

A STUDY OF CROSS-CULTURAL COMMUNICATION AMONG INTERNATIONALLY
EDUCATED TAIWANESE NURSES IN THE UNITED STATES

By

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To my parents

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“Laugh, and the world laughs with you. Weep, and you weep alone” (Ella Wheeler Wilcox, 1883). Pursuing a PhD degree was a lonely journey; however, I didn’t weep alone. Support from family, friends, professors, colleagues, and students have strengthened my belief to overcome challenges overseas.

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TABLE OF CONTENTS

	<u>page</u>
ACKNOWLEDGMENTS.....	4
LIST OF TABLES.....	10
LIST OF FIGURES.....	11
LIST OF ABBREVIATIONS.....	12
ABSTRACT.....	14
1 INTRODUCTION.....	16
Overview.....	16
Diverse Patient Population and Nursing Workforce.....	18
Nursing Migration and Pull/Push Factors.....	19
Internationally Educated Nurses.....	21
Visa Credentials Assessment of Internationally Educated Nurses.....	22
Statement of the Problem.....	25
Purpose of the Study.....	25
Research Questions.....	26
Significance of the Study.....	26
Definition of Terms.....	27
Chapter Summary.....	31
2 REVIEW OF LITERATURE.....	32
Overview.....	32
Review of Literature on Historical Perspectives.....	32
Interrelationship between Culture, Language, Education, and Communication.....	32
Culture.....	32
Communication.....	33
Language.....	35
Education.....	36
Conceptual Framework of Communicative Competence.....	37
Second Language Acquisition.....	38
Components of Communicative Competence.....	39
Review of Literature on Contemporary Issues.....	51
Comparative Medical Contexts.....	53
Mandarin-Speaking Medical Context.....	53
English-Speaking Medical Context.....	56
Factors Affecting Cross-Cultural Clinical Communication.....	59
Context.....	59
Culture.....	60
Education.....	62

Language	64
Chapter Summary	68
3 METHODOLOGY	69
Overview	69
Theoretical and Epistemological Perspectives of the Study	69
Research Design	71
Phase I: Pilot Study	73
Phase II: Dissertation Work	74
Setting	74
Sampling criteria	75
Sampling procedure	76
Nursing participants	78
Data Collection	81
Informed Consent	82
Background Information Survey	83
Interviews	83
Individual interviews	85
Focus group interviews	86
Observations	88
Observing communication in nonmedical settings in hospitals	88
Observing communication in private life and social activities	89
Transcribing, Summarizing, and Member Checking	90
Data Analysis	91
Method of Analysis: Narrative and Thematic Analysis	91
Procedures of Analysis	92
Analyzing primary data: Interviews	92
Analyzing supplemental data: Observations	94
Analyzing my own thoughts	95
Inter-analyzing multiple data	95
Member checking	95
Trustworthiness and Triangulation	96
Subjectivity Statement	99
Research Limitations	100
Chapter Summary	101
4 FINDINGS: PARTICIPANTS' PORTRAITS	102
Overview	102
Shya's Portrait	104
Home Family and Culture	104
Nurse and Language Training in Taiwan and the United States	106
Adjustment to the U.S. Healthcare Context	108
Context Up to Study Period	110
Bu's Portrait	113
Home Family and Culture	114

Nurse and Language Training in Taiwan and the United States	115
Adjustment to the U.S. Healthcare Context	116
Context Up to Study Period	118
Chen's Portrait	121
Home Family and Culture	122
Nurse and Language Training in Taiwan and the United States	123
Adjustment to the U.S. Healthcare Context	125
Context Up to Study Period	127
Wei's Portrait	129
Home Family and Culture	130
Nurse and Language Training in Taiwan and the United States	132
Adjustment to the U.S. Healthcare Context	133
Context Up to Study Period	134
Co's Portrait	136
Home Family and Culture	137
Nurse and Language Training in Taiwan and the United States	137
Adjustment to the U.S. Healthcare Context	139
Context Up to Study Period	142
Chapter Summary	143
5 FINDINGS: MAIN THEMES	144
Overview	144
Complex and Specialized Language in Clinical Settings ("My English isn't good enough.")	146
Oral Communication	146
Discriminating non-Mandarin sounds	147
Jokes, slang and multiple dialects	149
Occupation-specific vocabulary and hospital register	152
Written Communication	155
Open-ended writing in charting	155
Reading medical documents	157
Cultural Differences in Clinical Settings ("I was perplexed about everything.")	158
Linguistic and Cultural Diversity of Hospital Personnel and Patients	158
Independent Role of Nurses in U.S. Healthcare	161
Patient-Centered Care	163
Identity Negotiation in a New U.S. Environment (being Taiwanese or being American?)	170
Accent: Retaining or Reducing the Taiwanese Accent in English	171
Choices of Speech Registers	173
Sweet talk versus professional tone (with patients)	173
Assertiveness versus compromise (with patients/hospital personnel)	175
Pretentiousness versus humility (with hospital personnel)	177
U.S. Nurse Training Gaps: Language and Culture ("I wasn't well prepared.")	178
Lecture-Oriented Classes: Hospital Orientation	179
Lack of essential language needs	180

	Lack of cultural knowledge: Patient backgrounds, hospital subcultures, hospital policies, and nursing routines	181
	Learning by Doing: Clinical Shadowing	184
	Chapter Summary.....	185
6	DISCUSSION AND CONCLUSION	187
	Overview.....	187
	Discussion on Nurses' Cross-Cultural Communication Experiences	189
	Language Needs in Hospital Settings	190
	Oral language use.....	190
	Written English: Genre-specific medical reading and writing	194
	Culture in Hospital Settings	196
	Role of nurses: Patient-centered care and independent professional	196
	Discourse styles.....	198
	Education and Training: The Need for Specialized, Ongoing Training	200
	Pre-U.S. training: Language and culture assessment.....	201
	Early U.S. training: Hospital orientation and mentorships	202
	Application to the Communicative Competence Model	204
	More relevant aspects of the model: Grammatical, sociolinguistic, and cultural competence among international nurses.....	206
	Less relevant aspects of the model: Discourse and strategic competence among international nurses	210
	Implications for the Study.....	211
	International Nurses' Training in the United States	211
	Communication and cultural mediation	212
	Critical thinking in nursing care	214
	Clinical practice.....	215
	Implications for Researchers: Further Investigations.....	216
	Conclusion	219
A	IRB PROTOCOL.....	223
B	RECRUITMENT FLIER.....	224
C	EMAIL SCRIPT OF RECRUITMENT	225
D	INFORMED CONSENT FORM.....	226
E	BACKGROUND INFORMATION SHEET	228
F	INTERVIEW PROTOCOL.....	229
G	CONSENT TO BE AUDIO-TAPED	231
H	EXAMPLE OF NARRATIVE ANALYSIS	232
I	EXAMPLE OF THEMATIC ANALYSIS	233

LIST OF REFERENCES 234
BIOGRAPHICAL SKETCH..... 243

LIST OF TABLES

<u>Table</u>		<u>page</u>
1-1	Passing score of English proficiency examinations for registered nurses	24
2-1	Medical characteristics between English-speaking and Mandarin-speaking context.....	58
2-2	Comparison between Mandarin-speaking and English-speaking nurses	67
3-1	Overview of research taxonomy	72
3-2	Background information of participants	79
3-3	Quantities of data collection.....	82
3-4	Timeline of data collection	82
4-1	Summary of participants' portraits	103
5-1	Summary of main themes.....	145
6-1	Summary of discussion	188

LIST OF FIGURES

<u>Figure</u>		<u>page</u>
2-1	Chronological derivation of communicative ability development.....	50
2-2	Components of communicative competence.....	51
6-1	Components of communicative competence for international nurses.....	205

LIST OF ABBREVIATIONS

BICS	Basic Interpersonal Communication Skills
CALP	Cognitive Academic Language Proficiency
CGFNS	Commission on Graduates of Foreign Nursing Schools
CLD	Cultural and Linguistic Diversity or Culturally and Linguistically Diverse
CNA	Certified Nursing Assistant
DNR	Do Not Resuscitate
EFL	English as a Foreign Language
ENP	English for Nursing Purposes
ESL	English as a Second Language
ESP	English for Specific Purposes
IELTS	International English Language Testing System
IEN	Internationally Educated Nurse: A registered nurse who has received nursing training in his/her homeland, grown up with a language other than English in a culture outside of the U.S., and migrates to the U.S. working as a healthcare professional.
L1	First Language
L2	Second Language
LPN	Licensed Practical Nurses
NCLEX-RN	National Council Licensure Examination for Registered Nurses
RN	Registered Nurses
SBAR	Situation, Background, Assessment, and Recommendation
SLA	Second Language Acquisition
TCM	Traditional Chinese Medicine
TESOL	Teaching English to Speakers of Other Language or Teachers of English to Speakers of Other Languages

TOEIC	Test of English for International Communication
TOEFL	Test of English as a Foreign Language
TSE	Test of Spoken English
TWE	Test of Written English
ZPD	Zone of Proximal Development

Abstract of Dissertation Presented to the Graduate School
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Chair: Maria Coady
Major: Curriculum and Instruction

The diverse patient population and increasing nursing migration in the United States results in a need to improve the quality of cross-cultural, clinical communication (Andrews, 2003; Hancock, 2008; Sherman, 2007). Cross-cultural communication is necessary but challenging for patients and healthcare practitioners alike. The objective of the study was to construct an understanding of the interrelationship between language needs, cultural differences, educational training, and communication of internationally educated Taiwanese nurses.

The research question was, "How do internationally-educated nurses perceive their cross-cultural, clinical communication experiences in the U.S. medical context?" Case study was adopted as the research methodology. The data collection period lasted four months. Purposeful sampling was used to recruit five Taiwanese nursing participants. Primary data collection methods included focus group interviews and individual interviews. Supplementary data consisted of background information surveys, observations, and post-interview reflection journals. The data analysis method was a combination of narrative and thematic analysis.

The findings showed that the use of complex/specialized language and cross-cultural differences in clinical settings complicated the five participants' communication experiences. The findings also indicated gaps in language and culture in these nurses' training in the United States.

CHAPTER 1 INTRODUCTION

Overview

Alex (pseudonym), a 42-year-old British native, was heavily bandaged around the head, fidgety, half-comatose, and tossing from side to side. He was a visiting assistant professor, one of my former colleagues, teaching English as a Foreign Language (EFL) at a Taiwanese college. He was recovering from an 11-hour brain surgery caused by a serious car accident. One week later, he continuously murmured how hurt and frustrated he was in his bed, “They’re stupid! They’re deaf! They speak no English! My head’s exploding!” I patted his face and told him, “It is okay. Susan (pseudonym, one of our colleagues) and I are here to keep an eye out for you.” A few minutes later, the on-duty Taiwanese nurse came to me and complained about Alex’s rudeness and irrational behavior. I left my cell phone number and comforted her in Mandarin, “Ru guo you xu yao, kei yi da wo shou ji (If you need any help for interpretation, just call me).”

One year later, I met a small group of Taiwanese registered nurses (RN), Bette and Fannie (pseudonyms), in a community English conversation class. Through Bette and Fannie, I met Janet, Zoe, and Yvonne (pseudonyms). Some of them were applying for U.S. nursing positions. Some were working with foreign clients in Taiwan. For example, Zoe worked in the Anesthesiology Department encountering a high frequency of injured foreign patients. She was preparing for the U.S. NCLEX-RN examination (National Council Licensure Examination for Registered Nurses) and planning to work in the United States. Bette and Janet had passed the NCLEX-RN examination. However, their repeated failures in the English proficiency test—IELTS (International English

Language Testing System) impeded them from obtaining a U.S. working visa¹. Yvonne continuously self-studied English because she looked forward to studying abroad in the near future. Compared with other adult learners in the community English conversation class, this group of EFL learners was highly motivated and ambitious in their learning goals. Bettie and Zoe told me how necessary it was for them to be fluent English speakers. Yvonne was embarrassed when she was misunderstood by her foreign patients. Fannie complained of the discouragement she and her colleagues felt when language barriers deteriorated their service quality in nursing. Janet, Bette, and Zoe explained how urgent it was to pass English proficiency exams to obtain a U.S. working visa.

I could not suppress the image of Alex's anger and fear, sick in a strange land. I also identified with the EFL nurses' anxiety and eagerness regarding communicating with foreign clients and improving English competence to pursue their American dreams. By hearing the perspectives of both parties, I realized the importance of using English as a communication tool in the setting of transcultural nursing. As a former EFL instructor in an occupational-oriented College of Technology in Taiwan, I saw an opportunity to promote Nursing English education and facilitate cross-cultural healthcare communication. Examining international nurses' experiences of cross-cultural communication in the U.S. medical setting might expand my knowledge of communicative competence in the nursing profession and contribute to the literature on cross-cultural clinical communication.

¹ Registered nurses who were born outside of the United States are required to complete a four-step visa credentials assessment program in order to receive a working visa, including educational background investigation, licensure validation, English proficiency test (IELTS, TOEFL or TOEIC), and nursing knowledge examination (CGFNS Qualifying Examination or the National Council Licensure Examination for Registered Nurses) (CGFNS, 2008; USCIS, 2009).

Diverse Patient Population and Nursing Workforce

Since 1990, more than half the population growth in the United States has come from immigrants and their children -- and many of these immigrants, even if they can get to the hospital and pay for their treatment, may find mainstream health care culturally inaccessible. (Fadiman, 1997, p.270)

In general, nurses are the initial contact in the majority of patients' medical visits. Globalization has made English one of the most common languages in many cross-cultural medical interactions (Grice, 2003; Munoz & Luckmann, 2005). In an English as a Second Language (ESL) context, such as in the United States, New Zealand, Australia, the United Kingdom, and Canada, the growing population of diverse ethnic groups results in the demand for multicultural and multilingual nursing professionals in the healthcare workplace.

According to the 2000 U.S. census, more than 25% of the population in the United States consisted of ethnic minority groups. Meanwhile, approximately one-fifth of the population spoke a language other than English at home (U.S. Census Bureau, 2000). In 2004, while 32.6 % of the population was composed of multi-ethnic groups, only 12.2% of registered nurses in the nursing workforce identified themselves as having racially or ethnically diverse backgrounds (U.S. Department of Health and Human Services, 2004). Recently, over 100,000 registered nurses departed their home country to work as nursing practitioners in the United States (Sherman, 2007). Even though we have observed a growing rate of registered nurses from non-European, Asian, other Pacific Islander, Hispanic, and Latino backgrounds since 1980 to 2004, the actual numbers of registered nurses with culturally and linguistically diverse (CLD) competence remain low (U.S. Department of Health and Human Services, 2004). Moreover, the U.S. Census Bureau estimated that by the year 2080, ethnic minority

groups will amount to 51.1% of the population in the United States (Choi, 2005). The multiethnic population in the United States requires a culturally and linguistically responsive healthcare system to maintain quality medical services. Therefore, a shortage of CLD nurses and efforts regarding their education, recruitment, employment, and communicative competence has attracted a great deal of attention in the United States (Abriam-Yago, Yoder, & Kataoka-Yahiro, 1999; Adeniran, Rich, Gonzalez, Peterson, Jost, & Gabriel, 2008; Bola, Driggers, Dunlap, & Ebersole, 2003; Brown, 2008; Gardner, 2005; Hancock, 2008; Ross, Polsky, & Sochalski, 2005; Sherman, 2007; Xu, Gutierrez, & Kim, 2008; Yoder, 2001).

Nursing Migration and Pull/Push Factors

According to Hancock (2008), Kline (2003), and Tshweneagae (2007), the primary destination countries of international nurses include the United States, Canada, Ireland, the United Kingdom, Australia, and New Zealand where English is the dominant language in the healthcare industry and society at-large. The supplying countries and regions of foreign nurses are the Philippines, South Africa, the United Kingdom, China, South Korea, Japan, Taiwan, Vietnam, Hong Kong, India, Mexico, and Puerto Rico.

There are various factors pulling and pushing internationally educated nurses to leave home and work in developed English speaking countries. Coelho (1994) noted that pull factors are inducements to attract immigrants or migrants moving to a host country under their free will. Push factors are motivations for local residents to feel pressures or desires to leave their original countries. In general, factors pushing registered nurses to leave their home countries include unsatisfying status and involuntary issues, such as low standards of living, work overload, unorganized career promotion, political persecution, oversupply in the nursing market, and risks of

occupational injury and disease (Hancock, 2008; Hawthorne, 2001; Kingma, 2001; Kline, 2003; Ojo, 1990).

On the other hand, factors pulling registered nurses to move to the United States include the pursuit of professional development, educational opportunities, better income, improved working conditions, higher socioeconomic status, self-fulfillment, and ambitions of adventure (Hancock, 2008; Kline, 2003; Tshweneagae, 2007). In the case of Taiwan, registered nurses (RN) and licensed practical nurses (LPN) are both treated as physicians' assistants instead of independent professional practitioners. They implement similar nursing tasks in practice. Usually, they are not expected to make individual nursing judgments. In general wards, nurses are responsible for from eight to 12 hospital beds during day shifts, 12 to 15 beds during evening shifts, and 20 to 40 beds during night shifts, which are particularly demanding.

On the contrary, according to the California Board of Registered Nursing (2011), U.S. nursing professions are divided into detailed and specific divisions of duty, including nurse practitioners (NP), clinical nurse specialists (CNS), registered nurses (RN), licensed practical nurses/licensed vocational nurses (LPN/LVN), certified registered nurse anesthetists (CRNA), certified nurse-midwives (CNM), public health nurses (PHN), psychiatric/mental health nurses (PMHN), certified nursing assistants (CNA), and certified medical assistants (MA). Nurses in general wards take care of four to six hospital beds, work based on the three-shift system or 12-hour work shift, and receive \$20-40 payment per hour which is double to triple nurses' wages in Taiwan. Compared with practicing in the donor countries, the U.S. nursing market obviously provides better welfare and work environments for nursing professionals. Nevertheless,

the challenges of fitting into a new country are formidable. The challenges experienced by internationally educated nurses working in the United States are discussed in detail in Chapter 2.

With the exception of the United Kingdom playing the role of both a donor and host country, most internationally educated nurses are from non-English speaking countries. They receive particular nursing training in their home countries. They have unique perspectives on health, diseases, medication, life, and death. Additionally, they are accustomed to medical routines dissimilar from the U.S. healthcare environment. Nursing immigration has had tremendous impact upon international nurses' cultural adjustment, professional cultivation, transitional training, healthcare delivery models, and cross-cultural medical communication in the United States. However, except for the qualification evaluation administered at the U.S. national level, the contemporary procedures regarding internationally educated nurses' recruitment and on-board training are only implemented at the state and institutional level (Ross, Polsky & Sochalski, 2005). In the next section, I discuss the definition of internationally educated nurses (IEN) and visa credential procedures for international nurses in the United States.

Internationally Educated Nurses

According to nursing journals, ESL databases, and government documents, several terms are applied to discuss education, recruitment, and employment of registered nurses and nursing students from diverse ethnicities. Terms are listed alphabetically as follow: ESL nursing students (Abriam-Yago et al., 1999; Boshier & Smalkoski, 2002; Choi, 2005), ethnically diverse nursing students (Yoder, 2001), foreign-born nurses (Brown, 2008), foreign-educated nurses (Bola et al., 2003; CGFNS, 2008), foreign nurses (Sherman, 2007), immigrant nurses/student nurses (Boshier &

Smalkoski, 2002; Xu et al., 2008), internationally educated nurses (Adeniran et al., 2008; CGFNS, 2008; Hearnden, 2007; Xu & Kwak, 2005), internationally recruited nurses (Sherman, 2007), and racial and ethnic minority student nurses (Gardner, 2005).

Xu and Kwak (2005) stated that “an internationally-educated nurse is operationally defined as a RN (registered nurse) with an active license to practice nursing in the United States who obtained his or her basic nursing education in another country” (p.234). Adeniran et al. (2008) also declared that the term internationally educated nurses (IENs) is used to “refer to nurses who received their basic nursing education in a country other than the US and who later migrated to the US to practice nursing.” In this dissertation, ESL nurses refer to registered nurses who speak a first language other than English at home or in the community. Yet, they use English as a survival tool to work, live, socialize, and communicate in U.S society. In the study, I use the terms ESL nurses, international nurses, and internationally educated nurses (IEN) interchangeably. The alternative usage among the three terms is to emphasize international nurses’ educationally, culturally, and linguistically diverse backgrounds compared to U.S. dominant white nurses. This study addresses the group of registered nurses who have received nursing training in their homelands, grown up with a language and culture other than that in which U.S. residents are immersed, and migrated to the United States as healthcare professionals.

Visa Credentials Assessment of Internationally Educated Nurses

According to the U.S. Citizenship and Immigration Services (USCIS, 2009) and Commission on Graduates of Foreign Nursing Schools (CGFNS, 2008), Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996, registered nurses who were born outside of the United States are required to complete

a four-step visa credentials assessment program in order to receive a working visa, including educational background investigation, licensure validation, English proficiency test, and nursing knowledge examination. The CGFNS Qualifying Examination and the National Council Licensure Examination for Registered Nurses (NCLEX-RN examination) are two main assessment tools of evaluating international nurses' professional knowledge in nursing practices. In 2000 census data, residents from Chinese ethnic groups comprised 2,462,585 of the U.S. population (U.S. Census Bureau, 2000). In order to meet the increasing demand of serving the Mandarin-speaking population in the U.S. medical industry, CGFNS opened test centers in Taipei, Hong Kong, Beijing, Shanghai, Guangzhou, and Chengdu of the over 50 locations.

The format of the CGFNS Qualifying Examination is a paper test. The NCLEX-RN examination is a computer adaptive testing (CAT) version. The two nursing knowledge examinations emphasize nursing professionals' critical thinking and independent judgment of client needs (National Council of State Board of Nursing, 2007). Johnston (2001) conducted research about the correlation of 290 nursing graduates' primary language and their NCLEX-RN scores. 184 participants were native English speakers, 31 were bilingual, and 75 nursing graduates spoke a first language other than English. Findings suggest that native English speaking test-takers of the NCLEX-RN examination possessed a pass rate from 67.7% to 95% while ESL nursing applicants' success rate was between 33.3% and 47%. The distinct passing ratio between English native-speaking nurses and ESL nurses indicates that language barriers, unfamiliarity with the test content and format, and different nursing cultures can hinder ESL speakers' test achievement in the nursing knowledge exam.

As to international nurses' English proficiency, the VisaScreen program requires internationally educated nurses to demonstrate both oral and written competence in the following examinations, including 1) combination of the Test of English as a Foreign Language (TOEFL), Test of Written English (TWE), and Test of Spoken English (TSE); 2) the four-skill TOEFL internet-based version (TOEFL iBT); 3) combination of the Test of English for International Communication (TOEIC), TWE, and TSE; or 4) the academic module of International English Language Testing System (IELTS). The passing score of each test set and its reference to English proficiency level can be seen in Table 1-1.

Table 1-1. Passing score of English proficiency examinations for registered nurses

Test option	TOEFL combination	TOEIC combination	IELTS academic	TOEFL iBT
Score	Paper: 540 CBT: 207 TWE: 4.0 TSE: 50	TOEIC: 725 TWE: 4.0 TSE: 50	Overall: 6.5 Speaking: 7.0	iBT: 83 Speaking: 26
English level	High intermediate	Advanced	Advanced	High intermediate

Note. Adapted from CGFNS (2008) and LCCIBE (2010).

On the whole, the evaluation procedure of language tests and nursing knowledge examinations can only attend to basic nursing competencies instead of assessing ESL nurses' comprehensive abilities (Bola et al., 2003; Xu et al., 2008). The language examinations evaluate ESL speakers' verbal, listening, reading, and writing skills in the field of Academic English (e.g., TOEFL, TWE, IELTS), General English (e.g., TSE), and Business English (e.g., TOEIC). However, neither of the above English language tests target nursing professionals' communication in the particular field of nursing.

The above issues have turned attention to helping internationally educated nurses work and communicate competently in the unique U.S. nursing settings, including

language proficiency tests, transitional training programs, learning materials, and teacher preparation in the field of English for Nursing Purposes (ENP).

Statement of the Problem

How complex is the cross-cultural, clinical communication between nonnative English-speaking nurses and ethnically and linguistically diverse patients? Language barriers may be problematic but are generally obvious. When a Taiwanese nurse reports a Dutch female patient's normal symptoms under observation by saying to her, "normal, normal, OBS (observation)" the patient's perplexity can be evident. When night-shift EFL nurses avoid talking to an Afghan male tumor patient because they are not comfortable speaking English, one can imagine how upset the patient and his family may feel. Additionally, cultural clashes can be surprising and unpleasant. Taiwanese nurses wonder why American, Canadian, and European patients tend to ask for more pain medication than domestic clients do. In some Asian areas, a postnatal confinement is important, involving complicated diet therapy and care procedures. However, hospitals in the United States provide, for example, orange juice for ill and postpartum patients, while hot water is preferred over cold drinks for patients' recovering in Taiwan, Korea, China, and other Asian countries. Predictably, cross-cultural communication is confusing for patients and healthcare practitioners alike.

Purpose of the Study

The U.S. multiethnic population requires a culturally and linguistically responsive healthcare system to maintain quality medical services. Meanwhile, efforts regarding international nurses' education, recruitment, employment, and cross-cultural communication are noted in the contemporary nursing and ESP (English for Specific Purposes) field. In general, two common methods of solving the nursing shortage in the

demands of serving multilingual and multicultural patient population are either recruiting registered nurses from overseas or cultivating domestic student nurses from diverse ethnic groups. In the study, I focus on the population of internationally educated nurses who are recruited from the Mandarin-speaking country, Taiwan, including discussion of how they communicate in the United States. In other words, the objective of the study is to construct an understanding of how language, culture, and education background affect the communication experiences of Taiwanese nurses in the United States.

Research Questions

The following research question was investigated in the study, “How do internationally-educated Mandarin-speaking nurses perceive their cross-cultural, clinical communication experiences in the U.S. medical context?”

In order to build an outline of international nurses’ communication experiences, I used three supporting questions to probe their perceptions.

RQ1: How do international nurses describe language needs for communication in cross-cultural medical settings?

RQ2: How do international nurses perceive cultural factors as influencing communication events?

RQ3: How do international nurses believe their education and training prepared them for U.S. healthcare communication?

Significance of the Study

Transcultural nursing has become an important issue both in academic and practical nursing since its foundation in the mid-1960s (Giger & Davidhizar, 2008). The trend of U.S. nursing migration has had significant impact on Asian nursing relevant industries, including immigration agencies and RN test/English test preparation institutes. According to Munoz and Luckmann (2005), the world population of Mandarin

speakers is approximately 836 million, which is the most common spoken language in the world. If ESL speakers are included in the global demography, English becomes the second most widely used language with 418 million people. Generally, studies of transcultural nursing focus largely on communication between U.S. mainstream nurses and minority patients, such as American nurses with African-American or Mexican-American patients. However, research examining communication between internationally educated nurses and ethnically diverse patients is limited, such as studies of Taiwanese nurses with Hispanic patients in California. This can be attributed to the minority status of both parties or the complexity of cross-cultural communication per se. Even though a number of studies investigate ESL nurses' communication and working experiences (Abriam-Yago et al., 1999; Adeniran et al., 2008; Bola et al., 2003; Boshier & Smalkoski, 2002; Brown, 2008; Choi, 2005; Gardner, 2005; Hancock, 2008; Hearnden, 2007; Sherman, 2007; Xu & Kwak, 2005; Yoder, 2001), it is challenging to find research aiming at the specific group of Mandarin-speaking nurses. Therefore, there is a need to study this subgroup of international nurses.

Definition of Terms

My perspective is situational, meaning here a concern for what one individual can be alive to at a particular moment, this often involving a few other particular individuals and not necessarily restricted to the mutually monitored arena of a face-to-face gathering...I must be allowed to proceed by picking my span and level arbitrarily, without special justification. (Goffman, 1974, p.8)

Language is socially constructed, developed, shared, and amended by people. The meaning of language is perceived and interpreted individually according to our cultural frames. The expectation of communication is based on our organization of experience (Goffman, 1974), which is an individual database for people to interpret

language in situational use. Everyone has his/her unique schema of experiences which cannot be replaced and mimicked. Furthermore, the way we communicate is determined by our intersubjectivity (Bruner, 1990), which is how we interpret other people's mind in a socially appropriate manner. The speech reality is culturally co-constructed and no interpretation of another's mind is culture-free. The talent of intersubjectivity, the way that we make sense of meanings and present language, is in relation to our expected roles in family, community, workplace, academic field, and society. Therefore, to minimize readers' divergent expectations of the terminology in my study, the following section is to clarify key terms that I interpret and employ in the study.

ADDRESSIVITY. It is ability to talk to diverse speakers in various culturally specific ways (Bakhtin, 1986). It reflects speech participants' power, relationship, gender, socioeconomic status, and social proximity.

COMMUNICATION EVENTS. In this study, interactions take place between an international nurse and a non-native Mandarin-speaker in which he/she experienced enough to recall surprise, discomfort, and misunderstanding or the opposite typical, comfortable, and understanding.

COMMUNICATIVE COMPETENCE. It is language ability for people to functionally and meaningfully listen, speak, read, write, and physically interact with others within speech events and written texts (Hymes, 1971). It includes knowledge and skills of literacy, linguistic patterns, oral language, nonverbal cues, background information of speech events, inter-sentential relationships in discourse, cultural sensitivity regarding topic relevance, speaker-listener relationship, social functions in language use, linguistic register, detection of communication failures, and compensation for miscommunication.

COMPREHENSIBLE INPUT. It is understandable information generated with contextual support. Language knowledge is absorbed through comprehensible input (Krashen, 1981, 1983).

CROSS-CULTURAL COMMUNICATION. In nursing, it refers to oral, written, and nonverbal interactions between nurses and patients, patients' family, and hospital personnel who are from different cultural and linguistic backgrounds.

CULTURE. A schema guides people's ways with words, discourse patterns, social behaviors, and philosophy of life. It is transmitted through time and space by

language, face-to-face communication, social activities, generations, and material objects. Based on culture, we adopt co-constructed perceptions to predict, explain, and make sense of communication.

CULTURAL COMPETENCE. A continuous process requires nurses' cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desires to practice nursing in multicultural medical contexts (Campinha-Bacote, 2002).

CULTURAL FACTORS. In terms of transcultural nursing, cultural factors include hospital routines, medication, hospital subculture, nursing concepts, patient-nurse-doctor relationships, medical systems, nursing ethics, insurance policies, nursing procedures, communication pragmatics, conversational styles, social topic selection, and social skills.

DISCOURSE. It refers to oral and written texts, such as cross-cultural discourse.

EDUCATION. It is the way we are educated and regulated in school. It is determined by the mainstream culture (Bruner, 1996). It also dominates our ways of speaking and behaviors in family, community, and workplace. Education reinforces our mutual values and cultivates students to be members in a society. The discussion of education in my study highlights internationally educated nurse's schooling and on-the-job training.

EPISTEMOLOGY. It is the theory of knowledge. It is how we interpret knowledge and explain what perspectives we adopt to make sense of reality (Hatch, 2002).

FOREIGN PATIENT, FOREIGN CLIENT, INTERNATIONAL PATIENT, and INTERNATIONAL CLIENT. A patient comes from a nation other than the host country.

FRAMES. Principles govern subjective consciousness. Frames store cognitive structures and guide human perceptions of a coming speech event (Goffman, 1974).

INTERLOCUTORS. It refers to two people talking to each other.

INTERNATIONALLY EDUCATED NURSE. A registered nurse has received nursing training in his/her homelands, grown up with a language and culture other than that of the United States, and migrated to the United States as a nursing professional.

INTERNATIONAL NURSES and ESL NURSES. Nurses work in an English speaking country other than the home country.

LANGUAGE. A system of signs, symbols, sounds, and gestures is arbitrarily created and infinitely creative to express meaning. It is collectively constructed and culturally transmitted by human beings. Language changes over time and varies in

the essence of structures. It is a conventionally cultural tool to connect human interactions by means of negotiation and thought exchange (Vygotsky, 1978).

MANDARIN-SPEAKING NURSE. A nurse speaks Mandarin as his/her first language.

METHODOLOGY. It represents the research process guiding methods of data collection and data analysis.

PILOT STUDY. It is a trial for qualitative investigators to utilize a small scale of study before they carry out a complete research project.

REGISTER. A skill discerns social-cultural rules of language use in dynamic real-life dialogues. Register determines our word choices and ways of speaking when talking to diverse speakers in various situations (Halliday, 1978; Simon-Vandenberg, 1983).

REGISTERED NURSE. A nurse has graduated from nursing programs and passed state-board or national nursing examinations to practice in the healthcare setting.

SNOWBALL SAMPLING. A practical technique helps researchers get started with one or few key names. Then the network begins to roll like a snowball to drag in more and more participants who meet sampling criteria and are capable of providing rich information (Glesne, 2006).

STUDENT NURSE and NURSING STUDENT. They are alternatively used to describe a student who is enrolled in formal nursing programs in senior high school, vocational school, community college, or university.

THEORETICAL PERSPECTIVE. A philosophical assumption directs research methodology.

TRADITIONAL CHINESE MEDICINE. It is traditional medicine widely applied in East Asian areas. It comprises herbal medicine, cupping, acupuncture, massage, and body balance (Galanti, 2008).

TRANSCULTURAL NURSING. A science focuses on theories and practices on culturally relevant nursing care, such as a healthcare setting where nurses and patients are from different cultural, ethnic, or linguistic backgrounds.

TRIANGULATION. An approach validates the credibility of research findings. It is to “use multiple perspectives to interpret a single set of information” (Guion, 2006, p.3).

WESTERN MEDICINE, CONTEMPORARY MEDICINE and MODERN MEDICINE. A science retains and restores human healthiness, including two main disciplines of internal medicine and surgery.

Chapter Summary

In this chapter, I explored the issues of diverse population, nursing migration, shortage of multi-linguistically and multi-culturally competent nurses, and procedures of visa credential and English assessment in the United States. I also addressed the purpose and significance of the study. In addition, I defined key terms and posed one research question and three supporting questions in the study. The U.S. multiethnic population requires a culturally and linguistically responsive healthcare system to maintain quality medical services. Meanwhile, efforts regarding international nurses' education, employment, and cross-cultural communication should be noted in the contemporary nursing and TESOL field.

CHAPTER 2 REVIEW OF LITERATURE

Overview

The first section of this chapter reviews literature on historical perspectives of the interrelationship between culture, language, education, and communication. An emphasis on the conceptual framework of communicative competence is addressed. In the second part of this chapter, a discussion of empirical research and literature reviewing studies with regard to two issues is included: (a) comparing medical culture between the Mandarin-speaking and the English-speaking contexts; and (b) describing factors affecting international nurses' communication experiences based on literature review.

Review of Literature on Historical Perspectives

Interrelationship between Culture, Language, Education, and Communication

The relationship between language, culture, education, and communication is intertwined. In the following paragraphs, I review the literature with respect to culture, language, education, and communication.

Culture

Culture is the sum of shared attitudes, values, beliefs, worldview, traditions, customs, and behaviors. It is historically accumulated, revised, and developed by people. It is shared by members of a community in which people are bound together by a common history, religion, occupation, linguistic system, sexual-orientation, geographic location, or socioeconomic status. Therefore, it can be seen as a filter for outsiders to distinguish one group of people from others. Culture is a schema which guides people's understanding of words and discourse. It is also an integration influencing and reflecting

the interaction between language and thought (Brown, 2000). Nieto and Bode (2007) stated that everyone has culture. People have the ability to create and recreate ideas to affect their world in a variety of ways. Culture is transmitted through time and space by generations, material objects, symbols, and physical contact. Overall, the process of cultural construction is unconscious and continuous. Human beings grow up in the cultural environment surrounding them without intentionally noticing it. People develop cultural concepts and modify cultural elements through thinking, observation, participation, and interpersonal activities.

Interpreting the substances of culture is socially, culturally, and cognitively determined. Some cultural substances do not even exist in other communities. Fadiman (1997) indicates that burying placenta to bless birth seems normal for the Hmong community, but it is not widely acceptable in the U.S. medical context. In some Asian cultures, inviting spiritual treatments into the ward is a tradition and necessity, but it is out of the ordinary based on U.S. medical professionals' perceptions. Via the insight of culture, people can recognize a variety of communication styles, ethnic traditions, family structures, social distance, interpersonal relationship, social hierarchy, religion, gender sensitivity, and beliefs of health among diverse groups of people (Nieto & Bode, 2007; Peregoy & Boyle, 2008).

Communication

Communication is interwoven with cultural schemas, family values, and interactive patterns in the environment people are born into. It consists of verbal, written, and nonverbal components. Communication requires language proficiency and cultural knowledge to understand linguistic meanings and pragmatics. Based on culture, speakers and listeners adopt co-created perceptions to predict, explain, and make

sense of conversations. Furthermore, speakers shift speech styles from context to context. People present communicative skills in various ways in relation to their expected roles in society, such as in the family, classroom, workplace, and hospital. The way that speakers and listeners communicate is established by intersubjectivity (Bruner 1990), which is how people interpret others' minds in a culturally appropriate manner.

I take my own overseas study experiences as an example. As a female international student from Taiwan, I had limited access to diverse ethnic groups before I came to the United States. However, the U.S. academic world is filled with multicultural and multiethnic populations. In order to understand the American academic culture, I have observed senior graduate students' peer interaction on campus. I also use mass media as supportive data to acquire social skills, such as watching real-life shows, TV dramas, and Hollywood movies. I sometimes consult with friends, classmates, and professors who are from particular ethnic backgrounds about their cultural taboos and communicative politeness. Gradually, I have overcome my awkward feeling regarding hugging or even kissing cheeks with people for greeting and parting. I try to demonstrate humor and share my thoughts in order to fit into the U.S. academic atmosphere. However, on other occasions, I am careful with word choices and body language to reveal the serious part of me to Asians who are superior to me. Being cautious and speechless is a good skill to employ whenever I am afraid of offending someone. The switch of communication styles between outgoing and cautious may be unnecessary and stereotyping, but as an outsider and insider of both cultures, it is how I interpret sociocultural rules of communication in different speech communities.

Language

Likewise, language is a system of signs, symbols, sounds, and gestures which are infinitely creative and arbitrarily created by people. It is collectively built and culturally transmitted from generation to generation. Language refers to a specific civilized product of each era and it changes over times. For example, ancient Chinese literature is difficult for contemporary Mandarin-speakers to read, write, or comprehend. In addition, language varies in the essence of structures. While “I like you” is analyzed into the subject-verb-object syntax in English, it is presented by the subject-object-verb sentence pattern in Korean -- “na no jowa” (I you like).

Language is a conventionally cultural tool to connect human interactions by means of negotiation and thought exchange (Vygotsky, 1978). Meaning of language is perceived individually according to our thinking and cultural knowledge. It facilitates human development and interpersonal communication. Oral language development is a journey of socialization. It requires people’s thinking ability, linguistic knowledge, social skills, cultural sensitivity, and psychological mechanism to encode and decode information. Everyone has an inborn ability to acquire language in which he/she is immersed (Chomsky, 1965). Nonetheless, Everyone also needs opportunities to practice language by interacting with people and environment (Lindfors, 1991; Vygotsky, 1978).

In addition to oral interactions, language is correlated with communication in a printed world. Language reflects the purposes and functions of conversations and written texts. Literacy begins before school age and continues throughout people’s lives. It is not only involved in reading and writing, but also associated with independent

thinking and oral language ability. People develop literacy through real-life events containing meaningful functions (Taylor & Dorsey-Gaines, 1988).

Education

Education is usually dominated by people who hold superior sociopolitical power in society (Bruner, 1996). It has power over students' communication development and cultural cultivation. Everyone brings his/her home habits, family values, and oral traditions into classrooms. Education transmits mainstream cultural values to students, including time regulation, behavior models, manners, patriotism, formality and informality, conversational principles, ideologies, group identities, and attitudes toward economics.

According to Heath's (1983) ethnographic study of children's manners of communication, children from white and black working-class communities encountered learning difficulties in school settings when compared to students who grew up in town. Trackton African-American students' talents of imagination, creativity, and animated social/communicative skills were not appreciated by the mainstream middle-class school values. Their vitality and curiosity toward learning were eradicated by the confusing school routines, class regulations, and time/space concepts. In Roadville white family traditions, children were accustomed to discretion in word and deed. They obeyed parents' clear instructions, kept quiet unless they were invited to express opinions, and they were taught to make stories only based on truths. Parents had low expectations of children's academic performance and provided little support toward their school work. They believed that educating children was the school teachers' duty. The family values were quite opposite from the school culture where innovation, independent thinking, self-monitoring, and high expectation of school achievement were

advocated. These children from the white working-class community in Roadville encountered more and more obstacles in school due to the cultural conflict between family and school.

Educators recognizing ESL (English as a Second Language) and bilingual students' identities, home culture, first language literacy, second language proficiency, communication traditions, and life experiences can affect students' educational performance. Escamilla and Coady (2001) argued that some U.S. school teachers exhibited prejudice against Spanish-speaking students' English writing. It might be because of these students' spelling errors, misuses of punctuation, nonlinear logic, irrelevance of topic, and misapplying conversational language in English academic writing. However, these students were successful interlocutors in Spanish who were capable of transferring their L1 literacy skills to English. If ESL teachers ignore students' first language and neglect how it influences ESL learners' second language acquisition, teachers may underestimate these bilingual students' intellectual level.

The relationship between language, culture, education, and communication is intertwined. They are interdependent and mutually constrictive. Like a domino effect, people motivate changes in communication when their cultural values, educational background, and language immersion have been altered. The next section extends the discussion of the four correlated concepts by reviewing literature of the conceptual framework—communicative competence.

Conceptual Framework of Communicative Competence

Foreign language learning started to be viewed not just as a potential predictable developmental process but also as the creation of meaning through interactive negotiation among learners. Communicative competence became a household word in SLA, and still stands as an appropriate term to capture current trends in teaching and research.

(Brown, 2000, p.245)

The theoretical framework which I adopt for the study is communicative competence. It is the language ability that allows people to listen, speak, read, write, and physically interact with others in a functional and meaningful way. The competence of communication has derived from several perspectives. I start the discussion of oral language development from second language acquisition theories, and then connect to sociolinguists' interpretations of communicative competence and its components.

Second Language Acquisition

Krashen's monitor model (1981, 1983) is a well-known theory for second language development. First, Krashen distinguished acquisition from learning. Acquisition is an unconscious process to gain linguistic knowledge. It is an effective way to develop second language competence by acquiring language on the basis of real-life communicative purposes. On the other hand, learning is a formal and deliberate process to recognize and study linguistic rules. Second, in the natural order hypothesis, despite languages having different morphological, phonological, semantic, and syntactic structures, humans acquire languages in a predictable order. The progress sequence is universal and applied to most languages in the world.

Third, language knowledge is absorbed through comprehensible input. Comprehensible input is understandable information generated with contextual support. One example is, showing a mobile phone to ESL/EFL students when talking about cell phone devices, which is commonly known as a teaching strategy of using realia/pictures in class. Also, introducing abstract ideas through daily life activities can facilitate ESL/EFL learners' acquisition of complex concepts in a concrete way, such as

explaining finance management and economic issues via shopping activities. In the input hypothesis, Krashen adopted Vygotsky's (1978) Zone of Proximal Development (ZPD) to support the "i + 1" hypothesis, in which "i" refers to verbal and nonverbal input. Second language learners should receive input slightly higher than their current language competence. By means of "i+1", they are challenged to move to the next proficiency level.

Fourth, language acquisition is highly functional in a low-anxiety and less-stressful environment, which is identified as affective filter hypothesis. When students learn a second language under pressure and reluctance, the mechanism of affective filter has built up to hinder them from absorbing language input. Last, Krashen asserted that second language learners have an inherent monitor to regulate their language output in conversations, such as editing, self-correcting, and clarifying what they have said. Like the innate mechanism of first language acquisition, second language ability is developed in a natural, unconscious, and predictable way. Second language learners are able to "figure out" grammar through meaningful input. They also monitor their verbal performance and are aware of language errors.

Components of Communicative Competence

One needs fresh kinds of data, one needs to investigate directly the use of language in contexts of situation, so as to discern patterns proper to speech activity, patterns that escape separate studies of grammar, of personality, of social structure, religion, and the like, each abstracting from the patterning of speech activity into some other frame of reference.
(Hymes, 1974, pp.3-4)

The concept of communicative competence was initially introduced by Hymes (1971, 1972, 1974), a sociolinguistic advocate of ethnography of communication.

According to Hymes, when we refer to communication, it is not merely about linguistic

components, such as grammar, vocabulary, pronunciation, and spelling.

Communication is an ethnographic phenomenon. It is correlated with cultural values, roles and identities, conventions and formality, communicative channels, geography, ecology, and history of a community. Culture and context confine our interpretations of conversations within particular speech events. Sentences and purposes can be displayed in various ways. Hymes declared that communication is based on dynamic cooperation between speakers and listeners. In order to functionally and interactively exchange thoughts and express voices, we require linguistic knowledge, nonverbal cues, background knowledge of topics, and social information of participants. Schiffrin (1994) commented on Hymes' communicative competence as a combination of "knowledge of grammar" and "knowledge governing appropriate use of grammar" (p.140). Brown (2000) further interpreted Hymes' communicative competence as requisite knowledge which "enables us to convey and interpret messages and to negotiate meanings interpersonally within specific contexts" (p. 246).

The dynamic concept of communication is also discussed by Bakhtin (1986). He distinguished utterance from sentence. Sentence is a unit of combined linguistic features, including semantics, phonology, morphology, and syntax. Sentence reflects the literal structure of language instead of the reality of speech discourse. In contrast, an utterance is a unit of communication. Real life dialogue is based on the understanding of implications beyond sentences. We comprehend meanings by interpreting utterances in situated meanings. Utterance is unrepeatable and lively. It is guided by speakers' intentions and speech situations. Utterances also confine responses. For example, a competent ESL speaker is able to discover a literate

sentence of “how are you” functioning diversely in multiple situations. She/he evaluates the response based on the participant, time, place, and condition, such as replying with “Good, thanks” for daily life greetings and “I feel dizzy” for medical inquiry.

Meanwhile, Cummins’ (1979, 1980) dedication to bilingual children’s language development also contributes to the concept of communicative competence. Cummins proposed that academic language and social language require different capabilities: Cognitive Academic Language Proficiency (CALP) and Basic Interpersonal Communicative Skill (BICS). In Cummins’ Quadrant theory (1981), the level of cognitive challenge and contextual support affect bilinguals’ language performance. CALP is about demonstrating language skills in cognitively demanding and context-reduced situations. It usually involves abstract concepts and complicated speech tasks, such as giving a presentation about U.S. geology in class. BICS regards communicating with people in daily life conversations. Social language is less cognitively challenging and offers more contextual clues within conversations. For example, chatting with friends in a cafeteria is an easy situation for us to notice interlocutors’ speaking attitudes and facial expressions. Nonetheless, some contextually-reduced social events demand higher BICS, such as making a medical appointment via phone conversation. Many ESL/EFL speakers may agree that talking to someone face to face is easier than talking on the phone without seeing others’ facial and gesture cues. Cummins’ BICS and CALP theory, combined with cognition and contextual influences, has turned a new page for second language education since the late 1970s and early 1980s.

Canale and Swain (1980) and Canale (1983) adapted the concept of communicative competence and defined it as four dimensions: grammatical

competence, discourse competence, sociolinguistic competence, and strategic competence. A successful communicative participant has (1) grammatical competence: knowledge of language verbal and nonverbal codes, including words, grammar, and sounds; (2) discourse competence: knowledge of inter-sentential relationships in texts, such as cohesion and coherence of conversations; (3) sociolinguistic competence: cultural sensitivity regarding language use, such as topic relevance, social functions and speaker-listener relationship; for instance, to address interlocutors in an appropriate manner, and (4) strategic competence: ability to detect failures, make repairs for miscommunication, and facilitate communication efficiency, such as asking a participant to clarify what he/she has just said.

Bachman (1990) elaborated on Hymes' (1972, 1974), Canale's and Swain's (1980), and Canale's (1983) concept of communicative competence through a language testing perspective. He designed a theoretical framework of Communicative Language Ability (CLA). Communicative ability consists of "both knowledge, or competence, and the capacity for implementing, or executing that competence in appropriate, contextualized communicative language use" (p.84). It includes the interaction among knowledge of language, knowledge of the world, knowledge of speech situation, and strategic competence. Knowledge of the world constructs a conceptual foundation for people to make sense of interpersonal interactions. Knowledge of speech situation provides information for us to know who, what, why, when, and where concerning conversations. Strategic competence is a monitoring system to determine final speaking options generated by language knowledge. It enables us to identify speech situations, determine which competencies should apply, and form an entire plan for implementing

language output. When Canale's (1983) strategic competence is concerned with ability of conversational compensation in language, Bachman's strategic competence is more related to humans' neurological and psychological processes within communication.

Bachman (1990) named knowledge of language as language competence. Language competence enables us to control language forms (organizational competence) and functions (pragmatic competence) in spoken and written texts. Under the umbrella of organizational competence, Bachman adopted Canale's (1983) separated abilities between grammar (grammatical competence) and discourse (textual competence). Grammatical competence, is concerned with language rules at the sentence level: an ability to correctly master lexicon, spelling, syntactic rules, morphemes, phonemes, and other linguistics features. Textual competence involves rhetorical organization in inter-sentential level: a skill to make discourse logically sequential, coherent, and cohesive.

In the dimension of pragmatic competence, Bachman emphasized functional and cultural aspects of language use. Pragmatic competence regulates language functions in sociocultural use, including illocutionary competence and sociolinguistic competence. According to Halliday (1973, 1975), humans are capable of implementing multifaceted language functions to communicate meaningfully. For example, people use language as a means to get things done (instrumental function), to invite others to conversations and interactions (interactional function), to ask questions (heuristic function), to make up situations (imaginative function), and to convey a message to others (representational function).

Illocutionary competence is the ability to manipulate language functions (e.g., complaining, questioning, and criticizing) and to discover implications beyond indirect speech acts. Illocutionary competence can be seen as a derivation from Austin's (1962) and Searle's (1969) Speech Act theory. The core value of Speech Acts is the function of human language: how to accomplish actions by speaking. Examples of speech acts are apologizing, showing appreciation, and making suggestions. Austin divided utterances into locutionary act, illocutionary act, and perlocutionary act. Locutionary acts include sounds, words, and literal meaning of a sentence, such as a tag question "It's hot, isn't it?" to describe the hot status in a room. Illocutionary act is the true speech act containing a speaker's intention of performing an action. Take "It's hot, isn't it?" for instance; the illocutionary act is requesting the host to turn on the air-conditioning. Perlocutionary act is the effect on thoughts or actions by noting "the result that the host eventually turns on the air conditioner" in this example.

Searle (1969) further defined speech acts into five classes: representatives, commissives, expressive, directives, and declarations. Representative is an act to convey belief, such as "It's late." Directive expresses desires, like, "Go to bed now." Expressive conveys emotions, such as "I feel so sad without finishing the show." Commissive is an act to represent future planning; for instance, "I promise I'll brush my teeth after the commercial." Declaration refers to upcoming status, such as "Okay, I'll quit." Austin's (1962) and Searle's (1969) Speech Act theory, Bachman's (1990) illocutionary competence, and Halliday's (1973, 1975) language function theory all emphasize the significance of manipulating the multifunction of language within communicative competence.

Bachman's sociolinguistic competence is relevant to sociocultural knowledge of language use. It allows us to implement language functions appropriately in specific speech events. For example, people show politeness to the elderly in ceremonies and use formal language in business meetings. It requires people's awareness of dialectal variations and ability to reflect diversity.

Linguistic register (Halliday, 1978; Simon-Vandenberg, 1983) is related to the strategic competence which Canale (1983) proposed and the sociolinguistic competence that Bachman (1990) stated. It is a skill to discern social-cultural rules of language use in dynamic real-life dialogues. Register determines our word choices and ways of speaking when talking to diverse speakers in various situations. Brown (2000) defined register as a variety of words, pronunciation, phrases, and expressions which imply that speakers are from certain occupational groups or social class. Nonetheless, within systematic-functional linguistic viewpoints, register is not restricted to occupational or socioeconomic distinction. It is applied in a wider aspect that any single language speaker can make multiple linguistic choices within any social activity (Burns, Joyce, & Gollin, 1996). For instance, we naturally talk formally in front of people who are superior to us and talk casually to our intimate friends. We nickname our family members but carefully address new acquaintances by their highest socioeconomic achievement, such as Miss Chan, Professor Jackson, Dr. Yeh, or President Ma. We form and shift registers based on the contextual variables: field, tenor, and mode (Halliday, 1978 cited in Burns, Joyce, & Gollin, 1996).

Field is concerned with what the social communication related to, such as a dinner invitation. Tenor is about participants involved in the conversation, including social

relationship, power, and identity of the speaker-listener, such as student-professor, daughter-father, and husband-wife. Mode refers to how communication occurs, such as talking on the phone or writing in emails. Dimensions of register are varied across languages because every speech community has its own cultural values in terms of how to speak politely. The complexity of cultural influences in register explains the challenge facing second language speakers to perform English in a conventionally appropriate way in diverse speech situations.

Pragmatics is also an important concept when discussing competence of communication. It is a study of meaning and context of communication. It examines how we use language within a particular context and why we use it in a specific way. The following examples explain pragmatics in conversation.

Example 1: Student Mei-A (Taiwanese) is initiating small talk with her English teacher, Shane (American):

Mei-A: The traffic is terrible.

Shane: Yeah, right. You can say that again.

Mei-A: Oh, the traffic is terrible [answering Shane perplexedly].

Shane: . . . [silence]

Example 2: James (American) is talking to his big sister, Michelle (American):

James: The traffic is terrible.

Michelle: Yeah, right. You can say that again.

James: The traffic is terrible [teasing Michelle with a naughty smile].

Michelle: . . . [silence]

Example one, above, displays a lack of pragmatic skills leading to illogical dialogue. For the second language speaker, Mei-A, it is difficult to interpret specific idioms utilized in particular contexts. Example two provides the same literal sentences but a totally different atmosphere. English native speaker, James, is pretending that he doesn't understand what Michelle means.

The most well-known pragmatics theorist is Grice (1975), who stated that communication should be built on cooperative principles between speaking participants. Gricean pragmatics maxims comprise four principles: quantity, quality, relevance, and manner. Quantity is concerned with how we make information adequate and not excessive when speaking. Quality is about telling truths. Relevance is regarding appropriate/clear topic connections and talking in relevance to participants. Manner is the skill to talk clearly, concisely, and orderly. Like speech act theory, we don't follow literal meanings of a sentence (locutionary act) in discourse, but instead, we interpret speakers' intentions (illocutionary act). We analyze conversational implicatures to make conclusions of meanings. Implicatures are inferences helping us make sense of conversations through words, background knowledge of topics, and maxims of cooperative principles. If we go back to the example 2 with Michelle and James, Michelle is aware of James's personality, English proficiency, and sibling relationship with her. As a native English speaker immersed in American English culture, she masters enough conversational implicatures to detect James' purposeful violation of cooperative principles. Therefore, she is able to judge her little brother's naughty behavior of teasing her by responding based on the literal meaning of "you can say that

again” rather than the pragmatic meaning of “I totally agree with you” in the conversation.

Communication is an ethnographic phenomenon which represents a particular speech community’s behaviors, beliefs, attitudes, styles, actions, and conventions (Schiffrin, 1994). However, Gricean pragmatics maxims of quantity, quality, relation, and manner do not take nonverbal elements of communication into account. Like written and spoken language, nonverbal communication is one of the cultural products created by civilization. The way we act, approach, smile, nod, shake head, bow, step backward, wrinkle eyes, or shrink shoulders is highly associated with culture.

For example, patting a Thai boy’s head and praising him with “good job” can be viewed as rude because a boy’s head is his spiritual entrance and touching it may cause spirit loss. Even clothes and dressing play a role in interpersonal interactions (Brown, 2000). In U.S. wedding culture, wearing a white dress is bride’s privilege. It is considered aggressive when a female guest elaborately dresses up in white to disrupt a wedding. In Taiwanese culture, wearing red is commonly accepted to show guests’ blessings to the newly-married couple. Nevertheless, there is no white clothing taboo. Guests can dress in any color except for black at a wedding. In funerals, Taiwanese wear black clothes and cautiously avoid red dress.

Ariza, Morales-Jones, Yahya, and Zainuddin (2007) described the importance of cross-cultural pragmatics for ESL learners. Having correct knowledge of English grammar is not enough for fluent ESL speakers. They should also understand how language is specifically used and expected in the U.S. mainstream culture. For instance,

directly translating the greeting expressions of “have you eaten?” or “have you slept well?” from Chinese dialects is awkward to native English speakers.

Referring to my experiences as an international student in Australia and the United States, I was usually bothered when the supermarket charier asked me “How are you?” but never seemed to expect my response wholeheartedly. In my generation, modesty is highly promoted based on the regulations of Confucianism. I always feel uneasy accepting supervisors’ appreciation and compliments. Even though I know the appropriate answer to “Thank you so much” is “You are welcome,” I can’t help replying “No, I did nothing. I should thank you, really.”

Researchers’ dedication to calling attention to cultural and contextual influences in communication has shifted the emphasis of grammatical teaching toward the trend of a communicative-approach pedagogy and assessment in ESL and EFL education over the last 30 years (Baleghizadeh, 2007; Chen, 2006). The concepts of the above conceptual framework are also synthesized in two figures provided in the end of this section. Figure 2-1 establishes a chronological trace of language development in communicative competence. Figure 2-2 illustrates the components of communicative competence.



Figure 2-1. Chronological derivation of communicative ability development (Note: synthesized from Austin, 1962; Bachman, 1990; Bakhtin, 1986; Canale, 1983; Canale & Swain, 1980; Cummins, 1979, 1980; Grice, 1975; Halliday, 1973, 1975, & 1978; Hymes, 1971, 1972; Searle, 1969)

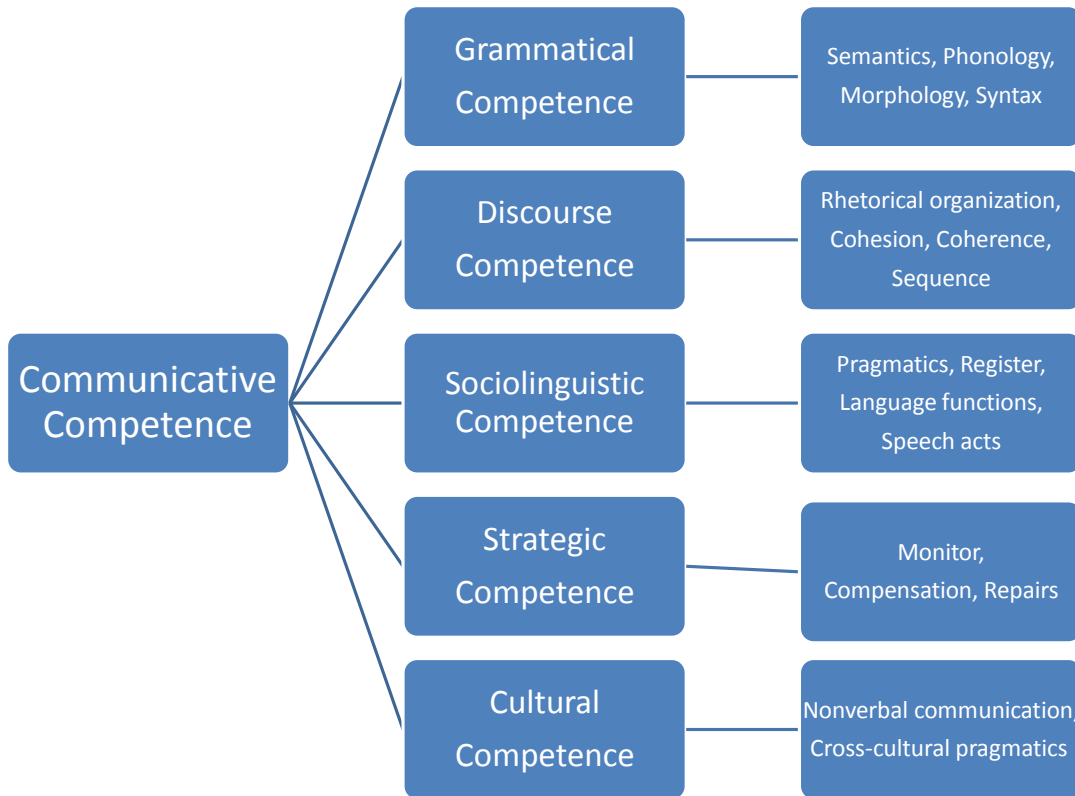


Figure 2-2. Components of communicative competence (Note: synthesized and adapted from Ariza et al., 2007; Austin, 1962; Bachman, 1990; Canale, 1983; Canale & Swain, 1980; Chomsky, 1959; Grice, 1975; Halliday, 1973, 1975, & 1978; Hymes, 1972; Searle, 1969)

Review of Literature on Contemporary Issues

A nurse's clinical experiences and therefore competence can vary from culture to culture, country to country, or even region to region. Despite these constraints, nurse migration continues to be fuelled by the assumption that a "nurse is a nurse. (Hancock, 2008, p.261)

Every community has its specific behavior patterns, mannersims of speech, attitudes toward education, and values of health, which also affect how we make sense of the world. Medicine is interpreted differently by people from diverse backgrounds. Unfortunately, the reality is that people usually expect internationally educated nurses to act exactly as mainstream nurses do in the host community. International nurses are capable of being sensitive to multicultural patients. Their bilingual and bicultural

competencies contribute considerably to the ethnically diverse society of the United States. Nonetheless, the challenges faced by international nurses working in a host country are culturally, linguistically, educationally, communicatively, emotionally, socially, physically, and politically extensive.

Hearnden (2007) conducted a qualitative research on communicative needs for internationally educated nurses in Canada. The study revealed that in order to work in an English-speaking country, international nurses dealt with stressful and extensive challenges, including immigration screening, cultural adjustment, communicative obstacles, financial burden, family responsibilities, and relationship disconnection with the original country. Xu and Kwak (2005) adopted a secondary analysis method to examine internationally educated nurses' characteristics from the 2000 National Sample Survey of Registered Nurses in the United States. Contrasting with U.S. mainstream nurses, internationally educated nurses were inclined to be single and young. They were assigned heavier duty and longer working hours. Moreover, Gardner (2005), Sherman (2007), and Xu et al. (2008) suggested that internationally educated nurses ran high risks of suffering isolation, homesickness, depression, injustice, racism, and discrimination. For instance, they left home alone and had limited social circles and family contacts to support them in the new community. Their responsibilities were great but their pay was small. They received less job promotion chances compared with white nurses. Sometimes, their accents were ridiculed by mainstream nursing peers. Furthermore, their nursing competence was frequently questioned by patients and healthcare colleagues simply owing to their skin color or accents rather than their professional training and nursing qualifications.

Comparative Medical Contexts

Contemporary medicine, also known as western medicine and modern medicine, is the science of retaining and restoring human healthiness by prevention and treatment of mental and physical illnesses. It includes two main disciplines, which are internal medicine and surgery. Western medicine rules the current U.S. medical industry. In Mandarin-speaking countries, such as China and Taiwan, it is common to see a mixture of Traditional Chinese Medicine (TCM) and modern medicine (D'Avanzo, 2008). Traditional Chinese Medicine comprises herbal medicine, cupping, acupuncture, message, and body balance. According to contemporary medicine, diseases are caused by germs. However, based on TCM perspectives, the upset of body balance is the key cause of illness (Galanti, 2008). While western medicine is defined as an invasive intervention to human body, Chinese medicine is well-known by its natural and moderate treatment towards health.

Mandarin-Speaking Medical Context

In Mandarin-speaking medical contexts, such as China and Taiwan, the entire healthcare system and atmosphere is doctor-centered. Physicians are images of authority and expertise who have superior medical knowledge. Nurses are usually females who serve supplementary roles to assist doctors. They are inclined to follow doctors' medical orders and accomplish task-oriented nursing jobs (Sherman, 2007; Xu et al., 2008). Nurses have a heavy workload and rush in and out in the stressful working environment. In China, the ratio between nurses and patients is 1 nurse per 1,000 people (D'Avanzo, 2008). In Taiwan, registered nurses and licensed practice nurses in general wards are in charge of eight or more hospital beds per shift, which is twice the U.S. nurses' working burden.

In Asian and Mandarin-speaking contexts, patients tend to be given little information about doctors' diagnoses, treatments and medications (Geissler, 1998; D'Avanzo, 2008). Similar situations can also be found in Taiwan. By and large, medical diagnoses and medical documents are written in English vocabulary and phrases instead of in patients' first language, Mandarin. Taiwanese patients usually have limited access to their health conditions and are discouraged to ask questions. Furthermore, Giger and Davidhizar (2008) also declared that Asian patients tend towards acting like subordinates to healthcare professionals. Although East Asian patients are confused regarding prescription, they may hesitate to ask for clarification. They are inclined to be less opinionative and make fewer requests during medical visits. Compared with patients from European and U.S. backgrounds, Asian patients are also more reluctant to express their feelings of pain.

To some extent, Asian people interpret health, illness, and treatment differently from mainstream American viewpoints. For instance, Asian people believe that humans neutrally co-exist with nature rather than control nature (Galanti, 2008). The core value of Traditional Chinese Medicine keeps the human body balanced rather than radically changing body conditions. The neutral perception also affects patients' acceptance of invasive treatments. Additionally, influenced by Taoism, Buddhism, and Confucianism values regarding the past, Asians seem to cherish the memory of the past and respect for the elderly (Munoz & Luckmann, 2005). They are dutiful for personally taking care of any elderly family member who is sick rather than leaving him/her alone with healthcare professionals. Lipson and Steiger (1996) argue that it can be more challenging to

persuade people who care about the past than who are present-orientated or future-oriented to change current behaviors in order to prevent illnesses.

Taiwan, the country where I grew up, has its specific medical system, hospital regulation, and nursing culture. The Taiwanese population is composed of five linguistic and ethnic groups, including Holo, Hakka, aborigine, mainland Chinese, and a host of immigrants (Perng, Lin, & Chuang, 2007). Mandarin is the official and popularized language in healthcare communication. We are accustomed to using Celsius for temperature, centimeter for height, and kilogram for weight. Taiwanese government establishes a national health insurance for citizens and foreign visitors who have legally resided in Taiwan beyond four months. Even though our medical culture encourages an appointment system, a walk-in policy is conventionally acceptable in many private clinics and regional hospitals.

In the outpatient department, patients are usually gathered in a waiting lobby before seeing a doctor. When a physician gives medical consultation, we probably share the same clinic room with one and two more patients during the consultation. Consequently, patients' confidentiality may not be completely concealed. When the physician keeps staying in one room throughout his/her clinical hours, outpatients are frequently asked to move from room to room in order to complete examination and treatment procedures. Generally, outpatients in Taiwan benefit from high clinical efficiency. Patients are able to complete the entire medical procedures with one-time medical visits, including seeing a doctor, making examinations, receiving medical treatments, picking up prescriptions, and paying medical bills at the clinic and hospital.

English-Speaking Medical Context

Broadly speaking, U.S. medical service is more patient-centered and privacy-oriented. Physicians are not the only actors/actresses who enjoy the spotlight in the medical setting. Healthcare professionals distribute the burdens of medical care. U.S. registered nurses are treated as nursing practitioners who are capable of thinking critically and managing cases independently. Compared with nurses from overseas, U.S. registered nurses benefit from a more flexible working schedule, a lighter workload, better welfare, and higher socioeconomic status (Hancock, 2008; Hawthorne, 2001; Kingma, 2001; Kline, 2003). On average, American culture values autonomy, independence, freedom, privacy, capitalism, health, and fitness (Galanti, 2008), which implies Americans' medical interactions. Americans are characterized by an adventurous spirit and a willingness to challenge nature by embracing the future and are open to new medicine and invasive interventions (Munoz & Luckmann, 2005). Mostly, families expect the hospital team to address patients' inpatient care, such as feeding, bathing and sputum suctioning. In addition, it is easy for patients to acquire health information from TV commercials, health magazines, medical consultations, or other channels. U.S. patients are able to form their own opinions about interventions, which is probably ascribed to the advocacy of individualism and critical thinking in the U.S. culture.

The U.S. patient structure comprises a culturally and linguistically diverse population. Americans use Fahrenheit, inch, and pound for health measurement. Patients are covered under private health insurance policies or hold a non-insured status. Except for particular emergency clinics and walk-in clinics, patients are usually expected to make an appointment before they seek a doctor's consultation. Outpatients

are usually assigned an individual room during the consultation. Contrasting with patients in Mandarin-speaking contexts, they enjoy better privacy and confidentiality (Xu et al., 2008). Patients are allowed to physically stay in one room alone while doctors and nurses are in and out of the room to provide medical services. Nonetheless, sometimes finishing a whole set of medical procedures for patients is time-consuming. Patients are expected to schedule multiple appointments to get cured. They may spend one day in doctor's consultation, other day for examination, and another day for treatment. Patients usually go to pharmacies outside the hospital to pick up prescription. Instead of paying fees right after the medical visit, patients wait for medical bills sent from health insurance companies to make a payment.

The above paragraphs provide readers an introduction to Mandarin-speaking and English-speaking healthcare environments. However, categorizing medical culture into Western and Asian, English-speaking and Mandarin-speaking, or U.S. and Taiwan context runs the risk of overgeneralization. Pointing out the characteristics of the comparative medical world constructs a foundation of understanding essential differences and building on similarities of the two medical communities for readers. It is important to understand intra-ethnic individual variables and avoid stereotyping healthcare practitioners and patients from certain ethnic groups. The characteristics of the comparative medical contexts are also presented in Table 2-1.

Table 2-1. Medical characteristics between English-speaking and Mandarin-speaking context

Characteristics	English-speaking context (i.e., United States)	Mandarin-speaking context (i.e., Taiwan)
Science of Medicine	Western medicine (also known as contemporary medicine and modern medicine) Diseases caused by germs	Modern medicine and Traditional Chinese Medicine Illnesses caused by upset body balance
Population	Radical and invasive medical intervention Culturally and linguistically diverse patients	Neutral towards body and health Five linguistic and ethnic groups: Holo, Hakka, aborigine, mainland Chinese, and various immigrants
Dominant Language	English	Mandarin
Health Insurance	Private health insurances	National health insurance
Measurement	Fahrenheit, inch and pound	Centigrade, centimeter and kilogram
Medical Atmosphere	Patient-centered	Doctor-centered
Time Orientation	Future-oriented (prevention is more acceptable)	Past-oriented (changing behaviors for future prevention is less acceptable)
Human and Nature	Challenging with nature (radical treatment is more acceptable)	Neutrally co-exist with nature (invasive treatment is less acceptable)
Role of Doctor	Shares duties with healthcare professionals	Image of authority and expertise of medical knowledge
Role of Nurse	Independent nursing practitioner Critical thinking and independent judgment In charge of 4-6 hospital beds per shift (general wards)	Physician's assistants Following task-oriented nursing care In charge of 8 or more hospital beds per shift (general wards)
Role of Patient	Privacy and confidentiality protected Aware of health related issues and opinionative about medicine, treatment and intervention	Less privacy protected Less informed about medical treatment
Role of Family	Reliant on hospital team to accomplish inpatient care	Responsible for family members' inpatient care

Note. Synthesized from D'Avanzo (2008), Galanti (2008), Geissler (1998), Giger and Davidhizar (2008), Lipson and Steiger (1996), Munoz and Luckmann (2005), Perng, Lin, and Chuang (2007), Sherman (2007), and Xu et al. (2008)

Factors Affecting Cross-Cultural Clinical Communication

The nature of transcultural nursing communication is intricate and complex. Internationally educated nurses' communication experiences are influenced by how people use language, how they interact physically, how they interpret culture, how they speak rhetorically, and how they apply conversational patterns.

Context

Contexts (also refer to environments) affect internationally educated nurses' communication experiences. The ethnicity and age population of patients' structures vary among nations. Also, every country has its particular common illnesses (Bola et al., 2003). For example, U.S. large proportion of obesity and hypertensive is not commonly seen in other countries. Furthermore, the U.S. culturally and linguistically diverse population increases the complexity of communication for ESL nurses. Providing healthcare services in the U.S. demands international nurses' competency both in language and culture. Without sound accommodation and transitional training, it is impractical to expect mono-ethnic nurses to demonstrate high communicative competence when they are in charge of ethnically diverse clients.

The U.S. healthcare context has its specific nursing care and discourse patterns distinct from international nurses' home experiences. Asian nurses seem used to a task-oriented and doctor-centered environment. They experience cultural confrontations when working in the patient-centered environment in the United States, highlighting nurses' autonomy and critical thinking (Sherman, 2007). Additionally, different medical systems, health insurance policies, and staff patterns lead to contradictory expectations of nursing jobs between patients and nurses. It is possible that internationally educated

nurses encounter a communication situation that never occurred to them when they worked in the home country.

Culture

Culture confines our interpretations of medical conversations. We all possess our own perceptions toward medicine. Culture influences our basic concepts and cognitions in many aspects, which leads to different expectations of medical interactions. Cultural barriers build even higher blockage than second language deficiency. A second language speaker or a medical interpreter who is unfamiliar with the beliefs of patients' communities can still encounter communication failures. Medical practitioners' lack of cultural knowledge, cultural awareness, and cultural skills may result in miscommunication or even worse fatal damage to patients.

Fadiman (1997) analyzed a cross-cultural medical case of a Hmong family in the United States. Through studying the Hmong's culture, history, philosophy of health, refugee status, and spiritual life, Fadiman concluded that the U.S. doctors' ignorance of the Hmong's English barriers and self-sufficiency traditions caused misinterpretation of their resistance toward medical interventions. For example, common medical routines, such as taking blood samples and giving injections, could result in severe communication conflicts because the two concepts had never existed in Hmong traditions. In addition, the illiterate background of the Hmong family increased the difficulties of reading measurements and administering medication. In Hmong community, the perception of time was not regulated by 24 hours as in modern society. The disease of epilepsy was rationalized as a spirit coercing the patient to make him/her fall down. Cross-cultural communication was frustrating for the medical team and the

Hmong family. The Hmong family just did not fit the interactive patterns that doctors and registered nurses had been trained to deal with.

Culture also restrains our perspectives of diseases. Depending on the culture, illnesses may be attributed to spiritual loss, spiritual damage, germs, or body imbalance. Galanti (2008) argued that some Asian cultures view humans as parts of nature rather than controllers of nature. It influences people's perceptions whether medicine is invasive or noninvasive to health. While middle-class Americans tend to be future oriented about time, progress, and change, Asian values seem to request people to remain in state. Nurses also require cultural competence to comfort patients and families about dying and death based on their cultural and religious backgrounds. Another example is how cultural customs conflict with hygiene. Some Indonesian patients refuse to use chopsticks and insist on using their bare hands to eat hospital meals (Chien & Tsao, 2009). The variety of cultural beliefs can result in diverse expectations of medical communication between doctors, patients and international nurses.

In some cultures, medical communication relies more on nonverbal cues than oral conversations. Lack of cultural knowledge in language use may also cause international nurses' miscommunication and social isolation. Bola et al. (2003) indicated that in the United States, communication largely depends on oral utterances. Relatively, in Japan and Korea, communication relies to a great degree on nonverbal cues to show emotions, personal distance, and social relationship, such as nodding, bowing, or standing behind or beside the speaker to show attention. Moreover, the intricacy of nonverbal cues also challenges ESL nurses' cross-cultural communication. For example, international

nurses should know that when native Alaska patients raise eyebrows, it represents yes, and when wrinkle nose, it signifies no (Nieto & Bode, 2007). Also, international nurses should be aware of gender and social distances in different cultural and religious regulations when they physically assist patients.

Education

School literacy is usually established by the people who have superiority in ethnicity or socioeconomic status. The way we are educated and regulated in school is determined by the mainstream culture which also dominates our ways of speaking and behaviors in family, community, and workplace (Heath, 1983; Bruner, 1996). Education reinforces mutual values and cultivates students to be members in a society. In Taiwan, education is highly valued and emphasized. From individual, family to the whole country, nearly everyone is judged by the philosophy of Confucianism. Our lives, learning, career, politics, relationships, and social behaviors are largely guided by humaneness (*ren*), ritual (*li*), loyalty (*zhong*), and filial piety (*xiao*). In my generation (1980s), we are taught to obey customs, respect the elderly, appreciate what we have, be filial to parents, be kind to people, and be loyal to authorities. Nonetheless, there are always exceptions. Individual differences and impacts brought by globalization gradually shift some traditional values toward the West, such as the nuclear family structure and Americanized social skills.

With regard to nursing education, Peng and Hsu (2005) adapted Huang's (1996) argument about the Western-Chinese nursing training. While science, law and religion tend to form the basis of Western school culture, Chinese schooling is founded on humanism and sensibility. Schooling in English speaking countries is more scientifically oriented and devoted to finding the omnipresent truth. In Taiwan, humanistic education

is valued. Nursing students develop both humanism and professional knowledge in nursing programs. They are taught to be kindhearted to people [virtues (*de*)], to tell right from wrong [wisdom (*zhi*)], to keep a healthy condition [body (*ti*)], and to be cooperative with patients, colleagues, supervisors, and social members [public relation (*qun*)]. In general, a test-oriented curriculum is common in Taiwan. There is a tendency for students to choose a field of study determined by their scores on the national college entrance exam (Yen & Stevens, 2004). Lack of options in choosing majors may lead to students' lack of devotion to the nursing profession after graduation.

However, in U.S. education, the flexible application system facilitates students' choices of major based on their personal interests. Wang, Singh, Bird and Ives (2008) collected 21 Taiwanese nursing students' learning experiences in Australia through semi-structured interviews and thematic content analysis. Findings indicated that participants had issues transitioning from teacher-centered and lecturing-oriented classes to seminar and tutorial-based classes. Success in the Australian curriculum relied on a large proportion of oral presentation, independent learning, and critical thinking. Nevertheless, from an Asian communication tradition in which listening is a virtue, the Taiwanese nursing students encountered academic obstacles caused by cultural clashes rather than English language deficiency or intelligence disability. Moreover, participants in Wang et al. (2008) research claimed that in addition to language barriers and cultural conflicts, the unique Australian nursing regulations, attitudes toward health, approaches to nursing, and medical systems also impeded them from succeeding academically and clinically.

Xu, Gutierrez and Kim (2008) conducted a phenomenological study examining nine immigrant Mandarin-speaking nurses' working experiences in the United States. Seven informants were from Mainland China and two came from Taiwan. In the in-depth interviews, participants declared that hierarchy was valued in their home countries. They were offended when the U.S. subordinates rejected their orders.

Additionally, education influences Mandarin speakers' rhetorical styles distinguishing from English speakers. Overall, Asian speakers tend to be careful regarding what they say. They are used to speaking in an indirect manner and allowing the listener to save face. On the contrary, American speakers are used to direct expressions (Escamilla & Coady, 2001; Kaplan, 1996). Gardner (2005) investigated 15 ethnic minority students' experiences studying in a white dominate nursing program in California. By means of analyzing in-depth, semi-structured interview, Gardner indicated that racial minority students were concerned about American peers' aggressive discussion styles and argumentative attitudes in and out of classrooms. Boshier and Smalkoski (2002) and Sherman (2007) also stated that one of the common difficulties facing ESL nurses and nursing students was showing assertiveness.

Language

Language is one of the main factors that influence nurses' communication experiences. First, the diversity of written and speech texts for medical purposes increases the complexity of cross-cultural communication for internationally educated nurses. According to Lee (1998) and Lee (2005), nursing involves a variety of tasks, such as dictating doctors' orders, listening to patients' chief complaints and symptoms, and reading diagnosis reports. Besides encountering discourses relevant to health issues, it is common for ESL/EFL nurses to face small talks with a variety of speakers.

Studies show that ESL nurses are requested to be competent in showing assertiveness to patients, communicating via telephone, pronouncing appropriate stress and intonation, asking patients and supervisors for clarification, and talking about social topics beyond healthcare issues (Bosher & Smalkoski, 2002; Sherman, 2007; Xu et al., 2008). Participants of international nurses in Hearnden's (2007) research also stated that talking on the phone was quite a challenge for them even in daily life situations, not to mention difficulties inherent in calling doctors for medical orders.

Second, changing speaking styles when talking to different speakers is complex. Addressivity is the ability to talk to diverse speakers in various culturally specific ways (Bakhtin, 1986). It reflects speakers' power, relationship, gender, socioeconomic status, and social proximity. As beginning English speakers, EFL/ESL nurses have difficulties in switching speaking styles from "talking to medical professionals" to "talking to patients". According to a prior study (Ho, 2008), the participant EFL nurses uttered fragments or incomprehensible sentences to foreign patients, such as "on IV" instead of "I'm going to put you on an IV drip", "He expire" rather than "He passed away", and "IV DC" in place of "The IV drip is completed." ESL/EFL nurses use their existing knowledge of medical terms and abbreviations to cope with cross-cultural communication. Nonetheless, insufficient knowledge of grammar and register leads to potential risks for misunderstanding. Selecting suitable words and comprehending patients' semantic choices are culturally and contextually relevant. The heterogeneity of speakers or registers result in particular communication styles and speech patterns in specific nursing discourses, such as using "IM" and "BP" among medical teams and using "give a shot" and "I am going to take your blood pressure" to patients and families.

Third, how nurses perceive the speech event and construct meaning is restrained by prior experiences. According to Goffman (1974), the principles of governing subjective consciousness are frames. Frames store cognitive structures and guide human perceptions of a coming speech event. For instance, when a nurse is informing family members about a patient's death (speech event), she is activating her preoccupied frame of dying and death (cognitive structure). However, frames are flexible and uncertain. We unconsciously adopt and adjust our frames based on particular occasions, participants, time, and communicative patterns of discourse. Communicative competence requires the ability to choose the appropriate frame. International nurses need to be familiar with various ways of talking about one topic with different people in various settings. For instance, they switch styles when talking about body care and death with Islamic people, Christians, or Buddhists in daily life conversation or in nursing discourse.

Fourth, diverse medical literacy also results in communication chaos. Take Taiwan and U.S. for example. When a patient has respiratory collapse, Taiwanese medical emergency team shout out "on endo" instead of "intubate" which is regularly adopted by the U.S. medical industry. Taiwanese nurses keep records of patients' fever symptoms as "mi mi fever" not "mild fever". In addition, hospitals in Taiwan and U.S. rely on different technology to manipulate medical equipments. The above examples imply that internationally educated nurses may easily misapply their homeland experiences to U.S. nursing practices and leads to unpredictable medical miscommunication.

I synthesize the above arguments and present them in the Table 2-2. The intention is to provide a comparative perspective to readers about characteristics between

English-speaking and Mandarin-speaking nurses rather than reinforcing any stereotypes of the two speech community.

Table 2-2. Comparison between Mandarin-speaking and English-speaking nurses

	Mandarin-speaking nurses	English-speaking nurses
Cultural Values	Harmony, hierarchy, and obedience Conformity and collectivism	Argumentative and challenging Uniqueness, individualism, and competition
Education	Humanism and arts; Sensibility-oriented education Choice of field of study is determined by scores of the national college entrance exam Structured, teacher-centered, lecturing-oriented learning environment	Science, law and religion; Science-oriented education Flexible application system in educational system to more direct students' interests of choosing fields Independent learning, critical thinking, presentation, assessment, seminar and tutorial learning environment
Communication	Indirect, beating around the bush, low occurrence of assertiveness Communication relies on a great degree of nonverbal cues Listening is stressed	Direct, linear, assertive Communication mostly depends on verbal utterances Expression and speaking out are stressed
Nursing Practices	Nursing care is more task-oriented Nurses serve in roles as physician's assistants Doctor-centered atmosphere	Nursing care is more independent with clinical judgment Nurses practice individual works, higher socioeconomic status Patient-centered healthcare philosophy

Note. Synthesized from Adeniran et al. (2008), Bola et al. (2003), Choi (2005), D'Avanzo (2008), Gardner (2005), Geissler (1998), Munoz and Luckmann (2005), Peng and Hsu (2005), Perng et al. (2007), Sherman (2007), Wang et al. (2008), and Xu et al. (2008)

Chapter Summary

To conclude, this chapter reviewed literature on culture, language, education, communication, second language development, and communicative competence. In the second part, this chapter compared medical culture and described factors affecting international nurses' communication experiences. Internationally-educated nurses' cross-cultural communication experiences are influenced by the interrelationship between environment, language, culture, education, and speech situations they encounter. Conflicting professional values, medical relationships, nursing philosophies, and expectations of nursing roles can cause dissonance in international nurses' communication experiences. Moreover, the differences in hospital subculture and medical literacy may also impede their communication. The unfamiliarity with the U.S. healthcare delivery system, management of pain, nursing assessment, nursing procedures, medication administration, medical technology, and working with multicultural populations all increase the difficulties of their adaption to the U.S. healthcare context (Adeniran et al., 2008; Bola et al., 2003; Sherman 2007).

CHAPTER 3 METHODOLOGY

Overview

This study was based on the theoretical perspective of constructivism embedded in the epistemology of constructionism. Qualitative case studies were employed in order to gain a better understanding of internationally educated nurses' perspectives, experiences, values, and beliefs of cross-cultural communication events. I used purposeful sampling to recruit five Taiwanese nurses to participate in the one semester research period. The primary data included individual interviews and focus group interviews. The supplementary data were composed of background information derived from surveys, observations, and post-interview reflection journals. A combination of narrative analysis and thematic analysis was used as an analytic tool to examine the data. In this chapter, I describe the research design, including the data collection methods and data analysis. I also discuss trustworthiness, triangulation, researcher subjectivity, and research limitations.

Theoretical and Epistemological Perspectives of the Study

Meanings are constructed by human beings as they engage with the world they are interpreting. Before there were consciousnesses on earth capable of interpreting the world, the world held no meaning at all. (Crotty, 2003, p.43)

This study investigated how internationally educated nurses perceived their cross cultural communication experiences in the U.S. medical context. In social science, epistemology is the theory of knowledge. It shows the relationship between the knower and what is known (Hatch, 2002). It includes how people interpret knowledge and explains what perspectives are adopted to make sense of reality. Epistemology is viewed as a philosophical base for qualitative studies because it guides the theoretical

perspective and research design. The theory of knowledge in this study is constructionism. According to constructionists (Berger & Luckmann, 1967; Crotty, 2003), knowledge is not discovered. Reality is neither instinctively determined nor neutral, as it cannot exist without human interpretations. On the contrary, humans construct knowledge through interactions with objects, other human beings, and the world around them. Constructionists posit that reality is based on what humans believe it to be.

Theoretical perspective is a philosophical assumption directing the research methodology. The perspective adopted in this study is constructivism. Constructivists emphasize how individuals value their worlds through their own meaning making (Crotty, 2003). In this perspective, multiple realities can co-exist because people use personal experiences and cultural frames to construct meaning. Meaning in communication depends on how the speaker and listener make sense of the encountered speech events. Further, within this perspective, knowledge neither exists arbitrarily, nor is it subjectively determined. People experience communication, behaviors, phenomena, and social events to identify their feelings via interactions between their surroundings and consciousness. Constructivists also posit that there is no absolute truth. Everyone's meaning-making is unique and valid. Humans simply use different perspectives to legitimize what they believe.

Hadjistavropoulos and Smythe (2001) suggest that "qualitative research seeks to understand and articulate the meanings of people's experiences rather than formulate general laws of behavior" (p. 163). Qualitative inquiry aims to investigate people's experiences in natural situations. It describes how people perceive their world. While quantitative research involves designing, deciding, predicting, and inferring data (Agresti

& Finlay, 2008) to find general rules or average results of specific phenomena by using statistics and numbers, qualitative researchers use detailed and thick descriptions to present findings. Communication is a dynamic social phenomenon. Cross-cultural communication involves complex elements of language, thought, culture, context, speech topics, speech members, and social relationships. This study sought to understand international nurses' experiences in their own terms. A final statistical number could not have descriptively and comprehensively answered my research questions. In order to have an insightful understanding of Taiwanese nurses' values and experiences of cross-cultural communication, I therefore chose to conduct a qualitative study to collect in-depth data from nursing participants.

Research Design

Methodology represents the guiding methods for data collection and data analysis in the research process. Baxter and Jack (2008) noted that the tradition of case study is research that explores a contemporary phenomenon with specific people within a particular context. The boundaries of the study are clear, which helps the researcher to focus on the interrelationship between participants, phenomena, and contexts. Case studies incorporate various data collection methods to gather deep and rich data from sources such as interviews, observations, documentation, artifacts, and field notes. In this study, I endeavored to discover how internationally educated nurses (the participants) described their experiences in communication (the phenomenon), and how they made sense of their feelings and perspectives associated with the unique U.S. healthcare setting (the context). As a result, I chose a case study design to answer my research questions. Table 3-1 provides an overview of the research taxonomy of the study.

Table 3-1. Overview of research taxonomy

Epistemology	Constructionism: Knowledge is constructed by people through interactions with objects, human beings, and the world around us. Understanding that reality is based on what we agree it to be.
Theoretical perspectives	Constructivism: The way that people see the world is a subject-object interwoven product. We experience communication, behaviors, phenomena, and social events to declare feelings via the reciprocal interaction between the surroundings and consciousness.
Conceptual framework	Communicative competence: This concept encompasses the language ability to functionally and meaningfully listen, speak, read, write, and physically interact with others within speech events and written texts.
Methodology	Case study: This methodology is a research tradition that helps researchers focus on the interrelationship among participants, phenomena, and contexts.
Sampling	Criteria of the five participants' selection: Speaking Mandarin as the first language Possessing intermediate or higher level of English Received nursing education and professional training in the home country (Taiwan) Currently working in the U.S. healthcare context
Data collection	Primary data: Individual interviews and focus group interviews Secondary data: Background Information surveys, observations and field notes, and post-interview reflection journals
Data analysis	A combination of narrative and thematic analysis: This method emphasizes the analysis of stories told by participants regarding their experiences in personal events. Patterns were identified as they emerged from the data

This research design had two phases: a pilot study and the main data collection period with the five participating nurses. An approved IRB protocol is located in Appendix A.

Phase I: Pilot Study

Pilot work is a trial for qualitative investigators to implement a small scale study before they carry out a complete research project. Sampson (2004) noted that pilot studies help researchers become “prepared and better prepared” (p.392). I conducted pilot work to examine whether the interview questions were robust enough to capture the data that I needed to conduct a larger-scale study.

The methods used included interviews with an internationally educated Mandarin speaking nurse and observation of cross-cultural, clinical communication among the international nurse, U.S. patients, and U.S. healthcare staff. I began the first pilot study under an approved, behavioral/nonmedical IRB in May, 2009. However, after realization that the observations in clinical settings required additional consents from patients, families, and hospital staff under the medical IRB approval, which I was not authorized to collect, I revised the pilot study by reapplying for permission. The revised pilot study sought to collect data from one international nurse via interview and non-medical observations. The study was subsequently implemented a second time in March, 2010.

Results from the pilot study indicated that I needed to narrow my interview questions by targeting international nurses’ communication rather than work experiences. For example, I revised the questions, “Can you describe the difficulties at work?” to “Can you describe the difficulties you face when you communicate with people at work?” I also edited the questions using field-specific (TESOL) terminology,

which caused my nursing participant some confusion. For example, I replaced the question, “What components of ‘communicative competence’ are needed when you work?” to “In what situations do you use (oral and written) English at work?; In terms of listening, speaking, reading, and writing, what skills do you use frequently at work?; and What skills are you good and not good at?” In addition, I revised an item on the background information sheet by adding home country professional background. I learned that international nurses’ former working experiences could be an influential element to guide their cross-cultural communication experiences in the United States.

Phase II: Dissertation Work

The current study began in December of 2010 following supervisory committee approval to conduct the study in California. The following paragraphs introduce the setting, sampling criteria, sampling procedures, participants, data collection methods, and data analysis.

Setting

The research goal was to investigate internationally-educated, Mandarin-speaking nurses’ cross-cultural communication experiences in the United States. The setting of the study was the U.S. healthcare context. It is commonly known that Taiwanese and Chinese immigrants reside principally in California or New York more than in any other state. Due to the limited population of Mandarin-speaking nurses in Florida, I sent fliers and emails to potential participants across the country (see details in sampling procedure section) in order to recruit the first Taiwanese nursing participant, Shya (pseudonym), in California. Next, I adopted snowball sampling to rely on Shya as a connection to recruit four additional Taiwanese nursing participants who were all internationally educated, Mandarin speakers working in southern California.

Sampling criteria

According to Xu and Kwak (2005), females dominate the U.S. nursing human resource field in the modern medical setting. While 93.8% of internationally educated nurses are women, 94.2% of U.S. nurses are females. Generally, social interaction, communication patterns, and politeness strategies are influenced by gender (Boxer, 2002) and may further influence cross-cultural, clinical communication. Nonetheless, I remained open-minded regarding the variability of gender when selecting the participants, as the research goal was to explore nurses' perceptions and beliefs of communication in clinical settings rather than to focus on gender issues. I utilized purposeful sampling procedures. The recommendation from the first participant, Shya, enabled me to recruit four additional Mandarin-speaking nursing participants, in addition to herself. As a result, all were acquaintances of each other and were Taiwanese females.

As noted above, I used four criteria to meet sampling requirements for the study. If a participant failed to meet one of the four criteria during the recruitment period, he/she was not invited to participate. The four selection criteria included:

1. a nurse who spoke Mandarin as his/her first language;
2. a nurse who possessed intermediate or higher level of English proficiency;
3. a nurse who received nursing education or professional training in a home country (Taiwan);
4. a nurse who was currently working in a U.S. healthcare setting.

The first criterion, the requirement to be a Mandarin speaker, meant that the participants were native Mandarin speakers. Second, theoretically, international nurses should have achieved high-intermediate or advanced English proficiency before

obtaining a U.S. working visa. The proficiency criterion was based on nurses' VisaScreen requirements, such as TOEFL (Test of English as a Foreign Language) and IELTS (International English Language Testing System) exam scores. Therefore, the participants had intermediate level or higher abilities in English. As to the third criterion, education in the home country meant that participants' home cultural background and schooling experiences were distinct from those in the United States. The final criterion, nurses' current work in clinical practice, was intended to ensure that the participants' communication reflections based on recent experiences.

Sampling procedure

Technically, due to my non-nursing background, my restricted access to nursing circles, and the limited population of Mandarin-speaking nurses in Florida, it was initially challenging to recruit internationally-educated Mandarin-speaking nurses who were willing to voluntarily participate in the study, an experience similar to other scholars (Hearnden, 2007). To overcome this dilemma, I used purposeful sampling to select participants. Unlike quantitative work aiming at discerning general patterns, qualitative research studies information-rich cases. Patton (2002) stated that intentionally selecting information-rich participants who specifically match the purpose of qualitative research contributes to a rich and deep outline of research findings. Purposeful sampling can include many sampling techniques.

In my case, I employed snowball sampling (Glesne, 2006) to identify five participants. Snowball sampling is a practical technique to help researchers get started with one or only a few key informants before rolling like a snowball to identify additional participants who meet sampling criteria and are capable of providing rich information. To locate potential participants, I posted fliers, e-mailed, and talked to Asian ethnic

associations, international student clubs, Mandarin-speaking religious institutions (e.g., Tzu Chi and Christian churches), Chinese communities, Chinese Sunday schools, U.S. hospitals, nursing academia, and university faculty involved in the nursing field. The recruitment flier and email script can be found in Appendices B and C. Internet search was also applied to expand my sampling network.

During the recruitment period, I received Shya's responses via email. She told me that her nursing professor had forwarded my recruitment invitation email to her. She found my research topic interesting and felt that it had been rarely discussed by others. She wanted to help shed light on the situation to benefit future Taiwanese nurses who planned to work overseas. Through several phone conversations and email correspondences, we realized that Shya was one of my nursing friends' college classmates. They enrolled in the same nursing program and attended one course together at university in southern Taiwan. We became friends because of this connection, and this helped build our rapport even though we did not have a chance to physically meet before I began data collection.

After I made contact with the first participant, Shya, I asked her to recommend other nurses who might be interested in my work. Shya referred me to Bu and Chen (pseudonyms). Afterwards, Bu introduced me to Wei and Co (pseudonyms). Shya, Bu, Wei, Chen, and Co were five Taiwanese nurses who worked in U.S. hospitals in urban cities in southern California. They were all Mandarin speakers. Their English proficiency test results were assessed as high intermediate to advanced level. They all received nursing education in Taiwan before they moved to the United States. Before I physically met with the five participants, I spoke with them on the phone and/or via the Internet. I

explained the informed consent form (Appendix D) as well as the purposes, methods, risks, and benefits of participating in the study. Each expressed her willingness to participate.

In mid December of 2010, I flew from Florida to a domestic airport in southern California. I stayed there for four months to conduct face-to-face focus group interviews, individual interviews, and observations. Shya was not only a research participant, she was also my landlord who subleased a room for me to stay in in California throughout the data collection period. In addition to utilizing formal data collection tools, such as interviews and observations, I studied Shya's cross-cultural communication experiences through living with, interacting with, and shadowing her. I also used the accommodations offered in southern California as an advantage to investigate the other four international nurses' perceptions of communication. To build rapport with the participants, I observed and engaged in their communication events during daily life, leisure time, social activities, and accessible working hours. The total number of observation hours for all five participants in the study was 112.

Nursing participants

The five participants had some background similarities as well as differences. I expand upon these in Chapter 4. An overview of the backgrounds of the five participants is seen in Table 3-2.

Table 3-2. Background information of participants

Name	Age	Education	English level	Specialty	Work years
Shya	30	BSN	Advanced: IELTS 6.5	Medical intensive care	5 years
Bu	35	BHM ASN	Advanced: IELTS 6.5	Surgical intensive care	4 years
Co	47	BSN	Intermediate: TOEFL 450	Surgical intensive care	7 years
Wei	45	BSN	Advanced	Orthopedics	7 years
Chen	27	BSN	Advanced: IELTS 6.5	Labor and delivery	3 years

Note. BHM: Bachelor of Healthcare Management; BSN: Bachelor of Science in Nursing; ASN: Associate of Science in Nursing; IELTS: International English Language Testing System; TOEFL: Test of English as a Foreign Language

Shya was a 30 year-old Taiwanese woman. She was a registered nurse (RN) in the medical intensive care unit (MICU) at the university hospital in southern California. She owned a house and lived with her Taiwanese-American fiancé at the time of the study. The house was located in a predominately American-dominant community where the Chinese population was a minority. Shya had a bachelor’s degree in science in nursing from southern Taiwan; however, she did not gain practical nursing experiences in Taiwan except for having a one-year internship there. She moved to the United States in 2005 and started working as a MICU nurse about three years prior to the study. She passed the U.S. VisaScreen requirement identifying her as being at an advanced English level according to her IELTS results.

Bu was a 35 year-old female Taiwanese nurse who worked in a surgical intensive care unit (SICU) as a registered nurse in a university hospital in southern California. She came to know Shya through the Taiwanese RN agency five years prior to the study. Bu lived with her boyfriend, a Lebanese-American doctor, in a townhouse she had recently purchased. Bu obtained two degrees in Taiwan, including an Associate’s degree in science in nursing and a bachelor’s degree in healthcare management. She

had nearly ten years of clinical experience as a thoracic surgical nurse in Taiwan before she worked in California. In 2006, she flew to the United States and started working in a hospital beginning in 2007. Bu also achieved high English proficiency scores gaining the status of an advanced English speaker based on her IELTS scores.

Chen was the youngest nursing participant in the study. She was 27 years old at the time of the study and has worked as a labor and delivery nurse in a U.S. community hospital for one year. Chen was acquainted with Shya and Bu because they took the RN preparation courses together in Taiwan. Chen settled down in southern California two years prior to the study. She lived with her Cantonese-American husband, Kevin (pseudonym), in a mixed-ethnic community. She obtained a bachelor's degree in science in nursing from a highly reputed medical university in Taiwan. She worked as a labor and delivery nurse in southern Taiwan for seven to eight months before she left for the United States. She achieved high IELTS scores in reading, listening, and writing but struggled with speaking scores. Nevertheless, her overall English test results categorized her as being at an advanced English level.

Co was a 47-year-old female Taiwanese nurse who has immigrated to the United States in 2004. Co was Bu's SICU colleague at the university hospital. Co was a religious Christian who had been married to her Taiwanese-American husband for six years. Co and her husband, niece, and in-laws lived together in an urban city in southern California at the time of the study. When Co was in Taiwan, she graduated from a nursing high school and then enrolled in a nursing university. She received a bachelor's degree in nursing after four years of study. Co had a more abundant work history than the other four participants. Before she immigrated to the United States, she

worked as an ICU (intensive care unit) nurse and as an anesthesia nurse for two years and twenty years, respectively. Her English proficiency level was intermediate, based on her TOEFL results.

Wei was in her mid 40's and lived with her 17 year-old son, James, and 11 year-old son, Jack (both pseudonyms), in an upper-class white-dominant community in southern California. Wei was a previous charge nurse who was in charge of the unit in the community hospital where Bu had worked. Wei had been living in the United States for 17 years at the time of the study. She had been working as an orthopedic nurse in U.S. hospitals for six and half years. Among the five participants, Wei was the one who had been involved with U.S. healthcare for the longest period of time. She graduated with a bachelor's degree in nursing from Taiwan. Before she moved to the United States, she worked in a surgical unit for five years in Taipei. Her English level identified her as an advanced speaker.

Data Collection

The data collection period spanned from December 2010 until the end of April 2011. The participants were asked to voluntarily participate in a study to share their communication stories in the U.S. healthcare context. The data collection methods included background information surveys, interviews (focus group interviews, individual interviews, interview notes, and post-interview reflection journals), and nonmedical observations (with field notes). These multifaceted collection tools contributed to gathering content-rich and focused data. The notes and reflection journals also helped record my reflections. The quantities of the data collected are noted in Table 3-3. The timeline for the data collection is in Table 3-4.

Table 3-3. Quantities of data collection

Methods	Numbers
Background surveys	5 surveys (one each)
Focus group interviews	5
Individual interviews	15
Casual conversations	Uncountable
Interview notes	20 pages
Observation field notes	26 pages
Post-interview reflection journals	20 journals entries

Table 3-4. Timeline of data collection

Date	Collected data
December 2010	Individual interviews: Shya Focus group interviews: Bu and Shya Observations: Shya, Bu, Wei
January 2011	Individual interviews: Shya, Co, Wei, Bu Focus group interviews: Chen, Wei, Bu and Shya Observations: Shya, Bu, Wei, Co, and Chen
February 2011	Individual interviews: Chen, Bu, and Co Observations: Shya, Bu, Wei, Co, and Chen
March 2011	Individual interviews: Shya and Chen Focus group interviews: Co, Chen, Wei, Bu and Shya Observations: Bu, Wei, and Chen
April 2011	Individual interviews: Co Observations: Bu, Wei, and Shya

Informed Consent

Before I gathered data from the five Taiwanese nursing participants, I explained the details of the informed consent form with them face to face, including the purpose of the study, the level of participants' involvement, potential risks and benefits of the study, compensation, participants' confidentiality, their right to withdraw from the study, and the persons whom they could contact for further inquiries regarding the research. Then, each participant signed the informed consent document, and I proceeded with the interviews and nonmedical observations. The informed consent form is in Appendix D.

Background Information Survey

Questionnaires and surveys are tools for obtaining background information on the distribution of chosen subjects' characteristics and values from a target population (Marshall & Rossman, 2006). In this study, I administered a background information survey to gather the participants' basic information, including language status, educational background, home country professional experiences, and U.S. professional practices. The background information survey facilitated the sampling selection and kept records of individual participants' linguistic, cultural, and educational information. The survey form can be found in Appendix E.

Interviews

Holstein and Gubrium (2003) note that "interviewing provides a way of generating empirical data about the social world by asking people to talk about their lives...all interviews are interactional" (p.3). To explore how international nurses view their cross-cultural communication experiences, I conducted two types of interviews: focus group interviews and individual interviews. I adapted Hearnden's (2007) interview questions to develop my own interview protocol (Appendix F). I probed issues regarding their communication, motivation, preparation, job orientation, social networking, and work training in the United States. During the interviews, I took notes on the conversations and observed participants' behaviors, body language, facial expressions, and attitudes toward the interviewer and other participants. After each interview, I maintained a post-interview reflection journal to keep track of my feelings and thoughts regarding the process and discern primary themes from the data. Writing notes and keeping post-interview journals accounted for supplementary data resources in order to help triangulate my research findings.

I conducted individual interviews and focus group interviews primarily in Mandarin, the participants' and my first language. Sometimes the participants switched among Mandarin, Taiwanese, and English. Mandarin is the national, official language in Taiwan, while Taiwanese is the second most popular dialect of Chinese in Taiwan. I transcribed the interviews and kept my post-interview reflection journals both in Mandarin. I translated documents and data from Mandarin to English for the purposes of this study.

The original data collection design was to use an initial focus group interview as a “warm-up event” to help me and the five participants build familiarity. By means of the first group interview, I intended to ask Shya to share her communication stories to break the ice. I also intended to elicit reactions from the other four nursing participants so that they would express their thoughts. The aim was to help me build rapport with the unfamiliar participants through sharing their stories and experiences. However, the outcome of the sampling revealed that the five participants were already acquainted with each other before they were invited to participate in the study. Because of Shya's referral, the other four Taiwanese nursing participants quickly treated me as a friend. This shortened the gap between us and facilitated a sense of rapport. More importantly, due to their distinct work schedules and private plans, it was extremely difficult to arrange the focus group interviews regularly during the data collection period. Therefore, I initiated the data collection by first conducting an individual interview with each participant, and then held focus group interviews and second, third, or fourth individual interviews intermittently throughout the data collection period. The long individual and focus group interviews helped me not only investigate participants' communication

experiences on a deeper level, but throughout our intensive interactions I also began to understand their feelings and perceptions about nursing in the United States.

Individual interviews

There were fifteen individual interview sessions. Each participant attended two to four interview meetings depending on her availability. Individual interviews were held at a place and time designated by the participants, including their homes, coffee shops, and/or restaurants. The duration of individual interviews ranged from 47 minutes to one hour and sixteen minutes. The length was determined by how much information the participants shared about their experiences. Mandarin was the dominant language used in the interviews. All interview conversations were recorded with a digital recorder. The consent form for audio-taping can be found in Appendix G. During the interviews, I took notes on the conversations. After each interview, I maintained a post-interview reflection journal to keep track of my reflections.

The format of individual meetings was semi-structured. The interviews emphasized eliciting participants' stories in order to investigate their inner thoughts and receive more natural data through detailed descriptions of communication events they had encountered. No personal health information was collected, discussed, or revealed in the interviews. Interview questions focused on international nurses' stories of communication events, immigration history, daily work, English language experiences, cultural encounters, and educational comparisons (i.e., hospital orientation, nursing degree training, and courses of English for Nursing Purposes).

At the beginning of each interview, I asked questions relevant to their experiences to start the conversation, such as "Please describe a typical work day. What kinds of nursing tasks are you involved with? What kind of communication is involved?" I also

asked them to share stories describing specific communication events that occurred during their work hours. Grbich (2007) noted that eliciting stories of personal experiences contributes to gathering more natural data than administering formal interviews. Within individual interviews, I used open-ended questions in order to elicit responses. I also allowed the flexibility of topic shift to maintain a flowing conversation. Additionally, I created a comfortable conversational atmosphere by using language familiar to the nursing participants. For instance, I investigated international nurses' perceptions of cross-cultural communication events by asking "whom/why/what do you commonly talk to/about or write to/about during your working hours?" rather than "what kinds of communicative competence do you think are required for international nurses?" I used pre-determined questions but remained open to their responses.

Focus group interviews

There were a total of five focus group interviews. The focus group interviews were composed of two-participant groups, three-participant groups, and a single group of five participants based on the nurses' schedules and availability. Focus group interviews were held at a place and time designated by the participants, including the houses of Shya, Bu, and Wei. I prepared food, beverages, snacks, and fruit for the group interview meetings. The five participants' focus group meetings were conducted during or after meals, depending on the atmosphere and how much time was provided for the get together. The duration of focus group interviews ranged from one hour and 18 minutes to one hour and 43 minutes. The length was determined by how much the participants shared about their experiences. Mandarin was used to conduct the interviews, and the interviews were recorded using a digital recorder. I took notes on the interview conversations. After each interview, I kept after-interview reflection journals.

The format of the five focus group interviews was semi-structured. These interviews emphasized establishing a comfortable atmosphere to encourage participant experience sharing. Sharing and discussions with nursing peers could elicit participants to echo each other, as well as to engage in storytelling. Participants were asked to exclude any personal identifiable information, employment status, and health information during the interviews. In the first group interview, I asked Shya to share her communication stories to help break the ice. This facilitated me, the interviewer, to build rapport with the other four participants in order to elicit discussion and encourage them to express their thoughts via stories and experience exchanges. As time went by, the participants gradually became familiar with the group interview template. Therefore, Shya, Bu, Wei, Chen, and Co felt more free and relaxed when launching into storytelling during the second to the fifth interview meetings.

Each focus group interview had one to two pre-determined, specific themes, including 1) daily work and communication events; 2) personal history and communication events; 3) nursing education and communication events; 4) English language and communication events; 5) work comparison and communication events; and 6) hospital training and communication events. Similar to the individual interview techniques, I used open-ended questions to elicit responses. I also provided flexibility for topic shifts and temporary digressions. Typically, I did not interrupt the flow of conversation. Nonetheless, when the turn taking was apparently uneven, I would intentionally invite particular participants to share their thoughts, such as “What do you think, Chen? What is your opinion regarding this experience?”

Observations

Initially, my study was restricted by the research review board, in terms of the observation of authentic clinical communication of the nursing participants. In the end, I was permitted to observe international nurses' communication events regarding their nonmedical interactions as the supplemental data, such as in daily life and social networking. Emerson, Fretz, and Shaw (2001) indicated, "observation-establishing a place in some natural setting on a relatively long-term basis in order to investigate, experience, and represent the social life and social processes that occur in that setting--comprises one core activity in ethnographic fieldwork" (p.352). In order to gather richer and deeper data with respect to nursing participants' experiences of cross-cultural communication, I used observations and the field notes as a supplemental data collection method. Observations and field notes totaled 112 hours and 26 pages. Each participant was observed three to seven times depending on her availability. Sometimes participants gathered together and other times they were observed individually. Each time, the observation period lasted from three to eleven hours. The two main observation categories were communication in nonmedical settings in hospitals and communication in private life and social activities.

Observing communication in nonmedical settings in hospitals

Since IRB 01 limited my access to the dynamic nurse-patient and nurse-nurse conversations in U.S. clinical settings, I studied the participants' social talk in cafés, lounge rooms, lobbies, and other nonmedical settings inside hospitals. I observed their cross-cultural communication with colleagues and non-patient related people in their workplaces. Observing nursing participants during their working hours when they were not involved with medical cases filled the research gap caused by the limitations of

confidentiality and the IRB restriction. The nonmedical hospital observations collected totaled 12. Each participant was observed two to three times. During each observation, I spent three to five hours in the nonclinical areas in the hospitals.

Observing communication in private life and social activities

During the research period, I encountered a variety of opportunities to interact with Shya, Bu, Wei, Chen, and Co, in addition to the pre-planned formal interview meetings. It was mentioned that I shared a home with one of the participants, Shya. Shya, Bu, and Chen were friends. Bu, Wei, and Co were all acquainted with each other. They were used to keeping in touch with each other and spending time together prior to the commencement of the study. I became familiar with their personal lives and social networks by observing them, learning from them, eating with them, hanging out with them, living with them, and chatting with them with the aim of collecting data. The observational data were gathered from shopping, BBQ events, beach activities, a New Year celebration party, dining, afternoon tea meetings, church, Chinese Sunday school, friends' home visits, and a family reunion. As a result, I was socially involved with the five participants when I was in southern California.

After I asked for permission to shadow them to observe how they lived and communicated in their personal life, casual conversations occurred. Casual conversations could sometimes contribute significant and insightful information with regard to participants' reflections on communication. It was important to observe whom they frequently talked to or wrote to and how they interacted and communicated. For example, in addition to communication difficulties at work, participants experienced communication conflicts in their daily lives. Furthermore, since the participants spent quite a lot of time together, many opportunities arose for me to observe their casual

conversations. I also took field notes of casual conversations during those social events with the participants' consent.

Transcribing, Summarizing, and Member Checking

During the data collection period in southern California, I transcribed the group and individual interviews verbatim after each meeting. Poland (2003) noted the significance of transcription quality, so I transcribed the details as precisely as I could, including intonation, interruptions, silence, turn-taking, and overlaps. The language that the participants used in the interviews was their first language, Mandarin. In order to keep their original voices to the most extent, I transcribed the interviews in Mandarin verbatim. I finished each transcription no longer than one week after each interview to ensure that I still had a fresh impression of the conversation. I transcribed the interview sound files in my private room to ensure that nobody was present at that time. I listened to the digital sound files multiple times in order to immerse myself in the data as fully as I could.

Whenever I completed each verbatim transcription and the accompanying observation field notes, I utilized preliminary analysis to summarize key points. I listed questions generated from the interview transcripts, interview notes, post-interview reflection journals, and observation field notes which needed to be clarified by the participants. Subsequently, I printed out the summaries and questions and showed them to Shya, Wei, Chen, Co, and Bu when we met next time.

I spent ten to twenty minutes asking them whether the summaries of the interviews and observations objectively represented their shared experiences and observed behaviors. The participants clarified the meaning when I misunderstood their expressions and actions. This method is known as member-checking (Glesne, 2006;

Hatch, 2002). By going back to the participants to clarify and verify, I was able to confirm whether the collected data and the interpretation represented what the participant was trying to express. Member-checking acted as an essential data collection step particularly for me as an outsider to the nursing field, who could have possibly misinterpreted their clinical communication experiences.

Data Analysis

Method of Analysis: Narrative and Thematic Analysis

The data analysis method employed in the study was a combination of narrative and thematic analyses. I adopted Grbich's (2007) descriptions of narrative sociolinguistic and sociocultural approach, and Bernard's and Ryan's (2010) and Gibson's and Brown's (2009) techniques of thematic analysis to interpret the interviews and observation data. In my study, narrative analysis served to analyze the structure, sequence, content, and context of participants' stories. What the participants really meant hidden in the communication stories was examined. Grbich (2007) stated that "eliciting narratives of personal experiences is seen as a more natural form of communication than face to face interviews" (p.124). I listened closely to the five internationally-educated nursing participants' discussion with their particular experiences, and I encouraged them to share communication stories that they encountered in the U.S. healthcare context.

Qualitative work does not seek absolute truths or general patterns of human experiences. In contrast, qualitative researchers attempt to transfer participants' inner thoughts into a more tangible form for the purpose of analysis. Narrative analysis is an approach used for interdisciplinary purposes in social science, such as linguistics, education, anthropology, sociology, and political science. It attempts to understand

participants' experiences of particular incidents. Analysis of narratives investigates the sociolinguistic aspect of stories, including plots and structures. Furthermore, it also examines the sociocultural aspect of narratives, such as the social and cultural frameworks that participants apply to make meaning of their personal events. Sands (2004) claimed that stories are "constructions created through interpersonal, sociocultural, and historical processes" (p.49). When I interpreted the five participants' stories, I also inferred and referred to the sociocultural meanings behind or beyond their narratives, rather than simply presenting the plots in stories.

I used narrative analysis as an analytic tool to interpret the participants' experienced reality of cross-cultural communication events via investigating their personal stories. In addition, I applied thematic analysis to analyze the multiple set of data, including interview transcripts, interview notes, observation field notes, and post-interview reflection journals. During the coding process, I found codes and inter-analyzed the codes to identify patterns, and eventually to find themes emerged from the data.

Procedures of Analysis

According to Grbich (2007), Bernard and Ryan (2010), and Gibson and Brown (2009), the analysis process consisted of the following steps.

Analyzing primary data: Interviews

The primary data of the study consisted of individual interviews and focus group interviews. There were three major stages to analyze the interview data. Within the major stages, several analysis steps and techniques were repetitively taken. In the first stage, I examined each individual participant's single story. In the second stage, I inter-analyzed the same participant's multiple stories to identify codes. After I completed the

individuals' analysis, in the last stage, I compared the five Taiwanese nurses' stories to find corresponding codes and generate themes that emerged from across the data.

During the initial stage of individuals' narrative analysis, I examined the participants' narratives. I focused on the structures and plots of their stories in the interview transcripts. I divided the stories into several sections, including abstract, orientation, complicating action, evaluation, resolution, and coda (see examples in Appendix H). Grbich (2007) and Labov (1972) noted that understanding the structures of stories can help researchers have a close insight into the key points (e.g., summary), sequential ordering (e.g., time and place), transformation (i.e., direction change), relationship of characters, and results and influences brought by the events.

In the next step, I moved to a broader analytic level. I looked at the clues which represented the political, social, and cultural context of the stories. The contextual information could help me interpret the way that the participants made sense of their communication experiences. Moreover, through the exploration of sociocultural backgrounds of their stories, I was able to interpret the participants' emotions and feelings within the communication events.

Bernard and Ryan (2010) declared that "rich narratives contain information on themes that characterize the experiences of informants" (p.62). Therefore, within the narrative analysis processes, I also used thematic analysis to examine the data. To code is to categorize the interview transcripts in order to portray a general feature of data. To begin with, I looked for apriori codes (Gibson & Brown, 2009). Apriori codes exist before the exploration of data. They are pre-defined based on researchers' motivations, research interests, research questions, and theoretical relevance. In the

study, I reviewed the research questions and read the data while paying attention to looking for codes relevant to the questions. To be specific, the apriori codes were related to language needs, cultural factors, and educational training affecting the participants' communication experiences.

Afterwards, the analysis focused on the empirical codes of the interview data to find “commonalities, relationships and differences across a data set” (Gibson & Brown, 2009, p.127). I examined information which was repeated, emphasized, agreed to, contradicted, similar, different, and missing among the participants. I re-read the transcripts and found distinct codes presenting the same patterns. I collected these codes representing the same features together to form a larger body of information, code family. For instance, I found in Shya's data, the individual codes of “independence, honesty, confidence, and hospitality” could be gathered together under a broader code family of “home family experiences.” The definition of the code included: the role of Shya's family background and culture in shaping her attitudes, belief patterns, and experiences in communication. As a second example, in Chen's data analysis, the codes of “discomfort, frustration, and low motivation” were collected to form an upper code family of “English level.” The definition included Chen's descriptions of herself (as a self-evaluation), test results of her English level, and how the level functioned in the cross-cultural, clinical communication events. I also created thematic figures to move the selected codes into the same body of information (see examples in Appendix I).

Analyzing supplemental data: Observations

The secondary source of data in this study consisted of observation notes. I followed the thematic analytic procedures (Bernard & Ryan, 2010; Gibson & Brown, 2009) illustrated above to examine the field notes.

Analyzing my own thoughts

During the research process, it was inevitable to include my own ideas when recording and interpreting the data. It was impossible to remove my personal perspectives in the study. Instead of eliminating my perspectives, I used reflections to review them and I used my subjectivity as a contribution to the study. I maintained post-interview reflection journals to record my own thoughts and ideas. Afterwards, I used thematic analysis to examine my role and voice in the interviews, reflection journals, and interpretation. I followed the same analysis techniques and verified new themes appearing from the interpretation process. Later, I summarized the interpretation and showed it to the participants for member checking.

Inter-analyzing multiple data

Within this step, I inter-analyzed the multiple forms of collected data (interviews, observations, and reflection journals) to correlate the information within each set of data with codes. I went back to the transcripts and field notes to compare meaning. I verified cross-data themes and organized them together. After the themes emerging from the whole database were finalized, I started constructing an outline for the finding chapters.

Member checking

As mentioned in the prior section, during the data collection period in southern California, I initiated primary analysis after each interview and observation event, and then I summarized the analysis descriptions and showed them to participants for primary member checking. In the data analysis stage, this member checking was also used to increase research trustworthiness. After I completed the inter-data analysis and created the description outlines of Chapter 4 and Chapter 5 about the findings, I sent the outlines to the participants. I asked for their comments and for them to consider

whether these descriptions accurately represented their meanings and experiences. The participants and I exchanged ideas and after-thoughts via online communication tools. Through the process of double-checking with participants via member-checking, I was able to verify whether the transcripts, interview notes, observation field notes, and my interpretations objectively represented what they said.

Trustworthiness and Triangulation

In order to increase the validity of the study, I was cautious with data collection methods, data analysis techniques, my rapport with the participants, the breadth and depth of my engagement, and the trustworthiness of data interpretations.

The first point is related to rapport-building with the participants and the breadth and depth of my engagement. Lincoln and Guba (1985) stated that long-term immersion in the research site and rapport building with informants is beneficial for obtaining credible data. From December 2010 to April 2011, the intensive interviews and observations with the five nursing participants contributed to the depth of my understanding of international nurses' communication experiences. Through sharing a house with Shya and taking part in the Taiwanese nurses' social circles, I engaged with my participants deeply during the data collection period.

In addition, I managed to avoid the "pitfalls" due to the close relationship between the researcher and participants. To collect information as much as possible, I almost kept notes of everything I saw, every word I heard from the participants, such as their personal lives, social and family relationship, and other concerns irrelevant to the study. However, when I started analyzing the data, I realized that the deep involvement with the participants could put the study at risk of presenting subjective findings. To avoid

this situation, I made decisions to exclude these personal data unrelated to the study purposes during analysis.

The second issue regards the data collection methods. The research design of the study was based on the theoretical perspective of constructivism. According to constructivism, the understanding of conversations is co-constructed by the interviewer and interviewees. Meaning does not naturally exist; instead, it is mutually interpreted by the researcher and the respondents. As a constructivist interviewer, I was aware of my obligation as a conversational partner to co-construct the interview events with the participants. To build sound interviewer-interviewee relationships and collect trustworthy data, Rubin and Rubin (2005) and Seidman (1991) provided practical interview techniques for qualitative researchers. I followed their suggestions to conduct the 20 interviews in a more trustworthy way, including listening actively, avoiding leading questions, clarifying oversimplified responses, respecting interviewees' voices, and paying attention to the flow of conversations.

Furthermore, triangulation is an approach used to validate the trustworthiness of the findings. It is to "use multiple perspectives to interpret a single set of information" (Guion, 2006, p.3). In this study, in addition to collecting the primary data by listening to the five international nurses' expressions through interviews, I gathered an additional four supplementary sources of data to facilitate triangulation of the data, including a background information survey, interview notes, observations and field notes, and my post-interview reflection journals. Collecting data by observing participants' communication behavior in different circumstances helped me to examine the manifold aspects of international nurses' cross-cultural communication from different angles.

Recording my own perceptions and feelings during the process of research, such as notes and reflection journals, functioned to verify my interpretations. Sharing the summary and primary analysis of interview transcripts and observation notes with the nursing participants, confirmed whether my interpretations truthfully presented their communication experiences.

The third point is with respect to the trustworthiness of the data analysis method. Gee (2005) emphasizes two concepts to assure analysis validity, including agreement and linguistic details. Agreement is similar to the member-checking mechanism, which allows participants to review the researcher's interpretation of their narratives. Bernard and Ryan (2010) also advocated that agreement of the data can help increase confidence in the validity of the emerged themes.

In general, the more accurately linguistic details of data are collected, the more valid the analysis will be. In this study, I transcribed the interviews verbatim in the original language, Mandarin, to record the participants' stories in detail. To maintain most of the linguistic features and avoid meaning loss resulting from translation, I also used Mandarin to code the interview transcripts, which enhanced the credibility of the analysis. After the patterns of these codes were identified, I translated these Mandarin codes to English and defined them in English. I am an ESL speaker with no native American-English-speaking background. I have a Mandarin-English translation certificate from an institute of higher education in Taiwan. I used my own translation skills and my perceptions of the two languages to interpret the data.

Moreover, writing deep, rich, and detailed descriptions of the data was helpful to increase the validity of my representation of the participants' world of meaning making.

That is why I used Chapter 4 to introduce participants' backgrounds and Chapter 5 to present their perceptions of communication experiences categorized into main themes. Furthermore, being aware of my speaking, actions, and relationships with participants during the interview facilitates my ability to reflect upon research validity.

Subjectivity Statement

Qualitative research is a process of discovery and description intended to transfer participants' inner minds to external literal interpretations. In this study, constructing international nurses' reality of cross-cultural communication required both the participants' and my reciprocal cooperation in making sense of meaning. Crotty (2003) and Hatch (2002) mentioned the unfeasibility of vacuuming out constructivist researchers' personal perceptions to become totally objective during data description, analysis, and interpretation. It is inevitable that my subjectivity would be involved throughout the research journey. Although I might not be able to directly relate to what the internationally-educated Taiwanese nurses experienced during cross-cultural, clinical communication, I am a Taiwanese female, an international student, an ESL speaker, a part-time employee, and a minority in the United States just like them. I am a researcher coming from a similar cultural/linguistic background and overseas experiences as the participants. I might see myself in them rather than to see them as distinguished individuals. Therefore, it was probable that I unintentionally attached personal bias when interpreting the data. It was also likely that I might have had difficulty identifying their culture because I was like a fish in the water. The possibility exists that I transferred my own cultural background, cross-cultural communication experiences, emotions, expectations, and assumptions to the data.

Glesne (2006) suggested that researchers should be aware of their own reflections and treat their subjectivity as strengths rather than as disadvantages. Therefore, in the study, I was conscious of my personal reactions. I used them as gatekeepers to monitor the trustworthiness of the study. To make my subjectivity concordant to others, I kept track of my feelings by maintaining reflection journals throughout the research period.

Research Limitations

There are four limitations of my study. To begin with, Boxer (2002) and Burns, Joyce, and Gollin (1996) claimed that gathering authentic conversational data is the primary method for collecting data, especially when studying communication experiences in qualitative research. However, due to issues of patient confidentiality, it was challenging to find research sites and recruit participants for clinical observation. Second, although the participants all came from Taiwan, they carried diverse characteristics. They had received different nursing training (i.e., high school nursing and college nursing), had particular nursing specialties, and grew up in different family conditions. Their individuality affected their attitudes toward communication. Overlooking their distinctiveness could deteriorate the validity of the research.

Third, my non-nursing background and subjective understanding of the data posed potential risks for prejudiced discussion. The findings from intensive interviews and observations were based on my individual interpretations of how internationally educated nurses described what they had perceived. The multiple layers of my participants' and my own perspectives actually increased the complexity of data analysis.

Finally, the study adopted case study, a qualitative method to investigate internationally-educated nurses' cross-cultural communication. I discovered how the five international nurses (participants) described their experiences in communication (phenomenon), and how they made sense of their feelings and perspectives associated with the unique U.S. healthcare setting (context). These details made the study specific to the five nursing participants. Unlike quantitative work, which results in general principles of average behaviors, these findings can neither be duplicated nor generalized. I do not imply that the study results can be transferred or applied to others without adjustment.

Chapter Summary

This chapter discussed the epistemology, theoretical perspectives, methodology, the setting, sampling procedure and criteria, participants, methods of data collection, and analytical tool of the data interpretation. I also discussed the research trustworthiness and my subjectivity as the researcher. The research design was aimed at answering the research questions. I did not seek to find absolute truths, indisputable explanations, or general patterns of human experiences. On the contrary, I sought to interpret nursing participants' experiences of cross-cultural communication and to convey their inner thoughts.

CHAPTER 4 FINDINGS: PARTICIPANTS' PORTRAITS

Overview

This study investigated how internationally-educated Mandarin-speaking nurses perceived cross-cultural, clinical communication experiences in the U.S. medical context. The three subquestions of this study included: (a) how participants described language needs for communication in those settings; (b) how they perceived cultural factors as influencing communication events; and (c) how they believed that their education and training prepared them for U.S. healthcare communication. In this chapter, I provide a description and background for each of the five internationally-educated Taiwanese nurse participants: Shya, Bu, Co, Wei, and Chen (all pseudonyms). The primary language of the interviews was Mandarin. I translated the interview data from Mandarin to English for the purposes of this study. The stories depicted in this chapter illustrate each participant's home family and culture, especially with respect to language use; her nursing and language training programs in Taiwan and the United States; and her immigration experiences and adjustment to the U.S. healthcare context. The participants' stories show how the above factors shaped their cross-cultural communication experiences. A summary of the participants' portraits is provided in table 4-1.

Table 4-1. Summary of participants' portraits

	Shya	Bu	Chen	Wei	Co
Home family and culture	Nurturing style- the result of home family: sincere, responsible, and hospitable	Conviction to learning- the outcome of home family and cultural influences: enthusiastic and diligent	Aptitude led by father: modest, easygoing, and gracious.	Parents as role models: no wants, no compromise	Values and attitudes toward communication influenced by parents: humble, helpful, and responsible
Nursing training	TW: BSN; US RN agency US: Nurse staffing services company; hospital orientation and continuing education	TW: BHM and ASN; US RN agency US: Nurse staffing services company; hospital orientation and continuing education	TW: BSN; US RN agency US: Community ESL classes; hospital orientation and continuing education	TW: BSN US: Private tutor; hospital orientation and continuing education	TW: BSN US: ESL courses; hospital orientation and continuing education
English language	Formal assessment: advanced (IELTS 6.5) Oral language: comfortable and confident	Formal assessment: advanced (IELTS 6.5) Oral language: uneasy and worried	Formal assessment: advanced (IELTS 6.5) Oral language: comfortable and uneasy	Formal assessment: advanced Oral language: comfortable and confident	Formal assessment: intermediate (TOEFL 450) Oral language: uneasy and worried
Nursing experience up to time of study	TW: Intern, 1 year US: MICU, 5 years	TW: Thoracic surgery, 9.5 years US: SICU, 4 years	TW: Labor and delivery, 8 months US: Labor and delivery, 1 year	TW: Medical /surgical, 4 years; orthopedics, 1 year US: Medical /surgical, 6 years; Orthopedics, 1 year	TW: ICU, 2 years; anesthesia, 21 years US: SICU, 4 years
Primary adjustment to US	Stress due to high language demands and cultural conflicts	Encountered language difficulties and cultural conflicts	Anxious working in the culturally diverse environment	Experienced more cultural conflicts than language difficulties	Stress due to high language demands and cultural conflicts

Note. BHM: Bachelor of Healthcare Management; BSN: Bachelor of Science in Nursing; ASN: Associate of Science in Nursing; IELTS: International English Language Testing System; TOEFL: Test of English as a Foreign Language; TW: Taiwan; US: the United States; MICU: Medical intensive care unit; SICU: Surgical intensive care unit

Shya's Portrait

Shya waited in the arrival lobby and waved to me with a big, sincere smile. While I was filled with guilt that the delayed flight had interrupted her schedule and kept her waiting in the terminal for hours, she took my carry-on luggage from me and said warmheartedly, "Are you hungry and tired? You must be hungry, right? How about I take you to grab some food before we drive home?"

Shya was a 30 year-old female Taiwanese registered nurse (RN) working in the medical intensive care unit (MICU) at a university hospital in southern California. During this study, Shya was also a welcoming hostess. She treated me like an inexperienced little sister with the aim of helping me settle down from Florida to California, despite the fact that I had more than five-years of overseas studying and living experiences and was biologically older than her. Literally, Shya was the nursing practitioner who provided me with the resources necessary for me to work. Additionally, she provided me with accommodations, emotional support, and friendship while I stayed in southern California during the data collection portion of this work.

Home Family and Culture

Shya's nurturing style was the result of her home family in Taiwan, the expectations that her parents had for her, and the care-giver responsibilities for her siblings that were required of her from a young age. The absence of her parents was significant in her view. She stated,

I separated from my parents at a very young age, at seven. We [sister, brother, and Shya] lived in Taichung with our grandparents. They [parents] stayed in NanTou for their business. We generally saw each other once per week, so there was nothing specifically for home education. I went to school for primary education. We moved when I was a junior high school student. At that time, they [parents] commuted between Puli and Taichung every day, and we met in the evening.

However, I usually prepared food for myself. I also took care of my younger sister and brother, to cook for them.

Shya was born in a municipality, Taichung, located in the center of Taiwan. She lived with her grandparents, parents, and one young sister and brother in a spacious house until college. In the community, Taiwanese and Mandarin were the two principal language varieties, and Shya naturally became orally fluent in the two languages. In the 1980s, Taiwan's economy took off, and, as a result, Shya's parents took the opportunity to build their own company: "They [parents] did not really educate me. They were so busy in their business. They just paid for my tuition, sent me to the cram schools." Cram schools in Taiwan aim to train students to pass the senior high school and college entrance examinations.

During that time, while her parents were striving for their livelihood, Shya's grandparents oversaw her siblings' education and care-giving. Shya became independent at a young age: "I started cooking when I was a high school student." She was responsible for food preparation and housework, and she looked after her two siblings: "I realized I have to be my brother's and sister's role model at that time, such as my school performance, my conduct. I also needed to share the responsibility from my grandparents', which made me more mature than other kids the same age" These characteristics and experiences shaped her work as a nurse by taking good care of patients, new friends, and people in need.

Although Shya's parents contributed less directly to her schoolwork, they had a deep influence on her communication and social skills:

My parents taught me to be sincere and nice to people. When I was young, my parents often took me to others' houses. They taught me guest manners. They would say, "You can't do this," "You can't do that," or

teach me how I should respond when the host invited me for food and drink. When guests came to our house, my parents would ask me to prepare fruit, drinks, and snacks. They taught me the proper way to provide food. I couldn't say, "Do you want some tea?" to guests when offering a drink to them. My father would immediately correct me: "You should have said, 'please have some tea' instead of 'do you want some tea?'; it is different." [laughs] In reality, he admonished me in front of the guests, not in private. When I said something wrong, he corrected me right away.

Shya's stories demonstrated that her parents were active in social events and influenced her concepts of communication. They were hospitable people who frequently invited relatives, friends, and clients to their home. Shya continued,

They [parents] showed me how to treat relatives, clients, and friends, so I am not afraid to get along with people. I behave pretty okay in public. I am sort of confident in getting along with people. I am easygoing. I believe that what I do is right. I am comfortable talking to strangers. I am not afraid of strangers.

Due to the fact that Shya had been surrounded by guests at home, she developed social manners and communication skills when she was a child, and these same communication patterns were evident in her interactions in both English and Mandarin. She often greeted people energetically in both English and Mandarin in her neighborhood, workplace, and at friends' parties. She found it easy to talk to strangers and often initiated small talk with customers in a queue or chatted to storeowners at supermarkets, restaurants, and car repair shops. Shya was eager to make friends, generous to share resources, and genuinely cared for people. Her optimism provided her with many opportunities to embrace U.S. culture.

Nurse and Language Training in Taiwan and the United States

Shya's communication experiences in U.S. healthcare settings were the outcome of both Taiwanese and U.S. training programs. These included English language learning and nursing education. Shya enrolled in English conversation and TOEFL (Test

of English as a Foreign Language) preparation classes at two private language institutes while she studied at a nursing program at a university in southern Taiwan. Although she attended additional language classes outside of the university, she lacked confidence in English: “I was only capable of uttering some basic phrases, such as ‘How are you? I am fine, thank you.’ I could not remember other phrases. My English had been bad since I was young.”

After she received a bachelor’s degree in nursing, Shya dedicated herself to excelling in a series of NCLEX-RN (National Council Licensure Examination for Registered Nurses) and IELTS (International English Language Testing System) preparation courses offered by a RN agency in Taiwan. After eight months of studying, the RN agency sent her and other Taiwanese nurses to a partnership U.S. nurse staffing services company to sit for the NCLEX-RN examination in California. The company offered a series of training courses, including IELTS, clinical communication, nursing practical skills, U.S. medical systems, U.S. insurance policies, and U.S. hospital regulations. To some extent, Shya believed that the training program offered limited help in terms of her communication skills in U.S. healthcare settings:

For instance, the company provided documentation courses to help us [international nurses] fill in medical records and compose nursing notes. However, the outcome was not as effective as expected. The course taught overall writing skills in charting. The over-generalized skills did not fit my specific needs in the departments where I worked. I was even laid off twice because I didn’t know how to chart.

Shya passed the NCLEX-RN shortly after she moved to the states, but she continuously failed the IELTS (English language) exam a total of four times. She noted that “the NCLEX-RN was easier; it was all about nursing knowledge, but IELTS was another story. English language test was so difficult and unpredictable.” Shya stated

that to her, the English language test seemed to have no boundary. She was drowned in academic language tasks, such as questions with respect to anthropology, archeology, science, sociology, political science, agriculture, architecture, and biology; these seemed largely irrelevant to the clinical nursing language she felt she needed.

Shya explained,

Studying for IELTS didn't directly prepare me to communicate successfully or confidently in nursing events, such as taking doctors' orders, writing nursing charts, reading laboratory data, or handling complaints from patients and families.

Adjustment to the U.S. Healthcare Context

Shya's early communication experiences in U.S. healthcare settings underscored two main ideas: English language demands in the context of nursing and cultural differences that influenced her professional judgment in nursing. During her first and second job assignments, she was laid off in the initial weeks of the hospital orientation period. Shya shared a story regarding her first job in the United States:

The preceptor was hosting a meeting, and then she asked everyone to leave the room except for me. She said, 'I could have helped you become a better nurse, but I think keeping you longer in the unit was meaningless for both of us.' She stressed that I had poor communication skills and was also lacking nursing skills.

Shya's view of these initial two work experiences in the United States were "miserable" and "terrified" her—principally a result of her English language ability. Her frustration included misunderstanding medical terminology, reading medical documents, giving (oral) shift reports, and engaging in telephone conversations with doctors and hospital personnel. These, she felt, impeded her from effectively implementing nursing work. Shya declared,

Take the basic duty, giving shift reports, for example. I remember I couldn't understand my colleagues at all, which was a very serious

problem. If I didn't know the condition of my patients, how could I take care of them? I was unable to call pharmacists. When they [nurses] asked me to make a phone call for patients' medication, I didn't know how to make that call. Also, I was unable to communicate with doctors. I didn't know how to take orders. I even didn't dare to talk to them. I was afraid of taking what they prescribed, what they ordered.

Shya continued,

Even if I received the prescription and medicine [from doctors], I didn't know how to explain it to my patients. For that reason, my patients would easily tell I was a novice in the unit [laughs], an inexperienced nurse.

Finally, the use of U.S. medical terminology differed greatly from that she learned in Taiwan. This caused her consternation:

Sometimes the medical terms we use in Taiwan are different from what Americans pronounce and use here. For example, in Taiwan we say "on endo," but U.S. nurses call it "endotracheal tube." U.S. nurses pronounced it (insulin) [ˈɪnsəlɪn] while Taiwanese medical teams pronounced it as [ɪnsjuˈlɪn]. In addition, I didn't know how to spell the terms. Although spelling was not a big deal, I still needed to carry a mini dictionary with me. I looked up words from time to time in order to know what diseases the doctors meant. I couldn't understand those terms unless I looked up their definitions.

Shya concluded, "I had difficulties in all four skills of reading, listening, speaking, and writing. It was terrible!"

Although she was laid off from her first two jobs, Shya was not discouraged. On the contrary, her optimistic attitude made her strive to improve her English communication skills. She noted, "I watched CNN (Cable News Network) and ER (Emergency Room series), studied for the IELTS exam, watched movies, and repeatedly took RN preparation courses." She also continued to work as a part-time certified nursing assistant (CNA) to improve her clinical conversation skills and become more intimate with U.S. hospital culture.

Eventually, after approximately one-year of continuous study, in June of 2006 Shya achieved an overall average IELTS score of 6.5 and a speaking score of 7.0 (i.e., advanced level), which were required by the U.S. VisaScreen program. Soon thereafter, Shya accepted an offer as a charge nurse in a skilled nursing facility. A skilled nursing facility was a medical center where patients in noncritical condition were cared for until end-of-life. She described the role of the nursing staff as, “We were skilled nurses, which meant our patients were not critical. They came here to wait for death.”

As a charge nurse, Shya was more responsible for human resource management than having direct involvement with patient care and nurse-doctor communication. She felt that this meant there was less risky communication, as compared to her prior two jobs:

I believe the reason I stayed in the third job, the skilled nursing, was because the job was slow. I was not responsible for taking care of patients personally. I was the one dealing with LVNs (Licensed Vocational Nurses) and CNAs (Certified Nursing Assistants).

Shya perceived the job “slow” because the demands of language and standard of nursing skills were not high and urgent. In contrast to her feeling unworthy of the job due to communication in English, in her third job Shya felt successful when allowed to take time to prepare for communication. She explained,

When I needed to communicate or consult with doctors, I would have time to prepare what to say. It was not like acute care. There was no heart attack or other severe symptoms that required us to contact doctors immediately for urgent treatments.

Context Up to Study Period

Up until the time that this study took place, Shya had been working as a MICU registered nurse in a university hospital in southern California for the prior three years, which was considered as her fourth job in the United States. In the workplace, in

addition to American nurses, many healthcare workers were from Korea, the Philippines, Taiwan, China, Vietnam, and Mexico. The inpatient (patients admitted overnight to the hospital) structure was also composed of diverse ethnicities, including Mexican, Anglo-American, African-American, Korean, and Chinese patients. The multilingual and multicultural working environment inspired Shya to share numerous cross-cultural communication stories during the research period.

Shya lived with her Taiwanese-American fiancé-Taylor (pseudonym) who was bilingual in English and Mandarin. Taylor effortlessly switched between English and Mandarin when he talked. Shya adopted Mandarin as the primary language she used to communicate with him. Even so, it was common to see Shya incorporate English terms, phrases, and sentences into conversations with him, such as “Weird!” or “Why the actor killed the actress?” Shya determined her language choices depending on the language that Taylor selected for communication.

Taylor had a group of friends who were also Taiwanese-American. Some of them spoke both Mandarin and English well, whereas others spoke English as their first language. Generally, Shya interacted naturally with them. On Shya’s 30th birthday, I was asked to help in the planning of the surprise party. When she came home from work, she was shocked to find the unexpected guests, candles, and cakes greeting her. Nonetheless, Shya gracefully responded to the unexpected situation and spoke fluent English to show her appreciation to her friends.

During the study, Shya claimed that she had no recent serious complaints about her communication experiences:

I am pretty confident in my current speaking and listening level. As for reading, I have become better at reading medicine-relevant reports. Yet,

in regards to writing, it is my weakest skill up to now.

Shya planned to pursue a master's degree in the nurse anesthesia program within two years. The year before, she received a rejection letter from a nursing graduate school. The refusal was determined on the basis of Shya's statement of purpose. The graduate school committee commented that Shya's writing skills were not satisfactory to accomplish the coursework and studies at the graduate level. They requested her to take college writing courses to improve her writing skills before submitting her next application.

Nonetheless, Shya was faced with a dilemma when talking to patients' families. Shya usually revealed no serious problems in terms of language use and cultural adaption. She was good at initiating social topics and chatting with familiar people and strangers. Thus, when she first stated that she was afraid of interacting with patients' families, I was perplexed. Shya said,

It's always an obstacle for me to talk to patients' families. I am pretty okay to talk to patients, asking such questions as 'Where are you from? How many sisters and brothers do you have?' and things like that. However, if I need to talk to the patients' family, I just cannot do it. I don't know what to say in front of them. I either simply explain the patients' health conditions or quietly accomplish my nursing tasks.

She did not clarify the reason she felt uneasy with families at that time. We both wondered why she was uncomfortable specifically when talking to families. After several formal and informal interviews over the period of a few weeks, we returned to the issue again. Because her patients were a disadvantaged minority, it was natural for Shya to care of them; she was able to freely pose questions and exchange information with them in order to improve their health. Families and visitors, nevertheless, sometimes acted like they distrusted her or as if they were "spies." They monitored Shya's nursing

tasks. They demanded that she offered additional nursing services. Occasionally, they criticized the quality of her nursing care. Shya also felt bothered by the frequent medical law suits which she heard about from her colleagues. Shya explained,

English isn't my first language. I'm not sure if what I'm saying is right or wrong. I don't want to be sued just because I say something that I don't mean.

Bu's Portrait

Bu followed a similar path as Shya, in terms of her journey to the United States as a registered nurse. Both Bu and Shya struggled to pass the IELTS exam, learn clinical communication for nursing purposes, and adjust to the cultural differences between Taiwanese and U.S. healthcare settings. However, Bu was highly concerned about her English language performance and communication skills in the workplace.

At my first meeting with Bu, she revealed a strong interest in my research topic. She also worried over her English ability at work: "My English is poor. What do you suggest I can do to improve it? . . . I'm very frustrated when speaking English. Can you recommend some books so I can study in my leisure time?"

Bu was a 35 year-old female Taiwanese nurse who worked in a surgical intensive care unit (SICU) as a registered nurse in a university hospital in southern California. She was highly dedicated to performing well, both in terms of her clinical nursing skills and communication in English. She had an intellectual hunger and was eager to discover the most up-to-date knowledge, trends, and innovative treatments in the nursing field and daily life context. This diligence was also discerned from Bu's constant efforts to improve her English accent, pronunciation, grammar, and vocabulary during the data collection period; she asked questions with respect to how to advance her

communication skills in English. She made the following comments during our interviews:

Do you know of any English courses that will help me reduce my accent?

Are there any books introducing the concept of 'phonics' you know that can help me to pronounce words right after I see them?

I am looking for a book of slang to teach me how to talk humorously with patients and families; otherwise, I just laugh abashedly out of not knowing how to respond whenever they say something amusing.

The doctors can't understand me sometimes because I misuse grammar in my utterances. Can you suggest any easy-to-follow grammar books suitable for my English level?

Home Family and Culture

Bu's dedication to learning was the outcome of her home family and cultural influences in Taiwan, the educational expectations from her parents, and the characteristics that she inherited from her mother.

Bu was from a suburban city in northern Taiwan. She was orally fluent in both Taiwanese and Mandarin. Unlike Shya's wealthy family with a business background, Bu grew up under more strained economical conditions. With limited education, Bu's father worked as a bus driver, while her mother was a full-time housewife taking care of three children and doing housework at home. Despite the fact that they were on a tight budget, Bu felt that her parents tried hard to support their children by advocating that they obtain a good education. Bu claimed,

We weren't rich, but my parents always said, 'You don't need to worry about money; you don't need to find a part-time job; just concentrate on your studies.' They always encouraged us to study more. They even managed to hire math and English tutors for me when my test scores were awful in high school.

In Bu's opinion, her father was "ineloquent" and an "introvert." One of his few hobbies was to meet old friends and drink occasionally. Her mother was more socially

active. Bu described, “My mom enjoyed learning, such as attending community classes to learn sewing, cooking, and singing. She also volunteered in hospitals and temples offering assistance to patients and visitors.” Bu’s parents did not intentionally coach children for manners, principles, ethics, and knowledge: “They didn’t really teach us. They were too busy earning a living.” She doubted whether her parents shaped her communication patterns and social skills. Bu recalled, “I had probably acquired most social rules and knowledge from school, peers, and friends’ parents, such as table manners and good conduct.”

Nonetheless, Bu seemed to have inherited some of her mother’s characteristics. Bu was a warmhearted person who was enthusiastic in pursuing updated knowledge and making friends. She was conversational and easy-going. I initially contacted her for research purposes, but she spontaneously took the initiative in befriending me, including sharing stories about her life, romance, friendships, and work. In addition to showing me around the university hospital where she worked, she voluntarily introduced me to her nursing friends in order to help me recruit research participants.

Nurse and Language Training in Taiwan and the United States

Bu’s communication experiences in U.S. hospitals were the consequence of both Taiwanese and U.S. training programs, including English and nursing education. During her schooling in Taiwan, Bu was frustrated about her English. She noted,

My English sucked! I only got 10 out of 100 on my college entrance exam scores. To me, English was a nightmare! Moreover, my reading, writing, and grammar were not very good when I was a nursing student, not to mention my speaking.

After Bu graduated from nursing college, she worked as a registered nurse in the thoracic surgery department in Taipei. She frequently met foreign patients at work. In

order to advance her English abilities to communicate “more successfully” with foreign patients, she attended a medical English conversation course provided by the same RN agency in Taiwan where Shya enrolled. Afterwards, the course provider convinced Bu to transfer from the medical conversation class to the U.S. RN preparation program. Bu continued, “Later on, they [RN agents] sent me to California to take the test. I was lucky enough to pass the NCLEX-RN.”

After Bu moved to the United States in 2006, she enrolled in a series of IELTS preparation and RN training programs offered by the same nursing staffing service company where Shya registered in California. Bu’s first attempt at the IELTS test in Taiwan resulted in an overall average score of 4.5 (i.e., intermediate level). After that, she took intensive IELTS preparation classes in California. The IELTS course was five hours per day and three days per week. Bu stated,

Can you believe? I took the IELTS exam once every month for 11 months! I eventually passed the English exam after I tried 11 times. It’s just way beyond craziness!

Bu declared that she had no idea how she passed the NCLEX-RN and IELTS examination because at that time, she felt that she still lacked basic skills and adequate proficiency in English. She commented,

The IELTS courses were not really helpful. The techniques that my roommate Cathy [a Taiwanese nurse] taught me were more useful. Passing IELTS was mostly related to test techniques, not my English level. Although my speaking score had reached 7.0 (i.e. advanced level) ultimately, I was like a mute during the first year when I worked in the community hospital.

Adjustment to the U.S. Healthcare Context

After Bu passed the VisaScreen, she then worked as a SICU (surgical intensive care unit) nurse in a U.S. community hospital for three years. Ten months prior to the

research period, she transferred to the university hospital where she continued to work as a SICU nurse. In the primary stage of Bu's immigrant experiences, she encountered "unforgettable" language and cultural experiences in terms of cross-cultural, clinical communication.

The first issue was about language. Bu told a story of how miscommunication caused by language per se seriously damaged her patient's safety:

One evening, I was working with a Chinese nurse Fen (pseudonym) to insert a Foley catheter in a male American patient to drain his urine. I was responsible for inserting the catheter and Fen was responsible for inflating the balloon. Then Fen asked me 'Do you *pass* the resistance?' I misheard the keyword 'pass' as 'feel.' I assumed she asked me whether I 'felt' the resistance rather than 'passed' the resistance," so I answered her 'yes.' This communication mistake caused Fen to inflate the balloon too early. The swollen object pierced through and caused the patient significant bleeding...Fen is not a native-English speaker; I am not, either, but we are both requested to speak English only at work. The night was a mess. We spent the rest of the night attempting to stop the bleeding. I felt so guilty to make such a mistake.

The second issue was related to culture. Bu declared that "humbleness was not taken as a virtue in the practical U.S. medicine." In a five-participant focus group interview, Bu shared her prior experiences of working with her American colleagues:

Bu: It does not work if you are modest here, no way! Let me tell you, one time, when I took over Jinny's [pseudonym] shift, I met the first neuro patient of my career. I had no relevant history of dealing with neuro cases. My coworkers had experience in this field. Hence, I observed their communication, and acquired knowledge and skills about how to take care of neuro-patients. I told Jinny that I stayed in SICU for many years but I was not familiar with neuro care. I said I would love to learn more if she was willing to teach...I told her I would learn harder, but her version of the conversation turned out to be a totally different story. She reported me to the PCC (psychiatric care consultant) and asked her to watch me closely. That shift was dreadful.

Wei: Wow, such big cultural gap between them and us. We are used to being humble. Seems that we can't be docile and yielding anymore. They just don't appreciate our communication styles.

Shya: That's right. You should have pretended you knew everything. Or

you ought to say 'It is exciting. I am interested in it. Can you tell me more about it?'

Bu unassumingly told her American colleague that she was not an expert in neuro care, but she was keen to learn. Bu explained that this was a typical Chinese-based expression. When the Taiwanese come upon an unknown situation, many people habitually underestimate their abilities as an expression of humility, while also demonstrating their dedication to learning. From this story, Bu's American nursing colleague Jinny was not pleased by Bu's modesty. Jinny reported Bu to the PCC saying Bu was not qualified to deal with the neuro patient. It put Bu under constant surveillance during that shift. Bu agreed with Shya's statement and made a comment:

That's right! Since that incident, I have had a different way to respond to my coworkers: if there is something I don't know, I won't reveal my weaknesses in front of Americans anymore.

Context Up to Study Period

Up until the time that this study took place, Bu had been working as a SICU nurse in southern California for four years. Bu lived with her boyfriend, a Lebanese-American doctor. Due to the different linguistic backgrounds between Bu and her boyfriend, English was the dominant language they used for communication. In addition to spending time with her boyfriend, Bu's circle of friends was limited to few Taiwanese nurses in California, including Shya, Wei, and Co.

Bu was an energetic person who liked challenges and excitement, including caring for surgical patients who were in critical condition. Bu even naughtily told Shya: "MICU [Shya's unit] is a boring unit. SICU is more challenging, has more fun!" Bu was diligent and keen to acquire the latest nursing and English knowledge. When she interacted with Mandarin and English speakers in social events, she demonstrated competent

communication skills, such as maintaining fluent and coherent conversations, making jokes, and providing backchannels (i.e., “um” and “well”) and appropriate nonverbal cues. Nonetheless, in the cross-cultural healthcare communication, Bu experienced more frustration when using English to implement nursing tasks.

Bu’s English proficiency exam results on the IELTS defined her as an advanced English user three years prior. However, Bu’s self-evaluation of her English level was that she felt insufficient while communicating with the hospital personnel, patients, and visitors in the workplace. Bu habitually worried about her communication performance and felt isolated while working in U.S. hospitals. Bu recounted,

Because of English barriers, I usually don’t speak much at work. I hardly chat with my coworkers. I just smile at them. I feel especially uncomfortable talking to white nurses and second-generation immigrant nurses. Their English is perfect. I’m worried that they won’t understand me. It really makes me feel ashamed.

Furthermore, Bu declared that in Mandarin, she was accustomed to talking in a circumlocutory style. She liked to use refined expressions implying main points during conversations. When Bu spoke English, she adopted these rhetorical, speaking features but realized that they were not always appropriate in English conversation. She noted,

I think my speaking is too indirect. It has happened many times. When I ask questions or request medical orders from doctors, they usually do not catch my meaning at first. I have to repeat several times or use another way to express myself, and then they may eventually guess what I am saying.

Bu then gave a specific example:

I asked a doctor ‘Do you want to have a sample draw after which doses?’ He didn’t understand the sentence. I paused a second and rearranged the sentence by putting keywords of ‘which dose’ at the start of my speech, ‘After which dose should I have a sample draw?’ This time he finally got it and prescribed an order. These communication failures become more apparent whenever I talk to doctors or pharmacists over the phone [than

face-to-face conversation].

In addition to language barriers, Bu encountered unpleasant communication experiences caused by different cultural perceptions. One day when Co, Bu, Wei, other Taiwanese, and I gathered together to celebrate New Year, Bu shared a story. She said that there was an elderly male patient who refused to be bathed the night before, but she completed the bathing despite his reluctance. In a focus group interview with other nursing participants, Bu explained:

Bu: I don't understand why he was so angry with me.

Co: He probably didn't want to be awakened in the middle of the night, right?

Wei: Or maybe he was uncomfortable being naked and served by a young female nurse.

Bu: I had to bathe him. It was a requisite nursing procedure to keep him clean, to prevent infection. But the next morning, the guy's daughter came to me and interrogated me, 'Didn't you understand what my father meant? He said he didn't want to be bathed. If you touch him again without respecting his wishes, I will definitely sue you for sexual harassment!'

Wei: You should protect yourself. Don't be too responsible [for finishing all nursing procedures]. If your patient has a strong opinion, just leave it to the morning shift nurse or your charge nurse. They'll know how to deal with the case.

Bu: I still think I was right. I was doing my job to maintain his hygiene, you know, to keep him from infection.

Bu recognized her challenges. She stated that "Working in Taiwan I felt just like a fish in water." However, when she worked in U.S. hospitals, she discerned that her nursing abilities were obstructed by language and cultural barriers. Moreover, she worried about how her hospital colleagues viewed her: "Sometimes they [doctors and nurses] are so impatient when they don't understand my English; I can tell from their faces." She also avoided talking to patients and families and confessed: "I am so afraid

they [patients and families] do not understand me well. I become nervous when they discuss social or cultural topics and use slang expressions beyond my knowledge.”

Bu concluded,

I wish I could be as happy as before. Working in the U.S. is tense. I have become anxious, quiet, and stupid. It is not me. I ought to be composed, talkative, and skillful like I was in Taiwan.

Chen's Portrait

Chen gained help from the same RN agency in Taiwan where Shya and Bu enrolled for the NCLEX-RN and IELTS preparation. Owing to budget concern, after Chen moved to California, she chose to discontinue the contract with the U.S. nurse staffing services company and walked through her U.S. immigration journey independently. Like Bu and Shya, Chen had difficulty passing the IELTS exam to obtain a U.S. working visa, and she also experienced obstacles when adjusting to U.S. clinical communication.

I met Chen through Shya when Shya invited Chen to her house. We spent an entire afternoon having lunch and chatting together. Chen was kind, polite, and a little quiet. As a guest, she made no requests and accepted all offers from a host. Whenever I asked her an opinion about an event or activity coming up, Chen would reply: “It’s fine. Do whatever you want. You decide.” During conversations, she preferred listening to speaking. Despite appearing withdrawn, Chen did build relationships with others, and was helpful and easygoing. She often needed time to become familiar with new people. During this study, after she came to know me better, Chen became more talkative and secure when we met privately at dinner, while shopping, and during interviews.

Home Family and Culture

Chen's aptitude was led by her father and the anticipations that her parents had on her. Chen grew up in Kaohsiung, the largest city in southern Taiwan. Her parents both had master's degrees. They were college lecturers teaching accounting and electronic engineering at a university in Kaohsiung. Chen declared,

My father is a refined and courteous man. He is polite, gentle, and modest. He rarely squabbles with people. When people feel resentful about him, my father apologizes. If someone is rude to him, he would smile back.

Chen's communication style was influenced by her father. Chen was gracious and unpretentious. She was calm and scarcely irritated by people. Whenever she had bad luck, she held her negative emotions in as not to disturb anyone: "It's not their [patients'] faults; I understand". Furthermore, she was too kind to turn people down when they asked a favor of her. Chen said, "My charge nurse just called me. I guess she wants to ask me to take on an additional shift. I purposely missed these calls because I am so afraid to say no to her." Once, when Chen was in my car, her cell phone continued ringing but she avoided picking it up. I reminded her of the incessant ringing and she replied to me, "It's a friend we met in church. He loves to talk about the bible and Jesus for a long time. I don't know how to interrupt him. So, it's better not to answer. I'll return his call after we finish our dinner."

Chen took words as gold. In public, she spoke sparingly. This attitude toward communication was notable during research meetings and at private events that we attended together. Chen usually took the position of a listener rather than eagerly sharing her own stories. She strictly followed the rules of conversation, including patiently waiting for her turn to speak and making an effort not to interrupt the speaker.

However, she was generous with sharing her feelings and thoughts, provided that she was invited to talk, such as being asked, “What do you think, Chen?”

Nurse and Language Training in Taiwan and the United States

For much of the time, Chen’s parents played an important role of assisting her decision making about school education and nursing career. Chen’s communication experiences in U.S. clinical settings were the result of both Taiwanese and U.S. training in terms of English learning and nursing education. Chen avowed, “I had no specific preference to study nursing. My parents came to the decision about my major based on my college entrance exam results. They felt that nursing was a stable job for women compared with other professions in Taiwan.” When Chen was a nursing student, her father persuaded her to hasten her overseas preparation, such as encouraging Chen to take TOEFL and English conversation classes in foreign language institutions in Taiwan. Chen claimed,

Somehow, I just obeyed my father’s demands to take the English courses, yet I had only a little interest in English. I seldom reviewed the content. I just put away the books whenever I got home. It’s common sense--people never realize how important something is until they definitely need it [to work and live in an English-speaking country].

Chen evaluated her college English level as “poor.” She was not motivated to acquire English because she felt no urgent need to use English in Taiwan. After graduation, Chen submitted to her parents’ advice and chose to specialize in labor and delivery: “My parents felt that delivering babies was the cleanest job in nursing.” In 2006, she followed the Taiwanese RN agency’s arrangement and traveled to California to sit for the NCLEX-RN exam.

In her initial experiences as an immigrant in California, Chen had a difficult time maintaining her residential status legally in the United States. She entered the United

States on a tourist visa, which allowed her to officially stay in the country for a maximum of six months. She did well on the nursing license examination (NCLEX-RN) but constantly achieved inadequate scores (i.e., 7.0) on the speaking section of the IELTS exam. Chen became discouraged: “I felt like I was a deflated balloon. The enormous cost of living in California, including food, rent, transportation, course fees, and exam fees almost drowned me.” By the end of 2006, with disappointment and regret, she left the United States feeling her “half-year effort was in vain.” Chen went back to Taiwan and pondered her future. Chen said, “There would be no way for me to improve my English conversation if I remained in Taiwan.”

One year later, with her parents’ encouragement and financial support, Chen decided to re-enter the United States for another six months. During this period, she attended English classes provided by nonprofit organizations. She self-studied for the IELTS and re-took the exam. She visited Chinese churches in order to make connections with people and sought emotional and social support. It was during this period that she first met her Cantonese-American husband, Kevin. She achieved an overall score of 7.0 in IELTS but once again received a less than acceptable score on the speaking section. Once more, she was trapped in the six-month time counting game. Chen declared,

I was terrified. I didn’t want my visa to be revoked. But I was running out of time [to be deported by the United States]. I regrettably felt couldn’t make it. I had no ideas how to get a score of 7 on the speaking section.

A few weeks before she left, she fell in love with Kevin. In early 2009, after four-years of going back and forth, Chen eventually achieved her goal. Although she didn’t

achieve the IELTS required score of the speaking section (i.e., 7.0), she was finally able to stay and work in the United States legally under her husband's spouse visa.

Adjustment to the U.S. Healthcare Context

Chen's primary communication experiences at work highlighted the ethnic and linguistic diversity in terms of hospital personnel and patient structure in the U.S. healthcare context. Chen began working in September of 2009 and was recruited as a night-shift labor and delivery nurse in a multi-ethnic community hospital. Her 18-month work history in the United States was shorter than the other four participants'. Chen described that the majority of the nursing staff was Filipino. They occupied 80-90% of the unit. The second largest population was nurses from China and Hong Kong. They spoke Mandarin, English, Cantonese and other Chinese dialects. Chen continued: "We have few White [Anglo-American] nurses and Black [African-American] nurses, but I rarely work with them during my shift."

On one hand, Chen was the only Taiwanese nurse on the night shift. To some extent, she felt disconnected from her Filipino and Chinese nursing colleagues. Her communication experiences with them left her feeling socially and emotionally isolated from them. Chen commented:

They [Filipino and Chinese nursing colleagues] form a circle. Except for their own people, no other ethnicity is invited into the conversation. They seem self-centered and exclusive. They share medical resources, assist each other's cases, help clean up at work, and discuss one another's family and life. However, when I and other ethnic minority nurses show our enthusiasm to join in the dialogue or make a connection with them, they involuntarily act over-polite or treat us indifferently.

On the other hand, Chen's patients were mainly Mexican expectant mothers. The second and third large population of patients in the department consisted of Chinese and Vietnamese women, respectively. Occasionally, Chen was responsible for the

Korean and Chinese patients. It was understandable how strained Chen was when using a nonnative language to communicate in such a culturally and linguistically diverse environment.

One time, she felt hurt by an American doctor who criticized her communication ability: “He blamed me for my speech. He doubted how I could deal with a medical emergency by speaking in such a slow pace.” In addition, Chen recounted that one night early in her employment, a Hispanic father-to-be welcomed too many visitors to the labor room. Chen explained, “I understand it’s their [Mexican] culture to celebrate the important moment [delivering a baby] with their family, relatives, friends, and even coworkers, but we have a strict ‘two visitor only’ policy.” After Chen advised the visitors to leave, the father-to-be initiated a severe quarrel with Chen. He yelled at her and asked her out of the room. He reproached her as an unprofessional “alien” nurse and requested to change for another primary nurse. He also wrote her up to her supervisor. Chen said she felt extremely wronged and could not stop crying in front of her colleagues. Chen commented,

No one would help me except for myself. If I didn’t learn to be strong enough for what I said, no one would listen. After that incident, I began modifying my speaking style to be firm and definite, particularly for the purposes of professional communication... I need to change. I can’t always be like my father. We are too polite. Here [in the United States], if you are too polite, people assume you are too soft.

Although Chen received an overall score of 7.0 on the IELTS exam, which placed her in the “advanced English level,” she noted, “It took me more than one year to become accustomed to using English to communicate [in the cross-cultural healthcare setting].” To some extent, Chen attributed her preliminary uncomfortable communication experiences to inadequate hospital training. She declared,

The orientation classes had limited help about our [international nurses'] adaptation to communicating in a multi-cultural hospital. No class aimed to improve our English communication skills. Although there was one lesson focusing on cultural diversity for nursing care, the content was boring and over-generalized. [Chen pointed at the orientation booklet.] You can see I took no notes. I have no idea what it was about for cultural diversity. I might have fallen asleep during this class.

Although her hospital employers did nothing to provide sufficient assistance in Chen's communication in a culturally-diverse work environment, Chen found a way to overcome these communication difficulties. Chen expounded,

I continued watching American soap operas, such as 'Dr. House,' 'Everybody loves Raymond,' 'Friends,' 'Desperate Housewives,' and 'Sex in the City.' I believe watching these TV programs can help me acquire English knowledge, popular expressions, slang, medical culture, and to begin to understand American humor.

Context Up to Study Period

At the time of the study, Chen was 27 years old and had worked as a labor and delivery nurse in the U.S. community hospital for one year. Chen settled down in the United States two years before this study, and she lived with her Cantonese-American husband, Kevin, in a mixed-ethnic community. It was a city with a large Asian population in California, including Taiwanese, Chinese, Korean, Vietnamese, and Thai residents. Chen's social network consisted mostly of Asian and Mandarin-speaking friends. During her leisure time, she met Kevin's family and members of the church who spoke Cantonese and Mandarin. She barely used English when she was off work unless it was at a particular event that would require the use of English:

There is no particular need for me to speak English off work. I spend most time with my husband and his family and friends. I may need to use English with Kevin's nieces and nephews because they don't speak Mandarin...I sometimes wake up in the morning and wonder whether I am in Taiwan or in California [laughs].

In most situations, Chen's Mandarin and English speech was elegant and unhurried. She acknowledged that she needed additional time to organize her thoughts before speaking. While speaking in English took a good deal of effort, writing was easier for her: "It is because writing offers the luxury of extra time to arrange my ideas." Up to the time of this study, Chen generally felt comfortable with cross-cultural clinical communication. She was confident in handling common nurse-patient and nurse-nurse conversations. Nonetheless, she envied her Filipino colleagues (in the Philippines, English is one of the official languages) and second-generation immigrant colleagues who were able to freely express their ideas in English. Chen sighed:

Every so often, I stammer and hesitate to talk when I lack sleep or when I am under pressure. My brain turns blank, especially during urgent situations. It's so bad.

Due to her immersion in the multicultural work environment, Chen had developed insightful cultural awareness of nursing care. For instance, she came to the realization that American mothers and Mexican mothers were more independent and self-assured regarding their beliefs on child-care. Chen found it interesting to see that Mexican mothers could not wait to cuddle with their newborn infants. They struggled to put their babies down for even a minute. Such mothers also tended to ask numerous questions about how to feed and raise the infants on their own. They were more willing to take care of their babies by themselves rather than being assisted by nurses or allowing them to watch over their newborns.

On the contrary, Asian mothers such as Chinese and Vietnamese seemed relatively more passive about baby care. They even asked Chen to take the infant away from the labor room in order to let them get some rest. Chen explained that Asian

mothers and their husbands would tell that mothers were exhausted after delivery, so they deserved a few quiet moments to regain their energy. They believed newborns were under better care in the nursery room than in their hands because parents were not medically trained but nurses were.

Through Chen's observation of mothers' various attitudes toward newborns, she modified her speaking strategies when serving patients from different cultural backgrounds. To be specific, Chen encouraged Asian mothers to have intensive interaction with their babies: "I advocate the bright sides of breast-feeding for Asian mothers. I also strive to increase mothers' confidence to look after their infants without our [nurses' and doctors'] intervention." On the other hand, Chen tried to tame Mexican mothers' enthusiasm about newborns: "I keep an eye on preventing them from unintentionally suffocating the baby. I also promote the necessity of formula milk for Mexican parents in those cases where babies are not satisfied with breast-feeding."

Furthermore, like the prevalence of patient care plans in SICU and MICU, Chen noticed that the culture of making a birth plan was widespread among expectant mothers in U.S. hospitals. Birth plans were composed by the patient of the procedures, methods, and care that the mother-to-be preferred during the delivery process. Chen had opinions about birth plans:

Mothers who have birth plans are usually troublesome to communicate with. They seem opinionated and bossy. Sometimes their plan violates medical procedures. It creates problems for nurses and doctors. In Taiwan, usually doctors dominate the procedures, not the mothers.

Wei's Portrait

Compared with Shya, Bu, and Chen, Wei had less concerns about these communication issues in clinical settings. Wei's continuous contact with English via

songs in the school, her excellence at academic achievement in Taiwan, and her 10 years long-term immersion in U.S. society before she worked, diminished her struggles with language barriers and cultural conflicts when working in U.S. hospitals.

On the first day when I visited Bu, she convinced me to drop by Wei's house. Bu kept persuading me: "You don't want to miss her. Wei is such a nice, generous big sister... Let's go and I'm pretty sure you're going to enjoy the time spent with her." We then drove to Wei's house. Wei was a confident mother and a loving person. Like what Bu described, Wei was warmhearted and content. She earnestly invited us: "Please stay with us for dinner. You guys must be hungry after the interview."

Wei had been a registered nurse in U.S. hospitals for about seven years. She lived with her two sons in an upper-class White-dominant community in southern California. She had been living in the United States for 17 years. Wei was a previous charge nurse in the community hospital where Bu used to work. Due to their parallel linguistic and cultural backgrounds, they quickly overcame the supervisor-subordinate relationship. They became close friends who shared happiness, worries, burdens, sorrows, stresses, and support regarding each other's work and life.

Home Family and Culture

Wei was born in Taipei, the capital of Taiwan in the 1960's. Her father was a director in an elementary school. From Wei's perspective, her parents were her model and backup. Wei claimed,

My dad is a welcoming, loving man who enjoys inviting friends, coworkers, relatives, and students over to the house. My mom is not as socially active as my dad. She is more like a traditional Taiwanese housewife who cares for children and husband and won't ask for credit. They always offer support and love to us [Wei and her siblings].

Wei commented that her father was passionate about singing. When Wei was a child, her father purchased a karaoke machine at home to sing Mandarin and Taiwanese pop songs with guests. Broadly speaking, Wei had her father's talents, singing and generosity. First, being immersed in a melody-rich environment, Wei had developed a strong interest in singing. She also built up her foreign language ability through singing songs: "I am talented at both classical and pop music, including many English songs. I was selected to participate in school choirs and won many singing competitions in college and at hospitals." Second, based on interviews and observations, Wei was a generous hostess who held a variety of BBQ parties, feasts, and holiday events for people whom she cherished.

In addition, Wei's father strictly stood to a Chinese maxim. Wei elucidated,

When I was a child, my father taught us '無欲則剛 (wu yu ze gang), no wants, no compromise.' He is a traditional Chinese man who emigrated from China. He always told us no wants, no compromise. If you have no desires from others, you'll have a firm will.

The maxim is close to the English proverb "Cease to hope, and you will cease to fear," which means if people do not have expectations, they won't be afraid of losing something. Wei kept in mind her father's doctrine. She was satisfied and responsible: "The last thing for me to do is to expect peers, siblings, friends, or colleagues to favor me." However, after Wei moved to the United States, she realized that the principle of 'no wants, no compromise' gradually led her to a detrimental situation at work. Wei noted,

In American culture, people go after what they want. It is seen as necessary to speak out one's thoughts. When people are in an unfavorable position, they are supposed to fight for their rights.

The conflict of “no desire” versus “pursuit” continued to impact Wei’s work and life communication experiences, as demonstrated below.

Nurse and Language Training in Taiwan and the United States

Wei’s communication experiences in U.S. medical settings were formed by her English and nursing training in Taiwan, the NCLEX-RN preparation in California, and her immigrant experiences in the United States.

In the 1980s, the university admissions rate in Taiwan was below 30% (while in 2010, the university admission rate jumped to virtually 90%). Under such competitive conditions, Wei gained excellent scores and was able to enter one of the top ranking medical universities in southern Taiwan where she enrolled in the nursing program. Wei recalled,

My parents valued a lot on my school learning... I did well at many subjects. . . At college, my performance was outstanding, and I graduated with honors. As an inexperienced nursing novice, however, my high GPA (Grade Point Average) helped me to get hired by the best hospital in Taipei.

Wei worked in the orthopedics and mixed-surgical unit in Taipei for five years. In the middle of the 1990s, Wei and her ex-husband moved to the United States. During the first ten years of her immigration, Wei played a role as a full-time housewife caring for their two sons, James and Jack. After James was mature enough to take care of himself, approximately seven years before the study period, Wei hired a private NCLEX-RN tutor to help her review nursing knowledge and gain an understanding of U.S. nursing culture. Afterwards, she self-studied for the examination for one year, passed it, and obtained a California RN license in 2004. This success led her to be recruited as a regular surgical medical nurse in a multi-ethnic community hospital. Wei declared,

There were no big challenges when preparing for the NCLEX-RN exam.

The exam helped me review the nursing knowledge and medical terms that I require to work in the United States.

Adjustment to the U.S. Healthcare Context

Due to the 10 years long immigration history before she began to work, Wei's early communication experiences in U.S. healthcare settings underlined more cultural conflicts than language issues. During her first employment in the surgical medical department in the United States, after a nine-month training period, Wei was promoted to the charge nurse position to lead the nursing team for five to six years. The community hospital was surrounded by the Korean town, the Vietnamese town, the predominately Mexican area, the Chinese community, and the U.S. mainstream residents. The hospital workforce was composed of Korean, Mexican, Filipinos, Chinese, Taiwanese, and American. Wei stated,

Mostly, you saw lots of Asians in that hospital, such as Korean and Vietnamese. To us [Taiwanese nurses], it was a good thing. We didn't have much pressure to speak perfect or standard English because there were many second language speakers in the hospital.

Nevertheless, at the beginning of her charge nurse job, Wei found it demanding to be in charge of the nursing team. One U.S. and one Hispanic subordinate nurse frequently challenged her authority by rebelling against her assignments over and over again. Wei mimicked their tones, "I don't want to do it. It's unfair. Are you blind? I'm busy." Wei recited,

Whenever arguments erupted, everyone in the unit waited to see how I would deal with the dispute. I was not only disheartened by the two nurses' aggressive talk, but also anxious about losing my leadership image in front of others. I innocently held hope that my teams would ultimately accept me as long as I kept a low profile, worked harder, and kept the principle of '無欲則剛(wu yu ze gang), no wants no compromise.' Unfortunately, I was reported to the nursing manager as being an incompetent leader by the two nurses.

In order to keep her position, Wei decided to alter the way of communication which her father taught her. Wei continued,

Then, I realized I couldn't be easy-going anymore. I should have told the truth. I bravely spoke up to my manager how the two nurses' uncooperative and arrogant attitudes compromised their nursing care. This blunt way of speaking led me to a long overdue victory. At last I comprehended 'no wants, no compromise' or 'silence is golden' are not applicable in the United States.

Context Up to Study Period

Eight months before the study period, Wei transferred to an orthopedic rehabilitation unit at a non-profit regional healthcare delivery network. This regional hospital provided more innovative facilities, higher standards of operation, and better welfare than her former employer. She was satisfied with resigning from the position of a charge nurse in the community hospital to become a regular nurse in the current healthcare center. Recently, she had been weighing the benefits of decreasing her work time: "I am thinking to reduce my working hours so that I can spend more time with my sons and Donny [pseudonym, her Taiwanese-American boyfriend]."

As a Taiwanese immigrant, Wei was enthusiastic in promoting the Mandarin language and Taiwanese culture. For example, she was devoted to her sons' Chinese school affairs, such as holding activities for Parent-Teacher Association (PTA). She closely monitored James' Advanced Placement (AP) Chinese classes and tutored him when necessary. She cultivated Jack's interest in learning kung fu. She also decorated the house with lunar calendars and spring festival couplets. Values, language, and culture derived from Taiwan could be seen everywhere in her home. Wei claimed, "Mandarin is such a beautiful language. They [James and Jack] should be able to use the language."

Wei usually spent time with people from Taiwanese population. She had no thoughts to expand her social contact from Taiwanese immigrants to American mainstream society. Wei declared,

We hardly hang out with Americans. It's natural for people to get together with someone from the same ethnic and language background. Americans are with Americans. Koreans spend time with Koreans. Chinese form a group full of Chinese. We feel comfortable to do that. That's all.

On the whole, Wei felt at ease about her communication experiences in the United States:

I don't have problems in English conversations. Maybe during the first three to six months [in her first employment], I was anxious about my job. I tried to pick up everything within a half year. But I was pretty okay after the first six months

Wei demonstrated her sense of humor and wit in communication by making people laugh regardless if she was speaking in Mandarin or English. She was fluent in English communication. For instance, she was capable of explaining complicated mahjong rules (a Chinese gambling game) to Bu's Lebanese-American boyfriend in English, which might be viewed as a challenging communication task to other nonnative English speakers. In Wei's opinion, it was satisfactory for her to speak English with a Taiwanese accent, with flaws, as long as her English was comprehensible to others. She realized her advantages at work: "They [hospital employers] hire me not because of my 'good' English. They want me because I have the professional skills they are looking for."

Wei was confident of her English ability, immigrant life, and nursing job in the United States. She was viewed as a warmhearted and thoughtful big sister by people

around her. She revealed few difficulties in language and cultural adjustment except for the contradiction that her father taught her. Wei reasserted,

We, Asians, don't call a spade a spade, but since I work here, in the United States, I have had to come up with a way to prove myself. I should become determined to be tougher.

Co's Portrait

In contrast to Shya, Bu, and Chen seeking for help from a RN agency, Co prepared NCLEX-RN exam and English proficiency test on her own in Taiwan. She believed that without having received assistance and training from the nurse staffing services company, she encountered "tremendous" language barriers and cultural obstacles in cross-cultural clinical communication. Co claimed,

Sometimes I envy Bu and Shya. They have a training background from the RN agency, which is I don't have. The company helped them prepare before they jumped into the U.S. nursing industry. I had experienced a hard time since I started to work here. Language, culture, even basic nursing skills all left me exhausted.

I met Co at a New Year's celebration party held by Wei. Co was a 47-year-old female Taiwanese nurse who had immigrated to the United States in 2004. Co's life experiences had turned her into a witty woman. She was loquacious, frank, and outgoing. She was the spotlight among many people. Everyone seemed to be attracted to her laughter and eloquent speech at the dining table. As soon as Wei introduced me to Co, Co grabbed my arm and teased me, causing everyone to double over with sidesplitting laughter:

Are you Cloudia? The doctoral student Cloudia? Come on, you must be joking, right? I assumed the doctoral student interested in nursing English was a lady in her mid-40's who was disappointed in romance, life, and everything else. You look young and healthy, what made you entwined with the PhD mess? [laughs]

Home Family and Culture

Co's beliefs, values, and attitudes toward communication and social interaction were almost a reproduction from her parents and home culture in Taiwan. Co grew up in Taipei, the capital city of Taiwan. She had one sister and one brother. She was the oldest child in the family. Co noted, "My father is a solemn man, like other fathers in a traditional family. My parents believed that honesty was the best policy. They taught me to be blunt and responsible." When she got into trouble, her parents always encouraged her to take responsibility for her actions. Moreover, they expected Co to take challenges and face difficulties. They advised Co to be cooperative in order to get along with siblings, friends, and colleagues. Co indicated,

I think my parents had a huge impact on me. I'm very grateful for their doctrines. I am humble about what I have and never exaggerate my abilities. I never claim I can do something which I don't know how to, which is quite different from (some) Americans. I am supportive of my coworkers, by doing additional work for them. Although (some) Americans may not appreciate our culture, I still keep these values.

Nurse and Language Training in Taiwan and the United States

Co's U.S. healthcare communication experiences can be traced back to her education history of English and nursing in Taiwan and language learning in the United States.

When she was 15 years old, Co enrolled in a 3-year nursing program in an occupational-focused senior high school in Taiwan. Co felt that the school paid little attention to students' English ability development in the context of nursing: "The teachers taught us to sing many English pop songs but not really covered the content of the textbooks. The class was fun, but I don't think my English improved much during the three years." After receiving her nursing diploma, Co enrolled in a nursing college

program. In the nursing college, it was her primary experience to be engaged with medical materials written in English. Co recalled,

In high school, our medical and nursing textbooks were all written in Mandarin. However, everything had changed in college. We were required to read loads of English medicine textbooks. It was extremely exhausting, especially for me such a vocational school nursing graduate with poor English.

Co's work history in Taiwan involved 2 years of intensive care and 15 years of anesthetic care, including working in a nursing management position in the anesthesiology department at a reputable hospital in Taipei. In the era of 1990s, the U.S. RN agencies in Taiwan were not as popular as at the present. Co self-studied and passed the NCLEX-RN examination in 1997. She also took a TOEFL (Test of English as a Foreign Language) paper-based exam and scored 450/677, which classified her at an intermediate level. In 2004, although her TOEFL exam results did not match the U.S. VisaScreen regulations for international nurses (i.e., advanced level), Co was allowed to work in the United States without the English test proof under her Taiwanese-American husband's spouse visa.

In spite of the fact that Co had nearly two decades of clinical experiences in Taiwan, her management background and outstanding qualifications in nursing did not contribute to her initial communication experiences in the U.S. medical setting. Co declared,

In Taiwan, I worked in the intensive unit and anesthetic department over 20 years. I was promoted to a nursing manager to handle the whole floor. I even participated in the unprecedented cardiac and multiple organs transplantation. However, after I moved to the United States, I had to revert my empirical skills to zero. Everything started from the beginning. I picked up nursing skills, hospital polices, medical systems, language, and culture day by day. I was as new as a novice. Even now, I am still learning new words, new phrases, new culture, and new nursing skills and

knowledge during my shift every day.

Adjustment to the U.S. Healthcare Context

Co's early communication experiences in U.S. hospitals accentuated two main issues: English language demands in clinical interaction and cultural differences in the context of nursing.

Co's first job in southern California was as a recovery registered nurse in the post-anesthesia care unit for half a year. The unfamiliarity with English language, U.S. medical systems, and hospital subcultures led to frequent confusion and misunderstandings for her. Co felt uneasy at work. Even worse, she suffered from mental and physical syndromes of strain: "I had sleep disorders, menstrual disorders, depression, and anxiety." Co continued,

I was tremendously discouraged. I had no choice except to tell my manager I wanted to quit. I felt overwhelmed. The pressure caused me hormonal disorders; what's worse, it caused my immune system to deteriorate, making me chronically ill!

After a six-month trial, she discontinued her job and took a 2-year leave to regain her health and confidence. Between the two-year interval of her first and second job, Co watched CNN news, read local newspapers, socialized with her husband's English-speaking friends, and practiced English conversations in daily life. She assumed, "If I immersed myself in U.S. culture and an English-speaking environment, I might be able to adjust to working in the United States." Furthermore, Co registered in a six-month ESL program at a community college in order to enhance her communication skills in clinical settings. Nonetheless, the ESL courses focused on academic English as well as general English, but not cross-cultural healthcare communication. Co commented,

The ESL courses improved my reading and writing skills but not my conversational ability. The courses didn't help me much. I picked up more

and more conversation skills during my second job.

Co noted that registered nurses usually preferred to work the day shift and rested at night in order to maintain a normal life style. Quite the opposite, she voluntarily worked the night shift for the first three and half years. Co explained,

In contrast to the day shift, working at night creates fewer opportunities to communicate with people in the hospital... In the day shift, I need to talk to patients' families. Families always have so many inquiries for me as a primary nurse because someone they care for is in an urgent trauma condition. Then the chief resident, attending doctor, neurologist, and cardiac surgeon all come to me to get patients' detailed lab reports, CT scan (X-ray computed tomography), and MRI (Magnetic Resonance Imaging) resources. I just can't stop talking, which is very demanding!

Moreover, Co declared that some American colleagues had prejudices against her, especially since Co was the first Mandarin-speaking nurse recruited by the SICU:

Actually, I cried in the car after work everyday for almost six months. Every day, every night, every shift, as long as I met new coworkers, as long as they didn't see my work but came across my speaking first, they always jumped to conclusions based on my poor English ability.

Co then shared a more specific story about the communication conflict with her American colleague in her early work experiences:

During my first day on duty, I was giving a shift report to Mary (pseudonym). Mary prompted a number of questions about the patient's conditions, but she gave little time for me to respond. I stuttered and paused for a while. I was processing English words and sentences in my head. All of a sudden, Mary became angry. She raised her voice and relentlessly condemned me, 'Where did you get your nursing degree? Do you even speak English? It isn't funny at all. If you don't do this right, you will kill people, you're aware that? I don't think you deserve this job!'

Co continued, "I bit my tongue, worked harder, and spent additional hours in the SICU to acquire nursing knowledge and improve my English." It was a struggle for Co to gain the approval of her nursing coworkers. As time went by, fortunately, her family

traditions and cultural values in terms of facing challenges and being helpful, strengthened her and drove her to overcome these communication difficulties at work.

Besides language barriers, Co perceived that the differences in nursing concepts and medical culture between Taiwan and the United States hampered her adjustment in the U.S healthcare context. She spent time developing critical thinking skills required by the U.S. nursing profession but not by Taiwanese nursing industry, such as nursing assessment and temperature measurement. In the primary immigrant stage, she often quarreled with her American colleagues about the way to measure patients' body temperature. Co described,

Do you remember that I have 20 years' working experience in Taiwan? Taking body temperature should have not been a big deal to me at all. Whenever I was corrected by my supervisors and colleagues, I felt insulted. But after I observed my coworkers' temperature measurement techniques for a couple of weeks, I finally realized they had profound knowledge about this basic skill.

In Taiwan, Co used whichever tools were available for her to measure patients' temperature. She had never considered that different methods of measurement could affect the patients' health. On the other hand, in the United States, nurses critically considered the advantages and disadvantages of taking rectal, ear, oral, and axillary temperature of their patients. Co clarified that as to patients with facial fractures, it was inappropriate to take the temperature orally. Regarding ENT (ears, nose, and throat) patients, it was unwise to measure the temperature from their mouths and ears. As for young children, checking their rectal temperature could generally result in the most accurate reading. She expounded,

A basic nursing skill actually requires our critical thinking ability to accomplish it; nevertheless, we (Taiwanese nurses) are not trained to think critically in Taiwan. Every nurse is used to following doctors' orders,

being their assistants. No wonder the ICU nurses here are only assigned one to two patients every shift. Since we are doing nursing in such detailed manner in the United States.

Context Up to Study Period

Up to the study period, Co had been married to a Taiwanese-American husband for six years. They adopted Co's 14-year-old niece Anna from Taipei. Co and her husband, niece, and parents-in-law lived together in an urban city in southern California. In the community, Anna was the only Mandarin-speaking teenager at school. The neighborhood they lived in was predominately filled with white Americans. Their social network was made up of a mixture of Asian and mainstream American friends.

Co had been working as a SICU registered nurse in California for four years. The nursing staff in the hospital included domestic and international nurses, who were Americans, Filipinos, Africans, Vietnamese, Mexicans, Koreans, Chinese, and Taiwanese. The patients were mainly Americans. Since the university hospital was near the Vietnamese community, there was also a large population of Vietnamese patients. A small proportion of Korean, Chinese, and Hispanic trauma patients were admitted to the hospital. Even though Co had developed better communication skills comparing with her first job experiences in the United States, in the current position, she was apprehensive about the communication challenges that she encountered in the linguistically and culturally diverse workplace.

For example, Co worried about her Taiwanese accent in English. She also felt confused by patients' unfamiliar accent in English. Co narrated:

The Hindu patient had a strong accent. I also have a noticeable accent. What he said was really incomprehensible. I had to ask him three times what he was saying, and he still couldn't understand my English. It was extremely frustrating.

Co appreciated the American culture of individualism and self-reliance: “I am adjusting myself to speak out my thoughts more day by day.” Meanwhile, she insisted on her family’s values of being humble and honest. Even if she had over 20 years working experiences in nursing, Co was fonder of keeping modest than showing off what she was capable of. Co stated,

Though I am good at nursing, in front of my coworkers, I still behave like I would like to try, like to learn, instead of being pretentious about my abilities and experience.

Chapter Summary

The pre- and post-immigration stories of Shya, Bu, Chen, Wei, and Co helped to paint a picture of their first language, home culture, prior training, feelings, the challenges they faced, and the changes they implemented into their lives in order to adjust to the U.S. culture, especially medical culture. Each of the five participants’ stories were unique yet there were overlapping similarities. This chapter offered an exploration of how language, culture, and educational experiences of the participants impacted and influenced their cross-cultural communication in the United States. Recognition of their past and present experiences helped to construct a framework from which their communication experiences in the cross-cultural environment could be interpreted. In the following chapter, I present findings from the cross case analysis. The four main themes include: (a) the use of complex and specialized language in clinical settings; (b) cross-cultural differences in clinical settings; (c) identity negotiation in a new U.S. environment; and (d) gaps in language and culture in U.S. nurse training.

CHAPTER 5 FINDINGS: MAIN THEMES

Overview

This chapter presents the findings and main themes which emerged from the cross case analysis aimed at answering the three research sub-questions of this study. The three sub-questions included: (a) how nursing participants described language needs for communication in clinical settings; (b) how they perceived cultural factors as influencing communication events; and (c) how they believed that their education and training prepared them for U.S. healthcare communication. The results of the analysis showed four main themes regarding how the participants perceived the roles of language, culture, and education that affected their clinical communication experiences in the U.S. healthcare context. These included: (a) the use of complex and specialized language in clinical settings; (b) cross-cultural differences in clinical settings; (c) identity negotiation in a new U.S. environment; and (d) gaps in language and culture in U.S. nurse training.

Shya, Bu, Chen, Wei, and Co all experienced clinical communication events not only with mainstream Americans, but they also interacted with people from various linguistic, racial, and ethnic backgrounds. The diversity of language uses, cultural differences, and hospital customs increased the complexity of their cross-cultural communication experiences. Using a nonnative language (English) in the context of life and death situations in a multicultural clinical environment meant that the participants encountered communication difficulties in the workplace. A summary of the main themes is provided in Table 5-1. The data in this chapter are presented in the order of frequency in the coded data.

Table 5-1. Summary of main themes

Themes	Sub-themes	Sub-sub theme
The use of complex and specialized language in clinical settings	Oral communication	Discriminating non-Mandarin sounds Jokes, slang, and multiple dialects Occupation-specific vocabulary and hospital register
	Written communication	Open-ended writing in medical charting Reading genre-specific, medical documents
Cross-cultural differences in clinical settings	Linguistic and cultural diversity of hospital personnel and patients Independent role of nurses in U.S. healthcare Patient-centered care	
Identity negotiation in a new U.S. environment	Accent: Retaining or reducing the Taiwanese accent in English	
	Choices of speech registers	“Sweet talk” versus professional tone (with patients) Assertiveness versus compromise (with patients and hospital personnel) Pretentiousness versus humility (with hospital personnel)
U.S. nurse training gaps: Language and culture	Lecture-oriented classes: Hospital orientation	Lack of essential language needs Lack of cultural knowledge: Patient backgrounds, hospital subcultures, hospital policies, and nursing routines
	Learn-by-doing: Clinical shadowing	Limitations in addressing nurses’ second language needs and building cultural knowledge

Complex and Specialized Language in Clinical Settings (“My English isn’t good enough.”)

All five participants identified specific difficulties in their early communication experiences in U.S. clinical settings. Up to the time of the study, the complexity of the English language demanded by the U.S. healthcare context continued to interfere in the participants’ clinical interactions with patients and hospital personnel. The language was complex; participants described this complexity as “difficult,” “diverse,” “confused,” “unfamiliar,” and “unpredictable” to the participants. For example, as Bu declared, “My English isn’t good enough. I often have miscommunication with doctors, my nursing colleagues, and patients in the hospital.”

The complexity of the English language in U.S. clinical settings appeared in two main categories: oral and written communication. In terms of oral communication, the participants encountered communication difficulties in three ways: discriminating non-Mandarin sounds; comprehending jokes, slang, and dialects; and discerning occupational-specific vocabulary and hospital register. In terms of written communication, the participants faced difficulty writing open-ended charting and reading genre-specific documents in hospitals. These issues are expanded upon below.

Oral Communication

The complexity of oral conversation was one of the primary challenges that the five participants encountered in their cross-cultural, clinical communication experiences. The challenges included (a) sound discrimination; (b) jokes, slang, and dialects comprehension; and (c) occupation-specific vocabulary and hospital register discernment.

Discriminating non-Mandarin sounds

The difficulty in distinguishing meaning from non-Mandarin sounds, such as English accents, English medicine and medical terminology, and English telephone conversations, made all participants experience communication difficulties. Shya, Bu, Chen, Wei, and Co all worked in a culturally and linguistically diverse healthcare context in southern California. The multicultural patient and hospital personnel structure introduced a mixture of native and non-native American accents and dialects to the five participants. The situation became more complex for the participants to interpret meaning when trying to navigate through differing American accents, such as African American Vernacular English, Hindi English, Vietnamese English, and Filipino English.

Bu narrated:

The largest proportion of nurses in my unit is Filipinos. Other nurses are Vietnamese, Korean, Chinese, Mexican, Romanian, African American, and White American. Patients consist of Americans, Koreans, Vietnamese, Mexicans, and a few Chinese. I have to deal with a variety of English accents and cultural differences in my work hours. It is demanding and confusing.

Participants provided multiple examples. Chen declared, “The accent of Hindi English is very incomprehensible to me.” Co had similar complaints about the Hindi English accent. Wei claimed, “It is difficult to discern meaning from the Vietnamese doctor’s English accent,” while Shya stated, “I have difficulties in understanding Arabic and Spanish English accents.” At times, native-English speakers’ dialects also hampered the participants’ listening comprehension in clinical settings. Bu added, “I was barely able to take a physician’s orders due to his typical southern American accent. Many words were obscure.”

Second, four participants (Shya, Bu, Chen, and Wei) acknowledged that they misinterpreted medicines and medical terms due to inconsistencies in pronunciation between the Taiwanese nurses and American healthcare professionals; this could often lead to miscommunication and even serious medical errors. Shya's different pronunciation of "insulin" was an example: "U.S. nurses pronounced it (insulin) [ˈɪnsəlɪn] while Taiwanese medical teams pronounced it as [ɪnsjuˈlɪn]." Even language pronunciation differences in stress in words created confusion. For example, Bu noted, "In Taiwan, we all pronounce respiratory [rɪspɑɪˈrətɔɹɪ], we put the stress in the back; but here, Americans call it [rɪˈspɑɪrəˌtɔɹɪ]. They put the stress in the front." Chen provided her explanation of this situation:

Nurses in Taiwan acquired inappropriate pronunciation of English medical terms in nursing programs. We continuously use them inaccurately in practice. We don't feel it's necessary to correct our pronunciation. If someone speaks accurately using the English pronunciation of medical terms, the Taiwanese medical teams may be unable to identify what he/she is referring to. It is our custom to pronounce these terms using a Taiwanese English accent.

Identifying and managing these inconsistencies in medical pronunciation complicated the five participants' communication experiences from their early experiences as nurses in the United States up to the study period. Wei claimed,

There are a lot of medical terms and medicines which are different from what we pronounce in Taiwan. There is always a new pronunciation, which is different from what we have heard. It happens during phone orders, shift reports, and ground meetings. We have to be very sensitive to these differences, to guess, to ask, and to confirm these terms.

Shya continued, "If we don't recognize these terms and we administer wrong orders, the consequence can be very serious."

Third, when face-to-face communication was largely influenced by speakers' American accents, such as pronunciation, intonation, and tones, negotiating meaning became increasingly complex especially during telephone conversation. One participant shared a story:

One time when I was on the phone, I misunderstood the doctor's oral diagnosis regarding the patient's 'phlegm' throat. I took it as a 'flame' throat. The charge nurse looked at my chart and yelled loudly: 'What? Is her throat on fire?' I didn't know I made a mistake until the charge nurse noticed it.

The word phlegm [flem] and flame [flem] were analogous sounds to the participant and may be difficult to discriminate for second language learners. Shya, Chen, and Co also experienced difficulties in communicating with doctors on the phone. Chen recounted, "Without seeing the doctors' faces, I feel it is more challenging to express my ideas and clarify misunderstanding freely."

Jokes, slang and multiple dialects

The specialized language used in American humor, jokes, slang, dialects, and social-cultural topics, made all participants experience communication difficulties when having casual conversations (or social conversation) with patients and hospital personnel in the clinical settings. Slang, jokes, social topics, and culturally-specific language required the participants' knowledge not only of the English language, but also of cultural meanings in the U.S. mainstream community.

Shya, Bu, Chen and Co discovered that, in addition to professional conversation, there was a need for them to engage in casual conversation with patients and healthcare colleagues in the workplace. Chen declared, "Nurses' ability to interact socially with patients and nursing colleagues is generally taken for granted by U.S. society." When the five participants paid more attention to their nursing tasks than

casual conversation, their quiet and introverted behavior was easily interpreted as indifference. Bu elucidated, “I always do too much and speak too little. (Some) Americans don’t appreciate that. They may assume I am not easygoing.”

All participants agreed that the most complicated aspect of casual conversation was responding to American cultural topics, slang, and jokes. Wei indicated, “My patients and their families like to talk about American sports, beer, potlucks, pop singers, and country music. I have no ideas about such things.” Chen narrated one experience: “When I left the labor room, a visitor grabbed me and asked whether the expectant mother had turned into ‘a happy camper’. I responded to him by asking ‘What?’” Co also shared her story:

A senior bragged about his ‘fabulous’ cowboy history. He explained how famous he and his son were in their hometown. Although it was a fun communication experience, I was unfamiliar with any of the cowboy vocabulary; besides, his southern accent was difficult to catch. I hardly understood what he said.

All participants felt bad when they misunderstood casual conversation; it was often attributed to their lack of knowledge of American slang or the topic-specific vocabulary. Shya had an American colleague Jenny (pseudonym) who frequently used slang and local phrases when describing job-related scenarios to her. Shya recounted,

One time, I was asking Jenny to cover my case. I asked her whether she could help me put in an IV drip for Mr. Li because I had to take a patient to do the EKG (electrocardiogram) straight away. Jenny replied ‘Certainly. I will put it in *in a New York second.*’ I had no idea what ‘in a New York second’ stood for. I did not realize people use this reference to ‘New Yorkers’ time’ to imply something that happens quickly. I muddily supposed that Jenny agreed to help me.

In another example, Jenny and I were gossiping about one of our colleagues’ retirement plan. Jenny said to me, ‘Amanda (pseudonym) is *out of her grandma’s mind.*’ Although I recognized the phrase ‘out of mind,’ I felt it was a little strange to hear Jenny using ‘grandma’s mind’ to describe the situation.

Wei and Co both experienced embarrassment when hearing sexually-charged jokes from their American colleagues. Wei described that one day William (pseudonym) and his supervisor Vivien (pseudonym) came to Wei to consult about a case:

William is my former subordinate who transferred to work in the emergency room. After the consultation, I said something casual to Vivien: 'I heard you are moving to another healthcare center.' She responded to me, 'Yes, I am leaving. I am thinking to take William with me.' Then I replied to her, 'No, you can't take my Willy.' William looked up astonished and said to me, 'What? Did you just say my willy?' Oh, no. I didn't mean it.

Wei asked me whether I understood the implication behind what she said. I told her I did: "Willy was an oral expression referring to the male sex organ." Wei clarified that she had no intention to sexually harass her male coworker when she used the word "willy." She mistook "willy" as a cute nickname for her acquaintance. Wei continued, "I was so embarrassed. My cheeks flushed right after I uttered the word."

Co shared another miscommunication story that had sexual implications:

One afternoon, I walked into a conversation that my coworkers' were having in the lounge. They joked around and laughed happily with each other. I kind of heard the word "bonus" within their dialogue. Subsequently, I interrupted them and asked, 'What's so funny for you guys to talk about bonus? Are we going to get an extra bonus this month?' They laughed more loudly. They taught me that the word "boner" refers to the erect state of the male organ rather than a raise or an additional benefit. I was too innocent to continue the conversation at that moment, so I just left the lounge room.

Shya, Bu, Chen, Wei, and Co noted that the ability of engaging in casual conversation could not only increase patients' trust in nurses but also smooth the nurse-patient interactions for the remainder of the shift. However, three participants (Bu, Chen, and Co) admitted that they often had delayed reactions to American jokes, or misinterpreted people's statements. The incomprehension of American humor and

English implications often resulted in a feeling of disconnection and isolation. It also led to unsuccessful communication between the participants and patients, families, and hospital personnel in the clinical settings and meant that they had an increasingly difficult time establishing relationships with them.

Occupation-specific vocabulary and hospital register

The complexity and specialization of occupation-specific vocabulary and the linguistic register of hospital talk made Shya, Bu, and Co experience difficulties when reporting their nursing cases to people from different occupational fields, such as coroners, social workers, and police officers. Co explained:

Our Taiwanese culture stresses that human life continues after death. Preserving the intact corpse is considered important for the afterlife. Medical examinations, organ donation and other intrusive actions toward cadavers are not encouraged in our society. In contrast, in the United States, we are legally requested to inform coroners and OneLegacy (a donate life organization) about our patients' death. It is a brand new concept for me, for Bu to call coroners to inform them of our dying and dead SICU patients.

The particular death report phone calls and custody procedures demanded that the three participants' proficiency in linguistic registers and vocabulary fields be broader than those restricted to nursing contexts. Shya declared,

I sometimes stutter when talking to OneLegacy or the coroner over the phone. I usually don't have trouble in my conversational English, but I am not good at expressing myself when talking about non-nursing issues at work, such as legal, administrative, or ethical stuff.

Bu said, "We have no such training. I lack of knowledge to speak with officers about the law or the social welfare system. Those conversations are trickier than the common English we use in nursing care."

Additionally, all participants depicted the specialized register of SBAR (Situation, Background, Assessment, and Recommendation) technique advocated by the hospitals

where they worked in California. They also discussed how this specialized technique affected their communication experiences at work. The SBAR technique aims to ensure healthcare professionals' conversation regarding patients' condition remaining brief, concise, and timely. It includes talk of patients' health states (situations), reasons for patients' admission (background), evaluation of patient health (assessment), and patient care plans (recommendation). Bu explained, "American physicians and nurses prefer the SBAR speech, pinpointing keywords to an indirect speech hinting at meanings." Wei elucidated more about the background of the SBAR skill:

Since in the United States many doctors stay in their own offices outside of the hospital and spend limited time with patients, it is seen as crucial for primary nurses to give brief and accurate information when talking to doctors. Given that doctors are frequently out of the hospital, nurses mainly rely on telephone conversation to obtain medical orders. Therefore, the SBAR technique is also used during phone conversations.

Hence, the complex speech task associated with utilizing SBAR was exacerbated by the difficulty in talking on the telephone, which meant that the nurses could not use face-to-face communication skills (interpreting body language, gestures, or reading lips).

In addition to talking to doctors, all participants were expected to use the SBAR standardized technique to communicate with all other hospital personnel, such as nursing colleagues, pharmacists, physical therapists, occupational therapists, and respiratory therapists. Shya, Bu, Chen, and Co confessed that the SBAR technique was totally strange to them in their early U.S. communication experiences. Co stated, "Based on our previous work experiences in Taiwan, we were under-trained for the assessment and recommendation technique required by the SBAR skill in the United States." Bu, Chen, and Co felt pressure to adapt to the succinct and instantaneous SBAR linguistic register promoted by the U.S. medical context.

Even up to the time of the study, Bu claimed, “I am still not used to this brief report skill. My indirect speech often makes my American colleagues and doctors confused about what I say.” Bu’s “sample draws” incident described earlier was taken as a support for her statements: “I asked a doctor ‘Do you want to have a sample draw after which doses?’ He didn’t understand the sentence...‘After which dose should I have a sample draw?’ This time he finally got it.” In addition, an American doctor blamed Chen for her “slow” speech because she didn’t perform the standardized manner needed using specific SBAR terminology.

Furthermore, three participants warned that nurses’ non-SBAR, indirect speech had the potential to bring trouble when reporting death cases to coroners. Shya, Bu, and Co noted that MICU and SICU nurses in California were obliged to report a patient’s death to the coroner over the telephone. Nurses should account for the patient’s diseases, wounds, symptoms, medical procedures, and cause of death in detail. The coroner would then determine the necessity of utilizing a postmortem examination on the case, depending on the nurse’s report. Therefore, the semantic choices, coherence, tones, and phrases that the participants used during the phone conversation required careful reflection and selection. One participant narrated a story of her Korean coworker:

I have a Korean colleague who stuttered in English when she reported a normal dead case to the coroner. Her indirect tone of speaking made the coroner feel suspicious about the cause of death. Hence, the coroner requested that the Korean nurse transfer the case to an inquest. This experience made me conscious of how indirect, non-SBAR speech could produce medical confusion. We should be more assertive and more skillful in SBAR when we make a report to the coroner.

Written Communication

The written communication events that the participants experienced in the U.S. healthcare context involved a large degree of reading and writing tasks to comprehend medical documents and record patients' health information. The lack of language skills in medical reading and nursing charting forced Shya to be laid off and Co to resign from a job in the United States. As noted in Chapter 4, the limitations in specialized American English for nursing contexts had a direct, negative impact on these two nurses' early careers.

Open-ended writing in charting

Shya, Bu, Chen, and Co were concerned about the specialized genre of keeping nursing notes, referred to as "charting" by the participants. Charting is a nursing skill to record patients' condition and the given treatment, medication, and care provided to the patients. Nurses and other hospital personnel rely significantly on reading the charts to understand patients' latest healthcare status in hospitals. Overall, Shya, Bu, Chen, and Co experienced difficulty in learning to accomplish charting at the beginning of their U.S. work experiences. The unfamiliarity with American-English spelling, American medical terminology, medicine used in the United States, and the format of charting increased the complexity for the participants to finish the writing tasks in clinical settings. One day when I was with Bu in her unit lounge, she showed me a pile of printed blank forms and said:

Nurses in our hospital rely on computers to record health-relevant information, including charting, diagnosis notes, shift forms, and incident reports. You see this? [She flipped through the paper.] I can spend 30 minutes to 1 hour to just fill out all these forms every shift.

Although nurses' charting involves a great degree of computer literacy, such as clicking on options and filling in medical numbers or laboratory data in columns, it requires nurses' ability to write accurate open-ended descriptions of patient health information. The main difficulty that all participants experienced in writing nursing notes was the open-ended descriptions and writing them with accuracy. Shya recalled in her first and second job in the United States, "I was incompetent to keep medical records. I was unskilled in charting." Co shared her frustration in her first employment as a recovery nurse in California:

I didn't know how to do charting at all. Nobody taught me or showed me. If you don't have a good charting, you won't be able to make (oral) shift reports appropriately (to nursing colleagues), which is the basic requirement of nursing care. . . It was an awful experience. I felt useless and frustrated so I quit my job.

Shya, Chen, and Wei were cautious about grammar and details in charting, because they were afraid of medical disputes or lawsuits caused by their mistaken charting. Chen was told that based on California law, a delivery nurse is held accountable for a child's health from the time he/she was born until the child turns 16 years old. Chen supposed, "For that reason, a comprehensive charting with accurate vocabulary and grammar can be seen as the only evidences to judge my responsibilities as a nurse in medical disputes." Wei remembered she took a charting class offered by her employer. She learned that careless nursing records could result in complicated lawsuits, particularly for second language writers who misused pronouns in charting:

I don't remember the exact sentence, but when the instructor showed us the slides, I was astounded by the authentic examples from an Asian nurse's charts. It was related to pronoun arrangement in sentences. For instance, in a long sentence, and maybe the second part of the sentence used 'which' or 'what', but the 'which' or 'what' didn't match the first sentence's pronoun, and what's worse it led to a total opposite meaning.

That's almost everything I can recall. I was totally shocked that minor grammatical errors in charting can even mess us up with medical disputes.

Besides English grammar, Bu worried about English spelling and vocabulary when she composed official nursing documents:

Some general vocabulary words, not medical words applied in charting are not easy for me to spell correctly, such as 'amplification' or 'clarification.' In addition, I misspell medical terms especially words constructed with the double L. For example, I omit one of the Ls in Moellerella and Molluscum. The English spelling errors appearing on my charts frequently embarrass me in front of my coworkers during the shift reports. I feel uncomfortable for them to notice my English mistakes. It doesn't make me look professional at work.

Reading medical documents

Shya, Bu and Co claimed that reading the genre-specific doctors' diagnoses, laboratory data, machine monitors, medical documents, and machine manuals were difficult in their U.S. communication experiences. They had limited knowledge of the meanings of American vocabulary and abbreviations, the interpretation of medical and laboratory numbers, and the layout of machine manuals.

Shya was reminded of her first job experience in the United States: "I was unskillful at everything. The job required me to read telemetry, CT (computerized tomography), EKG (electrocardiogram), something like that, but I was incapable of reading the data." Co resigned from her first job in California: "I felt extremely discouraged when I nearly became a 'medical illiterate.' I was unable to read doctors' diagnoses and medical notes in English."

During the study period, besides Bu's full-time position at the SICU, she worked as a per diem nurse in the dialysis department. As a per diem nurse, Bu was on-call and

filled in for other nursing members on leave. Bu acknowledged that it was difficult for her to read the machine manuals of the dialysis equipment:

The booklets on the newly arrival dialysis machines are so difficult to me. The manuals contain incomprehensible technological terms and complex sentences in an unusual format. It doesn't look like the medical documents that we read in the hospital. It is not like reading a newspaper or an English subject textbook. It is very hard to read. I am completely lost by the manuals. Those words are neither like medical terms nor daily-life vocabulary. I hardly understand what it says.

Cultural Differences in Clinical Settings (“I was perplexed about everything.”)

In addition to English language, culture was another main feature shaping the five participants' cross-cultural, clinical communication experiences in the United States. This study investigated the role of culture in communication from the perspectives of the five Taiwanese nurses. It identified three sub-themes, including (a) linguistic and cultural diversity of hospital personnel and patients; (b) patient-centered care; and (c) independent role of nurses in U.S. healthcare. Co declared, “I was perplexed about everything. I can't transfer my past 20-year work experiences in Taiwan to practice nursing care here. The culture, environment, people, and system are very different.”

Linguistic and Cultural Diversity of Hospital Personnel and Patients

Referring to Co's statement: “Cultural differences result in a huge impact on me. I've never experienced such diversity in my work history in Taiwan.” All participants experienced a more complicated work environment than in Taiwan because of the diverse population in California. Shya, Bu, Chen, Wei, and Co encountered speakers from a variety of ethnic and linguistic backgrounds who spoke English with various accents, dialects, and cultural interpretations. This diverse environment complicated the participants' clinical communication in the United States.

There were two groups of people whom the participants frequently interacted with, including (1) patients/families/visitors and (2) hospital personnel. First, the residential population of patients at each hospital determined which linguistic and ethnic backgrounds that the participants would face. To be specific, the hospital where Chen was employed had a large population of Mexican, Chinese, Vietnamese, and Cantonese patients. The SICU where Bu and Co worked was occupied by American, Vietnamese, Chinese, Korean, Mexican, and Middle Eastern trauma patients. The healthcare center to which Wei was devoted was famous for taking care of Korean, Chinese, Vietnamese, Taiwanese, Mexican, and American elderly orthopedic patients. Wei commented, “The culturally and linguistically diverse patient structure results in a growing need for us, bilingual nurses to serve the multi-ethnic community here.”

Second, all participants indicated that their healthcare colleagues were also from diverse cultural and professional backgrounds. The hospital personnel was composed of Americans, Filipinos, Japanese, Koreans, Chinese, Taiwanese, Mexicans, Cambodians, Indians, Lebanese, Arabians, and Turks, among other ethnicities. Besides their varied and diverse linguistic and cultural backgrounds, these people represented and were trained in different occupations and positions in the hospital, such as doctors, pharmacists, dieticians, respiratory therapists, physical therapists, occupational therapists, speech therapists, and nurses.

The diverse population in the U.S. healthcare context required the participants’ cultural knowledge not only of Americans but of people from multicultural backgrounds. Referring back to data presented in Chapter 4, Chen’s observation of expectant mothers’ reactions to newborns, patients’ cultural-specific dietary preference, and

people's diverse expectations toward medicine, health, illness, life, and death, all complicated the participants' communication experiences in U.S. clinical settings. These complex contexts meant that the nurses, who lacked training in multiculturalism, were required to navigate cultures about which they had limited knowledge.

For example, four participants (Shya, Bu, Wei, and Co) had experiences of interacting with patients from different cultural backgrounds who disliked being cared for by the opposite sex (females). Wei shared a story about gender issues with one of her American male patients:

When I entered the ward, the elderly male complained to me that he hated old women. He was referring to my colleague, an experienced American nurse in her 50s. I didn't know whether he discriminated against 'old women' or if he detested females of all ages. But the next day, he requested a male nurse to replace my American female coworker. Probably in this situation he favored men. Who knows?

Co came across a gender issue in nursing care with a Hindu male patient:

One morning, I was given charge of a 60-year-old male Hindu patient. This guy is an academic with a PhD degree and his son is a physician. Before I met him, I was told by my coworker that this guy was labeled as a difficult patient due to his aggressive behavior and irritating attitudes toward our female nurses. Likewise, I found it very challenging to interact with him. He refused to take pills and barraged me with insults.

At the end of the shift, I was informed that this patient's son had requested a male nurse to be in charge of his father's health care. My coworker said, once the change was made, this patient's annoying behavior diminished and his complaints disappeared. We discussed his transformation: inferring from his age bracket in Hindu culture that men and women might be segregated based on hierarchical differences. His high academic achievement could have contributed to him being easily offended and upset by women. Moreover, he was weak from his illness. He could be unhappy that we female nurses were in charge of his care.

Shya learned to be cautious not to uncover a mid-60s Muslim lady while Shya was bathing her:

I have to be very careful when I take care of female Muslim patients. Their

bodies can't be exposed to males. I put a 'do not disturb' sign on her bed curtains and started bathing her. I used a towel to cover her body except for the area that I was cleaning. I was paying attention to anyone who came close to the bed to avert unexpected exposure while my patient was undressed. If I failed to respect the patient's Muslim culture, which did not allow me to expose the lady's body, particularly in front of males, I could imagine that a big communication clash would easily occur.

Independent Role of Nurses in U.S. Healthcare

Shya, Bu, Chen, Wei, and Co noted that nurses in the United States were taken as independent professionals rather than doctors' assistants. Bu discussed the different nurse's roles in Taiwan and the United States:

In Taiwan, nurses are viewed as caring machines. We are expected to be silent about our opinions of medical care. Once we provide professional opinions, we will be considered arrogant or thought to be challenging doctors' decisions.

In the United States, nurses were required to have more independent judgment and critical thinking ability to implement nursing care and to determine patient priority than in Taiwan. Shya's story below represents an example of how critical thinking played a crucial role in her nursing practices in the United States:

I had a code-blue patient today. We spent the entire afternoon resuscitating her. My arms and shoulders are sore now. We took turns doing CPR (cardiopulmonary resuscitation) for nearly two hours. Earlier this morning, I received a doctor's order to send her to do an EKG (electrocardiogram). I noticed this patient's vital signs were unstable. In addition, her respiratory rate was not good. Then, I evaluated that she was too weak to move. To prevent acute deterioration, I made a phone call to the doctor and told him my concerns. I also advised the doctor to prescribe injections in the case that a critical condition would emerge. Besides picking up the injections, I carried a crash cart (a cart with emergency medication and equipment for life support) with her when we were heading to the EKG room. Like what I assessed, her heart was abruptly stopping when we were only half way to the examination room.

Due to Shya's critical thinking and advance professional judgment, she was fully equipped to save the patient's life. Shya concluded,

It is our job to discover and predict potential problems. Doctors are out of the unit most of the time. It's the primary nurses' duty to estimate whether patients are at risk. We are not submissively waiting for medical orders or submissive toward our jobs.

The participants all felt more pressure and required more responsibility when communicating with patients and hospital personnel than when they worked in Taiwan.

Wei claimed,

In non-teaching U.S. hospitals, doctors are not on duty 24-hours in the department. Attending physicians often have their own personal clinics outside the hospital. They may conduct rounds twice a day and rely principally on our patient reports. They monitor patients via our phone calls throughout the rest of the day. Our jobs are similar to what interns and resident doctors do in Taiwan.

Shya, Bu, Chen, and Co agreed with Wei's perspective that what registered nurses did in U.S. hospitals were more like what resident physicians did in Taiwan. Shya presupposed that due to their assistant roles with doctors in Taiwan, nurses were less responsible for medical lawsuits. Physicians and surgeons in Taiwan were typically blamed for controversial medical cases that arose. On the contrary, nurses in the United States required additional assessment skills, professional contributions, and intensive interaction with patients. Nurses were sharing the responsibilities for medical care and disputes. Co stated, "Working in U.S. hospitals requires our critical thinking skills to independently assess a patient's primary condition. Therefore, we are held legally responsible for medical disputes." Shya also declared,

Nurses and doctors cooperate together by consulting each other about patients' cases. If there is a question about a medical case, we and doctors are both liable. As a result, we have to be very careful about what we say at work.

To effectively communicate with doctors and nursing colleagues, all participants were implored to create care plans and to develop independent judgment. It took them

time to transit from obeying doctors' orders to thinking independently within clinical settings. Co's "temperature incident" was a support of this statement: "After I observed my coworkers' temperature measurement techniques for a couple of weeks, I finally realized they had profound knowledge about this basic skill." Co admitted, "I didn't know what critical thinking is until I worked in the United States. My past 20-year work experiences in Taiwan didn't help me develop this ability." Chen acknowledged, "It took me several months to get used to thinking and judging independently at work. People rely on me to make decisions, to say something even if I have no idea what to say and what to do." Shya also indicated, "When I was in Taiwan, I wasn't trained to think critically and independently to help the patients. I suffered a difficult time in developing this thinking ability in my first and second job."

However, in contrast to nurses' passive roles in Taiwan, all participants perceived that nurses were more appreciated in U.S. society. Wei addressed, "The public assumes that nursing involves complicated knowledge and professional qualifications which cannot be substituted by others easily." Co stated, "Although I feel more pressure, I prefer to work in the United States. It is because I discern people are respecting me as a nurse who is competent to think critically, judge independently in my profession."

Patient-Centered Care

All participants stated that the patient-centered care in the United States was different from the doctor-centered environment in Taiwan, including the emphasis of patient safety, patient rights, patient confidentiality, family/visitor-friendly policy, and intensive communication between nurses and patients. Chen declared, "I feel more pressure to work here (to take care of nursing tasks and satisfy patients' needs). Patients have such big privilege." Bu revealed, "I feel like we (nurses) are in the service

industry to serve our clients, instead of working in the healthcare industry.” Wei also claimed, “Patients’ rights are a priority. This country requires us to take more responsibility for being a nurse than in Taiwan.”

The patient-centered care resulted in intensive communication between nurses and patients. Bu declared that it was standard for nurses to introduce themselves to patients and to explain how they could be reached in the hospital department, which was a practice that was not required in the Taiwanese nursing industry. Bu expressed more about the contrasting doctor-centered versus patient-centered care between in Taiwan and in the United States:

Registered nurses in Taiwan are viewed as doctors’ assistants. We are usually not that valued or respected by doctors and patients. We are generally overwhelmed by an excessive workload of eight to 20 beds per shift. We are busy running in and out of every ward to change intravenous injections (IVs), administer medicine, check vital signs, do assessments, and monitor data from medical equipments. When I was in Taiwan, I was normally occupied in the entire morning just conducting my first round. After a short lunch break, I began the second round. By the time I finished the second round of patient checks, it was often already past working hours. You can see other than informing patients about essential nursing procedures and treatments, we rarely have the need and opportunity to initiate relaxing, social, casual conversation with our patients, their families and visitors.

On the other hand, to make up for the lack of time doctors’ spent in hospitals, nurses in the United States took charge of only two to six patients depending on the unit types per shift in the participants’ hospitals. Bu continued,

We are expected to have intensive interaction with patients and families in order to build rapport between patients and nurses. Due to the patient-centered culture, we bump into a lot of communication events which we didn’t go through when we worked in Taiwan. My awkwardness of these communication events make me look unprofessional and unprepared in front of my coworkers and patients. I feel shameful whenever it happens.

Second, patients were highly aware of their rights and care in the hospital. All participants noted that in contrast to Taiwanese patients, patients in the United States tended to have a greater interest in being informed by the nurses and doctors of their detailed care plan. Wei noted, "Patients are eager to understand their health condition and the medicine they are on." Shya claimed, "Families ask numerous questions about remedies and request to be kept regularly apprised of the patient's condition." Bu declared, "Patients won't let me physically assist them unless I can offer clear explanations to clarify their concerns and questions." Wei added,

American patients are aware of their rights, which is different from Taiwanese patients. I have several patients in the U.S. who refused to take the prescription pills or rejected the prearranged treatments until they received a second medical consultation. Moreover, patients are educated enough to give opinions to doctors about pills and treatments benefiting their condition, which is not common in Taiwan.

Two participants described the different reactions from patients in Taiwan and in the United States. They felt the pressure to explain a lot to patients:

Shya: In Taiwan, patients don't express opinions. They take medicine acquiescently. They don't even need you to explain what pills you are distributing.

Bu: That's right. Here, you have to explicitly make clear the effects of drugs while you are giving medications. It's bothersome, especially when you have a patient who keeps asking you questions.

In addition, patients in the United States seemed to be alert to the food they eat in the hospital. Understanding the patients' preferred diets became an important part of the nurses' jobs. All participants were requested to monitor patients' food intake in order to maintain their physical condition, such as some patients who were on a cardiac-friendly diets and others were on regular, unrestricted diets. Shya compared patients' dietary preferences to the issue of patient rights between Taiwan and the United States:

In Taiwan, it is easy to observe patients' dietary control because patients usually follow meal plans which are prescribed by dietitians. Taiwanese patients tend to express few opinions about hospital meals. They accept the fact that they are ill and weak and the hospital team is providing the most professional care for their condition. They listen to our suggestions. Some patients even assume that bad-tasting food can have better curative properties. It is rarely seen that nurses and patients discuss dietary preferences in the hospital.

On the contrary, patients in the United States usually desire personalized services. They are not content with hospital meals. They are liable to make many requests about their meal choices. Occasionally, their questions and requests are difficult to answer because I have no such dietary knowledge from their cultures.

To prevent patients from eating inappropriate foods, all participants were under stress to be familiar with popular American foods as well as the dietary preferences of multi-cultural populations. The following dialogue occurred regarding four participants' perceptions about patients' diverse dietary preferences:

Chen: Korean and Chinese moms should be given warm or hot water after they give birth. Yet, if you offer hot water to American and Mexican mothers, they won't be happy. They ask for iced drinks. They feel they sweat a lot while laboring. They desperately want a pitcher of orange juice to cool them.

Shya: The cooler the better.

Chen: Yes, the cooler the better. And you don't wait till they ask. You are supposed to prepare the stuff spontaneously. Labor is an exhausting process. Mothers usually don't have much patience to wait.

Co: Some Hindus and Muslims do not eat pork. They consider it to be common sense and anticipate you should know instinctively. You have to check their menu containing no pork... When a patient orders gorgonzola cheese, I have to know whether the ingredients of gorgonzola cheese are suitable for a diabetic diet. How could I know this? I don't know what gorgonzola cheese is, so how could I possibly know its ingredients? I think it's one of the biggest challenges for international nurses. We have no idea about foods and dietary habits (across cultures).

Bu: Exactly. Like Co, we always carry a mini notebook with us. We write down patients' requests for any food or dishes which are unfamiliar to us, and we ask our American coworkers about them or Google them on the internet.

Furthermore, cultural differences about food and drink could cause communication difficulties between the participants and patients. Co confessed,

I often need to search for ingredients. This action frequently postpones my reply to the patients' inquiries. I am worried that my professional image will be depreciated if the conversation between me and the patient is disrupted by the need to look up food vocabulary again and again.

Third, the protection of patient confidentiality in the United States was different from how the participants were trained in Taiwan. Shya, Bu, Chen, Wei, and Co referred to the HIPAA (Health Insurance Portability and Accountability Act), the federal rule to preserve the privacy of patients' personal health information. They explained how the HIPAA laws affected their communication experiences. Interesting, three participants, Shya, Bu, and Co, associated the concept of privacy protection with patients' family structures and relationship status in the United States. Shya described,

In Taiwan, when patients are hospitalized, their relatives and friends normally show sympathy by visiting them in the hospital. We (nurses) are usually not bothered by who is invited or who is prohibited to see our patients. Visitors are generally appreciated by our patients and their families. Moreover, it is taken for granted that when someone alleges he/she is the patients' family member, we will inform him/her about the patients' health condition.

Nevertheless, four participants (Shya, Bu, Chen, and Co) were perplexed by patients' fastidious concerns about visitors in the United States. They discovered that patients in the United States tended to be sensitive about their medical privacy. Bu wondered: "I don't get it. Even though children may have been born by a man's ex-wife, how can a current wife forbid the man's children from visiting him?" Shya stated, "I cannot let go that my mid-40 year old patient refused to let his biological mother see him. She's his mother. They have blood connection!" Co narrated:

I met a man who claimed my patient was his wife, so I told him about the

patient's condition. All of a sudden, the legal husband showed up to correct me that this man was my patient's ex-husband. I was blamed for violating the HIPAA because I shouldn't have revealed patient health information to the inappropriate person.

Wei then made a comment about these phenomena:

I think a large proportion of Americans have multiple marriages and multifaceted family structures. Besides the next of kin (i.e., parents, spouses and siblings), we care for patients who have extended families due to marriage, such as stepparents, stepchildren, ex-wives, and ex-husbands. When the family has broken relationships, the next of kin and the power of attorney will protect the sick one from being harmed by anyone whom they don't favor. Maybe that's why American patients become particular about the visitors when they are in the hospital.

Because of this, four participants (Shya, Bu, Wei, and Co) declared that besides a patient's physical condition, there was a need for them to study the patient's family structures and social relationship at work. Co elucidated,

I remember the first time Michelle (pseudonym) gave me a shift report. She spent 10 minutes talking about the patient's physical condition, and the other 20 minutes explaining the patient's family relationships, including his first and second marriages, his relatives from other states, his cousins from out of state, his stepchildren's spouses, and so on. I was confounded at that time. But now, I realize how important it is to communicate with my patients by understanding their family backgrounds. It's a part of nursing communication.

Fourth, the patient-centered care was also observed from the hospitals' establishment of a 24-hour a day visitor period for patients and their families. According to Shya and Bu, in the intensive care unit (ICU), their hospitals offered a 24-hour visiting policy for the ICU patients' families and visitors. An additional bed was also found inside the ward, allowing caregivers to sleep near the patients. Shya illustrated how this was different from the Taiwanese medical context:

In Taiwan, the hospital culture is driven by a doctor-centered care. Doctors are thought of as superiors who hold medical knowledge which is difficult for the public to obtain and understand. The ICU is a high-alert

unit. In order to precisely monitor patients' critical condition, visitors and families are restricted from visiting at certain times of the day. They are only permitted to enter the ICU twice a day, such as for half an hour in the morning and afternoon.

The different cultural emphasis in hospitals resulted in the participants having stressful communication experiences from time to time. Bu and Shya disclosed their fretfulness about the ICU 24-hour visiting policy:

Shya: It is annoying to have the family around you all the time. It is an intensive unit. We deserve a work environment without disturbances in order to keep a cautious eye on our patients.

Bu: You're right. Families like to keep asking you questions and expect you to engage in conversation with them. But as you know, SICU patients are generally seriously injured. Their conditions are supposed to be bad. Some serious treatments and procedures are required. Sometimes it is nothing big. However, while I am busy saving patients' lives, I should not have to be distracted by answering family's questions and pacifying their anxiety.

Shya: True! I usually feel stressed about that kind of conversation.

An additional finding related to the patient-centered environment was the role of pets in Americans' lives. According to Wei's training in Taiwan, cats and dogs carried viruses and parasites, which posed a threat to hospital hygiene. Wei asserted, "It is well-known that pets are prohibited from entering hospitals and clinics in Taiwan." Wei was astounded when she discovered the hospital where she worked in California allowed pets to visit patients. Before she was informed of the pet-friendly policy, she was irritated by American visitors who brought pets to the hospital. One time, when she was about to prohibit a visitor who carried a puppy from entering the unit, she was stopped by an American coworker. Her coworker clarified that pets were viewed as family members in many America families. The hospital just announced a new policy to tolerate bathed pets to accompany the hospital inpatients. Wei concluded,

I can say it is a culture shock to me (because of the pet-friendly policy). I

was close to starting a quarrel with the visitor, and it turned out to be my misconception of the hospital policy. Nevertheless, I learned a lesson about the relationship between pets and my American patients. U.S. hospitals make efforts to accommodate their patients, which is hardly found in Taiwan.

Identity Negotiation in a New U.S. Environment (being Taiwanese or being American?)

From time to time, all participants discerned the need to negotiate who they were and chose how they talked and/or acted depending on whom they were with in the U.S. healthcare context. They experienced complaints and arguments from patients, families, visitors, and the hospital personnel caused by cultural and language misconceptions. They detected people's distrust and unfriendliness because of their non-Americanized looks and ways of speaking. They also balanced and negotiated notions of assertiveness and compromise. However, while all of the participants discussed the need to negotiate their identities and feelings of separation, three of the participants found this uncomfortable and difficult (Bu, Chen, and Co) and two of them (Shya and Wei) did not. For example, although Shya and Wei were comfortable in being Taiwanese, Bu conveyed that she wanted to be more Americanized in her speech: "Sometimes I wish I can speak like an American nurse, work like an American nurse; then no one will look down on me in hospitals."

One way that two participants (Bu and Chen) felt culturally isolated was in informal, social settings in the hospital. For instance, the participants described the typical seating arrangement in the nursing lounges at their places of work. They were usually ethnically and socially separated from their coworkers. Bu illustrated,

In the lounge room, American nurses are staying with Americans. Hispanic nurses are talking in Spanish in one table. Filipino nurses speak Tagalog. Asian nurses, such as Korean, Chinese, Vietnamese, Japanese, and I are clustered around one table. Nurses from different cultures greet

each other and occasionally joke around, but generally we only engage in intimate conversations with the coworkers of the same or similar language background. I am not satisfied with this segregation. I hope I will be considered a member of my nursing peers someday.

Chen also revealed her frustration of being lonely in her unit. When Bu and Chen were disappointed at the social isolation and emotional remoteness that they felt from their coworkers, Wei and Co held more positive perspectives about the phenomenon. Wei declared, “I think the interaction boundaries between Taiwanese nurses and other ethnic nurses are acceptable. We all like to hang out with people from similar backgrounds.”

All participants had similar experiences of being humiliated by people who worked or stayed in U.S. hospitals. These people verbally insulted the participants and questioned their nursing qualifications owing to their imperfect English and Asian looks. One doctor doubted Chen’s emergency competence based on her “slow” speech. Shya, Wei, and Co had American certified nursing assistants (CNAs) and nursing students who rebelled against the tasks for which they assigned. Furthermore, Co noted, “I have had some patients ridicule my Taiwanese accent in English.” These incidents remarkably impacted the participants’ cross-cultural, clinical communication experiences. They were forced to not only negotiate meanings and quell arguments, but also to fight for their professional image in front of patients and hospital personnel.

Accent: Retaining or Reducing the Taiwanese Accent in English

As mentioned in the prior section, all participants experienced difficulty in discriminating the diverse English accents in U.S. hospitals, but Shya, Bu, Chen, Wei, and Co held different viewpoints of retaining or reducing their own Taiwanese accent in English.

On one hand, besides being influenced by people's accents in clinical settings, Bu and Co were highly aware of their own Taiwanese accent when speaking English. They had strong concerns about it and considered taking steps to reduce their accent. They felt embarrassed when people didn't understand them by their "poor" English. Co said apprehensively, "My Taiwanese accent causes a lot of miscommunication for the doctors, pharmacists, and my nursing coworkers. I wish I could speak without the accent, but I am too old to get rid of it." Bu asked, "Are there accent reduction courses so that I can enroll in? I feel guilty whenever my accent hinders the smoothness of the conversation with my coworkers and doctors."

Moreover, Bu and Co indicated that their obvious Taiwanese English accent reduced their professional image in the eyes of the hospital personnel. It also made people question their nursing competence. Co claimed, "Many hospital personnel, upon meeting me, look down on me. They jump to conclusions that I am unqualified because of my poor English with a strong accent. Their impatience towards me is observable."

On the other hand, Wei and Shya held optimistic perspectives towards their Taiwanese accent in English. They had no thoughts to reduce their accent. Wei asserted, "I don't discern a need to remove my accent. It is a part of my identity. I am hired not because of my 'perfect or standard' English; instead, it is because I am qualified to work as a registered nurse in the United States." Shya stated that her Taiwanese accent didn't obviously impede the flow of the clinical conversation at work: "I am fine with my accent. In fact, I am confident in my current speaking ability in clinical communication. It's acceptable to speak with an accent as long as we can understand each other."

Choices of Speech Registers

In the focus group interviews, individual interviews, and casual conversations, several questions arose related to the differences in speech registers between Taiwanese nurses and American nurses. These questions inspired enthusiastic discussions from the participants along three main subthemes: sweet talk versus professional tone; assertiveness versus compromise; and pretentiousness versus humility. Shya, Bu, Chen, Wei, and Co all experienced the conflict between altering and maintaining their native, natural ways of speaking, in order to deal with the specialized speech registers in U.S. clinical settings. These are described below.

Sweet talk versus professional tone (with patients)

While in Taiwan, Shya, Bu, Chen, Wei, and Co were comfortable with working hard and talking little in front of patients. They were used to engaging in brief conversations in a professional tone when talking to patients and families. As a result of those communication patterns, when they worked in the U.S. context, the participants suffered from feeling awkward when attempting to be friendly or making casual conversation with patients and families. The following conversation is extracted from one of the interviews:

Bu: My colleagues, American nurses, Filipino nurses, and other second-generation immigrant nurses, are good at family communication. Patients share stories of their family and relationships to the nurses. They always have pleasant conversation. My colleagues also like to use 'honey' to address patients of all ages. They use 'sweet talk', similar to talking to babies, which sounds a bit ridiculous to me. We are SICU nurses, not kindergarten teachers or babysitters.

Co: They also use 'Oh, dear, darling, sweetheart' [She raised her tone to imitate the sound] to address adult patients. They have very good language skills when communicating with patients and families. We need to improve this weakness.

Chen: Yes. They use such as 'I am so sorry, sweetie.' [She raised her

tone to imitate the sound] Patients favor this, you know, but somehow I feel it's too much.

Although four participants (Shya, Bu, Chen, and Co) expressed that they were not totally accustomed to using "sweet talk" with patients, they gradually adapted to it in order to "act like" American nurses, in order to fit into the U.S. hospital culture. Bu declared,

Although it is uncomfortable, I persuaded myself to use 'honey, dear, sweetie' such sweet talk when addressing patients in order to fit into the hospital culture... I cannot understand why my colleagues always apologize to patients when the patients feel hurt owing to their wounds or diseases. When we assist patients by bathing them or moving them, during which, patients may experience pain. Patients' discomfort is caused by their own physical condition, not by my fault. I don't agree we are responsible for the patients' suffering. I also believe it is unnecessary to make apologies in this kind of cases. Nonetheless, in order to act like American nurses, I am forced to adjust my speech. I am an Asian. I am already different from my colleagues. If I want to play a part in the U.S. medical settings, I need to adapt to this kind of sweet talk in the workplace.

Furthermore, all participants viewed American nurses had more apparent language advantages to communicate with patients than they did. Shya addressed,

When speaking English, American nurses are linguistically eloquent and socially skillful. They are good at handling demanding patients and visitors. They know how to diminish medical disputes. They are experts at persuading patients and families to accept accessible medical resources which are limited to their needs. They also excel at pacifying patients' and families' anxiety by offering sweet talk, such as 'Honey, I'll hold your hand. I'll be by your bedside till you wake up.'

Four participants (Shya, Bu, Chen, and Co) avowed that when they practiced English in clinical settings, they became clumsy at these negotiation skills. Particularly, Co and Bu worked in the SICU. Trauma patients, such as gunshot and wound patients resulting from fights, occupied a large proportion of the patient population. It was tense for them to solve disagreements between patients and visitors who were gang members

or had criminal backgrounds. Co stated, “I usually call for help from my American coworkers to ease squabbles. I envy their cleverness in talking to patients and families.”

Bu said,

I have to admit that I envy their positive relationships with patients and families. I don't have such talent for getting along with patients. I have no clue to how to become as good as they are in the workplace. English is an unending problem for me.

Assertiveness versus compromise (with patients and hospital personnel)

First, all participants believed that, compared with Americans, they were “too soft” (meaning too nice or too concessionary). In order to survive in the U.S. work environment and to contend with American nurses, they modified their speech to demonstrate that they were determined and assertive in their words in front of patients and hospital personnel. They also learned to fight for their rights when injustice occurred. Wei's cultural conflict regarding 無欲則剛 (wu yu ze gang) (no wants, no compromise) provided an example of how this contradicted her identity in the United States:

American nurses are more confident and definite in their words. I told you my father's '無欲則剛 (wu yu ze gang), (no wants, no compromise)' is not practicable in the United States, but I didn't notice it in the early stage of my work. That's why I suffered in my first six-month employment. But now, I realize if I concede, people will think I am weak, and then they can take advantage of me. I don't like to be mean, but if I want to get along with my colleagues, I should learn to be more assertive in my words, to be more determined in my attitude.

Similarly, Chen's “two-visitor-policy” story with a Mexican father described in Chapter 4 also changed her communication habits from being delicate and modest to taking a stronger approach: “I learned to be more assertive when I talk to my colleagues, patients, and their families. If I keep being nice, people will infer I am too soft.”

Second, all participants found that the U.S. hospital culture highlighted individualism. Nurses tended not to have misgivings about challenging their superiors.

Co recounted,

In Taiwan I was a charge nurse. A hierarchy in the Taiwanese workplace is easily perceived. One of the prevailing occupational ethics for us is to be submissive to reasonable supervision and tolerant of irrational management. Nonetheless, since I have worked here, I have been challenged by my subordinates many times, including certified nursing assistants (CNAs), licensed vocational nurses (LVNs), new graduate nurses, and student nurses. They refused to do what was asked of them.

Interestingly, all participants assumed that their American nursing coworkers would not likely encounter similar “communication bullying” as they had faced. They concurred that American nurses were “tough enough” to handle the situations. The following dialogue took place in one of the interviews:

Bu: Sometimes you just don't know how to get along with CNAs.

Co: They (verbally) bully you.

Shya: Because you don't know them well.

Cloudia: Is it due to language barriers?

Bu: It's not only related to language.

Co: They bully you because you are new (in the U.S. medical environment) and they have been there.

Wei: They think they are better and more knowledgeable than you, so they bully you.

Cloudia: Do they only target the international nurses like you guys, or do they also bully American new grads?

Chen: No way! Americans cannot be taken advantage of by others!

Bu: They (CNAs) don't bully people who speak out.

Shya: I presume every ethnicity has its own culture. Basically, it's impossible for Americans to be stepped on by others, but Asian nurses are another story.

Pretentiousness versus humility (with hospital personnel)

Shya, Bu, Chen, Wei, and Co reached a consensus that humility was not “valued” in the same way as it is in U.S. culture, where competition and “self” is valued more than humility. This caused cultural conflict at work. All participants revealed that they were in an unfavorable situation because of their humility. However, they didn’t agree to some of their American colleagues’ “pretentiousness (炫耀、自負)” at work, especially “showing off or exaggerating” their job ability. All participants were trying to find a way to balance between humility and confidence. In order to work alongside their American colleagues, they learned to present themselves in a confident manner without being arrogant.

First, all participants noted that Taiwanese nurses had a tendency to bear hardships and hard work silently, whereas American nurses might like to highlight their work to others verbally. Co claimed, “Many American nurses ‘report’ a good shift while we (Taiwanese nurses) ‘practice’ a good shift.” Competing with American nurses, the participants’ efforts often went undisclosed out of their quietness and humility in the U.S. clinical settings. Bu’s unpleasant communication experience regarding “neuro-patient care” introduced in Chapter 4 was attributed to her humility: “I told her I would learn harder...She reported me to the PCC (psychiatric care consultant) and asked her to watch me closely.” Chen also addressed, “They (American nurses) are all good at making you notice their contributions to the hospital. Nevertheless, when I work so hard and feel so exhausted, there is usually few people would be aware of what I have done.”

Second, to certain extent, all participants appreciated the American culture of individualism and self-reliance. Shya, Bu, Chen, Wei, and Co were all adjusting to

speaking their thoughts more day by day. Nonetheless, all participants still insisted on their family and cultural values of being humble and honest. For instance, although Co had nearly two decades of work experiences in nursing, she was fonder of keeping humble than of showing off what she was capable of. Co claimed,

Many of my American colleagues and subordinates are inclined to highlight their excellence at nursing. Even the nursing students whom I supervise have a propensity to exaggerate their competence during the internship. It can lead to my unrealistic anticipations of those students' performances. I learned to underestimate those students' credibility when I assign them tasks; otherwise, I may put my patients in danger, such as being fed or injected improperly.

U.S. Nurse Training Gaps: Language and Culture (“I wasn’t well prepared.”)

Generally, the hospital training for new nurses was composed of two portions: lectured-oriented classes and clinical shadowing. The two-portion training period lasted from three weeks to three months depending on the hospitals. All participants declared that hospital training in the United States overlooked their specific language needs and cultural adjustment for clinical communication. Communicating in a multicultural context required the participants' sensitivity to different language uses and their understanding of patient backgrounds and hospital subcultures, policies, and routines. However, there was little education focusing on developing the participants' cultural awareness and communication ability to deal with the cross-cultural, clinical communication events.

Shya recalled her first and second job experiences in California:

In the hospital training programs, except introducing medical concepts, the application of the English language, culture, and law that we require to communicate at work were usually neglected and over-generalized. Although I have completed the whole hospital orientation requirements, I wasn't well prepared to work here. My conversation skills were poor. My reading comprehension was bad. My charting was a mess. I couldn't keep up with other nurses.

Lecture-Oriented Classes: Hospital Orientation

All participants agreed that the mandatory lecture-oriented classes which they attended in their first three weeks to three months of employment were limited in two ways: (1) helping them to adapt to the US healthcare context and (2) providing support for cross-cultural communication. Getting a superficial understanding through quick and casual observation of hospital rules and policies did not suffice for their clinical communication needs.

Surprisingly, all participants noted that American nurses and international nurses received the same training in the hospitals where they worked. In the orientation classes, American nurses, the participants, and nurses from other ethnic backgrounds who were newly recruited by the hospitals were clustered together in a meeting room to listen to lectures. Co claimed, "The orientation classes were designed based on the assumption that American nurses and international nurses have the same English level, work experience, cultural background, and nursing knowledge." Bu commented,

Our employers may have overestimated international nurses' oral communication ability during our job interviews, but the interview language is very different from the language we use in clinics.

Wei affirmed,

Our employers depend a lot on the NCLEX-RN results to determine if international nurses are capable of cross-cultural nursing care. However, a test cannot cover everything. Passing the exam doesn't mean we have all knowledge in hand.

In other words, as long as the participants were hired, it was supposed that they were both competent in nursing and in communication skills to work in the multicultural medical environment. Furthermore, all participants inferred that their hospital employers

were “reluctant to waste resources and budget” in accommodating international nurses’ cultural and language adjustment:

Bi: Come on. Don’t be silly. They won’t provide such courses (developing language and cultural skills).

Wei: Yes, don’t be naïve.

Co: They don’t have extra money to train you. They won’t waste their time helping international nurses.

Wei: They assume you are ready to work and you are as capable as an American nurse.

Lack of essential language needs

All participants perceived that the lecture-oriented classes didn’t fit their essential language needs in terms of oral and written communication in clinical settings. The classes had no emphasis on developing the participants’ and other international nurses’ English language skills in clinical communication settings. Wei expounded,

The classes were instructed by the nursing managers and supervisors from each department. They introduced the hospital history, medical equipments, environment and facilities, department regulations, and the latest knowledge with regard to diseases, illnesses, and nursing skills. Nonetheless, I can’t recall content targeting language development for international nurses.

The difficulties that subsequently arose in all five participants’ clinical communication settings were not prevented (or even predicted, as would be indicated in the orientation training curriculum) by the hospital orientation classes. There was a great need for training in oral language development (discriminating accents, pronunciation, and phone conversations), social conversations (comprehending jokes, slang, and dialects), occupation-specific vocabulary and hospital register (talking in specialized occupational fields), open-ended writing in charting (keeping nursing notes), and genre-specific reading (reading laboratory data and medical documents). The only

course content related to nurses' communication was SBAR (Situation, Background, Assessment, and Recommendation). Unfortunately, nurse-patient communication was not included in the curriculum, which was one of the major communication difficulties that the participants encountered in the workplace.

Shya, Chen, and Co particularly addressed the lack of training in charting made it difficult in their early work experience. These classes missed the mark in showing them how to compose medical documents. Shya said, "I didn't know how to chart medical notes. I didn't understand what these numbers, abbreviations meant on the document. No one ever taught me." Co even worse suffered from emotional and physical illnesses due to the anxiety of her "medical illiterate" in English. Co indicated,

The way which American nurses chart looks very different from what I did in Taiwan. The hospitals provided no support to develop our document skills. They just assumed you are able to chart because you have the nursing license. Usually, I imitated my American and Filipino coworkers' charts. I observed their writing and learned from their sentences. That's how I overcame my writing shortcomings. Even now, I still rely on my coworkers a lot. They also help me chart whenever I have difficulties in English. They can chart more quickly than I do.

Lack of cultural knowledge: Patient backgrounds, hospital subcultures, hospital policies, and nursing routines

All participants indicated that the lecture-oriented classes didn't satisfy their particular needs of cultural adjustment when cultural differences caused them to experience communication difficulties in the workplace.

First, patients' diverse cultural and ethnic backgrounds were only superficially introduced in the classes. This meant that there was an acknowledgement of cultural differences but there was no training on what to do as a result of those differences. Bu claimed, "I don't have much impression on whether we had this course, cultural diversity." Wei recalled, "The hospital didn't go through the cultural issues seriously

because they thought we have learned them in the NCLEX-RN exam already.” Chen expounded that although there was one course focusing on cultural diversity for nursing care in her orientation classes, the content was unattractive and over-generalized. She continued,

After the class, I remembered I had no ideas what was about for cultural diversity. I actually pick up most cultural knowledge when I really practice in U.S. nursing. I observe my patients. Whenever arguments and conflicts occur, I learn from these lessons.

Second, all participants declared that the classes didn't explicitly explain the medical systems, hospital subcultures, hospital policies, and nursing routines. They felt confused and concerned whenever they broke the hospital rules that resulted in communication conflicts, including the hospital specialized medical terms, patient confidentiality (e.g., next of kin and power of attorney), dying and death care (e.g., advanced directives, DNR, organ donation, and coroners), dosage amount, and visitor policy. Co narrated,

Patient confidentiality and the California law were not included in the course content. I have been uninformed about the concept of power of attorney and who can make decisions for my patients if they are in coma. I was also confused whom I should reveal information about my patients' condition to. Therefore, I mistakenly kept all family members informed at the beginning of my work.

Based on Wei's experience, every hospital had its particular regulations regarding medication, but this aspect was not emphasized in the classes: “I was unaware the maximum dose of morphine for my patient is two milligrams until I was corrected by my preceptor. The dosage is less than what I could give in my prior hospital.” Moreover, Shya, Bu, Co, and Chen were apprehensive about medical disputes and lawsuits that resulted from violating these uninformed hospital regulations. Chen stated, “I am very

uncomfortable about the frequent lawsuits that my coworkers have discussed. I am anxious whether I will be sued someday if I innocently breach the rules that I don't mean to."

Shya, Bu, and Wei pointed out that the hospital orientation classes lacked training to help them decipher medical acronyms and abbreviations. Bu indicated that her American colleagues used the term "LAT /lat/" to represent laceration, such as liver laceration, which perplexed her. Nevertheless, the orientation classes did not mention such issues. Below is a dialogue between Wei and Bu from one interview:

Wei: Are you sure your people say "LAT"? It's weird. I've never heard it. We don't use this abbreviation in our hospital.

Bu: Yes. They use "LAT" to mean laceration.

Wei: They should have told you first; otherwise how can you understand it?

In addition, Shya noted that her unfamiliarity with subcultures and policies in the U.S. healthcare context negatively affected her in her primary work experience: "I was so frightened in the first three months because everything was new and unknown."

Shya described an incident when she had worked in the skilled nursing facility:

I remember the first time when I called a doctor. . . I was newly arrived in the center for just about two weeks. I didn't know the system of our facility. The LVN was new, too. She told me 'Call the doctor right away! The patient is crashing!' Then, I made a phone call. However, the doctor couldn't understand what I said. I couldn't understand him, either.

Shya tried hard to overcome these communication challenges with limited supports from the doctor and her subordinate, but she remained dedicated to the care of her patients: "We decided to call 911 to transfer the crashing patient to the hospital ER (emergency room)." Shya continued,

While the ER team was resuscitating the patient, they found that it was unnecessary for us to transfer him. Thus, they sent the patient back to our

facility. He died in the middle of the way, in the parking lot... He had signed the DNR (Do Not Resuscitate) form, but I wasn't aware and informed. We were not supposed to be busy rushing in and out throughout the night. Sarcastically, we should have done nothing but just watched him die peacefully.

Despite the medical mistake made due to inadequate orientation and lack of training regarding facility policies, Shya did not blame anyone for this incident. Instead, she reminded herself of becoming more cautious about patients' documents and learning specific terminology that would affect their care.

Learning by Doing: Clinical Shadowing

In contrast to the lecture-oriented classes, all five of the participants appeared to benefit more from clinical shadowing, that is, learning by doing. Clinical shadowing is a system of assigning each newly-recruited nurse a preceptor (a senior nurse) to follow when the new nurse works. The clinical shadowing period is typically arranged for from six weeks to three months in the participants' hospitals. Shya, Bu, Chen, Wei, and Co consented that shadowing under a preceptor was "the most practical and efficient way" to improve their communication and work skills in the cross-cultural, clinical settings:

Co: Doing is better than simply listening to lectures.

Bu: Following a preceptor was really helpful. You know the proverb, 'practice makes perfect.'

Shya: That's right. Actions speak louder than words.

Bu: I acquired more communication and nursing skills interacting with patients by shadowing a preceptor than attending the classes.

Chen: I agree. I forgot many things which I was taught merely sitting in the classes. I was even dozing off during the lectures. There were too many slides to study.

Wei: When you personally come across a case, the impression will naturally imprint itself on your mind.

During clinical shadowing, preceptors explained and showed the participants work routines, nursing skills, department specific regulations, work environments, and medical equipment. All participants claimed that they were able to build their knowledge of the particular hospital subcultures at that time. Shya said excitedly,

My manager even matched the preceptor's characters and personality with me when she assigned clinical shadowing. I love to talk and I am eager to ask questions. Thus, I was matched with a tolerant preceptor who has powerful theoretical background in nursing in order to satisfy my curiosity about work.

Co was supervised by an elderly female nurse known for her even temper and attentiveness: "My preceptor helped me establish my confidence in work. She showed me nursing skills and hospital care step by step. She modeled the way to negotiate with patients and families if they have irrational requests." Bu stated, "Observing the preceptor and being supported by an experienced nurse has helped me a lot. It made me feel secure when I was a novice in a completely strange work environment."

Nonetheless, all participants perceived that clinical shadowing didn't comprehensively develop their second language ability, namely specific English medical terminology and pronunciation, or cultural knowledge, which they needed in cross-cultural, clinical settings. Wei declared, "Nurses can't just rely on their preceptors. It is impossible to teach you everything within a couple of weeks." Bu also claimed,

Nursing jobs are complicated and unpredictable. Shadowing could only give me general ideas of how to practice here, but I often feel anxious and stressful whenever new things come up. It is not enough for our (international nurses) preparation to work here. I actually keep picking up new vocabulary and new skills during my shifts.

Chapter Summary

In this chapter, the four main themes, (a) the use of complex and specialized language in clinical settings; (b) cross-cultural differences in clinical settings; (c) identity

negotiation in a new U.S. environment; and (d) gaps in language and culture in U.S. nurse training that emerged from the cross case analysis were presented. These included how the participants perceived that language, culture, and education influenced their clinical communication experiences in U.S. healthcare settings.

Results from analysis of the data indicated that the complex and specialized language complicated nurses' oral and written communication in clinical settings. The diversity of the patient and staff populations and cultural differences in hospitals meant that the nurses' experiences were frequently negotiated on the spot, and this complicated the participants' communication experiences. The participants also discerned a need to negotiate their Taiwanese identity in the U.S. hospitals. However, their hospital training programs overlooked the multicultural and multilingual diversity of the U.S. healthcare context. These courses put more emphasis on equality, or providing the same training to nurses from the United States as for international nurses. Therefore, the participants' experiences to understand language and cultural differences in cross-cultural clinical settings were left unaddressed. Finally, the preceptor model of shadowing in clinical settings was a welcomed relief to the nurses, but it did not comprehensively include the specific language and cultural knowledge that the participants needed in cross-cultural, clinical settings. In the following chapter, I discuss these findings as they relate to the literature on second language teaching and learning contexts and second language acquisition and draw implications for international nurses' training.

CHAPTER 6 DISCUSSION AND CONCLUSION

Overview

This qualitative study was designed to understand the perceptions of five internationally-educated Taiwanese nurses about their cross-cultural communication experiences in the U.S. healthcare context. The findings revealed that the communication experiences of Shya, Bu, Chen, Wei, and Co were complicated due to (a) the complexity (specialized vocabulary and linguistic registers) of English language use in clinical settings; (b) cross-cultural differences in the healthcare context; (c) personal identity negotiation in a new U.S. environment; and (d) gaps in language and cultural training of international nurses in U.S. hospitals. The five participants were required to communicate in high-pressure, multicultural, clinical environments in hospital settings; all were located in southern California. Despite the fact that four of the participants (Shya, Bu, Chen, and Wei) were categorized as having an advanced English level based on the U.S. VisaScreen regulations, this study suggested that language demands and cultural differences played a crucial part in the five international nurses' cross-cultural, clinical communication experiences.

This chapter connects findings with the theories, empirical studies, and the theoretical frameworks of second language development and communicative competence presented in Chapter 2. According to the definition of terms in Chapter 1, this chapter uses “internationally-educated nurses,” “international nurses,” and “ESL nurses” alternatively to refer to the study participants. This chapter is presented in two sections. First, the five participants' cross-cultural communication experiences are discussed according to (a) language needs; (b) cross-cultural differences; (c) the role of

education; and (d) communicative competence model. A summary of the following discussion is illustrated in Table 6-1. Second, this chapter provides implications of the study for international nurse training programs and for researchers.

Table 6-1. Summary of discussion

Main findings	Connection to theory	
Language needs in hospital settings	Oral language use	Specialized language and hospital register: Verbal orders: nurse vs. hospital personnel (Bola et al., 2003) Speech register: nurse vs. patients and nurse vs. hospital personnel (Bosher & Smalkoski, 2002; Halliday, 1978; Sherman, 2007; Simon-Vandenberg, 1983) Taiwanese-American pronunciation: Sound (Bosher & Smalkoski, 2002; Bola et al., 2003; Xu et al., 2008) Decontextualized language: telephone consultation: Phone conversation (Hearnden, 2007; Xu et al., 2008) Quadrant theory (Cummins, 1981) Charting and medical documents (Adeniran et al., 2008; Bola et al., 2003)
	Written English: Genre-specific medical reading and writing	
Culture in hospital settings	Role of nurses: Patient-centered care and independent professional	Patient-centered care (Galanti, 2008; Munoz & Luckmann, 2005) Assistance role vs. independent professional (Sherman, 2007; Xu et al., 2008)
	Discourse styles	Direct vs. indirect discourse (Escamilla & Coady, 2001; Kaplan, 1996)
Education and training: The need for specialized, ongoing training	Pre-U.S. training: Language and culture assessment (Bola et al., 2003)	

Table 6-1. Continued

Main findings	Connection to theory	
	Early U.S. training: Hospital orientation and mentorships (Abriam-Yago et al., 1999; Adeniran et al., 2008; Bola et al., 2003; Hancock; 2008; Sherman, 2007)	
Application to the communicative competence model	More relevant aspects of the model	Grammatical competence Sociolinguistic competence Cultural competence (Bachman, 1990; Campinha-Bacote, 2002; Canale, 1983; Canale & Swain, 1980; Grice, 1975; Hymes, 1971, 1972)
	Less relevant aspects of the model	Discourse competence Strategic competence (Bachman, 1990; Canale, 1983; Canale & Swain, 1980;; Hymes, 1971, 1972)

Discussion on Nurses' Cross-Cultural Communication Experiences

In many (medical) interactions, communication is cloudy... Health does not only refer to one's state of being. It is connected to how individuals perceive and construct reality, and reality is based on cultural experiences, beliefs, values, and practices. (Munoz & Luckmann, 2005, pp.12-15)

Cross-cultural, clinical communication is a critical issue in the current U.S. healthcare context (Galanti, 2008; Giger & Davidhizar, 2008; Munoz & Luckmann, 2005). The nature of clinical communication in a multi-cultural context is intricate and complex. While Abriam-Yago et al. (1999) declared that language ability, cultural knowledge, and nursing education are influential factors in preparing ESL nurses to participate in U.S. medical settings, this study revealed that the five international nurses' communication experiences were influenced by how they acquired and used the L1 (first language) and

L2 (second language), how they perceived and interpreted the home and host cultures, and how they were trained in both Taiwan and the United States. The communicative competence model provides insight into the experiences of international nurses in the context of oral and written clinical communication events in U.S. hospitals.

Language Needs in Hospital Settings

This section discusses the main findings related to research sub-question 1: “How do international nurses describe language needs for communication in cross-cultural medical settings?”

Lack of communication skills hinders foreign nurses from assuming professional nurses’ role and responsibilities. Communication barriers lead to frustration for the nurse, other staff members, and patients. (Bola et al., 2003, p. 40)

The findings of this study verified that language barriers are one of the main forces obstructing the five international nurses’ communication in the U.S. healthcare context. Xu et al. (2008) also pointed out that, although internationally-educated nurses’ varied professional training, diverse cultural backgrounds, and unfamiliarity with the U.S. medical system can hinder the smoothness and precision of clinical communication, international nurses’ English language barriers are a leading contribution to healthcare miscommunication between the nurses and patients/hospital personnel in the United States.

Oral language use

Specialized language and hospital register. The five nursing participants described their English language use in clinical settings as “difficult,” “diverse,” “confused,” “unfamiliar,” and “unpredictable.” This study found that complex language use in the context of healthcare included (a) a specific hospital register (e.g., context-

specific terminology with patients/families and medical personnel); (b) multiple meaning in semantics (e.g., occupation-specific vocabulary; dialect); (c) culturally-relevant pragmatics (e.g., jokes and slang); and (d) genre-specific reading and writing (e.g. reading medical documents and writing open-ended nursing notes).

Bola et al. (2003) had similar findings and noted that international nurses face particular language difficulties in understanding verbal orders from doctors. When international nurses fail to understand their nursing coworkers' and doctors' verbal instructions, miscommunication arises. These communication difficulties between international nurses and hospital personnel can result in risks to patient care or, even worse, cause serious or fatal damage to patients. This finding was similar to those in the current study. For example, the participants' "DNR (do not resuscitate) patient" and "Foley-catheter incident" demonstrated how language barriers between international nurses and hospital personnel severely compromised patient safety.

In addition, this study found that there is a specific linguistic register related to hospitals, and lack of knowledge of that register is one of the main issues that complicated the five international nurses' communication in the workplace. All five participants discerned a need to adjust their speech in particular situations and to use the speech registers valued by the U.S. hospital culture. For example, the participants adopted American nurses' "sweet talk" when caring for adult patients. When talking to hospital personnel to discuss patient cases, the participants were required to apply the SBAR (situation, background, assessment, and recommendation) skill, a brief and concise technique to make an oral report.

Adopting a speech register is a strategy of changing speaking styles when talking to different interlocutors in different situations (Halliday, 1978; Simon-Vandenberg, 1983). It is a skill that requires one to discern the social and cultural rules of language use within conversations. Register plays an important role in international nurses' clinical communication. For example, besides medical conversations, the specialized hospital register also included social conversations in clinical settings. The participants' discomfort and lack of confidence in talking socially with patients, families, and hospital personnel made them feel socially and emotionally isolated in the workplace.

Bosher and Smalkoski (2002) and Sherman (2007) found that in addition to engaging in communication events relevant to medical issues, there is a need for international nurses to be engaged in social conversations with interlocutors from a variety of cultural, linguistic, and occupational backgrounds. International nurses' unfamiliarity with American jokes, slang, and socially-culturally specific topics frequently hinder their communication and social interaction with patients, families, and hospital personnel. It is stressful for international nurses to converse with the patients of diverse backgrounds, especially when patients and families talk about cultural-relevant matters beyond healthcare topics.

Taiwanese-American pronunciation. In this study, unfamiliarity with English phonology further complicated the five nursing participants' clinical communication, including phonemes, accents, intonation, and stress. Shya, Bu, Chen, Wei, and Co struggled with difficulties either discriminating English sounds or pronouncing English words, such as the examples of the different stresses on “insulin [ˈɪnsəlɪn] versus [ɪnsjuˈlɪn]” and the phonemic distinction of “phlegm versus flame.” These English

phonological confusions between Taiwanese and American pronunciation resulted in frequent miscommunication between the participants and hospital personnel. The participants also encountered embarrassment by not comprehending patients' speaking due to their diverse accents.

Several researchers suggested that the ethnically and linguistically diverse population of U.S. patients and hospital personnel can provide a range of phonological input for international nurses to negotiate. Boshier and Smalkoski (2002), Bola et al. (2003), and Xu et al. (2008) noted the difficulty for international nurses to master enunciation, pronunciation, stress, intonation, and accent in cross-cultural, clinical conversations. Although international nurses were overall assessed as advanced English speakers, they require more phonological assistances to help them overcome difficulties in discriminating sounds and pronouncing words in English.

De-contextualized language: Telephone consultation. The nursing participants revealed their worries regarding consulting with doctors, pharmacists or coroners over the phone. Likewise, studies emphasized that it is more challenging for international nurses to comprehend phone conversations rather than face-to-face dialogue. Hearnden (2007) found that calling doctors to request medical orders is a challenge for international nurses. Xu et al. (2008) claimed that communication is specifically demanding over the phone for Mandarin-speaking nurses in the United States.

Data from this study support Cummins' quadrant theory (1981), which indicates that the level of cognitive challenge and contextual support in a given context affects bilinguals' communication performance. Cummins argues that academic language skills [also known as CALP, Cognitive Academic Language Proficiency (Cummins, 1979,

1980)] reflects cognitively-demanding and context-reduced situations. Specific medical language used on the phone is one example of this type of language. These skills typically involve using abstract concepts and complicated speech tasks, such as medical-relevant terminology. On the other hand, social language [also known as BICS, Basic Interpersonal Communication Skills (Cummins, 1979, 1980)] occurs in everyday communication. These contexts are less cognitively challenging because they provide more contextual clues within conversations, such as interpreting the speaker's utterances and observing his/her nonverbal cues in daily life face-to-face interactions (e.g., checking out items with a supermarket cashier).

Again, using Cummins' quadrant theory, international nurses' phone consultation with doctors and pharmacists is a typical contextually-reduced and cognitively demanding speech event. Phone conversations require a combination skill of two areas, including mastery of medical English (i.e., CALP) as well as social English (i.e., BICS), all delivered without the use of nonverbal cues. Talking on the phone about medical issues without seeing doctors' and pharmacists' facial expressions, gestures, and body language can be extremely difficult for international nurses. Nurses lack nonverbal cues to know that they should repair conversations. If technological devices are used in these cases, such as teleconference and online meeting assistance, it is possible to help international nurses decrease miscommunication in phone conversations. International nurses are able to observe doctors' and pharmacists' facial expressions and read their lips via computers, laptops, tablets, and smart phones.

Written English: Genre-specific medical reading and writing

Reading and writing in clinical settings were integral aspects of international nurses' communication experiences. The nursing participants had a difficult time

reading genre-specific laboratory data/medical documents and charting nursing notes, especially using open-ended writing. Furthermore, varying English acronyms or abbreviations of medical terminology and medication used by U.S. hospitals led to communication difficulties for the five participants, such as the usage of “LAT” for laceration in one hospital but not found in others.

Generally, the various uses and understanding of medical terminology and genre-specific reading/writing between international nurses and U.S. hospital personnel is a potential risk to cause miscommunication. Bola et al. (2003) noted,

The differences in medical terminology, abbreviations, jargon, medication names, suffixes, and prefixes—even the names of common items—can pose a significant limitation for these (international) nurses. (p.40)

Adeniran et al. (2008) highlighted nurses’ unfamiliarity with the use of medical idioms, acronyms, and abbreviations in U.S. hospitals as being a common challenge for internationally-educated nurses to overcome. Bola et al. (2003) discovered that, although international nurses may make documentation errors unintentionally, their less-developed writing skills in nurse charting are a possible threat to patient care and may even have legal repercussions. In order to shorten the gap between academic reading/writing in school settings and genre-specific medical reading/writing in clinical settings, it is important to provide international nurses specific training about reading comprehension of medical documents/laboratory data and charting skills of nursing notes.

Culture in Hospital Settings

This section discusses the main findings of cultural differences that relate to the research sub-question 2: “How do international nurses perceive cultural factors as influencing communication events?”

Culture is the sum of mutual attitudes, values, customs, and behaviors. It includes thoughts, communication patterns, ethnic traditions, family structures, social hierarchy, religion, and beliefs on health among people from different communities (Brown, 2000; Nieto & Bode, 2007; Peregoy & Boyle, 2008). Culture also influences people’s interpretations of clinical conversations. Speakers from diverse communities interpret and value health-relevant conversations in different ways. Everyone possesses his/her own frameworks and perceptions toward healthcare. Therefore, cross-cultural, clinical miscommunication results not only from language barriers, but also from cultural differences.

Role of nurses: Patient-centered care and independent professional

A variety of medical systems, health beliefs and traditions, and hospital staff patterns between the English-speaking healthcare context and the Mandarin-speaking healthcare context give patients and nurses different expectations of what a nurse’s job entails. First, this study revealed that U.S. medical culture is patient-centered and privacy-oriented. Lacking knowledge of patient confidentiality in the U.S. medical system, for example, made all participants encounter communication difficulties in clinical settings. They also felt “bothered” by intensive interaction with patients and families due to the U.S. hospital patient-centered care.

Several researchers, such as Galanti (2008) and Munoz and Luckmann (2005) have documented patient-centered care in the United States. The U.S. healthcare

context assumes a specific standard of nursing care, with particular expectations of a nurse's role, which is different from that of international nurses in the home country. When international nurses are perceived to be "unprofessional" by patients or hospital personnel in the United States, this is frequently a result of cultural differences regarding nurses' roles and expectations between the two communities, rather than these nurses' "inability" to provide adequate care.

For instance, the patient-centered care in the U.S. healthcare context requires nurses to provide patients with low-skilled tasks, such as Activities of Daily Lives (ADLs), and some Asian nurses find this to be an inappropriate task (Xu et al., 2008). Similarly, in Taiwan, due to the heavy workload that nurses manage, registered nurses are not in charge of patients' ADLs. Patients usually request family members or hire caregivers to help them arrange their meals and with bathing. It is not difficult to imagine that a Taiwanese international nurse is perplexed and irritated when family members request him/her to take care of patients' ADLs in U.S. hospitals. In the study, the contradictory expectations of the medical systems and staff duties between the U.S. and Taiwan also caused frequent communication difficulties for the participants.

In addition, the five international nurses were used to a task-oriented, doctor-centered medical environment in Taiwan. On the contrary, nurses in the United States are treated as professional practitioners who can think critically and independently to manage patient cases. The participants perceived it stressful to adapt their working styles from following doctors' orders to assessing patients, providing professional advice to doctors, and taking legal responsibility for medical disputes.

Wang et al. (2008) claimed that Taiwanese nursing students who studied overseas had difficulty transitioning from task-oriented classes to seminar and tutorial-based classes. Abriam-Yago et al. (1999), Sherman (2007), and Xu et al. (2008) stated that it is important to help ESL nurses transition from task-oriented nursing traditions to a U.S. work environment where critical thinking and individual judgment are valued. Using needs analysis (Dudley-Evans & St John, 2002; Hutchinson & Waters, 2006) to investigate international nurses' cultural traditions of nursing care can help discover their learning needs in terms of cultural transition in U.S. hospital settings.

Discourse styles

The five international nurses experienced cultural shock with respect to the different discourse styles between themselves and Americans. They perceived that humility and compromise were not as valued as pretentiousness and assertiveness in American society. They claimed they were perceived to be weak due to their "soft" discourse style, as compared with hospital personnel and patients in the United States.

According to Sherman (2007), many Asian nurses come from settings that emphasize harmony and collectivism where agreement and obedience are appreciated within communication. Relatively speaking, American culture emphasizes individualism, being unique, and expressing personal and professional opinions. Therefore, different concepts between the two contexts can result in confrontations for international nurses. Additionally, immigrant Mandarin-speaking nurses in Xu et al. research (2008) demonstrated that hierarchy and hard work are important work principles in their home country. They felt discouraged when American subordinates blatantly refused to follow their orders. Shya, Bu, Chen, Wei, and Co also viewed their nursing subordinates' (CNAs, LVNs and nursing students) refusal and noncooperation as rebellious behaviors.

Consequently, Yoder (2001) suggested improving ESL nurses' negotiation skills in terms of speaking in an assertive manner, in order to convince nursing subordinates, nursing colleagues, nursing supervisors, doctors, patients, and families in clinical settings of their professional views and to build trust.

Moreover, the five participants' discourse styles transferred from the first language, Mandarin, clearly distinguished them from native English-speaking American nurses. For example, Bu and Chen were accustomed to speaking in an indirect manner, which made them encounter communication difficulties at work. Escamilla and Coady (2001) and Kaplan (1996) have indicated that many American speakers are used to adopting a linear and direct logic to express their thoughts. When speakers are from two different discourse traditions, it is easy to imagine that in addition to language barriers, the different cultural emphases on discourse strategies can result in communication obstacles in cross-cultural, clinical settings.

At times it was easier for American nursing supervisors to attribute international nurses' communication difficulties to their "limited" English language proficiency, while ignoring the role of culture. However, knowledge of the international nurses' culturally-specific discourse traditions, in which "listening is stressed" and "indirect speech is advocated," may have alleviated many of these miscommunications.

A background survey can contribute to U.S. employers' understanding of international nurses' first language and cultural traditions regarding discourse styles. It is also beneficial to listen to international nurses' voices, provide counseling services to these nurses, and invite experienced nurses from the same first language and cultural background to share perceptions of their struggle with English discourse. It may be

impractical to expect every mainstream American to appreciate or embrace discourse diversity. Nonetheless, it is practicable that the hospital provides courses to teach international nurses to switch between first language discourse and second language discourse when talking to different speech communities. By means of switching between two discourse styles, international nurses can both maintain their identities in the United States and communicate more successfully in U.S. clinical settings.

Education and Training: The Need for Specialized, Ongoing Training

This section discusses the main findings of the role of education to relate to the research sub-question 3: “How do international nurses believe their education and training prepared them for U.S. healthcare communication?”

Foreign-educated nurses leave familiar settings and move into a system with which they're not accustomed... From the employee perspective, these difficulties weren't necessarily the result of inability... differences in nursing practice and training between the two countries contributed to the confusion. (Bola et al., 2003, p.41)

The above quotation suggests that international nurses' prior education influences their communication experiences in education, such as schooling and nursing training in Taiwan, RN exam and English test preparation, and hospital training in the United States. Education reinforces cultural values for students from a particular community (Bruner, 1996; Heath, 1983). The different educational training programs prepared nurses in different ways in terms of communication and nursing care. Nonetheless, it appears from this study that international nurses require specialized, ongoing training both before and after they work in the U.S. healthcare context.

In English for Specific Purposes (ESP) courses, the main purpose is to satisfy both students' and employers' specific needs while taking time-limitations and resource-constraints into consideration (Dudley-Evans & St John, 2002; Hutchinson & Waters,

2006). Due to the diverse linguistic, cultural, clinical, and educational backgrounds of individual international nurses, needs analysis is essential. Needs analysis is not only the preparation of an ESP course, but also a continuing “process of establishing the what and how of a course” (Dudley-Evans & St John, 2002, p. 121). Listening to international nurses’ own voices regarding education and training, language difficulties, work concerns, curiosities, and worries is as important as identifying target needs and prerequisite knowledge for U.S. nursing care (Abriam-Yago et al., 1999; Bola et al., 2003; Choi, 2005). In addition, collecting background research on internationally educated nurses can help prevent redundant instructions of medical knowledge or nursing skills, which the international nurses have already learned in their home countries.

Pre-U.S. training: Language and culture assessment

On the whole, international nurses are requested by the U.S. Immigration Bureau to meet the English language proficiency criterion. Even though Shya, Bu, Chen, and Wei were categorized as advanced English users based on their academic English language test results (i.e., IELTS or TOEFL), their initial communication experiences in the workplace were overwhelmingly frustrating. This study suggested that English language tests (e.g., TOEFL and IELTS) and nursing examinations (e.g., NCLEX-RN) can only attend to basic competencies, instead of assessing the five participants’ comprehensive communication abilities in transcultural nursing care. In short, the language and nursing examinations did not reflect the language and cultural needs of the international nurses.

Several empirical studies have indicated that language and cultural issues hamper the smooth execution of ESL nurses and international nurses’ clinical communication,

despite the fact that the nurses have passed a rigorous English language and nursing license assessment (Bosher & Smalkoski, 2002; Sherman, 2007; Xu et al., 2008). Bola et al. (2003), for instance, found that the VisaScreen process in the United States, which included language and nursing tests, failed to address issues regarding (a) differences in translation (i.e., documentation, medication titles, medical terminology, and abbreviations); (b) cultural conflicts (i.e., hospital subculture, nonverbal cues, concepts of medicine, and nursing ethics); and (c) transitional confusions (i.e., immigration experiences) for international nurses' preparation to work in the United States.

Although international nurses are qualified as nursing professionals to work in the United States based on their nursing license examination (i.e., CGFNS and NCLEX) and English language test results (i.e., IELTS or TOEFL), the reliability, validity, and feasibility of relying on non-medical-relevant academic English tests to evaluate international nurses' clinical communication ability is questionable. The study signified a need for specialized kinds of assessment. Through preparing for the assessment, international nurses can develop and be evaluated for their English proficiency and cultural knowledge in cross-cultural, oral and written clinical communication.

Early U.S. training: Hospital orientation and mentorships

In this study, U.S. hospital employers assumed that the five participants are competent enough to provide transcultural nursing care and to attend to cross-cultural communication based on the results of their nursing license exams and English language test scores. They did not acknowledge that context-specific language needs and nursing skills play a crucial role in international nurses' English communication, particularly in terms of vocabulary (semantic choices and spelling), grammar (syntactic

structures), pronunciation (phonemes, accents, intonation, and stress), and slang and dialect (pragmatics). Unfortunately, the employers neglected the five international nurses' need for second language development and cultural adjustment in the new U.S. environment. Shya, Bu, Chen, Wei, and Co received limited assistances from hospitals to help them transfer from the L1 to L2 medical context.

Nursing remains a vocationally based activity, and therefore curricula have to be based both on education and practice settings if the goal of producing 'knowledgeable doers' is to be realized." (Hancock, 2008, p.260)

The data from this study revealed that lecture-oriented classes during the early U.S. training and hospital orientation placed little and surface attention on enhancing the participants' cross-cultural, clinical communication ability. Although clinical shadowing (following an assigned preceptor) did not provide comprehensive training to facilitate these nurses' language and cultural transition, Shya, Bu, Chen, Wei, and Co developed more communication skills and cultural knowledge through learning by doing than by sitting and listening to oversimplified class content.

When Abriam-Yago et al. (1999), Adeniran et al. (2008), Bola et al. (2003), and Hancock (2008) discuss training programs for international nurses and ESL nurses, all highlighted the importance of clinical practice in these nurses' early transition in the U.S. healthcare context. Sherman (2007) promoted the mentor-mentee system as a valid method to help international nurses' communication ability development and cultural adjustment.

Every hospital has its regulations and cultures that U.S. supervisors and nurses may take for granted. Nevertheless, international nurses are truly "alien" to these concepts, and without precise training may not learn those rules. Research has shown

that international nurses' word choice may be interpreted as a professional error, such as mistakenly referring to a male patient as "she" (Bola et al., 2003) or using "Panadol" (a pain medication in Taiwan) instead of "Tylenol" (the same pain medication in the United States) for acetaminophen between patient-nurse conversations. In order to bridge the gap for international nurses in the U.S. medical culture, Sherman (2007) emphasized the necessity of providing a comprehensive orientation program to internationally-educated nurses by addressing the details of medical literacy and nursing care in the hospital, including

physical assessment and systems review, I.V. (intravenous) placement, nasogastric placement and ECGs (electrocardiogram), scope of practice and professional expectations, supervision and delegation, critical thinking in patient care situations, pain management, instruction on unit technology and equipment, medication review, planning the workday U.S. healthcare delivery system and health beliefs, physician/nurse communication, documentation, and cultural competency with diverse populations. (p.16)

Application to the Communicative Competence Model

Andrews and Boyle (2003) estimated that 90% of cross-cultural, nurse-patient interaction failures are caused by miscommunication. It is important to help international nurses be linguistically and culturally competent when taking care of patients from diverse backgrounds. Andrews and Boyle (2003) described nurses' communicative competence from a medical perspective:

Cultural and linguistic competence refers to an ability by health care providers and health care organizations to understand and effectively respond to the cultural and linguistic needs brought by clients to the health care encounter. (p. 16)

A communicative competence model emphasizes both the form and function of language. Form refers to structures of language, while function refers to cultural norms in language uses (Hymes 1971, 1972, 1974). There are two aspects of the

communicative competence model, including linguistic and cultural competence.

Linguistic competence consists of grammatical, sociolinguistic, discourse, and strategic competences. Nonetheless, not all components of the communicative competence model that researchers (Bachman, 1990; Canale, 1983; Canale & Swain, 1980; Hymes 1971, 1972, 1974) proposed appeared to carry the same emphasis among the international nurses in this study. This study showed that grammatical competence, sociolinguistic competence, and cultural competence played a larger role in the five participants' cross-cultural, clinical communication experiences than did discourse and strategic competences (discussed below). Figure 6-1 illustrates the components involved in communicative competence for international nurses.

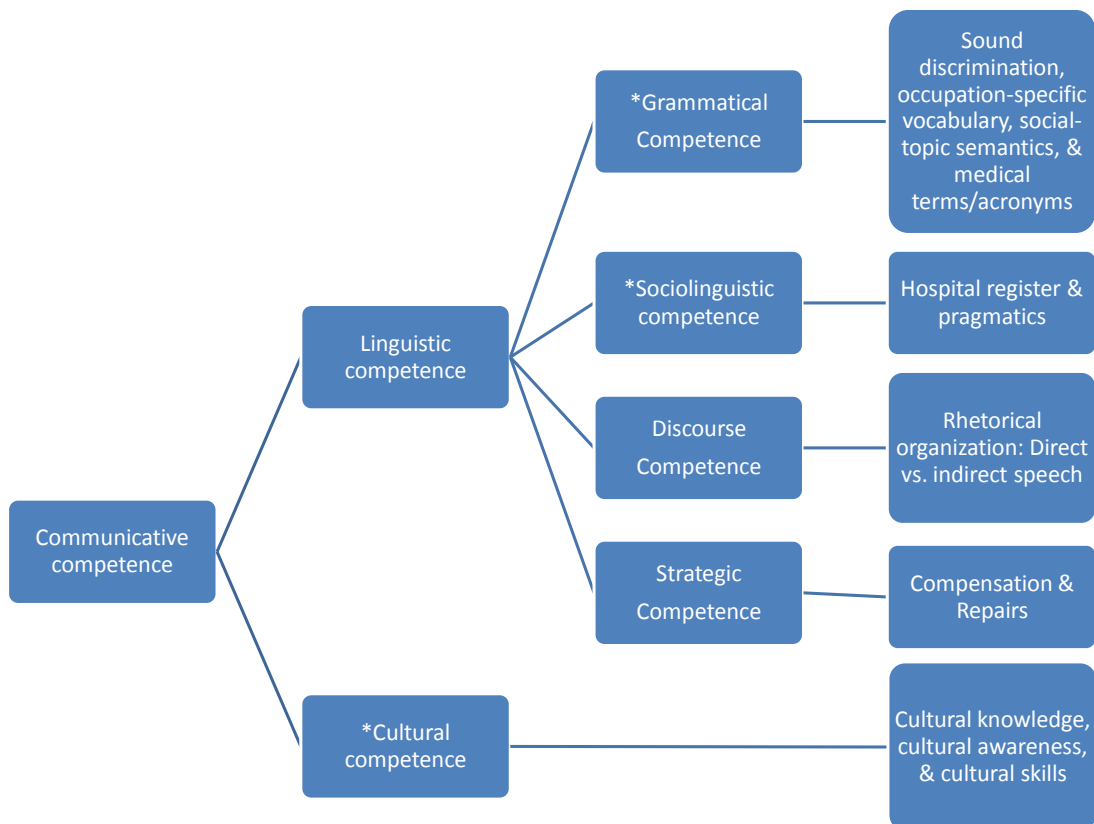


Figure 6-1. Components of communicative competence for international nurses

More relevant aspects of the model: Grammatical, sociolinguistic, and cultural competence among international nurses

Grammatical competence. Bachman (1990), Canale (1983), and Canale and Swain (1980) defined grammatical competence as the knowledge of language rules at the sentence level, including vocabulary (i.e., semantics and morphology), grammar (i.e., syntax), and pronunciation (i.e., phonology). It assumes speakers' ability to master lexicon, spelling, syntactic rules, morphemes, and phonemes.

This study revealed an urgent need for the five participants to develop grammatical competence in sound discrimination, occupation-specific vocabulary, social-topic semantics, and medical terminology/abbreviations/acronyms. For instance, in their communication stories, the words and phrases such as "willy," "boner," "a happy camper," and "in a New York second," which the participants misunderstood at work, suggested how the knowledge of semantics in the category of grammatical competence influenced the flow of their social conversations with patients and hospital personnel. Moreover, the study showed that phonology, including differences in English pronunciation and the diversity of English accents in U.S. hospitals, further complicated the five participants' communication experiences. The participants were concerned that they would easily misunderstand their coworkers' reports and doctors' orders because some medical terms and medication were pronounced in a way different from what they had heard and used in Taiwan. If they had developed the grammatical competence in terms of sound discrimination, they could have avoided miscommunication in nurse-patient and nurse-hospital staff conversations.

Sociolinguistic competence. Sociolinguistic competence refers to the sociocultural sensitivity of language use. It emphasizes functional and cultural aspects

of language use (Bachman, 1990; Canale, 1983; Canale & Swain, 1980; Grice, 1975; Halliday, 1973, 1978). The components include pragmatics, speech register, topic relevance, language functions, and speaker-listener relationship. The study indicated that lacking sociolinguistic competence was one of the main factors to obstruct the five participants' communication in U.S. clinical settings

The finding suggested that the participants' limited knowledge of occupation specific vocabulary and less-developed linguistic register impeded them from competently switching between speech registers with different interlocutors, such as switching from "talking to patients/hospital personnel about social topics in an informal manner" to "discussing/reporting patient condition with doctors/nurses/coroners in a professional tone." In addition, this study found that the participants needed to develop sociolinguistic competence in medical writing. Four of them had passed the IELTS academic writing exam but they all stated difficulty composing open-ended writing in nursing charting.

Additionally, interpreting multicultural patients' and hospital personnel's meanings from their slang and various dialects was difficult for the participants. As part of building sociocultural competence in communication, there is a need to develop the international nurses' pragmatic skills in clinical settings. Pragmatics (Grice, 1975) is a study of meaning and context of communication. It examines how speakers use language within a particular context and why they use it in a specific way. Boxer (2002) claimed that an awareness of cross-cultural pragmatics in face-to-face interaction can facilitate ESL speakers' communication in the workplace. When international nurses have the ability to interpret culturally specific meanings beyond interlocutors' utterances, they are able

to interact more socially with patients, families, and hospital personnel in the U.S. healthcare context.

Cultural competence. In addition to linguistic competence which was addressed in the above section, knowledge of culture can considerably affect the smoothness of cross-cultural communication. Munoz and Luckmann (2005) claimed that cultural competence has become a necessity for nurses as documented both in U.S. nursing academic and professional associations. Like all other international nurses, the five participants were striving to develop culturally-relevant communication skills to accommodate the ethnically-diverse patient structure in the United States.

Campinha-Bacote's (2002) cultural competence model is well-known for its application to healthcare delivery. Based on this model, cultural competence is a continuous process requiring healthcare providers' cultural awareness, cultural knowledge, cultural skill, and cultural encounter; this occurred spontaneously based on immediate need rather than as a planned learning task.

Cultural awareness requires deliberate reflection of one's own cultural belief system. It is considered the first step and basis for healthcare professionals to develop cultural competence. Once nurses are aware of their own cultural perceptions of ethnic belonging, heritage, socioeconomic status, communication patterns and behavior styles, education history, language, and professional background, they are able to discern their prejudices about people who are different from them. In this study, Shya, Bu, Chen, Wei, and Co were aware of their own identity, culture, and advantages and disadvantages of nursing care in the United States. Shya and Wei believed that their bilingual

competence and nursing qualifications made their employers hire them, rather than whether they could speak standard or perfect English or not.

Cultural knowledge requires knowledge of patients' backgrounds. Cultural knowledge for nurses includes patients' health values, common diseases, and treatment efficacy. Fadiman's (1997) descriptions of communication conflict between a Hmong family and U.S. healthcare team demonstrated that understanding patients' attitudes toward life, death, health, and illness is important for cross-cultural medical care. Looking through the patients' lens can help international nurses comprehend their patients' worldview and modify their own utterances and behaviors to facilitate communication. In this study, the five participants' perceptions of Mexican, Asian, and American patients often determined the success of cross-cultural communication.

Treatment efficacy refers to the study of cultural medications and medication effects and side-effects on a particular ethnic population. Every cultural group has its own life styles, dietary preferences, and daily routines. If the five participants had access to knowledge of these treatments, such as food therapy, alternative herbal remedies, or religious remedies, they might have been able to assuage their apprehension of meeting patients' dietary preferences.

In addition, cultural competence can be viewed as a skill intertwined with sociolinguistic competence. It considers international nurses' knowledge of the sociocultural conventions required to communicate with people from diverse backgrounds. During the process of cultivating nurses' cultural competence, international nurses can gain knowledge of interlocutors' word choice, discourse patterns, nonverbal communication, and cultural views of healthcare and medicine.

Less relevant aspects of the model: Discourse and strategic competence among international nurses

Discourse competence. Discourse competence is advocated by Bachman (1990) and Canale and Swain (1980). It is the knowledge of rhetorical organization in inter-sentential relationships, a skill to make discourse logically sequential, coherent, and cohesive. This study did not reveal major findings from the five participants' reflections regarding the need to make clinical discourse coherent or cohesive; hence, this competence may be considered less important overall for nurses' cross-cultural communication.

Nonetheless, this study found that the five participants' indirect and modest rhetorical organization borrowed from L1 speaking was contradictory to English speakers' direct and assertive discourse strategies in the United States. Boshier and Smalkoski (2002), Gardner (2005), Sherman (2007), and Yoder (2001) claimed that many ESL nurses and international nurses were not accustomed to Americans' directness and assertiveness in speaking. International nurses are advised to develop discourse competence in order to respond to these particular rhetorical strategies.

Strategic competence. Strategic competence is a skill that reflects one's decisions and ability to compensate for errors and miscommunication in face-to-face communication (Bachman, 1990; Canale, 1983; Canale & Swain, 1980). Chinen (2001) highlighted the importance of the compensation skills for EFL Japanese nurses, including confirming information, asking for repetition/clarification, and raising cross-cultural awareness. These skills can give EFL nurses' the ability to understand foreign patients' utterances and to avoid any serious problems or medical mistakes caused by miscommunication.

Although this study showed that the five participants experienced communication difficulties at work, they revealed no major problems in discerning misunderstanding and repairing miscommunication with the interlocutors at work. Their overall advanced English proficiency endorsed by the English language tests, appeared to correspond to their performance of this competence. For that reason, the development of strategic competence for nurses to (a) confirm treatment procedures with nursing colleagues; (b) double-check doctors' verbal orders; and (c) verify patient complaint and background, is more urgent for nurses who are beginning English speakers, such as Mandarin speaking nurses working in Taiwan, in the EFL medical context.

Implications of the Study

International Nurses' Training in the United States

There are several implications for developing international nurses' communicative competence and cultural knowledge for clinical communication. These implications derive from my interpretation of the findings from this study.

The objectives of international nurses' training are to increase these nurses' abilities both in cross-cultural communication and nursing practices in multicultural, U.S. clinical settings. According to Nieto and Bode (2007) and Peregoy and Boyle (2008), multiculturalism addresses both mainstream and other cultures. Researchers, including Coady, Hamann, Harrington, Pacheco, Pho, and Yedlin (2007), de Jong and Harper (2007), and Knight and Wiseman (2006), have noted that culturally responsive pedagogy is a learner-centered approach that supports ESL learners' academic and social development in a culturally and linguistically responsive way. Likewise, international nurses have their existing knowledge of language use, communication patterns, nursing skills, job experiences, and worldviews. It is important for hospital

employers to remain open to the culture that international nurses bring to the United States. A training program embracing international nurses' first language, identity, cultural traditions, and work values can help enhance international nurses' confidence in their cross-cultural communication experiences.

The main learning goals of international nurses' training are to (a) relate class content to nurses' prior experiences and to build on new knowledge based on what they have been already capable of; (b) develop nurses' ability to transfer language and communication skills (linguistic competence); (c) facilitate nurses' understanding of cultural knowledge and nurses' role in U.S. clinical settings (cultural competence); and (d) learn by doing (clinical practice).

Communication and cultural mediation

Samway and Mckeon (1999) claimed that second language acquisition depends largely on the development of conceptual and linguistic knowledge, and it can be added successfully at any age. International nurses are efficient adult ESL learners because they are able to transfer their first language concepts and structures to second language. Therefore, it is important to facilitate international nurses' language transfer of linguistic competence, such as grammatical competence (e.g., sound discrimination and recognition of medical terminology/abbreviation/acronym), sociolinguistic competence (e.g., hospital register and pragmatics) and discourse competence (e.g., rhetorical organization for SBAR skills).

Furthermore, nursing care is a vocationally based activity (Hancock, 2008). Every hospital has its special framework of routines and emphases. It is important for international nurses to be familiar with U.S. hospital routines and traditions. According to the study, doctor-centered care is valued in Taiwan while patient-centered care is more

stressed in the United States. The different perspectives on nursing care can lead to diverse expectations of clinical communication between international nurses and interlocutors in U.S. hospitals. In order to familiarize international nurses with U.S. hospital culture, Adeniran et al. (2008) recommended introducing the following concepts during the hospital orientation training program for ESL nurses: (a) the U.S. healthcare delivery system; (b) skills that are necessary to practice communication successfully in U.S. hospitals; (c) legal and ethical matters relevant to U.S. nursing practice; and (d) the roles of multidisciplinary members of the healthcare team in the United States.

Nursing is an occupation-based profession that relies on hands-on practice. Classes which rely 100% on lectures do not result in significant outcomes of international nurses' comprehension. It is more effective to improve international nurses' communication skills by providing contextual background of nursing care, explaining nursing procedures through authentic cases, and practicing nursing tasks via hands-on activities. Abriam-Yago et al. (1999) and Choi (2005) suggested adopting Cummins' model of second language acquisition (1983 & 1984) to increase contextual support and reduce cognitive demands of course content for ESL nurses. During the training period, instructing with context-embedded and contextualized language can help develop international nurses' conceptual ideas to understand English language and U.S. medical culture. Course instructors or nursing supervisors are suggested to model the steps of accomplishing nursing tasks, writing nursing notes, and manipulating medical equipment. It is also advantageous for international nurses to observe and practice each aspect of nursing care, rather than receiving overview introduction to these

procedures. Finally, encouraging international nurses to formulate ideas and give feedback can help them reflect upon what they have learned in a more concrete way.

In addition, cultural competence is a continuous process requiring nurses' cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire (Campinha-Bacote, 2002). International nurses' bilingual backgrounds may make them become sensitive to multicultural patient groups, but like all U.S. medical professionals, international nurses should receive sound, ongoing cultural education of diverse patient groups. They need to regularly examine personal biases and assumptions of certain ethnic groups. It is also important to continually collect cultural data regarding patients' illnesses in order to bridge the cultural gaps between themselves and the served community. On the whole, a community-based nursing care project creates practice opportunities for international nurses to develop their cross-cultural communicative competence. Abriam-Yago et al. (1999) claimed that a home care practicum extends the interaction and communication between international nurses and their ethnic diverse patients in a context-embedded situation.

Critical thinking in nursing care

The U.S. hospital culture places emphasis on nurses' critical thinking, autonomy, and independent role at work. Neither speaking fluent English nor passing language/nursing exams can significantly help international nurses develop their critical thinking skills in nursing care.

A collaborative classroom culture encouraging inquiry and personal views can contribute to learners' development of critical thinking skills (Bruner 1996; Townsend & Pace, 2005). To transition international nurses who are from previous task-oriented/instruction-guided nursing traditions to independent judgment, explicit

demonstration of how critical thinking functions in the U.S. healthcare context is advocated.

One way to do this is to ask international nurses to compare nursing procedures between their home country and in the United States. Additionally, role-playing is a practical tool for international nurses to simulate and apply critical thinking. By means of group discussion of scenarios, international nurses can learn to be critical about nursing care via seeking modeling from other nurses. More importantly, allowing international nurses to brainstorm ideas rather than just recalling nursing steps contributes to their development of critical thinking (Abriam-Yago et al., 1999).

Clinical practice

It is important to physically prepare international nurses for the U.S. hospital environment and increase their social interaction with American society. Abriam-Yago et al. (1999) and Yoder (2001) suggested valuing international nurses' bilingual and bicultural background as a resource for medical services in ESL nurses' training programs, especially in ethnically and linguistically diverse communities.

Constructing a supportive environment for internationally educated nurses in clinical practice is primary. It is beneficial to incorporate international nurses' cultural backgrounds and help preserve these nurses' ethnic identity. American nurses may be advised to show positive attitudes toward international colleagues. They may also be open-minded toward the differences that international nurses bring into the United States. Once American nurses gain insight into how international nurses perceive the medical world, they are able to accommodate the (dis)similarities between the two groups of nurses. Furthermore, international nurses can be more comfortable in maintaining their identity in the new U.S. culture. Building a supportive environment can

not only promote work efficiency among medical teams, but may also enable them to retain their employment.

Moreover, research shows that the mentor-mentee relationships can improve immigrants' personal lives and professional career in the new environment (Jeffries & Singer, 2002). In this study, all five participants described the positive effects that their preceptors brought to their cross-cultural, clinical communication experiences. If the reality allows, it is helpful for the new-coming international nurses to follow the preceptors who have similar ethnic/linguistic backgrounds and immigrant experiences. Sherman (2007) recommended that assigning international nurses who have similar transitional experiences as mentors can help the nurses overcome their unease in the primary immigration stage.

Linking international nurses with successful and experienced ethnic role models in U.S. clinical settings will increase these nurses' confidence in cross-cultural communication. Yoder (2001) suggested that joining ethnic nurses' professional associations or ethnic nursing clubs is helpful for international nurses' social integration in the United States. It also sets up a tangible goal for international nurses to achieve because they see someone like them as successful in the new U.S. environment. By means of access to the same ethnic community, international nurses receive social and emotional support from people who understand them and who act/speak/think like them. They can also build on their understanding of U.S. medicine in a professionally, culturally supportive way from their ethnic role models.

Implications for Researchers: Further Investigations

This study can inform both TESOL (Teaching English for Speakers of Other Language) educators and nursing trainers about the ways in which the Taiwanese

subgroup, internationally-educated nurses perceived communication in cross-cultural, clinical settings. From a theoretical perspective, the study provided examples for TESOL and nursing researchers to discern the relationship between language, culture, education, and communication. In practical terms, the study explored the components that international nurses lacked or required for cross-cultural, clinical communication by looking at the insights gained from the five nursing participants' experiences.

The first implication is to gather authentic data from cross-cultural, clinical settings. In many qualitative empirical studies, investigating real discourse is the primary method used, especially when studying ESL speakers' communication experiences (Boxer, 2002; Burns, Joyce, & Gollin, 1996). This study was conducted by a TESOL graduate student without access to the U.S. healthcare context to examine international nurses' authentic communication. In addition, the researcher's non-nursing background with subjective understanding of the data may have led to a biased discussion. For that reason, future studies can be conducted in cooperation with the nursing field and the TESOL field. English for Nursing Purposes (ENP) and communicative competence for international nurses count as cross-field research that require acknowledgement of both second language acquisition and transcultural nursing knowledge. The collaboration between the two fields can facilitate the data collection procedure, such as the IRB approval process for clinical observation, as well as data analysis, findings, and discussion. This would allow for a more comprehensive interpretation of international nurses' perceptions of cross cultural communication.

The second potential research area is an extension of this study to invite more culturally, ethnically, linguistically diverse internationally educated nurses to participate

in the research. I used my first language and cultural background as an advantage to focus on the exploration of Taiwanese nurses' communication experiences. However, it is noted that the U.S. nursing market is replete with multi-ethnic and multilingual nursing professionals (Abriam-Yago et al, 1999; Adeniran et al, 2008; Bola et al., 2003; Brown, 2008; Gardner, 2005; Hancock, 2008; Ross et al., 2005; Sherman, 2007; Xu et al., 2008; Yoder, 2001). Although this study provided perceptions of the five Taiwanese nurses' communication experiences, international nurses from other cultural communities may have divergent perspectives of clinical communication. It would be beneficial if the voices of international nurses from different subgroups can all be heard.

Third, in addition to studying international nurses' experiences, it would be helpful to investigate the perceptions of communication experiences from the perspectives of nursing supervisors, hospital personnel, and patients/families/visitors in the United States. Their reflections can help researchers examine multi-faceted aspects of cross-cultural communication, rather than plainly fixing on international nurses' subjectivity.

This section introduced three areas of prospective investigation that emerged from the study, including (1) gathering authentic data from cross-cultural, clinical settings; (2) inviting more culturally, ethnically, linguistically diverse internationally educated nurses to participate in the study; and (3) investigating the perceptions of communication experiences from the perspectives of nursing supervisors, hospital personnel, and patients/families/visitors in the United States.

There are possibly other aspects of the research that are worthy to be explored in the future. Any empirical study intending to increase the understanding of international nurses' cross-cultural, clinical communication experiences is encouraged.

Conclusion

Transcultural nursing has become an important issue in the U.S. healthcare context since the mid-1960s (Giger & Davidhizar, 2008). However, little research has been conducted in the field on the communication experiences and perspectives of internationally educated nurses.

The study was based on the theoretical perspective of constructivism embedded in the epistemology of constructionism. The research question was, “How do internationally-educated nurses perceive their cross-cultural, clinical communication experiences in the U.S. medical context?” The three sub-questions of this study were: (a) how do participants describe language needs for communication in those settings?; (b) how do they perceive cultural factors as influencing communication events?; and (c) how do they believe that their education and training prepared them for U.S. healthcare communication?

Qualitative methods were employed in this study in order to gain a better understanding of internationally-educated nurses’ perspectives and experiences of cross-cultural, clinical communication. Purposeful sampling was used to recruit five internationally-educated Taiwanese nurses, Shya, Bu, Wei, Chen, and Co, to participate during the four-month research period. Data collection methods included (a) primary data: focus group interviews and in-depth individual interviews; and (b) supplementary data: background information derived from surveys, intensive participant observations, and post-interview reflection journals. Data analysis methods included both narrative and thematic analyses.

This study provided a description and background for each of the five nursing participants. The stories illustrated the participants’ home family and culture with respect

to language use; their nursing and language training programs in Taiwan and the United States; and their immigration experiences and adjustment to the U.S. healthcare context. By investigating the participants' communication stories, this qualitative study described the ways in which the five international nurses perceived how language needs, cultural differences, and educational training influenced their communication in U.S. clinical settings. Shya, Bu, Wei, Chen, and Co came to the United States with knowledge of their home culture, first language, English proficiency, nursing skills, and worldviews. Although the five participants were from the same ethnic group, findings indicated that their different family backgrounds, social surroundings, immigration experiences, and preparation methods resulted in each having a unique perception of themselves in cross-cultural, clinical communication.

In addition, this study presented the findings, which emerged from a cross-case analysis. The results showed four main themes: (a) the use of complex and specialized language in clinical settings; (b) cross-cultural differences in clinical settings; (c) identity negotiation in a new U.S. environment; and (d) gaps in language and culture in U.S. nurse training. The four main themes indicated how Shya, Bu, Chen, Wei, and Co perceived the roles of language, culture, and education affecting their U.S. clinical communication experiences.

This study also used findings from the five participants' communication experiences to draw discussion and implications for developing international nurses' communication ability and cultural skills in clinical settings. Shya, Bu, Chen, Wei, Co were much like professionally trained American registered nurse, but their

communication in the workplace was often impeded by the fact that they faced unfamiliar language and cultural environments.

It is important for U.S. supervisors and American nurses to remain open to the cultural resources that internationally-educated nurses bring to the United States. A comprehensive training program paying close attention to international nurses' background knowledge and the development of communication ability, cultural competence, and critical thinking skills is suggested. Generally, the improvement of international nurses' communicative competence and critical thinking ability require sufficient language input and output. A dynamic dialogic class giving ample opportunities for international nurses to ponder, to question, to practice, and to present their communication skills is advocated. The training program aims to help international nurses diminish language barriers and contribute to their second language development and cultural adjustment in the United States. The recommendations included (1) facilitating international nurses' language transfer of linguistic competence; (2) familiarizing international nurses with U.S. hospital routines and traditions; (3) providing contextual background of nursing care, explaining nursing procedures through authentic cases, and practicing nursing tasks via hands-on activities; (4) providing international nurses sound, ongoing cultural education of diverse patient groups; (5) explicitly demonstrating how critical thinking functions in the U.S. healthcare context; and (6) establishing a supportive work environment, including the mentor-mentee system.

Finally, there are two major contributions of this study to the field of TESOL and nursing. First, it outlined how language factors, cultural differences, and educational training influenced the five participants' U.S. clinical communication experiences

through deep, detailed, qualitative case study descriptions. By living with the participants, listening to their stories, and sharing their joys and burdens, this study disclosed individuality and commonality in the cross-cultural communication via the participants' stories. Second, this study discussed the linguistic theory of communicative competence and communication from a transcultural nursing care perspective. Second, this study discussed linguistic theory of communicative competence and communication from a transcultural nursing care perspective. The connection established by this study between second language acquisition and transcultural nursing can help both TESOL educators and nursing researchers to have insight into the what, where, why, who, and how of affecting international nurses' communication experiences.

APPENDIX A
IRB PROTOCOL

UF Institutional Review Board
UNIVERSITY of FLORIDA

Health Center Institutional Review Board


FWA00005790

PO Box 100173
Gainesville FL 32610-0173
Tel: (352) 273-9600
Fax: (352) 273-9614

MEMORANDUM

DATE: December 15, 2010

TO: Ya-Yu Cloudia Ho
2901 SW 13th St Apt 226
Gainesville, FL 32608

FROM: R. Peter Iafrate, Pharm.D.
Chairman, IRB - 01 

SUBJECT: Revision of IRB Project #717-2009

TITLE: EXEMPT: LANGUAGE, CULTURE AND EDUCATION : CROSS-CULTURAL
COMMUNICATION OF INTERNATIONALLY-EDUCATED MANDARIN-SPEAKING
NURSES IN THE UNITED STATES

On 11/29/2010 the IRB reviewed and APPROVED the submitted revision(s) listed below:

****Number of Research participants increased from 5 to 6 people****

INTRODUCTORY QUESTIONNAIRE
Item # 3 Research Procedures revised

INFORMED CONSENT FORM
Research Procedures revised
Compensation added: \$100 gift card
Confidentiality information revised
Contact information revised

DOCUMENT REVISED
Interview Protocol
Recruitment Flyer
Email Script

A copy of the revision letter dated 11/20/2010 has been stamped with the date of IRB approval and is enclosed.

Thank you for keeping the IRB informed about your research project, thereby allowing us to keep accurate files. If the IRB staff can be of any further assistance, please feel free to call.

encl: Dated, IRB-approved Revision Letter

cc: IRB file

An Equal Opportunity Institution

APPENDIX B
RECRUITMENT FLIER

I am looking for 5 Mandarin-speaking nurses to participate in a cross-cultural communication study.

- If you are an internationally-educated nurses who
 - speaks Mandarin as a first language
 - possesses intermediate or higher level of English proficiency
 - has received nursing education and professional training in your home country
 - currently work in a clinical setting in the U.S. healthcare context

You may be eligible to participate in my study.

- What you will be asked to do is to
 - participate in focus group interviews and individual interviews to talk about your experiences of communication in U.S. medical healthcare settings.
 - Participate in observations regarding social non-medical talk.

For more information, please contact:

Ya-Yu Cloudia Ho
Doctoral student in ESOL/Bilingual Education
School of Teaching & Learning, College of Education
University of Florida.
Phone: (352) 870-8143
E-mail: cloudiaho@hotmail.com

APPENDIX C
EMAIL SCRIPT OF RECRUITMENT

Dear Sir/Madam,

I am a PhD candidate in the College of Education at the University of Florida, conducting dissertation research on internationally-educated Mandarin-speaking nurses' cross-cultural, clinical communication under the supervision of Dr. Maria Coady. The purpose of my study is to investigate how internationally educated nurses perceive their experiences of cross-cultural, clinical discourses and explore how language, culture, and education influence international educated nurses' cross-cultural communication experiences in U.S. healthcare settings. The results of the study can help to understand the nature of cross-cultural communication and benefit future curriculum and material development of English for Nursing Purposes.

The study includes focus group interviews, individual interviews, and nonmedical observations of social events. The compensation is \$100 gift card. If you are interested in my study or have any questions about this research, please contact me at 352-870-87143 cloudiaho@hotmail.com or my committee chair, Dr. Coady (mcoady@coe.ufl.edu, 352-273-4228). Questions or concerns about international nurses' rights as research participants may be directed to the IRB01 office, University of Florida, Gainesville, FL 32611, (352) 846-1494.

Best Regards,

Cloudia

Ya-Yu Cloudia Ho
PhD Candidate
ESOL/Bilingual Education, School of Teaching and Learning
College of Education, University of Florida.
Tel: 1-352-870-8143 E-mail: cloudiaho@hotmail.com
Address: 2901 SW 13th Street, Apt 226, Gainesville, FL32608, USA

APPENDIX D INFORMED CONSENT FORM

Purpose of the research study:

The purpose of my study is to investigate how you perceive yourself as an internationally educated nurse experiencing cross-cultural, clinical communication in U.S. healthcare settings.

What you will be asked to do in the study:

You will be asked to participate in focus group interviews and individual interviews regarding your cross-cultural communication experiences. You will be also asked to participate in nonmedical observations of social events.

You will be asked to voluntarily attend three focus group interviews and three individual interviews to talk about your experiences of healthcare communication, language, culture, and education in cross-cultural communication while you are working in the United States. You will be asked to exclude any identifiable information, personal health, and employability information in the interviews. The focus group interviews will be held for about 90 minutes and individual interviews will be held for 60-90 minutes. Interviews will be held in a place where you feel comfortable except in your workplace. Conversations will be audio-taped and transcribed.

Risks and Benefits:

There are no anticipated risks to you as a participant in interviews. You are free to withdraw your consent to participate and may discontinue your participation in the interviews at any time without consequence. The benefit of my study is to develop a more insightful exploration of language use, cross-cultural awareness, educational effects, and communicative competence for international registered nurses working in the United States.

Compensation:

\$100 gift card

Confidentiality:

Information that you provide will be completely confidential. Your name, identity, employability, and institution' identification will be concealed and never shown to others except the study investigator. Study will include discussion of general phenomenon in the United States rather than any regional issues, which risks identifying you and your employability. No personal medical history will be revealed, discussed or included in my study. I will transcribe the interview tapes in a private room and ensure that nobody will be present when I am transcribe them. These audiotapes will be never played under

any circumstances except when I am making transcriptions and analyzing the data. The audiotapes will be destroyed when the study is completed. The interview notes, transcripts, and observation field notes will be stored in a locked cabinet where only the principal investigator will be able to access to them after the study is completed.

Voluntary participation:

Your participation in my study is completely voluntary. There is no penalty for not participating.

Right to withdraw from the study:

You have the right to withdraw from the study at anytime without consequence.

Whom to contact if you have questions about the study:

Ya-Yu Cloudia Ho, PhD candidate in ESOL/Bilingual Education, School of Teaching & Learning, College of Education, University of Florida. Tel: 352-870-8143, E-mail: cloudiaho@hotmail.com.

Dr. Maria Coady, Ph.D. Associate Professor in ESOL/Bilingual Education, School of Teaching & Learning, College of Education, University of Florida. Tel: 352-273-4228 E-mail: mcoady@coe.ufl.edu

Whom to contact about your rights as a research participant in the study:

IRB01 Office, University of Florida, Gainesville, FL 32610-0173; phone 352-846-1494.

Agreement:

I have read the procedure described above. I voluntarily agree to participate in the procedure and I have received a copy of this description.

Participant: _____ Date: _____

Principal Investigator: _____ Date: _____

APPENDIX E
BACKGROUND INFORMATION SHEET

NAME	_____
GENDER	<input type="checkbox"/> Male <input type="checkbox"/> Female
AGE	_____
NATIONALITY	_____
RELIGION	_____
YEARS IN U.S.	_____
U.S. VISA STATUS	<input type="checkbox"/> Foreigner working visa <input type="checkbox"/> Citizenship <input type="checkbox"/> Permanent resident with Green Card <input type="checkbox"/> Other _____
PHONE NUMBER	_____
EMAIL	_____
ADDRESS	_____

Sampling Criteria

Is Mandarin your first language?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your English level intermediate or higher?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you receive nursing education/training in your home country before you enter the United States?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently working in the U.S. healthcare settings as a registered nurse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Home Country Professional Information

Place of Employment	_____
Position of Employment	_____
Department	_____
Years of Working	_____

U.S. Professional Information

Place of Employment	_____
Position of Employment	_____
Department	_____
Years of Working	_____

Education Information

Language Information

<p>Highest Education in Home Country _____</p> <p>Highest Education in U.S. _____</p>	<p>English Level <input type="checkbox"/> Intermediate _____</p> <p><i>Exam results if applicable. e.g., IELTS 6.5</i> <input type="checkbox"/> Advanced _____</p> <p><input type="checkbox"/> Native-like _____</p> <p>Years of Learning English _____</p> <p>Other Languages _____</p>
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APPENDIX F INTERVIEW PROTOCOL

The following questions are examples of the questions which were asked during the interviews.

Daily Work and Communication Events

1. Describe a typical work day. What kinds of nursing job are you involved with? What kinds of communication are involved? [prompts: listening, speaking, reading, writing, nonverbal]
2. Please share any specific experiences/stories of cross-cultural communication “events” you encounter during your working hours. “Events” are interactions that take place between you and a non-native Taiwanese and non-native Mandarin-speaker in which you experienced (enough to recall) surprise, discomfort, misunderstanding or the opposite – typical, comfortable, understanding.

Personal Background History and Communication Events

Data collected from the previous interviews will inform questions, such as the following:

1. Please share your stories of moving to the United States. (How did you prepare to work as a U.S. register nurse here? Why? What made you come to the US?)
2. Whom do you commonly talk to or write to during your working hours? (Why do you frequently communicate with them? What do you talk or write to them about?)
3. Can you share any special stories of communication during your working hours (such as talking to colleagues or patients, cultural adjustment, relationship with supervisors, salary and job promotion, immigration and visa application)?
4. Probe individual themes that appear from the 1st focus group interview

Nursing Education and Communication Events

Data collected from the previous interviews will inform questions, such as the following:

1. Please share your stories regarding your nursing education in your home country and in the United States.
2. Can you compare the two country’s nursing education and nursing environment?
3. Can you share any special stories of cross-cultural, clinical communication events you encounter?

Language, Education and Communication Events

Data collected from the previous interviews will inform questions, such as the following:

1. Can you describe your own English ability? To what extent do you feel confident in or used to using English to talk to or write to patients, families, caregivers, or medical colleagues during your working hours?
2. What kinds of nursing education have you had?
3. Can you share any special stories of communication during your working hours?
4. Probe issues of 2nd focus group interview

Working in Home Country vs. U.S. and Communication Events

Data collected from the previous interviews will inform questions, such as the following:

1. Please share your stories about working in your home country. What kinds of nursing job are you involved with?
2. Can you compare working in your home country versus working in the United States (e.g., medical terms, routines, medication, hospital culture, nursing concepts, patient-nurse-doctor relationships, medical systems)?
3. Can you share any special stories of cross-cultural, clinical communication events you encounter?

English programs, Hospital Orientation and Communication Events

Data collected from the previous interviews will inform questions, such as the following:

1. Have you attended any English programs for nursing purposes in your home country or in the United States? Can you describe these English programs? To what extent did they contribute to your clinical communication abilities in the U.S.?
2. Please share your hospital orientation stories. (What was it like? How long did it take? Any specific experiences regarding cultural and communication events?)
3. Can you share any special stories of cross-cultural, clinical communication events you encounter?

APPENDIX G
CONSENT TO BE AUDIO-TAPED

Consent to be Audio-taped and to Different Uses of the Audiotape(s)

With your permission, you will be audio-taped during this research. Your name or personal information will not be recorded on the tape, and confidentiality will be strictly maintained. When these audiotapes are played, however, others may be able to recognize you. To prevent this, the Principal Investigator will transcribe the tapes in a private room and ensure nobody will be around when he/she is making the transcriptions.

The Principal Investigator of my study, __Ya-Yu Cloudia Ho____ will keep the audiotapes in a locked cabinet. These audiotapes will be never played under any circumstances except when the Principal Investigator is making transcriptions.

Please sign **one** of the following statements that indicates under what conditions _____ has your permission to use the audiotapes

I give my permission to be audio-taped solely for this research project under the conditions described.

_____ Signature
_____ Date

I give my permission to be audio-taped for this research project, as described in the Informed memo, and for the purposes of education at the University of Florida

_____ Signature
_____ Date

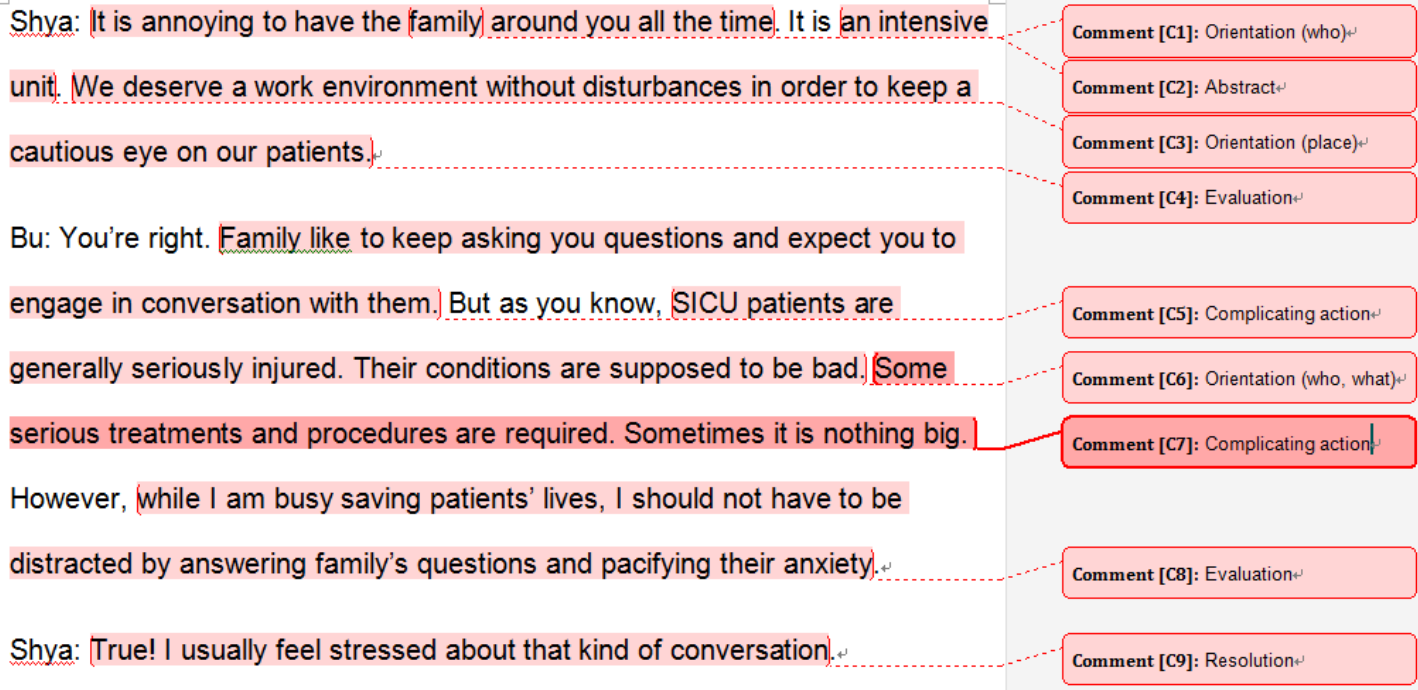
I give my permission to be audio-taped for this research project, as described in the Informed memo; for the purposes of education at the University of Florida; and for presentations at ESOL, language teaching, and science meetings outside the University.

_____ Signature
_____ Date

Ya-Yu Cloudia Ho
Doctoral student in ESOL/Bilingual Education
School of Teaching & Learning
College of Education, University of Florida.
Phone: (352) 870-8143
E-mail: cloudiaho@hotmail.com

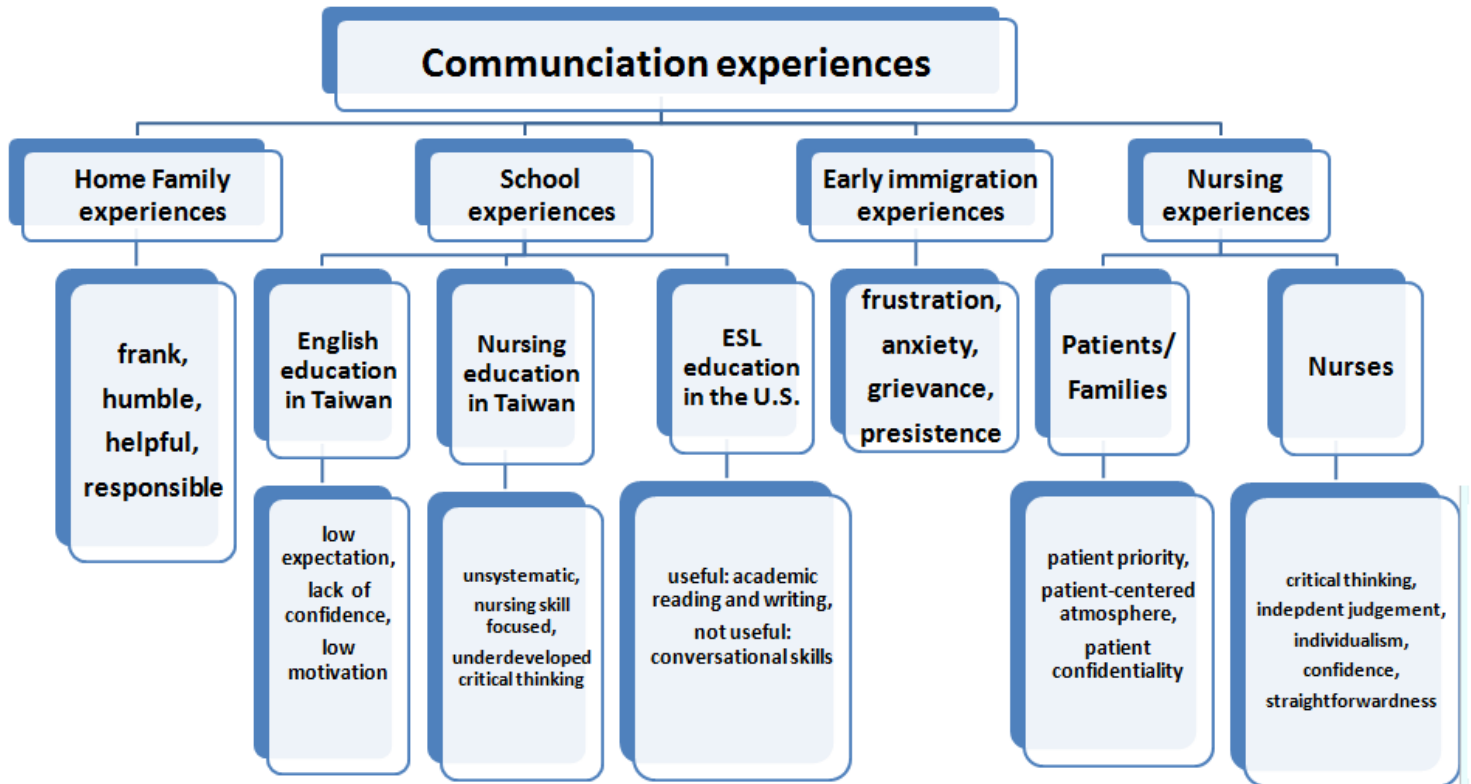
APPENDIX H EXAMPLE OF NARRATIVE ANALYSIS

Data are extracted from 12.29.2010 Shya and Bu, Focus Group Interview



APPENDIX I
EXAMPLE OF THEMATIC ANALYSIS

Codes are extracted from Co's data.



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BIOGRAPHICAL SKETCH

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