its history, educational requirements, and practice roles of the healthcare team. Nurses follow a standard of practice and code of ethics that is similar to Nursing Councils/Governing bodies (e.g. Indian Nurses Council in India and American Nurses Association in the USA) around the world.

Baker and colleagues (1998) describe the concept of worldview as referring to any community that shares a common understanding regarding life experiences, history, language and beliefs. All human beings partake in many communities based on race, gender, geographic location, economic status, marital status, religious affiliation, and profession/career. Therefore, any phenomenological interpretation is grounded in this same understanding of worldview within a particular "community."

Heidegger included in his concept of persons as having a world, the concept of "throwness" (Leonard, 1994). This means that persons are "thrown" into a particular place in time, race and culture, economic status, geographic location and family at birth. One's personal concept of self is established within the confines of the culture and world into which they were born. "In other words, world sets up possibilities for who a person

can become and who she cannot become" (Leonard, p. 48). A consequence of "throwness" that is experienced when an individual is thrown into a new world, she/he often encounters the Heideggarian principle of "breakdown." A person's concept of their world is generally unchanged until something happens out of the ordinary in how they experience their world, and then there is some form of "breakdown" (Leonard, 1994).

The recent shootings in Aurora, CO at a movie theatre on July 21st, 2012, where a 24 year old graduate neuroscience student open-fired and killed 12 individuals and injured 58, provides an example of "breakdown." The individuals, who were shot, were likely to have never thought their lives were in danger by going to a movie theatre, since this is a perceived safe place for the general public to go. Therefore, they would have experienced a significant sense of "breakdown" in their perception of their world.

The person as self-interpreting.

Heidegger describes human beings as being engaged in "interpretive understanding" in the context of our "linguistic and cultural traditions" (Leonard, 1994, p. 52). Leonard (1994) provides further understanding of the person as self-interpreting by his assertion that nothing can be encountered independent of our background of understanding. "Every encounter is an interpretation based on our background" (p. 52). To further clarify, we interpret our world based on our own personal perception that is influenced by the world we personally experience.

The person as embodied.

Leonard (1994) explains that from the standpoint of phenomenology, people do not have bodies, but rather are embodied. We are made conscious of experiences through our bodies and our senses (Speziale and Carpenter, 2007).

To bring greater understanding, Leonard (1994) asserts that nurses have a greater awareness as compared to medical doctors the need for patients to, "reclaim that sense of embodiment that allows for their taken-for-granted, unselfconscious transactions with the world" (p. 53). For example, if a nurse is working with a woman who has been a victim of a rape, there is an understanding that the patient does not only experience the physical trauma of the rape, but she is impacted within her emotions, cognition, spiritual beliefs, and understanding of herself. Another example to include Indian nurses would be the change that they must encounter as they transition from what they once knew in India was expected in their role with nurse-physician collaboration to the differing expectation that comes now that they are practicing in the USA. All that they had experienced with physicians in India effects how they will adjust to this new relationship with physicians in the USA. This fact is present, because this adjustment will mandate not just their knowledge of the differing practices of collaboration in USA as compared to India, but will also involve the nurses' emotions and their entire sense of self to effectively make this change.

The person in time.

Heidegger viewed time as essential to being. His concept of "being in time" can only be understood in the context of "having–been-ness and being expectant" (Leonard, 1994, p. 54). However, traditional Western notions of time are linear in nature (Leonard, 1994, p. 53). Under this notion, time is filled with a series of events that are related to one another in a successive way, but may be unrelated. An example of Indian nurse practicing in the USA may include a nurse's inclination to relate to physicians as she did in India which is a having-been-ness. A nurse being expectant includes an awareness that she

learned very quickly that nurse-physician relationships are very different in the USA, and she is expected by her employer to collaborate in a new way. The anxiety that may ensue due to the vast differences she encounters between India and the USA can be attributed to being influenced by her past and future.

Heidegger's philosophy of *Being in the World*, provides an understanding of what it means to be a person in a given experience and to know how that person views the world. Heidegger uses the term, *Dasein* to describe the aspect of being human that seeks to find meaning of *Being in the World* as a being in the world (Heidegger 1927/1962). For example, every human experience has a picture of that lived moment, and only the person who is having that particular experience can understand the meaning of the experience. However, it can be shared with others through using the process of interpretative phenomenology.

Heidegger's concept of "being" is significant for exploring Indian nurses' experiences with physician collaboration. The concept of being, according to Heidegger, will help to facilitate a better understanding of the nurses' experiences with the phenomenon, nurse-physician collaboration as it relates to their understanding of their being. The understanding of their being includes where they have been and where they come from (their cultural background) and its effect on them where they are now.

Gaps in the Literature

There are no studies that have addressed the importance of cultural competency among health care providers to ensure positive collaboration and patient safety. Given the profound emphasis that has been given with cultural competency for providers in relationship to patients, it would seem even more important to ensure cultural

competency for provider-to-provider interactions to ensure positive collaboration. In addition, there are no qualitative studies that have been conducted with nurses trained in India and now practicing in the USA and their perceptions of nurse-physician collaboration and its relation to patient safety.

Summary

Nurse-physician collaboration has been shown to be a significant factor in patient safety. In addition, the need for cultural competency among healthcare providers' cannot be denied as an imperative mandate to ensure safe patient care. In addition, the growing trend of recruitment of IEN's for the U.S. nursing workforce fuels the importance of the proposed study. This study not only has potential to inform the nursing and medical communities, but also all organizations that have employees that are from differing cultural backgrounds that must collaborate together to achieve positive outcomes.

Chapter Three: Methods

Design

Interpretive phenomenology as influenced by the work of Martin Heidegger was used to guide this study in gaining an understanding of the lived experience, attitudes, and perceptions of Indian nurses regarding nurse-physician collaboration. Heidegger's approach to phenomenology is interpretative in nature and allows the "phenomena to 'show themselves' in a way in which they are intelligible to human being" (Mitchell and Cody, 1993, p. 175). Consequently, a theory was not used, but an interpretative phenomenological approach based on the philosophical works of Heidegger was used.

Heidegger's philosophy of *Being-in-the-World* provides an understanding of what it means to be the person in a given experience and how the person views oneself in the world. This concept proposed by Heidegger was used to guide the study in order to illuminate the meaning and significance of the experiences, attitudes, and perceptions of Indian nurses practicing in the USA with nurse-physician collaboration.

Participants

The sample for this study included nurses who trained in India and are now practicing as nurses in the USA. 10 participants were selected using purposive sampling and snowballing techniques.

Inclusion criteria included:

1. Nurses of Indian origin who trained in nursing in India.

2. Indian nurses who are currently employed in nursing in the USA.

3. Indian nurses will have practiced in the USA for at least two years.

4. Indian nurses will be fluent in English.

5. Indian nurses will have access to a computer with the ability to do an interview through the use of Skype over the Internet.

6. Indian nurses who are local to the researcher may prefer and request an in-person interview.

Exclusion criteria included nurses:

1. Who are not of Indian origin.

2. Who did not complete training in nursing in India.

3. Not currently employed.

4. Who are not fluent in English

5. Who are not local to the researcher without access to a computer with the ability to do an interview through the use of Skype.

Procedures

Participants were recruited through the National Association of Indian Nurses of America (NAINA). NAINA is a national organization of professional nurses of Indian origin and heritage formed to identify and pursue the unique professional, social, cultural, and political need of its members. Their primary goal is to unite all Indian nurses as a professional body under one umbrella at the national level. NAINA is the official voice for Indian nurses in America and outside for professional nursing issues and problems (http://www.nainausa.com/about.html).

A letter was distributed by the NAINA president, Dr. Soleymole Kuruvilla to the distribution list of NAINA. The letter described the study and its purpose, explained study requirements, and included the contact information of the investigator. The prospective participants were asked to respond either by email or telephone to the

investigator of their interest in participating in the study after reviewing inclusion criteria. Once the study was explained and questions were answered, an interview time through te use of Skype or in person was arranged. My experience with Indian nurses practicing in the U.S. is that they are familiar with Skype as this is a popular means to talk with their family in India. The face-to-face or Skype interviews were arranged at the participant's convenience. Skype, an encrypted internet telephone/teleconference network was used to conduct interviews. Skype can be downloaded free to all Internet users and provides a secure Internet access for taped on camera interviews. This allows for a more natural setting to conduct interviews, because it provides face-to-face interaction for the interviewer and interviewee.

The interviews lasted approximately 30-60 minutes and were recorded through Skype for accuracy of the data collection. In addition, field notes related to information obtained during the interview were recorded. Face-to-face interviews with local participants were audio- or digitally recorded as well.

The interview began with the first question listed below. The other questions listed were used as probes as needed. Additional questions were added as the participant brought up topics or situations, as well as from previous interview information.

1. Tell me what does collaboration mean to you?

2. Describe a time when you felt that you had a positive collaborative experience with a physician?

3. Describe a time when you felt that you had a negative collaborative experience with a physician?

4. Describe a time when you felt that collaboration with a physician affected patient
    safety and/or care?

5. How has your view of nurse-physician collaboration changed over time?

Interviews were transcribed by one of the investigators or by a professional transcriptionist knowledgeable of IRB and HIPPA regulations. These interviews were de-identified and returned encrypted through email to the co-investigator once completed. By re-listening to the recording, the co-investigator verified the accuracy of the verbatim content of all the interviews.

Participants received a $20 gift card to a local store at the completion of the interview for participating in the interview.

Measures

Demographics: Demographic data gathered from participants included age, gender, state of origin in India, religion, years of experience as a nurse both in India and in the U.S., current title within nursing, membership status with NAINA, and educational level (e.g. BSN, MSN, etcetera).

Protection of Human Subjects

Permission to conduct the study was obtained from Indiana University Institutional Review Board. In addition, permission from the president of NAINA was obtained and a request made for information to be distributed to members and affiliates of NAINA of the opportunity to participate in the study.

Consent from the participants was obtained verbally from each participant just prior to conducting the interview.

It was made clear to the participants that they may excuse themselves from answering any questions and/or they may withdraw from the study at any time without a penalty. Benefits were explained to the participants to include the opportunity to share their story and knowledge of their experiences with nurse-physician collaboration. All data were kept in an encrypted file with access limited to the co-investigator. A study number was assigned to each participant, and no names were identified with the data that were collected. In order that all persons mentioned in the transcripts were protected, pseudonyms were used at the time of transcription. The protection of all confidential information was ensured throughout recruitment, data collection, data storage, data analysis, and dissemination of new information by strict adherence to HIPPA guidelines.

Data Analysis

A key component of interpretive phenomenology research is the interview with the participant and is the first level of analysis. It is through the interview that the researcher will be able to gain an understanding of the world as perceived by the participants as they are immersed in a transaction with the researcher. This method results in the ultimate goal of the interview being to understand the lived experience with a particular phenomenon from the point of view of the participants (O'Brien et al., 2009). Along with the verbal interaction that takes place during the interview, much more is happening that must be observed and considered when analyzing the verbal interaction. Thus, vocal inflections, facial expressions, gestures, and other non-verbal communication were documented in the researcher's field notes. In addition, any significant information relating to the interview setting was added to the transcript where appropriate.

The second level of analysis was the verbatim transcription of each interview as they were completed. This process enables the researcher to appropriately revise questions in order to gain the anticipated knowledge as themes from the interviews unveil themselves in the data.

The third level of analysis includes the interpretation of findings across the transcripts. This occurs as the researcher is immersed in the data and the identification of themes and patterns emerge. The collection of data was discontinued when it was evident that saturation of the data had been accomplished through the repetition of themes and patterns.

At the completion of the initial interpretation of data by the researcher, the interpretations were shared with the members of the IRB-approved hermeneutic circle at Indiana University School of Nursing. This group included two nursing faculty experienced in this method as well as the primary investigator for this study and graduate students learning to use interpretative phenomenology. The hermeneutic circle is the process of repeatedly returning to a text, or to the world, and finding a new interpretation of it each time we, or someone else sees it (Munhall, p. 111, 2007). In addition, Sloan (2002) asserts that the circle is helpful in controlling for the researcher's preconceptions and expectations.

Data analysis is not linear, but occurs in a helical fashion when keeping with Heidegger's hermeneutical circle. Sloan (2002) identifies three moments when interpretation occurs:

Moment 1. "In the moment" interpretations occur simultaneously with gathering the original narrative.

Moment 2. Interpretations of each individual narrative as an entity to itself.

Moment 3.   Interpretations of an ensemble of narratives collected across a life's work (to date) of inquiry (p. 129).

During "moment 1," researchers clarify with the participant the meaning of what is said. The researcher keeps field notes, which detail each interview in regard to thoughts and observations. In "moment 2", when typing up transcripts from interviews, the researcher takes note of any observations regarding body language and/or non-verbal expressions, with the intent to provide as much information regarding the original interview as possible. This is a significant moment in the process of analyzing the data, as it is during moment 2 that each individual transcript is analyzed alone for what is contained within that single narrative (Sloan, 2002). During "moment 3", the narratives are analyzed collectively to reveal patterns of meaning that are shared by all interviews.

The hermeneutic process allowed for the examination of patterns and themes from all of the narratives and to determine the continuity of them or to determine if there were different themes and patterns that emerged from the data. The engagement of the research team allows for the most accurate interpretations of the data through the process of, "engaging in cycles of understanding, interpretation, and critique" (Benner, 1994, p. 116).

Unlike quantitative research studies that seek to demonstrate validity, qualitative research focuses on establishing trustworthiness or credibility. In addition, qualitative research seeks to determine consistency in the findings among the participants in the study and the reviewers of the interviews. The data are considered saturated when there is adequate consistency among the themes and/or patterns that emerge from the data (Struebert and Carpenter, 2003). Generalizability or predictability of the findings that is determined in quantitative research will not be determined using this methodology.

However, it is the usefulness of the data as it provides understanding to the phenomenon being studied that is determined in this interpretative research study (Sloan, 2002).

From this work, it was intended that the readers would gain an understanding of the experiences, attitudes, and perceptions of Indian nurses practicing in the USA with nurse-physician collaboration. In addition, nursing managers/leaders would have a greater awareness and sensitivity to nurses who trained in India and their experiences and perceptions of nurse-physician collaboration. Consequently, receiving this knowledge would facilitate a more effective approach to helping these nurses in collaborating with physicians in the USA to ensure safe patient care.

Summary

This chapter provides a brief discussion of the methodology of interpretative phenomenology, which was used to guide this research. Participants were recruited using purposive sampling with snowballing through an email that was sent out by the President of NAINA to all chapter presidents that was subsequently sent to their contacts/chapter members with an invitation to participate in the study. The snowballing technique was facilitated by the chapter presidents of NAINA who were able to not only help recruit from their chapter members, but also from their acquaintances who would fit the study criteria. Study approval was obtained from the IRB of a large Midwestern university. Participants' privacy was assured through necessary precautions. The materials, which included the de-identified transcribed interviews and field notes, used in the study as well as in the collection of data were discussed with each of the participants before conducting the interview.

A brief discussion of rigor in qualitative research was outlined along with limitations and strengths of a recently proposed framework for the assessment of rigor in the nursing literature.

Chapter Four: Findings

Hermeneutic phenomenology seeks to reveal what has been concealed. To understand this concept better, Heidegger (1962) explains, "Discourse is the meaningful discourse of the understandable structure of being-in-the-world" (p. 204). Consequently, being in the world is never fully defined by Heidegger. However, Guigon (2006, p. 11) describes being in the world as our everyday contextual experiences that are inseparable from our practical everyday involvements in the world in which one exists. The researcher was able to gain an understanding and practical knowledge of what it is like for Indian nurses to live in this world. This was done through the process of interviewing and interpreting the narratives as the nurses revealed their experiences with nurse-physician collaboration.

As described in Chapter three, interviews were conducted through the use of Skype, an encrypted Internet telephone service or in person when the participant was geographically accessible to the researcher. Seven interviews were conducted through the use of Skype on the Internet, and two were conducted face-to-face. Each interview lasted approximately 30-60 minutes. Below is a table describing the Biodemographics of the participants.

Table 1. Biodemographic Data

Educational level	Mean years of practice in India	Mean years of practice in USA	Indian state of origin	Religious affiliation
GNM-n=5	4.6 years	10.2 years	Bengal-n=1	Catholic-n=2
BSc.-n=3			Kerala- n=7	Christian-n=6
MSc.-n=1			Punjab-n=1	Hindu-n=1

Overview of the Findings

The majority of participants did not fill-out the Biodemographic data sheet that was sent electronically to them before the interview. Therefore, these questions were answered before the start of the interview. As a result, it appeared the time provided to answer these questions with the researcher before beginning the interview, the interviewee was more at ease and comfortable with answering the researcher's questions. This may also be attributed to the ability of the researcher to identify with being familiar with India due to her experience with working as a Nursing Administrator there for 4 years.

The probes were revised after the third interview to elicit more information and to provide clarity and understanding of the concept of collaboration for the interviewees. In addition, the president of NAINA, Dr. Solyemole Kuruvilla was consulted on how probes might be revised in order to allow for a greater understanding of the concept of collaboration, so that the interviewee might be able to answer the probes more fully. This was done as a result of the researcher perceiving that the interviewee's understanding of collaboration may need to be redefined when asking questions related to the concept of collaboration. For example, the question, "What does collaboration mean to you?" was revised to, "What does the professional relationship between nurses and physicians mean to you?"

Once the interviews were completed, the interviews were transcribed verbatim, deidentified, and shared with members of the Hermeneutic Circle for members' individual interpretation. Each member of the circle read an interview and presented their interpretation as a gift to the researcher. Themes and patterns were identified in

individual interviews and across all interviews. Through on-going discussions with the

members of the Hermeneutic Circle, the most meaningful and accurate interpretations

were determined. Table 1 below displays the themes that emerged from the participant

interviews and briefly describe what positive nurse-physician collaboration meant to

them through the quotes provided in the table. A detailed discussion of these findings

follows Table 1.

Table 2. Summary of Emerging Themes from Participant Interviews

Emerging themes from participant interviews	Participant statement providing example of emerging theme
1. Respect/feeling heard	*"Some of the doctors, that is on our floor, the chief doctors, they want nurse, charge nurses, for better communication. It is a good idea, and our chief doctor tried to hear their decision and to hear our concerns regarding each patient and it is a good thing, and we really welcome that."* Shalini
2. Being trusted	*"If the patient has changes, I call and tell them (doctors). They trust me"* Sangeetha
3. Assurance of accountability	*"Here I realized that everyone, even the physicians, supervisor nurse, nurse, everyone works in an environment where the team is collegial. If I would give the wrong medication or treatment and something happens the patient is going to sue me. But in India we not bothered about that."* Priya
4. Finding freedom (to practice nursing as they were taught in India, but never able to practice due to cultural constraints)	Describing the differences between USA and India, "*in the US nurses have the freedom to think, to use their brains*". Preety

Theme One: Respect/Feeling Heard. Theme one of respect/feeling heard

establishes the nurse's recognition of a key component to effective nurse-physician

collaboration. Many of the narratives revealed that the nurses' experiences in India were

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much different from the USA in regards to respect that they received from physicians. Participants describe their perception in regards to respect from physicians towards nurses while practicing in India as compared to the USA.

Summana, who is 35 years old from southern India who practiced in India for 5 years and now 9 years in the USA, described her experiences as follows:

> " Back in India, it's hard to have a good communication unless you
> make friends with the doctors. In the unit I stay in, when they
> come for rounds we have to be, the nurses have to be ready. They
> don't give us any respect at all; the doctors don't give any respect
> shown to the nurses. Some senior nurses, they will talk to the
> doctors, but the junior nurses, like the new grads, really cannot
> communicate with the doctors. They're working for them, you
> know? They don't have a good relationship with the doctors."

Sumanna makes clear through her experience in India the importance of respect in the nurse-physician relationship. However, what she previously experienced in India with physicians did not include respect.

For Sangeetha, who is 60 years old from Southern India who practiced in India for 2 years and now 33 years in the USA, describes how she feels that respect is a key component to the collaborative process between nurses and physicians. She has spent the majority of her nursing career in the USA, so she describes about her experiences here in the USA.

> "So they respect me a lot for my experience. I just tell them if the
> patient is deteriorating, and I call them and say okay so and so (a
> patient) has changes, and I need this patient to be moved to (a
> Cardiac ICU). They (the doctors) take us (nurses) very seriously
> and they say go ahead and, say I'll be right there and (will send the
> patient to the necessary unit for the appropriate level of care)."

Sangeetha goes on to explain how collaboration is not just something that happens, but it is a process that is built upon every interaction between nurses and

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physicians. In addition, she points out that respect is contingent on having a foundation of

trust between both nurses and physicians.

> "If the patient changes, I call and tell them (doctors). They trust me
> (with the physical findings I find on the patient). So they are really
> okay. They give me orders right back (to be able to care for my
> patients) and we take care of that like that."

Heidegger's concept of "being" resonates with Sangeetha's description of her

experiences with nurse-physician collaboration. Over time, her understanding of her

"being" has included where she has been and where she has come from (her cultural

background) and its effect on her where she is now. Just as nurses and physicians have

had to welcome the other discipline into a relationship of collaboration over time, so has

Sangeetha as she moved from practicing nursing in India to the USA. She also explains

that as she gained this understanding there was the development of trust, which builds

respect between nurses and physicians.

> "So you learned to collaborate with the doctors and call them and
> to have confidence. As (you get) more experience you are close to
> the doctor. In the beginning it's hard, and they ask you questions
> you don't know the answer, so you put your ducks in a row before
> you call them, so you know what you're going to tell them."

> Now in the past few years, if you find something, you call them
> and they thank you so much. (And they will say), I think that's a
> great idea, let's do it. So they're having more willingness to listen,
> more agreeing, and work together as a team and are more
> supporting and appreciating to the nurses what we do and what
> kind of problems (we face).

> It's like the patient potassium level is 1.2 and normally 2 or above
> and I know the patients are (in trouble). Or a patient is having
> (chest pain and I would ask the doctor) would you like me to get a
> (nitroglycerin tablet). (And the doctor will say), Okay, that is a
> great idea, call and get one."

In an effort to better understand the barriers to respect for physicians to nurses in

India, I asked Summana why she thought doctors did not give respect to nurses and she

replied:

> "I don't know. I think they have a superiority thing. They want
> respect from everybody. I don't know if you know this back in
> India, they (doctors) are like the big bosses. When the doctors
> come in, they (anyone in room) stand up and we're all supposed to
> stand up and look to the side. They get great respect from
> everybody. The doctors are like gods, back in India. They get
> respect from everyone."

> "There needs to be more respect there (India). From the patient's
> side and also from the doctors. We don't get appreciated from the
> doctors (in India), like we do here (USA)…..Especially from
> doctors (in USA), when they come here, they always go find the
> nurses and they'll ask them, okay, is there something that I should
> know? Did something happen over the night that I should know?
> They will come and talk to us, and they're a little more free to talk
> to. And they give us the respect too. When we do things that they
> want done, we get appreciation."

Pullon (2008) in her qualitative study that sought to discover the components that

comprise positive nurse-physician relationships found that where professional

competence was demonstrated and understood, interprofessional respect developed and

facilitated the development of trust. It would appear that it is this lack of understanding of

nursing competence in India by physicians that impedes respect in the nurse-physician

relationship.

Sheeba, who is 55 years old from southern India who practiced in India for 6

years, and then 15 plus years in the Middle East, and now 6 years in the USA, provides

an interesting perspective. She explains a possible reason behind this societal thinking of

viewing the physician as a god and higher than the nurse:

> "To be a doctor, it's not that easy. It's sort of high-class families,
> All the rich people only could go for medicine, and the lay people,
> they considered them as, giving too much respect to the doctors.

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Even now, I see the older generation, when they go to see a doctor
they stand in such a respectful way. They (physicians) are
somebody beyond your reach, as if a god or something."

Grace who is 41 years old from northern India who practiced in India for 10 years and now 7 years in the USA, describes one of the major differences between individuals trained as nurses as compared to physicians:

"Nurses used to come from very poor homes."

Grace personally identified with coming from a very poor home. She only had the chance to go to nursing school because a nun at the church where she attended was able to get her a scholarship from a foreign donor. She never even dreamed that she would have the opportunity to come to the USA to work as a nurse, since she came from such a poor family.

The narratives indicated a sense of frustration among the interviewees as they described the lack of respect given to nurses in India not only by physicians but by society as well. It was not entirely clear if this sensed frustration was a result of nurses being influenced by their positive experiences with interactions with physicians in the USA and then comparing to what they had experienced in India. This left the unanswered question of not knowing if the nurses would still have this frustration if they had never practiced outside of India or would this just be accepted due to the cultural implications of hierarchy and the low societal view of nurses in India. It was clear that the experience of practicing in the USA had a significant effect on Preety when she provided her response to being asked if she would return to India to work as a nurse. Preety is 42 years old from southern India who practiced 3 years in India, and now 14 years in the USA.

"I don't know if I do feel that I would be free to think on my own
and say something (to the doctors), if I were to go back to India."

My own experience of working in India, provided many accounts where I observed nurses not communicating or collaborating with physicians in regards to medications, care of the patient, etc. for fear of being scolded in front of their peers and their patients. Through many conversations with the nurses, I learned that their fear was that they would lose what little credibility they did possess with their patient if they attempted to speak to the physicians. Even when I would role model, collaborating with physicians in regards to the patient care (for example, on patient rounds) and then would ask the nurses why they did not do the same, the frequent response was, "You can speak-up to the physicians as a white foreigner, but we as Indian nurses, cannot speak-up!"

Not only through my own experience as a nurse leader in India, but also as a student at a government-run language school in New Delhi, I faced first-hand the scorn from the language teachers when I would speak-up to ask questions. Instead of answering my questions, the majority of the time I was told that I should have read my book or studied the material that was given to me. I found through my own experience the issue of hierarchy between teacher to student was the cause of the reprimands in response to my legitimate questions. I also learned that for a student to ask questions of the teacher in front of the classroom could be seen as challenging the teacher's authority. In my experience with nurses and doctors in India, I believe the same cultural barrier is at stake for nurses should they attempt to collaborate with a physician in regards to the care of their patients.

Another cultural implication related to hierarchy that may be a barrier that negatively affects the nurse-doctor relationship may have to do with the concept of

"saving face." Scollon and Scollon (2001) define saving face as the negotiated public image, mutually granted each other by participants in a communicative event (p. 45).

Theme Two: Being Trusted. Theme two of being trusted as already mentioned in theme one of respect that the participant's experiences revealed that trust follows when there is respect between nurses and physicians. This provides an example that collaboration is a process. It is not just through having trust that one can effectively collaborate, but there must be a process of obtaining respect first in order for trust to follow. This finding is validated in Petri's (2008) concept analysis of Interdisciplinary collaboration where it was found that Interdisciplinary collaboration is a process and is a complex relationship between disciplines.

Sheeba, describes this process of the development of trust with physicians:

"They (doctors) respect the nurses. They know the nurses are always with the patient, 24 hours, so they know what is happening with the patient, so I think it is more approachable for the nurse to go the doctor here than back home (India)."

Sangeetha describes a similar experience,

"If the patient has changes, I call and tell them (doctors). They trust me".

Savita who is 50 years old from southern India who practiced in India for 6months, and then for 12 years in the Middle East, and now for the past 6 years in the USA, also describes the development of trust with physicians,

"Of course, you know if a patient's condition goes worse on the assessment, they (doctors in USA) think our assessment is right and they support us and can change the treatment according to our data. If the patient is getting worse or if something is happening, we call the doctor…. They believe us."

The theme of trust was seen to be in very close relation to the theme of respect. Many of the interviewees described that the natural progression with positive collaboration with physicians, first begins by gaining respect and then trust follows. For example, Preety explains,

> "Nurses, they are accepted better than they are in India, because here (USA) it would be like okay, they probably think they (nurses) know what they're doing and they (doctors) have more trust in the nurses."

Theme Three: Assurance of Accountability. Theme three, Assurance of accountability, emerged first in the third interview with Shalini who alluded to how the fact of superiority that is present with physicians to nurses, and how it inhibits the nurses from being brave enough to collaborate with physicians for fear of retribution, even if harm would come to the patient. For example, when Shalini stated:

> "And there (India), the nurses won't question them (doctors), if its really a good order or something not appropriate, like really inappropriate, the nurses won't talk, just follow what he (doctor) said. But here (in USA), nurses have that judgment and we are responsible for we carry licenses, we are responsible for all that, all that stuff we do. Here (USA) we have little more authority and if we write in the patient chart, like inform the physician and stuff like that, we are legally safe. Out there, in India, it is not that kind, so the doctors are like they take their rounds in their time and we have to have everything ready when they round."

Priya who is 46 years old from northern India who practiced in India for 22 years and now 5 years in the USA describes her perception of accountability:

> "Here (USA) I realized that everyone, even the physicians, supervisor nurse, nurse, everyone works in an environment where the team is collegial. If I would give the wrong medication or treatment and something happens, the patient is going to sue me. But in India, we are not bothered about that."

Priya's statement is very much contradictory to the, *Code of Professional Conduct*

for Nurses in India (2006), as stated by the Indian Nursing Council, the governing body

for nursing in India. Under section 4.0-Valuing Human Being that include:

4.1 Takes appropriate action to protect individuals from harmful unethical
   practice.
4.2 Considers relevant facts while taking conscience decisions in the best
   interest of individuals.
4.3 Encourages and supports individuals in their right to speak for
   themselves on issues affecting their health and welfare.
4.4 Respects and supports choices made by individuals.

One must have a greater understanding of the culture of India, in order to be able

to understand that despite particular standards to ensure accountability in the care of

patients, there is still a lack of consistency in following these standards.

In chapter two, the effect of the caste system in India, which is closely tied to

Hinduism, the predominant religion in India was briefly touched upon. Further

explanation of the caste system helps to shed light on Priya's statement. Wolpert (1991)

explains, "Brahmanic (highest caste) "purity" and ex-Untouchable (lowest caste)

"impurity" remain the polar stars of India's social hierarchy (p. 118). Consequently,

untouchability has been abolished by law in modern India. However, it is very evident

today that the caste system remains in India. One example, would be that an individual

from an untouchable caste would rarely be seen to marry someone from the Brahman

caste.

An excerpt from the Rig Veda, one of the four sacred texts of Hinduism, describes

the hierarchy that exists between the Brahman and Untouchable castes:

When the gods spread the sacrifice with the Man as the
Offering, spring was the clarified butter, summer the fuel,
autumn the oblation.
They anointed the Man, the sacrifice born at the beginning,

upon the sacred grass
When they divided the Man… His mouth became the Brahmin;
His arms were made into the Warrior, his thighs the People, and
from his feet the Servants (untouchables) were born.

Perhaps the caste system, which is seen in this poem to be closely linked to

Hinduism in India, does affect the level of obligation of health care professionals to

provide the ethical treatment that is mandated for nurses by the Indian Nursing Council.

However, in addition to the caste system, there is the issue of poverty that also might

have an effect too. While working in India, I did observe numerous times that patients

who were very poor and most probably considered from the untouchable caste did not

receive the same level of care as those patients from a higher caste. This cannot fully be

attributed to caste, but potentially more to do with the fact that the poorer patients could

not pay for their medical services, so less was done for them, as opposed to those patients

who were educated and had money to pay. Poverty is widespread with nearly one-third of

the world's poor living in India. In 2011, the World Bank reported that 42% of people

living in the rural areas and 26% of those living in the urban areas of India were living

below the poverty line in 2004-05 (retrieved from: www.worldbank.org.in).

Theme Four: Finding Freedom. Theme four, Finding freedom, captures what

many of the interviewees described they have felt through practicing nursing in the USA

as compared to India. Freedom is what they have found through their experiences with

being respected/feeling heard, being trusted, and through the assurance of accountability

for both physicians and nurses. They described that it has been a process to find this

freedom. Henry Ford (retrieved from www.brainyquote.com) describes what this process

looks like:

"Coming together is a beginning,
Keeping together is progress,
Working together is success!"

"Freedom" is the overarching theme that was found in this study with being respected/feeling heard, being trusted, and assurance of accountability to be the antecedents to this "freedom."

A link between freedom and empowerment was found by Rodwell (1996) in her concept analysis of empowerment, which provides the defining attributes of empowerment to include:

1. a helping response

2. a partnership with values self and others

3. mutual decision-making using resources, opportunities and authority, and

4. freedom to make choices and accept responsibility

For the participants in this study, the freedom that they have found and described in their interviews about their practice of nursing in the USA in relation to nurse-physician collaboration resounds with the concept of empowerment. This sense of freedom and empowerment is something that all of the study participants recognized as a significant difference between their practice of nursing in India as compared to the USA.

Preety describes finding freedom through practicing nursing in the USA,

"In the US, nurses have the freedom to think, to use their brains.
Here there is more freedom for the nurses to think on their own
and at least come up with suggestions, make some decisions and
then call the doctor and say this is what's going on, but if I go back
(to India) and if I don't feel that freedom, that would be pretty
frustrating for me."

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Grace attributed finding freedom to the knowledge that she has received in the USA compared to India. She describes how the knowledge has affected her ability to collaborate with physicians:

> "My knowledge was not so broad there (India), but here (USA), I feel they are giving us the opportunity to study…. So, I think I am equipped with knowledge. I can talk with the physicians. I feel more like I am educated, my knowledge of nursing is more here (USA) than I was in India."

Priya described the theme of finding freedom when asked when her view of collaboration changed after coming to the USA:

> "My view of collaboration changed the first day when I came here (USA)…. The company I came with were giving more emphasis on SBAR (communication system for healthcare professionals to ensure patient safety), and the SBAR made me think that how much nurses and doctors are having collaboration to get the best care, to give the best care to the patient in a definite timeframe…I understood everything and I can be confident enough to work with any kind of population of patient like any acuity and then get connected with the physician."

This description of collaboration that she experienced in the USA was far different from any of the descriptions made by the interviewees in regards to their perceived experiences with collaboration with physicians in India.

The famous Indian poet, *Rabindranath Tagore* explains exquisitely the freedom that Indian nurses described in their interviews that they feel with collaborating with physicians in the USA to ensure patient safety:

Where the mind is without fear and the head is held high

Where knowledge is free

Where the world has not been broken up into fragments

By narrow domestic walls

Where words come out from the depth of truth….

Where the mind is led forward by thee

Into ever-widening thought and action

Into that heaven of freedom, my Father,

let my country awake.

Summary of Nurse's Views of Collaboration

The first question of the interview posed to the interviewee's was, "What does

collaboration mean to you?" There was typically a pregnant pause when the question was

asked and some clarity requested by the interviewee in order to better understand the

question. In consultation with Dr. Solyemole Kuruvilla (president of NAINA), this

question was revised to, "Describe the professional relationship between nurses and

physicians." This aided in the interviewee's understanding, and then they were able to

proceed with their answers with less hesitancy. Many of the interviewee's described

collaboration or the professional relationship between nurses and physicians in the USA

and in India, emphasizing that collaboration was much better in the USA. For example,

Shalini stated:

> "The collaboration between the physician and nurses, I feel it is
> better here (USA)."

Priya described collaboration as:

> "Collaboration is like, I mean for me it's a team process. It's a
> teamwork with the physicians. For example, we both are an
> important part of the team too who works with the physician for
> the patient to have a better outcome. Collaboration means like how
> we are taking orders from them, how we are getting the report to
> them and then connecting with the patient management and care."

Sheeba also recognized the importance of teamwork in collaboration:

"I always think that we cannot get 100% outcome of the care we give without collaborating with the family and the physicians and the paramedicals. It's a teamwork. You cannot do it as a nurse alone. You cannot do it as a doctor alone."

Grace emphasized the relationship component of collaboration with

physicians in the USA:

"We are more like friends type, in sorting things out. It's more closer, the relationship I think, with the doctors. There are some doctors who think of themselves as bossy, but most of the time they are very close to the nurses and we can share our views for the betterment of the patient, for the treatment, its good."

Savita explained the positive outcome of collaboration:

"I feel that the collaboration, it will make for time-saving and we can give good nursing care to the patient. We are safe and patients are safe."

Sangeetha describes how she has learned over time to develop a

relationship of collaboration with physicians. This process takes time through

establishing trust, which has enabled her to build respect between her and

physicians. She explains:

"So you learned to collaborate with the doctors and call them and to have confidence. As you get more experience, you are close to the doctor. In the beginning it's hard, and they ask you questions you don't know the answer, so you put your ducks in a row before you call them, so you know what you're going to tell them. So the experience as a nurse that I have had has made a lot of difference. Now I have been here for this long (33 years), and I know almost all the doctors and the new doctor is no problem. I can call them and tell them what my patients need or information that is pertinent for them to know, and it is just like talking to a friend. So, I have no problem now but maybe a young nurse with little experience, might find talking with doctors a lot different."

Most of the interviewees alluded to the fact that collaboration was only developed over time, and that it is was something that was taught in their nurses training in India. However, due to cultural constraints, such as hierarchy that is present in India in the societal view of physicians in relation to nurses, the role of power that physicians have that dominates the relationship between nurses and physicians, and the limited knowledge growth opportunities for nurses stifles the development of collaboration between nurses and physicians in India.

Description of the Study Sample

The demographic data pertinent to the study sample include age, gender, marital status, nationality of spouse, state of origin in India, spiritual (religious) affiliation, educational level, nursing degree level, and years of practice experience in India and in the USA. The study group was comprised of five General Nurse Midwife-prepared nurses (3-year degree with 6 months internship after 12th standard/grade-Admission does not require to have studied sciences in 11th and 12th standard), three Baccalaureate-prepared nurses, and one Master's-prepared nurse.

Overall, the age range of the participants was from 35 years to 60 years of age. All interviewee's were married to men of Indian descent. On average, each nurse had 2 children.

Years of nursing practice experience in India ranged from 6 months to 10 years, mostly in acute care specialties in both private and government hospital settings. Years of experience in the USA ranged from 5 years to 33 years, again mostly in acute care specialties. Table 1 provides a summary of the description of the sample of participants.

Summary

The most significant finding revealed in this study was that despite the nurses coming from a culture that did not allow for positive nurse-physician collaboration in order to ensure quality and safe patient care, this fact has not hindered them from striving towards collaboration and ensuring that their patients receive safe care now that they are practicing in the USA.

The nurses described the themes of respect/feeling heard, being trusted, assurance of accountability, and finding freedom to be integral components to their ability to effectively collaborate with physicians to ensure safe patient care. In addition, the attributes that the interviewees most commonly associated with the concept of collaboration included: teamwork, receiving respect from physicians for their knowledge about their patient's condition, a friendly relationship, and both physicians and nurses taking responsibility for their respective role in the care of the patients.

The study participants appear to have been surprisingly positively influenced by their experiences in India with collaboration. Ironically, even though these experiences were mostly described as negative, these experiences have provided them with a strength and empowerment as they journey towards collaboration and ensure safe patient care. Due to the researcher's own experiences working with nurses in India and her own understanding of Indian culture and research, it was not anticipated that the Indian nurses experiences with collaboration in India would positively effect their ability to positively collaborate with physicians in the USA. These experiences in the journey towards collaboration can be seen as what Heidegger (1962/1998, p. xiii) would call a "twisted woodpath" where thought may lead down a blind alley or down a clearing of

understanding. Through studying the nurses' narratives in this study, it was evident that they had traveled a journey to collaboration that presented many challenges along the way. From being taught in nursing school the importance of collaboration and then mandated by the Indian Nurses Council Code of Professional conduct the necessity to collaborate, but due to the cultural constraints they were inadvertently prohibited from practicing collaboration. Since coming to the USA, they describe a sense of freedom to practice collaboration that had been taught to them in India. The interviewees' narratives revealed their perceptions of what is important to collaboration, but their list was not complete with all that has been listed in the literature as critical components to collaboration. However, they were cognizant of the fact that their experiences of practicing nursing in the USA brought them much closer to a "clearing" as described by Heidegger (1962). This is the place where specific experiences are revealed and shared. What was once hidden, is now visible and seen for what it really is.

Nurse-physician collaboration is a journey. It is not a concept that can be learned alone in a classroom or just in practice. It is a journey that is learned with each experience nurses and physicians have with one another as they collaborate together in patient care.

Chapter Five: Discussion

In this section, the specific aims and the results of the data analysis will be briefly discussed, as well as the hermeneutic process, implications for nursing practice, and education, the limitations of the study, and recommendations for future research.

Revisiting the Specific Aims

The results of the data analysis provided insight on both intended aims of the study.

Aim 1: Describe the attitudes and perceptions of Indian nurses trained in India and now practicing in the U.S. towards nurse-physician collaboration in the USA. Each nurse identified both positive and negative experiences with collaboration with physicians. However, it was the experiences with collaboration in India that were identified as negative more often than the experiences in the USA. The experiences in the USA were described in a much more positive light. All of the nurses described a significant change in their perception of collaboration with physicians when coming to practice nursing in the USA. The description of experiences has helped to illuminate what it has been like for Indian nurses to practice collaboration in India and the USA with the USA having the majority of positive experiences.

Aim 2: Explore the perceptions of the participants' collaboration experiences and its effect on patient safety. Most of the nurses described the experiences with collaboration with physicians as it related to patient care. Several nurses described their experiences in India to have a negative effect on patient care and safety, because of their inability to collaborate or communicate with the physicians due to cultural constraints. However, their described experiences with collaboration with physicians in the USA

were much different from those in India related to patient care. The nurses described a sense of accountability for themselves, but were also very aware of the accountability that physicians are held to in the USA to provide safe patient care. In addition, the nurses found a positive level of respect and trust that they received from physicians in the USA that facilitated them to be able to collaborate with physicians in the safe care of their patients, which was very different from what they experienced in India.

This study reveals that the foreign training these nurses received in India has increased their awareness and ability to collaborate, even though they might not have been able to practice it in India due to cultural constraints. Evidence that their India training base supports collaboration here in the USA should decrease the concern that foreign trained nurses from India are less likely to collaborate with physicians, resulting in possible harm to patients here in the USA.

The Hermeneutic Process

The Hermeneutic process is a unique process that allows for gaining an understanding of the significance of everyday experiences as they occur in the world by the people who experience them. This understanding comes from finding the common threads in meanings, encounters, events, customs, traditions, and exploring them without changing their meaning.

For this study, the hermeneutic process consisted of the researcher conducting interviews that were transcribed verbatim and shared with the members of the Hermeneutic Circle at Indiana University School of Nursing for interpretation. Each member of the circle read an interview and presented their interpretation as a gift to the researcher. Themes and patterns were identified in individual interviews and across all

interviews. Through on-going discussions with the members of the Hermeneutic Circle, the most meaningful and accurate interpretations were determined. In order to reduce the risk of researcher bias, staying very close to the original text and open discussions scrutinizing potential biases were discussed openly in the circle.

Implications for Practice

Nurse-physician collaboration has been shown in the literature to have a tremendous effect on patient safety. Therefore, the topic should be continually addressed with nurses and physicians. It should not be first addressed when nurses and physicians get out in their practice, but should be initiated when they are studying in their respective fields. It is not enough to have a one-time in-service or a mandatory education module. Learning effective collaboration is a process, not a one-time learned competency or skill. Due to the imperative nature of this topic brought on by the staggering number of medical errors and sentinel events in the USA related to poor nurse-physician collaboration and communication, there must be intentional strategies to address the problem of poor nurse-physician collaboration on an on-going basis.

One such strategy is the resource that has been made available by the Agency for Healthcare Research and Quality and the U.S. Department of Defense in 2006, is an evidence-based program, TeamSTEPPS, which focuses on teamwork and communication. This comprehensive curriculum was developed as a result of health care professionals receiving little or not training in effective teamwork and communication (Clancy, 2009). Nurse leaders and hospital administrators are encouraged to take advantage of this program to ensure patient safety through the development of effective teamwork and communication of all healthcare staff.

Another strategy for nurse leaders to consider in order to facilitate collaboration to ensure safe patient care includes exposing US nurses to written, film, or other ethnographic studies of nurses trained in non-western cultures. Thus, the US trained nurses might gain a greater appreciation for the opportunity to collaborate with physicians. In addition, they will gain a greater understanding of the challenges with collaboration encountered by nurses in eastern cultures.

Implications for IENs Practicing in the USA

Due to the current state of nurse-physician collaboration in the USA, it was believed that foreign-trained nurses, for example from India, might have an even more difficult time in collaborating with physicians due to the potential barriers imbedded within the culture from which they grew up and were trained in nursing. However, this was not what was found in this study. It was the exact opposite. Indian nurses seem to be even more positively influenced by their experiences in India to be able to practice effective nurse-physician collaboration in the USA that positively influences patient care. Their experiences in India were described as a whole as less than positive due to the hierarchy, societal view of nurses and physicians, view of power, and lack of educational opportunities. Even though, the nurses in the study may not have described all the components of nurse-physician collaboration, they have a positive outlook and desire to ensure safe patient care and are well on their way in their journey of nurse-physician collaboration.

Despite the fact that these nurses come from a more hierarchical, class conscious, and male centric society, they have found freedom in the culture of the USA that

facilitates collaboration. Consequently, they have been enabled to enthusiastically adapt to an environment of positive nurse-physician collaboration

As the nursing shortage increases and there are more IEN's coming to the USA to fill this shortage, there are great possibilities that nurses from India or similar types of cultures to be strong advocates for nurse-physician collaboration. I would propose that providing them the opportunities to share their experiences in India with other nurses and physicians would be helpful in leading others to journey toward positive nurse-physician collaboration that will positively affect patient care.

Recommendations for Further Research

Future research should include a similar type of qualitative study to include physicians trained in India and practicing in the USA, their perceptions and attitudes towards nurse-physician collaboration. This may provide future insight into the findings from the nurse's perceptions of nurse-physician collaboration found in this study. In addition, future studies that seek to discover the perceptions of nurses and physicians working with individuals from a different culture other than their own and its effect on nurse-physician collaboration. This type of study will help to shed light on the effect of one's culture and its effect on the ability to effectively collaborate.

Limitations

One limitation to this study might include the number of participants that could be recruited for the study. The goal was to have at least 10 participants. Despite, the multiple emails from the chapter chairs of NAINA to their chapter members and contacts, only two directly responded to participate. Many of the other participants were recruited directly through the NAINA chapter chairs through personal phone calls inviting them to

participate and then providing the researcher with their contact number. Through this intentional contact and not just through the use of email, the participants agreed to participate. Unfortunately, several contacts were unable to follow-through with their interview time that was set-up. This may be in part to not feeling comfortable to continue with the interview with the researcher due to the unfamiliarity with each other. However, once the interviewee and researcher began the Skype interview with the Biodemographic data information, there seemed to be an ease in their voice and relaxed body posture when continuing with the interview. This can be attributed to the fact that I was able to speak to where their home in India was located, because I had visited most of where the interviewees came from or where they took their nursing training during my time living in India.

A second limitation is that the interviews were conducted through the use of Skype over the Internet. It was thought that this would be a relatively easy way to conduct the interviews. Consequently, it may have been a barrier for recruiting participants due to the less personal aspect of not meeting in person and/or not having a personal relationship with the interviewee beforehand.

Lastly, there was the limitation of the sample being primarily made up of individuals from the Christian faith. Consequently, the sample was not representative of the diversity of faiths in India. In addition, the sample was primarily from Southern India. George (2005) in her book, *When Women Come First: Gender and Class in Transnational Migration*, states the history of women migrated from India included these women leaving their villages in Southern India, specifically from the state of Kerala. The state of Kerala is historically known to have the most concentration of individuals from
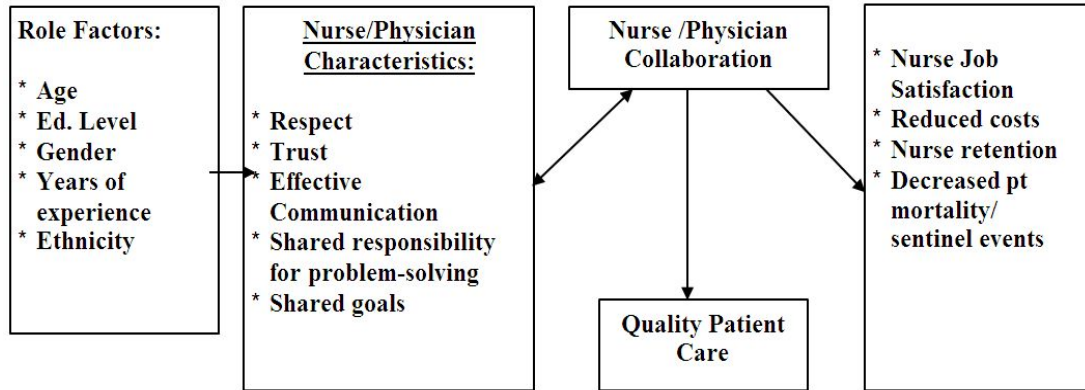
the Christian faith in the country of India. These women from Southern India would initially migrate to the larger cities of northern India, such as New Delhi to study nursing. From there, they would continue their migration process to immigrate to different parts of the world.

Even with limitations, the content at of the interviews had reached saturation by the 8th and 9th interviews. Thus, there was sufficient data to conduct the analysis based on 9 interviews. In addition, the nurses were from varied geographical places in India and varying religious backgrounds, which was thought to have an effect on their perceptions of collaboration.

In spite of the limitations, the findings of this study are useful and will add significantly to the knowledge base of nurse-physician collaboration. Specifically, for nurse leaders who will gain a greater understanding into the perceptions of Indian nurses who practice in their units. This greater understanding will give them the necessary knowledge of their Indian nursing staff and how they can best facilitate nurse-physician collaboration on their units. In addition, the Indian nurses can provide to their American-born co-workers a greater appreciation for nurse-physician collaboration based on their experiences in India compared to that of the USA.

APPENDICES

Appendix A. Nurse-physician collaboration

| Role Factors:

* Age
* Ed. Level
* Gender
* Years of experience
* Ethnicity | → | Nurse/Physician Characteristics:

* Respect
* Trust
* Effective Communication
* Shared responsibility for problem-solving
* Shared goals |

Nurse /Physician Collaboration

Quality Patient Care

* Nurse Job Satisfaction
* Reduced costs
* Nurse retention
* Decreased pt mortality/ sentinel events

Appendix B. Invitation letter to participate in study

An invitation to participate in a research study: The lived experiences of Indian nurses trained in India practicing in the USA with nurse-physician collaboration

Dear Colleague,

      I am writing to invite you to participate in a research study that is being conducted to explore and to describe the lived experiences of Indian nurses who trained as nurses in India, and are now practicing as staff nurses in the USA with nurse-physician collaboration.

      My name is Robyn K. Hale, MSN, RN, a Sr. Clinical Manager at Banner Estrella Medical Center in Phoenix, AZ, and a doctoral student in nursing at Indiana University School of Nursing (IUSON) in Indianapolis, IN. I am conducting a dissertation research study under the supervision of Dr. Mary Fisher. She is a professor of Nursing at IUSON and is the Associate Vice Chancellor for Academic Affairs Participation in the study is voluntary. The study participants will be asked to take part in a 60-90 minute audio/video interview via the internet using the Skype application. All information about individuals is kept confidential and only aggregate findings commonly found in the collections of data from all participants are discussed in the report of the dissertation. I will present the findings to my research when I defend my dissertation.

      The Institutional Review Board of Indiana University has approved this study. Their guidelines for the protection of human subjects will be followed at all times.

      If you want to learn more about this study and consider participating, please email me at robyn@hale.cc and I will get back with you as soon as possible. If you would prefer to leave a telephone message, please call me at 317-670-9812, and leave a number where I can return your call.

Sincerely,

Robyn K. Hale, MSN, PhD(c), RN
IUSON Doctoral student

Appendix C. Participant Biodemographic Data Form

1. AGE: _____ years

2. GENDER: __Female __Male

3. MARITAL STATUS: ___Single ___Married ___Widowed

4. NATIONALITY OF SPOUSE: _____

5. NUMBER OF CHILDREN: _____

6. STATE OF ORIGIN IN INDIA: _____

7. NUMBER OF LANGUAGES FLUENTLY SPOKEN: _____

8. SPIRITUAL (RELIGIOUS) AFFILIATION: _____

9. EDUCATIONAL DEGREE IN NURSING: ____GNM ____BSN or BSc.

10. NAME OF INSTITUTION AND PLACE WHERE YOU COMPLETED YOUR
 NURSES TRAINING IN INDIA: _____

11. AREA OF PROFESSIONAL NURSING PRACTICE IN INDIA:
 ____Acute inpatient care (Please specify area, ICU, L&D, Med-Surgical, etc.) _____
 ____Outpatient care ____Emergency Care ____ Long Term care
 ____Other (Please specify) _____

12. AREA OF PROFESSIONAL NURSING PRACTICE IN USA:
 ____Acute inpatient care (Please specify area, ICU, L&D, Med-Surgical, etc.) _____
 ____Outpatient care ____Emergency Care ____ Long Term care
 ____Other (Please specify) _____

13. NAME & PLACE OF CURRENT EMPLOYER: _____

14. YEARS OF NURSING PRACTICE EXPERIENCE IN INDIA: _____

15. YEARS OF RESIDENCE IN U.S.A: _____

16. YEARS OF NURSING PRACTICE EXPERIENCE IN USA: _____

17. ARE YOU A MEMBER OF NAINA (NATIONAL ASSOCIATION OF INDIAN
 NURSES OF AMERICA): _____

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    nurses and physicians in the medical-surgical patient care setting. *MEDSURG*

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    patient length of stay. *Journal of Nursing Management*, 17, 797-803.

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    toward each other: A qualitative study in one U.S. teaching hospital. *Association*

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    perspectives on working with nurses. *American Journal of Nursing, 109*(7),

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Xu, Y., Davidhizar, R., & Giger, J. (2005). What if your nursing student is from an Asian culture? *Journal of Cultural Diversity*, *12*(1), 5-11.

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Zwarenstein, M. & Reeves, S. (2002). Working together but apart: barriers and routes to Nurse-physician collaboration. *Joint Commission on Accreditation of Healthcare Organizations*, *28*(5), 242-47.

CURRICULUM VITAE

Robyn Kathleen Hale

EDUCATION

Doctor of Philosophy, 2006-2013
        Minor: Medical Anthropology
        Indiana University, Indianapolis, IN

Master of Science in Nursing, 2003-2006
        Minor: Teacher Education
        Indiana University School of Nursing, Indianapolis, IN

Bachelor of Science in Nursing, 1988-1993
        Indiana Wesleyan University, Marion, IN

EXPERIENCE

January 2013-present
Banner Thunderbird Medical Center, Glendale, AZ
RN Director Professional Practice

May 2011-January 2013
Banner Estrella Medical Center, Phoenix, AZ
RN Sr. Clinical Manager, Women and Infant Services

January 2011-May 2011 (Part-time)
Indiana Wesleyan University, Marion, IN
Clinical Instructor

September 2009-October 2010 (Part-time)
Wishard Hospital, Indianapolis, IN
Staff Development Coordinator, Women & Children Services

January 2006-September 2009 (Part-time)
Wishard Hospital, Indianapolis, IN
Staff Nurse III, Women & Children's Services

August 2007-April 2008 (Part-time)
Indiana University School of Nursing, Indianapolis, IN
Clinical Faculty—Environments for Health Department

February 2007-August 2008 (Part-time)
Indiana Wesleyan University, Marion, IN
Adjunct Faculty—Nursing Leadership & Management

January 2004-January 2006 (Part-time)
Wishard Hospital, Indianapolis, IN
Staff Nurse II, Women & Children's Services

March 2005-May 2006 (Part-time)
Indiana University School of Nursing, Indianapolis, IN
Clinical Faculty—Family Health Department

December 1999-May 2003 (Full-time)
Emmanuel Hospital Association, New Delhi, INDIA
Nurse Administrator

December 1997-July 1999 (Part-time)
Wishard Memorial Hospital, Indianapolis, IN
Staff Nurse II, Women, and Children Services

April 1997-September 1997 (Full-time)
Holdsworth Memorial Hospital, Mysore, INDIA
Registered Nurse, Maternity Ward

November 1996-March 1997 (Full-time)
Dr. Surajit Sahu's Private Clinic and 5-bedded Hospital, Cuttack, INDIA
Registered Nurse

May 1993-October 1996 (Full-time)
Wishard Memorial Hospital, Indianapolis, IN
Staff Nurse I & II, Women and Children Services

1996 (Part-time)
Lincare Inc., Indianapolis, IN
Homecare Nurse, Obstetrics/Postpartum

1995-1996 (Part-time)
Vita-Link, Indianapolis, IN
IV Start Nurse

1995-1996 (Part-time)
University Healthcare Inc., Indianapolis, IN
Triage Nurse

1991-1993 (Part-time)
Marion General Hospital, Marion, IN
Student Nurse-Medical Surgical units

1987–1988 (Part-time)
Hamilton County Hospital, Syracuse, KS
Certified Nursing Assistant

1986–1987 (Part-time)
Hamilton County Nursing Home, Syracuse, KS
Certified Nursing Assistant

PROGRAM/COURSE DEVELOPMENT

- Grand Rounds at CMC/Ludhiana Punjab, India: "Striving for excellence in patient care: The Magnet Model," 2008.
- Nursing Leadership Workshop at Hero Heart Institute, Punjab, India (1 day), 2006 & 2007.
- Nursing Leadership/Training Workshop in Bihar, India with Emmanuel Hospital Association (5 days), 2005.
- E-learning for Staff Educator's with Dr. Diane Billings/Indiana University School of Nursing, 2004.
- Nursing Student Elective/Mentoring program in India, 2004.
- Nursing School Faculty Training/Workshop in India (5 days).
- Standardized Monthly In-Service Training for all 19 EHA Hospitals and 4 Nursing Schools in India, 2003.
- Nursing Leadership/Training Workshop in India (7 days), 2002.
- Nursing Leadership/Training Workshop in India (10 days), 2001.
- Orientation program (2½ weeks) for first year nursing students in India, 2000.

PROFESSIONAL MEMBERSHIPS

- AWHONN, 2010.
- Transcultural Nursing Society, 2005.
- Sigma Theta Tau International, 2004.
- Nurses Christian Fellowship, USA, 2003.

PRESENTATIONS

- The Lived Experiences of Indian Nurses working in the United States: Perceptions and Attitudes towards Nurse-Physician Collaboration. Midwest Nursing Research Society conference, Dearborn, MI, April 2012.
- Promoting Nursing Excellence in India. Global Medical Missions conference, Louisville, KY, November 2010.
- Nurse-Physician attitudes and perceptions towards collaborative relationships in India. National Association of Indian Nurses of America conference, Houston, TX, October 2010.

- Care Rounds: Hardwiring Care Rounds into the Wishard culture. Wishard Hospital 2nd Annual Clinical Professional Poster Fair. Indianapolis, IN. August 2010.
- Care Rounds: A Culture of Caring, Engaging and Empowering ALL Staff. University Healthsystem Consortium. Grapevine, TX. March 7-9, 2010.
- Care Rounds: Expanding our Culture of Caring. Wishard Hospital 1st Annual Clinical Professional Poster Fair. Indianapolis, IN. December 2009.
- Nursing Leadership Development through short-term mission's trips. Global Medical Missions conference, Louisville, KY, November 2009.
- Cultural Diversity Day in Healthcare. Wishard Hospital, Indianapolis, IN, November 2009.
- Nursing Research and Scholarship: Improving Global Health, Sigma Theta Tau Induction Ceremony, Indiana Wesleyan University, Marion, IN, April 2008.
- Striving for Excellence in Nursing—An International Model, India Medical Association, Ludhiana, Punjab, India, October 2005.
- Culture of Care in India/Indiana University School of Nursing, 2005.
- Cultural Diversity in Death & Dying, Spiritual Care Workshop, Indiana University School of Nursing, Nursing Student Elective in India, Indiana University School of Nursing, 2004.

RESEARCH STUDIES

Nurse-Physician attitudes and perceptions towards collaborative relationships in two mission hospitals in Northern India. May/June 2009

A clinical simulation for Nursing and Medical students facilitating a focus on nurse-physician collaboration. Indiana University School of Nursing, Indianapolis, IN. November 2008.

PUBLICATIONS

- Bullock, Robyn K. (2006). Magnet Nursing and Kingdom of God principles. Journal of Christian Nursing, 23 (4), 26-8.
- Cherian, A., Seema, S., Bullock, RK, Antony, AC (2005). Incidence of neural Tube defects in the least-developed area of India, a population-based study. The Lancet, 366, 930-31.
- Job Descriptions for all Nursing Staff of Emmanuel Hospital Association, India, co-author with all nurse leaders of organization, 2000–2004.
- "Set of Standards for Nursing Care" for Emmanuel Hospital Association India, facilitator for compilation of document, 2000–2004.

AWARDS

- Conference Travel Scholarship/Award, Indiana University School of Nursing, Indianapolis, IN. Fall 2010, Spring 2008, Spring 2006, and Spring 2012.
- Outstanding Nursing Alumna, Indiana Wesleyan University, Marion, IN, 2003.
- Della Blackburn Award—"Excellence in Nursing," Indiana Wesleyan University, Marion, IN, 1993.
- Who's Who in America's Universities and Colleges, 1993.

VOLUNTEERISM

Cross-Cultural

March 2010–present
Emmanual Hospital Association, INDIA
Volunteer Nurse Consultant
        *Short-term mission trips-Conduct Nurse Leadership training workshops

June 2003–February 2006 (1-4 visits for 2-4 weeks every year)
Emmanuel Hospital Association, INDIA
Nurse Consultant

February 2007–August 2008 (Five visits for 2-4 weeks over 19 months)
Christian Medical College/Ludhiana, Punjab, INDIA
Nurse Consultant

OTHER ACTIVITIES

- Deaconess, Desert Springs Community Church, Phoenix, AZ, Jan. 2013-present.
- Deaconess, Pendleton Christian Church, Pendleton, IN, Jan. 2009–Dec. 2010.
- Worship Team, Redeemer Presbyterian Church, Indianapolis, IN, 2006–2008.
- Volunteer Staff, Nurses Christian Fellowship, USA, 2003–2007.
- Counselor for Teen moms, Open Hand, Indianapolis, IN, 1999.
- Office Assistant, Youth for Christ. Indianapolis, IN 1997–1998.
- Medical Mission trip, INDIA, Jan. 1996.
- Youth Staff worker, Faith Missionary Church, Indianapolis, IN, 1995–1996.
- Worship Team/Choir, Faith Missionary Church, Indianapolis, IN, 1993–1996.
- Counselor, Crisis Pregnancy Center, Indianapolis, IN, 1994–1996.
- Mobile Medical Clinic for indigent and poor, Indianapolis, IN, 1993–1994.
- Counselor in-training, Crisis Pregnancy Center, Marion, IN, 1992–1993.