

Conscientious and proud but challenged as a stranger: Immigrant nurses' perceptions and descriptions of the Norwegian healthcare system

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Abstract

The number of nurses in Norway educated outside of the European Union is increasing. The purpose of this study is to explore how immigrant nurses, all educated as nurses in their home countries, experience working as a nurse in Norway. The study has a qualitative design with a social constructivist perspective and is based on written narratives from open-ended questions representing 144 nurses from 18 different counties. Two main themes based on patterns from the participants' text were constructed: 'conscientious and proud as nurses' and 'impressed but challenged as strangers'. The findings are discussed in relation to research in cultural understanding. Immigrant nurses contribute with important knowledge and cultural competence to nursing and the Norwegian healthcare system, but there are also challenges. More knowledge is needed in education, research and in individual institutions about the contributions and challenges immigrant nurses bring with them.

Keywords

culture, migration, nursing, social constructivism

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Introduction

Globalization brings the world closer together, which results in both positive and more challenging cultural encounters. Migrating nurses stand between the culture, education and practices of the homeland they are leaving and the culture, education and practices of the country to which they are migrating. Nurses from the Philippines and India are the largest source of foreign healthcare labour for the Organisation for Economic Co-operation and Development (OECD) countries, according to the International Labour Organization.¹ In 2014 there were some 91,583 nurses working in Norway, and of these 3267 were from countries outside the EU.²

Nurses educated in countries outside the EU, like all other health personnel, must apply for certification of their education. In addition to documentation of equivalent nursing education, the Norwegian Registration Authority for health personnel requires migrant nurses to pass a language test and an authorization course in national subjects. The Oslo and Akershus University College of Applied Sciences conducts authorization courses on behalf of the Directorate of Health; the first authors of this article have academic responsibility for these.

The aim of the study was to explore what happens when internationally educated nurses (IEN) from countries outside the European Union (EU) come to Norway to work as nurses.

Background

A social constructivist perspective on culture underlies this study and has a long history referring to the idea that individuals constitute social systems and social systems shape individuals. As argued by Berger and Luckman "Homo sapiens is always, and in the same measure, homo socius".^{3(p. 69)} Our concepts and mental representations over time create institutions and social systems that, so to speak, create the circumstances within which individuals and groups act and think.^{4,5} Another more interpretative angle is that multiple realities are constructed by different groups of people and those constructions have implications for their lives and interaction with others, according to Patton.⁶ Social constructivism from this perspective, emphasizes the importance of culture and context in understanding what occurs in society and in individuals, and of constructing knowledge based on this understanding. Constructivism focuses on the unique experience that each of us experience and perceive, while social constructivism also adds up to a broader understanding of where the

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social space or the fields that surround us have an impact on what we feel and understand.⁵ In relation to this study, this means that the positions that immigrant nurses occupy in the Norwegian healthcare field and their practices and representations both draw on, and are structured by, their former socialization in upbringing, education, profession and country.

Nurse and anthropologist Madeleine Leininger, in particular, is credited with developing the term 'culture in nursing'. She claims that nurses throughout the world possess a set of common core values, but that they have different ways to express them culturally.⁷ This perspective on culture seems to be important for understanding reality as perceived, constructed and interpreted by immigrant nurses working in the Norwegian healthcare system. The following definition of culture is an underlying premise for the study: knowledge, values and behavioural patterns that people acquire as members of society.^{8,9} This entails a kind of mental matrix for acting, since culture comprises a cognitive, an affective and a psychomotor dimension. The point is as much what we see when different cultural expressions are perceived and communicated.⁸ Cultural competence is important for nurses to act in a multicultural context. Based on a literature review¹⁰ this article uses the core components of cultural competence as cultural cognitive, practical and affective competence. Cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural sensitivity are included in this.¹¹ Geert Hofstede has developed a model comprising classification systems for understanding cultural differences. The model is based on research from 72 countries over a period of 30 years. The author discusses individualism and collectivism in relation to vocational affiliation, family structures, norms, language, personality, behaviour, school, workplace, communication technology, ideas and politics.¹²

Studies associated with migration and nursing are primarily obtained from industrialized countries such as Australia, New Zealand, Canada, the USA, England, Germany, the Netherlands and Spain¹³ – the countries to which most nurses migrate. This article does not problematize why the nurses are leaving or what attracts them to another country. Be that as it may, there are several studies about nursing and migration that discuss issues involving the reasons they leave their home countries (push factors), and what attracts them to new countries (pull factors). A qualitative content analysis of 17 articles¹⁴ shows that the motivation behind migration derives from financial, professional, political, social and personal factors; however, financial reasons are frequently the main driver. A Canadian study shows that nurses from the Philippines often feel pressured by their families to get an education as a nurse.¹⁵ A nursing education often provides social status, and educated nurses will also often work abroad in order to support the family financially.

Experiences and challenges about working as an immigrant nurse are present in research. One systematic review of 44 studies¹⁶ shows that foreign-trained nurses encounter different challenges in a new country. The challenges cited are problems related to authorization, communication,

racism, discrimination, underrated nursing competence, differing views concerning nursing practice, cultural change and affiliation with family. The studies refer to language and communication as one of the most common difficulties, one which creates emotional stress, frustration and embarrassment and consequences for patient safety. The language challenges include being misunderstood, misunderstanding, being perceived as slow, becoming 'paralyzed' by stress and social isolation, but are not described as a major impediment to finding employment. One study investigating Chinese nurses in the US found that nurses experienced communication challenges, different and conflicting values and roles, marginalization, inequality, discrimination, transformation through clinging to hope, (un)learning, as well as resilience and cultural dissonance.¹⁷

In one study based on literature review related to Indian nurses who had migrated to New Zealand, the author found migration, education, language, nursing skills, competence, cultural safety and reflection on practice to be key problem areas.¹⁸ Cultural safety has been defined as the effective nursing practice of a person or a family from another country, determined by that person or family, and is viewed as a core competency for all registered nurses in New Zealand, Australia and Canada.¹⁸

One of the studies the literature review refers to discusses how language and prejudices may affect patient safety. The authors had conducted focus-group interviews and individual interviews for both patients and various health professionals from 27 different ethnicities where the focus was cultural racism. The findings show cultural racism in terms of language, religion, habits, norms, dress code and food.¹⁹

A Norwegian literature review concluded that IEN experienced silencing, cognitive fatigue and exclusion and cited the important role nursing management has in providing information, training and creating an inclusive work environment to prevent this.²⁰ Other studies of IEN describe challenges related to communication, exploitation and isolation. These experiences may have an impact on patient care. Nurses from different ethnicities in the US experienced discrimination and shared similar coping strategies.²¹ Two other studies have focused on how IEN experience their lack of informatics knowledge. Challenges due to different perspectives on family care are discussed in another study.^{22,23}

Different models and instruments concerning cultural competence have been developed and used since 1982.¹⁰ Cowan and Norman discuss the term cultural competence and emphasize the importance of introducing this subject into nursing curricula and formal programmes.²⁴ Cultural competence in nursing thus appears to be important in order to ensure respect for diversity, a key attitude in the encounter with the immigrant nurse.

Flynn and Aiken have applied parts of Hofstede's model in their classification of nurses in a quantitative study of 799 nurses.²⁵ They compare various values held by 547 nurses born in the USA with those of 252 nurses from 34 other countries, and found no significant

differences. The results show that there is little difference in the core values associated with nurses from various cultures, but that nurses express cultural differences, such as the fact that nurses from collectivistic countries have lower tolerance for differences and do not value independence in the same manner as do nurses from individualistic countries.

It seems that most studies are primarily focused on the EU, the USA and Canada and these studies mainly refer to challenges. There are few studies encompassing the positive professional and cultural opportunities and competence that cultural diversity can foster. One American study shows that foreign-trained nurses from Asia have benefited greatly from an accreditation course when it leads to greater labour participation and greater probability of being in work.²⁶

Conclusively, this study adds to the current knowledge by investigating the experiences of immigrant nurses in Norway. Furthermore, it aimed to highlight the migrant nurses' understanding of and contribution to cultural competence in the healthcare system. Based on this literature review, our own experiences as tutors in the accreditation course, and increased migration, we decided to focus on the following research questions about how immigrant nurses describe nursing in the Norwegian healthcare system:

1. How do immigrant nurses describe their perception of and encounter with the Norwegian healthcare system?
2. How do the migrant nurses describe their role and function as a nurse in their homelands compared to their role and function in Norway?
3. How do migrant nurses describe their encounters with patients from a different culture than their own?
4. In what areas do migrant nurses experience challenging and difficult encounters with patients in the new culture?

Study design and methodology

This study design focussed on understanding reality as perceived, constructed, structured and interpreted by migrated nurses from different countries outside the EU. The study is mainly based on Patton's view of social constructivism as qualitative inquiry.⁶ This tradition views society as a social and historical construction. In the social-constructionist tradition, acknowledgement of the research participation in all phases of the research process is a key factor. The research process is reflected in this and involves an active effort and creation on the part of the researchers. Furthermore, researchers are expected to both bring and disclose biases to the research.⁶ The inspiration from social constructivism implies that the representations of the migrant nurses are described and explained as both structured by and structuring the social and cultural environment. But it also implies that it is we as researchers who construct the research project, involving choice of questions, respondents, methods, results, etc. Therefore

we create and represent the creations and representations of the participants, as a realistic approach²⁷ in a research work.²⁸

Narrative analysis with a main focus on a constructivist-interactionist perspective was used.²⁹ Interactionism has an assumption that an action or a phenomenon is created through interaction between people or between people and things.³ With this understanding, nursing is understood as phenomenon and as actions that are created in interaction with the surroundings, and is always changing. Thus we analysed the phenomena that emerged when migrated nurses narrated their interactions with the Norwegian healthcare field.

Participants

The participants were recruited through an authorization course in national subjects in May and November 2012. A total of 144 nurses from 18 different countries outside the EU accepted the invitation and participated. Countries in Asia and Eastern Europe were predominant, with respective percentages of 66% and 23% and with an average age of 32 years. The gender distribution was 84% women and 16% men. Most of the nurses had been educated nurses in their homeland two to five years ago and had been evaluated equivalent to the Norwegian nursing education. All participants were working as auxiliary nurses, mostly in elderly care in Norway, waiting for an authorization. We refer to these participants as nurses in the article.

Data collection

The questionnaire consisted of a quantitative and a qualitative section. The qualitative section consisted of open-ended questions on which this article is based. Written texts based on open-ended questions were collected from 144 immigrant nurses. By using so many participants we were able to gather comprehensive feedback. The nurses filled out the questionnaire with open-ended questions in the classroom at the beginning of the four-week course, and the researchers were present to answer any questions that might arise in terms of wording comprehension or other language problems. The participants were given the time they needed.

Analysis

First, texts returned by the nurses were carefully read and reread by the first and the second author by asking the research questions to the text. Through this analysis, recurrent patterns from the participants' descriptions were detected, and words, themes and expressions were discovered. The material was first segregated into three groups: participants from East Asia/Philippines, Eastern Europa/Serbia and others. This made it more expedient to identify meaningful units by writing down expressions used that supported and crystallized into emerging themes. During the reading, we discovered that the text had more commonalities than discrepancies²⁹ independent of

geographical group. Therefore we decided to read the material as a whole and not to divide the texts into geographical groups. This expedited identification of meaningful units in the whole text. The two researchers read and reread individually the whole text and parts of the text, and met regularly to discuss the themes emerging from the text. Gradually, we continued by analysing the texts asking pre-formulated questions, such as: How do the participants perceive, react to and construct their reality about nursing in the Norwegian healthcare system? What is their relation to their earlier role and function as a nurse in the homeland, when working in Norway? Through this, two main themes emerged through a process of discovering nurses' actions and interaction with their surroundings, which underlines the importance of emphasizing that the migrated nurses created narratives in interaction between themselves and the Norwegian healthcare system.²⁹

Ethical considerations

The study was approved by NSD (Norwegian Social Science Data Services) in 2012. Written, informed consent was collected, and all the invited course participants were willing to participate. All participants in two courses were given oral and written information about the study, and it was underscored specifically that they could withdraw at any time and that participation was voluntary, and that they were granted anonymity. As tutors of the courses, we were very committed to ensuring that participants understood the information they received. Several spontaneously expressed that they thought it was positive to be able to participate. Nevertheless it is probably a disadvantage that the researchers were also the teachers in the accreditation course.

Findings

The term 'immigrant nurses' is used as a concept covering some characteristics of the participants: it does not reflect individual respondents but characteristic traits in a general. In this regard, none of the individual informants completely exemplifies the characteristics; on the other hand, all of them will possess a few or several characteristics.

Two main findings emerged from the texts provided by the migrated nurses, based on their perceptions and descriptions of the Norwegian healthcare system.

- Conscientious assisting and proud as nurses (research questions 1 and 2)
- Impressed, but challenged as strangers (research questions 3 and 4)

The most marked finding in the text was derived from the immigrant nurses from another culture and their encounter with the Norwegian healthcare system.

Conscientious assisting and proud as nurses

This construction highlights how the nurses described their role and function as a proud and conscientious nurse.

Recurrent expressions pertaining to traits of a nurse showed patterns that included high work tempo, large capacity, efficiency, dutifulness, and excellent knowledge in natural sciences. The traits also included the role of doctors as well as the role of family member to the patient.

The nurses described themselves as efficient, a characteristic they attributed to their own home country. A work day in the home country consists of shifts at large hospital departments with a very large number of admitted patients and few nurses on the staff. More than 90% of the participants in the study had hospital-based nursing experience; fewer than 10% had work experience from nursing homes.

Expectations of and experiences from being nurses on large hospitals wards included working quickly and efficiently: 'We have to work quickly, fast, and a nurse has to be able to handle stress and be able to act quickly in stressful situations. We must not complain'. Moreover they described that 'A nurse has to be resourceful and have a large work capacity'. The word resourceful frequently occurred in conjunction with statements about being creative. This was often recurrent along with statements about not having proper equipment available, hygienically challenging surroundings or other facts that required the nurses to be creative and to 'make do with what we had available'. The nurses showed two different and partly contradictory patterns in being conscientious and proud: the way the nurses from the Philippines described it – be smiling, humble, an angel – or the way nurses from Serbia described it – determined, strict and serious in their encounter with both patients and colleagues.

Furthermore, the nurses described daily activity as one of dutifulness when executing tasks assigned to nurses by other people. For example: 'Nursing is being an instrument for the doctor's orders'. A nurse reacted to Norwegian nurses whom she perceived as being highly independent: 'Nursing in Norway is doing tasks independently; they don't ask the doctor very often'. The nurses' explanation of work capacity and efficiency was not only based on the workload, but was also attributed to experiences from working in their home country's hierarchical system. The nurses did not only describe the amount of work as a reason for working quickly and being expected to have a large capacity for work, but also on the experience as a nurse in their home country where the system is still hierarchical. The nurses described being accustomed to spending time carrying out procedures and tasks ordered by the doctor.

The nurses in the study were proud of their knowledge, especially in natural science: 'Together with the Norwegian [nurses], who notice the ethical issues, it makes for perfect nursing'. The nurses stated this in connection with a description of their own knowledge of the natural sciences as being superior to that of the Norwegian nurses they have met. Nursing activities were described as being primarily the execution of tasks that are based on a scientific approach to the patient: 'We have much more knowledge in the natural sciences'; 'Nurses in Norway do not have very good knowledge in the natural sciences'. 'We take blood pressures on more than 100 patients every day and we insert

Venflon tubes 100 times a day'. The immigrant nurses described themselves as nurses with sound practical knowledge: 'If the bladder scanner is broken, for example, we can use our practical experience to find out what is wrong'. These nurses stated that most Norwegian nurses do not have practical knowledge. The reason for this, according to the nurses, is that the Norwegian healthcare system is so well equipped with medical equipment that nurses' practical knowledge has become obsolete in Norway.

The nurse's role as a family member emerged from recurrent patterns and descriptions pointing to the relationship to the patient, the relationship to the next of kin/family and how this knowledge was applied. Recurrent words and expressions in this respect were knowledge of the natural sciences, procedures, personal versus professional, family member and family. For example one nurse stated: 'We look at the patient as if he or she is one of our own family members' and she repeated several times 'Our education programme's motto is tender, loving, care'. Moreover, another nurse described: 'It's the family who bring food and who comfort the patient in my home country'. The term 'next of kin', generally speaking, does not occur in our material.

Impressed, but challenged as strangers

Recurrent words and expressions in the material are: well-financed health system, independence for both patients and nurses, language challenges and cultural exclusion.

Immigrant nurses in the study described being nurses in an opulent environment that is both impressive and highly unusual which creates the feeling of being a stranger: 'You [Norway] have a lot of money and a lot of equipment', 'The employer pays for courses and professional development'. The nurses noted that these possibilities were scarcely heard of in nursing practice in the home country. The impression of a well-financed care system, and the fact that the work day, in this view, is largely uncomplicated by a lack of money was also reflected in nurses' perceptions of the working environment: 'In Norway there is a nice atmosphere at work', 'There are lots of breaks and better working conditions'. The nurses stated that they were sometimes sceptical about what they observed in the working environment, for example laziness, which they described as not only foreign, but also to some extent worthy of criticism.

Nevertheless, the immigrant nurses appreciated other aspects of the Norwegian nurses' behaviour: 'Nurses in Norway respect the patient and listen to what they say', and 'Nursing in Norway is doing tasks independently; they don't ask the doctor so often'. They described that this approach towards patients and colleagues was somewhat unfamiliar, and they emphasized that compared to their own culture, their patients and nursing colleagues in the Norwegian healthcare system are very independent. In addition, patients enjoy broad access to information and the right to co-determination.

The results show two particularly challenging areas which are: linguistic challenges in general and racist statements by patients. The immigrant nurses often experienced

that the work day is complicated by linguistic challenges during interactions between patient and nurse: 'I can't find the right words and I am misunderstood' and 'I find it hard to get to know a new culture and language is the most difficult and challenging for me'. Also challenges in interaction with colleagues are present in the material: 'Health personnel in Norway use less Latin than I am used to; they use Norwegian terms all the time'. Further, experiences of racism are present in the material, such as: 'The patients don't have confidence in me' and 'One Norwegian inmate was very racist and she would not accept help from those who were not Norwegian, she said we were poor and stupid and may not be in Norway – it hurts'. The nurses more or less expressed the experience of being rejected by patients, and one nurse asked: 'What do you do when the patient doesn't want you?' The nurses also pointed to two different and contradictory ways of meeting such a challenge: either with a smile and humility, or with seriousness and irritation. One example of such irritation is: 'Norwegian patients can be rude and less open to health professionals, they are specific and have difficulty accepting proposals'. These different ways of meeting these challenges often followed the pattern that eastern European nurses met them with seriousness, and Asian nurses with humility.

Discussion

Critique of methodology

The analysis was congruent with the study's social-constructivist perspective on culture because the participants applied descriptions and expressions from their encounter with the Norwegian healthcare system and from their experience as trained nurses in their home countries. In the course of analysis we remained consciously alert to any dichotomies, ambivalence or other discrepancies in the material (bias).

Research on the cultural understanding of nurses, collectivistic versus individualistic frames of conceptions and cross-cultural perspectives^{8,12,30} was used to discuss how immigrant nurses experience nursing when working in the Norwegian healthcare system. It is important to include the increasing diversity from various foreign cultures and the worldview values which demonstrate that social anthropology, like knowledge and science, has become an important discipline in nursing.^{7,12,25,31} The fact that the nurses in the study were influenced by, and based their descriptions and expressions on, their fresh encounter with the Norwegian healthcare system, as well as on their more-or-less fresh educational background and experience from their home country, coincides with the interactionist perspective of the study and has an impact on the material analysed.

Analysing texts from 144 participants, representing experiences from 18 countries without losing important information has been challenging, and the researchers' ability to understand a broad range of cultural perceptions of nursing competences has been vital. The researchers always tried to include this cultural perspective when analysing the

text. The researchers' role in the authorization course placed them in an asymmetrical power relationship with the informants, which may have resulted in informants not feeling truly free to refrain from participating, and which may also have influenced the informants' responses.

One challenge is that the participants were educated nurses, but worked as auxiliary nurses in the Norwegian healthcare system, which may have affected the results. We are aware of this and bring it into the discussion.

Conscientious assisting

One of the main themes discovered is that of taking pride in being a nurse. Among the characteristics underpinning this we find: rapid work tempo, efficiency, work capacity, dutifulness, humility, and both a pleasant and a terse disposition. How can these expressions be understood based on a collectivistic and individualistic perspective?

The majority of immigrant nurses regard themselves as the doctor's assistant. They react to Norwegian nurses who are perceived as being independent. This is perhaps in line with a collectivistic view involving deep respect for authority, in other words, the doctor. The doctor has traditionally been placed at the top of the Norwegian health sector as well but Norway's modern health system is currently more characterized by individualistic values, egalitarian rights and equality among the various professions.^{9,12,25} Nevertheless, it turns out that in practice, there are still marked dominance relationships and professional hierarchies between the various vocational substrata in the Nordic welfare states.³²

The description of the nurse as a doctor's assistant is not congruent with the International Council of Nurses' (ICN's) definition of nursing as an independent function³³ nor with the common view of nursing in Norway. The immigrant nurses' identification with the role of doctor's assistant may have consequences for the extent to which the nurse can make independent assessments in her encounter with the patient. Might this have consequences for patient safety in Norwegian nursing homes, where the nurses' functional independence is highly significant? These results correspond to those of other studies.¹⁷ It could also be a consequence of the fact that these nurses are working as auxiliary nurses while waiting for authorization and have not found their proper roles as registered nurses.

Hofstede et al. describe behaviour in collectivistic countries as encouraging we-thinking, avoidance of saying 'I', encouraging shows of sorrow, but not joy and using a slower gait.¹² Individualistic societies are characterized by the converse: using a quicker gait, encouragement to say 'I' often, and 'we' infrequently, as well as showing joy more often than sorrow. The characteristic of using a slower gait, however, is not congruent with our empirical material, which shows that efficiency, dutifulness, quick work tempo and the ability to handle stress are typical characteristics of the nurses in the study, who largely come from countries with predominantly collectivistic values. This is an example of how complicated it is to discuss collectivistic and individualistic patterns and the degree to which they

characterize the behaviour of nurses. Might one expect that the migration of nurses from countries outside the EU could bring more dutifulness, efficiency and structure to the Norwegian healthcare system?

Contradictory patterns emerged in the material when some nurses from Asia described themselves as having a smiling and humble manner, whereas the nurses from Eastern Europe described themselves as strict and serious. This reminds us that, in cross-cultural care encounters, an interaction occurs between specific cultures in the process of providing care. Donnelly³⁴ refers to Ray³⁵ when she claims that interaction consists of two components: the one within the diverse population of nurses and the one between nurses and the culturally diverse patients. This may have repercussions for nurses in the Norwegian healthcare system, prompting health managers to include cultural competence in training programmes for their employees. These results also correspond with those from other studies.^{10,11}

The family member

An unexpected, but essential finding showed that the nurses felt like a member of the patient's family. Furthermore, as the nurses expressed this, the personal versus professional role as a nurse differed from how this is managed by Norwegian nurses. Statements describing oneself as a family member of the patient and the way of regarding the patient's family and responsibility for the patient were also different. These findings are consistent with the findings from Alexis and Shillingford's study of the experiences of international nurses in England.²³ To what extent, in Kleinmann's model, does the family-versus-professional sector influence the environment and relationship between the patient and the nurse? Several immigrant nurses described the term 'next of kin' as unknown, but maintained that the family's participation in the patient's suffering is both natural and expected. It is the family that attends to many of the tasks that in Norway, and according to the ICN,³³ are regarded as natural duties of the nurse, for example providing nutrition and comfort. The culture and values underpinning societal structures appear to be highly important for the way the nurse perceives his or her function. This has consequences for the extent to which and the way in which interaction occurs with the patient and next of kin. Cultural differences appear to lay a basis that promotes various values and patterns for the way some of the basic needs of the patient are met. However, the point does not seem to be whether or not the needs are met, but how, and in which sector this occurs. For some nurses, the responsibility for interpersonal needs appears to lie more within the family sector than within the professional sector. One nurse, for example, performs physical care tasks at the nursing home in a conscientious, quick and efficient manner, and when the caregiving is over, the patient's family arrives and relieves her by providing food, comfort and their presence. The presence of family in Norwegian nursing homes is relatively marginal, given the fact that the expectation of public services is to take care of these tasks.

Proud of knowledge

In terms of types of knowledge, it appears that some immigrant nurses place a higher value on scientific, factual knowledge. The practical experience that nurses claim to possess stems from practice in their own countries, in which equipment and medical aids are generally deficient or lacking. Based on this, it appears that some nurses have developed and maintained practical knowledge, for example, in palpating the patient's abdomen to ascertain the amount of urine in the bladder when the bladder scanner does not work. This article's authors do not think that Norwegian nurses are in the process of losing this practical skill, but realize that it is important to maintain this and similar nursing skills, even in a technological world.

Certain studies show that nursing education in Serbia, for example, builds on traditional and out-dated programmes in which 92% of the lectures are given by medical specialists.^{36,37} Serbia joined the Bologna process in 2007 and thus began working on raising the level of nursing education from the upper secondary school level to a bachelor's degree level.³⁸ Some of the nurses react to what they perceive as Norwegian nurses' insufficient knowledge in the natural sciences. The nurses in this study worked primarily in the municipal health services as auxiliary nurses (although having been educated as nurses) where they perhaps did not have the opportunity to observe Norwegian educated nurses' natural science knowledge to the same extent they would have had if they had worked in hospitals. According to this, it nevertheless appears that the nurses mainly performed tasks based on scientific knowledge, a trait that was also relevant and made them proud.

The impressed foreigner

The immigrant nurses seemed to be both positive toward and impressed by the good economic situation, state-of-the-art equipment, available time, the opportunity to develop one's professional competence, and the statutory regulations and rights in the Norwegian healthcare system. The cross-cultural phenomena of using various words and expressions to meet the challenge of racist slurs emerged in this study, as it has in others.^{16,18,19,21} In our study everyone perceived being rejected by patients and being the object of racist remarks as painful. The fact that racist expressions come from patients causes us to wonder whether the foreign and unfamiliar behaviour displayed by the immigrant nurse might be seen as extra threatening by a fragile, elderly patient. Could it be that old people's perceptions about what a nurse should look like and how they should behave are more rigid than those of younger people? Hopefully, cultural competence will soon be acknowledged as an integral part of the scientific knowledge needed for ensuring high quality healthcare in an increasingly multicultural society. Core components of cultural competence are, as mentioned, cognitive, practical and affective competence.¹¹ These perceptions of, on the one hand, being impressed by the Norwegian healthcare

system, and, on the other, feeling like an outsider are important because they exemplify what may be unknown phenomena in nursing in Norway. Acquiring efficient nursing care in transcultural situations irrespective of differences in personal values and views and cultural congruence occurs when the nurse's cultural beliefs and worldview are in conformity with the patient's treatment and care process. In our view, cross-cultural phenomena challenge the need for, and knowledge about, cultural competence in research, education and in nurses' workplaces. It appears conclusively that Norway is facing organizational (e.g. insufficient staffing, etc.) and cultural challenges when it comes to providing comprehensive healthcare in Norwegian nursing homes. The cultural competence possessed by immigrant nurses is important to appreciate. This competence in this study includes cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural sensitivity.¹¹

Conclusion

Throughout time, societies are both formed by and forming individuals and groups, involving institutions in the healthcare sector, social work, education and research. Nursing is institutionalized in most countries, but in the modern society nursing is changing and practiced differently in countries around the world. Further, nurses are travelling abroad to work in different countries. Nursing has changed in an interplay with a broad social and cultural environment and dynamics within the discipline. This is still the case today, where multiculturalism, both inside and outside the healthcare system, is on the rise. Therefore diverse cultural backgrounds are important and relevant to understand both in nursing and in society in general. In nursing education and in clinical practice it is relevant to understand how and why nurses from more or less collectivistic countries act as they do in the Norwegian healthcare system. A greater number of immigrant nurses seem to view the nurse as the doctor's assistant, and to emphasize the importance of natural science knowledge more than other knowledge domains in nursing. Relational competence appears to be viewed more as a personal rather than a professional responsibility for these nurses. Research show that in cross-cultural settings, language skills and cultural understanding are essential for both acting as, as well as being perceived as a competent nurse. Certain contradictory behavioural patterns in immigrant nurses appear to challenge collaboration in cross-cultural situations in clinical practice. Cultural competence in education, research and the individual institution is of great importance in order to ensure quality, safety and patient security in the Norwegian healthcare system.

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Conflict of interest

The authors declare that there is no conflict of interest.

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