INDONESIAN NURSES’ EXPERIENCES OF CARING:  
A PHENOMENOLOGICAL STUDY IN  
A MULTICULTURAL-MULTI RELIGION COUNTRY

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# LIST OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF CONTENTS</td>
<td>2</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>5</td>
</tr>
<tr>
<td>LIST OF FIGURE</td>
<td>5</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>5</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>6</td>
</tr>
<tr>
<td>DECLARATION</td>
<td>7</td>
</tr>
<tr>
<td>COPYRIGHT</td>
<td>7</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>8</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENT</td>
<td>9</td>
</tr>
<tr>
<td>THE AUTHOR</td>
<td>10</td>
</tr>
<tr>
<td>CHAPTER ONE</td>
<td></td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>11</td>
</tr>
<tr>
<td>1.1 Caring in nursing practice</td>
<td>11</td>
</tr>
<tr>
<td>1.2 Sociological and psychological perspective on caring</td>
<td>18</td>
</tr>
<tr>
<td>1.3 Ethical and political perspective on caring</td>
<td>20</td>
</tr>
<tr>
<td>1.4 Culture and caring</td>
<td>21</td>
</tr>
<tr>
<td>1.5 Indonesia, a multicultural and religiously diverse country</td>
<td>23</td>
</tr>
<tr>
<td>1.6 Nursing care in health care system of Indonesia</td>
<td>28</td>
</tr>
<tr>
<td>1.7 Summary</td>
<td>30</td>
</tr>
<tr>
<td>CHAPTER TWO</td>
<td></td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>32</td>
</tr>
<tr>
<td>2.1 First narrative review</td>
<td>33</td>
</tr>
<tr>
<td>2.1.1 Search strategy</td>
<td>33</td>
</tr>
<tr>
<td>2.1.2 Inclusion and exclusion criteria</td>
<td>34</td>
</tr>
<tr>
<td>2.1.3 Data management</td>
<td>35</td>
</tr>
<tr>
<td>2.1.4 Data extraction</td>
<td>42</td>
</tr>
<tr>
<td>2.1.5 Quality assessment</td>
<td>42</td>
</tr>
<tr>
<td>2.1.6 Result of the literature review</td>
<td>43</td>
</tr>
<tr>
<td>2.1.7 Discussion</td>
<td>56</td>
</tr>
<tr>
<td>2.2 Second narrative review</td>
<td>59</td>
</tr>
<tr>
<td>2.2.1 Research on caring in Indonesia</td>
<td>59</td>
</tr>
<tr>
<td>2.3 Summary</td>
<td>62</td>
</tr>
<tr>
<td>CHAPTER THREE</td>
<td></td>
</tr>
<tr>
<td>RESEARCH METHODOLOGY AND METHODS</td>
<td>64</td>
</tr>
<tr>
<td>3.1 The aims of the study</td>
<td>64</td>
</tr>
<tr>
<td>3.2 Methodology</td>
<td>65</td>
</tr>
<tr>
<td>3.3 Sampling</td>
<td>80</td>
</tr>
<tr>
<td>3.3.1 Sampling method</td>
<td>80</td>
</tr>
<tr>
<td>3.3.2 The number of samples</td>
<td>82</td>
</tr>
</tbody>
</table>
## CHAPTER SEVEN

### DISCUSSION

7.1 The barriers influencing nursing care ........................................ 184
   7.1.1 Workload issues ......................................................... 185
   7.1.2 Cultural issues ......................................................... 202
   7.1.3 Spiritual issues .......................................................... 248
7.2 Nurses’ attitude towards patients’ identities ............................. 253
   7.2.1 Describing and stereotyping ......................................... 253
   7.2.2 Cultural and ethnic ties ............................................... 256
   7.2.3 Trying to be fair ......................................................... 257
   7.2.4 Respecting differences ................................................ 259
7.3 Strategies in addressing differences ........................................ 260
   7.3.1 Communication strategies ........................................... 261
   7.3.2 Cultural approach and spiritual support ......................... 263
7.4 Summary .................................................................................. 264

## CHAPTER EIGHT

### CONCLUSION

8.1 Why nurses seem uncaring .................................................... 266
8.2 Study limitations and strengths ............................................. 269
   8.2.1 Limitations of the study ............................................... 269
   8.2.2 Strengths of the study ................................................... 270
8.3 Implication and recommendation ........................................... 271
   8.3.1 Policy and practice ....................................................... 271
   8.3.2 Nurse education ........................................................ 272
   8.3.3 Future research .......................................................... 272
8.4 Summary .................................................................................. 273

### LIST OF REFERENCES

--------------------------------------------------------------- 274
List of Tables

Table 1. Reason for excluding papers ........................................ 38
Table 2. Reason for excluding papers ........................................ 41
Table 3. Demographic data ..................................................... 90
Table 4. Overarching themes of findings .................................. 183
Table 5. Data extraction of first literature reviews ....................... 341

List of Figure

Figure 1. Evidence map of the included studies ......................... 37
Figure 2. Evidence map of the included studies ......................... 340

List of Appendices

Appendix 1. Protocol of approved ethical application ................... 308
Appendix 2. Letter of Ethical approval ..................................... 328
Appendix 3. Participant information sheet (English version) ........ 329
Appendix 4. Participant information sheet (Bahasa version) ......... 332
Appendix 5. Consent form (English version) ............................. 337
Appendix 6. Consent form (Bahasa version) ............................. 339
Appendix 7. Letter of accuracy of the translation of PIS .............. 340
Appendix 8. Interview schedule ............................................. 341
Appendix 9. Confidentiality Agreement ..................................... 344
Appendix 10. Data extraction of first literature reviews .............. 346

Total Word Count 81279 (excluding the references and appendices)
ABSTRACT

INDONESIAN NURSES’ EXPERIENCES OF CARING: A PHENOMENOLOGICAL STUDY IN A MULTICULTURAL-MULTI RELIGION COUNTRY

The concept of caring differs across cultures, being unique to each patient due to differences in culture and context (Wikberg & Eriksson, 2008). Nurses need to maintain awareness of the possibility of culturally diverse behaviour among their patients. Within the hospital community, racial, cultural and religious matters cannot be entirely avoided by nurses. The absence of understanding of specific cultural, religious and spiritual beliefs and customs can lead to inappropriate or unfair treatment of those who are from minority ethnic groups (Samanta, 2012). This cultural and religious awareness is particularly critical in a country with a community as religiously and culturally diverse such as Indonesia. Nevertheless, despite the acknowledged diversity of the patient population, thus far there has been no critical examination of how Indonesian nurses manage caring for patient with the inherent challenges and barriers they experience. The aim of this study is to explore a deeper understanding of the lived experience of Indonesian nurses in caring for patients in a multicultural-multi religious country.

In this interpretive hermeneutic phenomenological study, 20 nurses from two primary health centres and two hospitals were interviewed about their experiences in caring for diverse patients. Data analysis was completed utilising five phases of the hermeneutic circle elucidated by Crist and Tanner (2003) based on a Heideggerian philosophy-based approach. After the data were analyzed, three themes emerged reflecting the essence of what Indonesian nurses experienced: (1) barriers to caring in a heterogeneous society; (2) attitudes towards differences and similarities in patients’ cultural and religious identities; (3) strategies in addressing cultural and spiritual issues.

The findings reveal several barriers: barriers related to cultural issues, barriers related to spiritual issues and barriers related to workload issues. Barriers related cultural issues include family, language barriers, perceptions of illness and treatment, and traditional beliefs. This study indicates four types of attitude towards patients’ diversity. These are describing-stereotyping, feelings of shared cultural ties with people from the same ethnicity or same local origins, trying to be fair and respecting differences. Three strategies were demonstrated in the research, including communication strategies, cultural approaches and spiritual support.

This research enables a deeper insight into caring, particularly in heterogeneous societies. The research highlights how nurses can optimise supporting factors and overcome inhibiting factors in caring for their patients to develop quality nursing care.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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DEDICATION

I dedicate this thesis to the nurses who have offered their time to this research, disclosing their personal life experience in caring for culturally and religiously diverse patients. This research presents a genuine picture of how nurses struggle with multiple barriers to perform caring activities; how nurses devote their energy in order to address the clashes of culture and spirituality which shadow their work.
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CHAPTER ONE
BACKGROUND

This chapter presents the study background of the present PhD thesis. It provides an introduction to nurses’ experiences in caring for patients. This chapter also offers an elaboration of the reasons why it was considered important to undertake this phenomenological study in Indonesia, a multicultural and religiously pluralistic country.

The first chapter begins with an overview of caring in nursing practice; this consists of the concept of caring in nursing science, sociological and psychological perspectives on caring, ethical and political perspectives on caring, and an account of the relationship between culture and caring. It then goes on to describe social culture in Indonesia as a multicultural and religiously diverse country, and lastly, to provide a general review of nursing care in the Indonesian health care system.

1.1 Caring in nursing practice

Nursing is considered both a science and an art developed on the basis of caring (Delaune & Ladner, 2011). The nursing workforce is a key component in the health care system, given that nurses are the largest group of workers providing health services and that those services are provided day and night (Huber, 2006). Much of nurses’ time is spent in caring for hospitalised patients, and nurses have more opportunity to interact with clients than do other health care professionals. Therefore, nurses are in an ideal position to be leaders of patient care (Draper et al., 2008). However, in order to do so successfully, nurses need to be knowledgeable, skilled, and caring (Hunt, 1992).
Many discussions on caring have emerged since the 1950s (Brilowski & Wendler, 2005). Caring has been classified according to a wide range of perspectives by many theorists; these include definitions of caring as a behaviour, an ideal, a process, a value, a phenomenon, a principle, and a core of the body of knowledge in nursing (Procter, 2000). Nevertheless, ‘it is difficult to claim caring as the province of any one professional group or organisation’ (Procter, 2000, p.59) as caring has frequently been defined as a universal activity (Morse et al., 1991) or as a social ideal (Fine, 2007). Caring has been discussed within various subject specialties including philosophy, sociology, psychology, and politics as well as nursing. A brief overview of the different perspectives of caring is included in this chapter.

In their professional practice, nurses often view the term ‘caring’ in different ways (Kuhse, 1997). Although the theory of caring has developed and the number of empirical studies relating to caring has grown extensively, Brilowski and Wendler (2005, p.641) argued that ‘the concept of caring in nursing remains ambiguous’. Conducting a literature search using the keywords ‘nurse’ and ‘caring’ revealed that different researchers use different concepts of caring in their work. It was identified that caring was defined by various scholars as either a technical proficiency or as a nurse’s involvement in patient care as a whole.

Caring, at a philosophical level, is often related to a human moral imperative (Bry kcynski, 1997). Caring has been recognised as being the essence of nursing and the most vital element of nursing practice (Leininger, 1988) in which the aim is to promote human dignity (Watson, 1988). This promotion of caring in the nurse-patient relationship protects patients against ‘being reduced to the moral status of objects’ (Gadow, 1985, p.34) as caring is considered as a way of helping others to grow and practice self-actualisation (Mayeroff, 1971/1990). Caring consists of several levels beyond mere concern for patients; it can be deeply relational, spiritual, and meaningful as one engages in the lives of others (Ray,
Caring, therefore, requires a personal, social, moral, and spiritual involvement of the nurse and a commitment to one’s self and other human beings (Watson, 2012).

Ray (2010) posited that the main component of caring is compassion. Compassion can be seen through ‘doing works of mercy’ involving empathy (Fox, 1979, p.7). According to Ray (2010), Florence Nightingale viewed compassion as doing ‘God’s work’. Compassion may evoke an individual’s awareness of the interdependence inherent in human living (Ray, 2010); that is, people are part of one another and all are in need of each other.

Compassion has been described by Jane Cummings, Chief Nursing Officer (CNO) of England, as ‘Intelligent kindness’ (2012, p.13). Cummings described the so-called 6Cs in nursing and the six areas of action (Department of Health of UK, 2012). These 6Cs are care, compassion, commitment, courage, communication, and competence. The six action areas include helping people to stay independent, maximising well-being and improving health outcomes, working with people to provide a positive experience of care, delivering high-quality care and measuring the impact of care, building and strengthening leadership, ensuring that the right staff with the right skills are in the right place, and supporting positive staff experiences (Department of Health of UK, 2012, p.14).

Further, Cummings (2012) defined compassion as a way to provide care based on empathy, respect and dignity. Thus, compassion involves a consideration of ‘being there’ for others. For Mayeroff (1971/1990), empathy is the essence of caring for other people. It is therefore arguable that due to having a particular role in the provision of nursing care, nurses are expected to unify body, mind, spirit, knowledge and attitude in caring action. Benner and Wrubel (1989) described this as the integration of mind and body, while Sherwood (1991)
noted that nurses should perform dual roles, embodying skilful competence and employing a person-centred approach.

Halldorsdottir (1991) argued that dimensions in true professional caring rely on ‘the depth of attachment developed between nurse and patient’ (p.44). The professional carer contributes positively to the healing process through the ‘psyche of a person’ (p.46) in which the patient is treated holistically, combining body, mind, and soul. Caring therefore, requires personal, social, moral, and spiritual involvement from the nurse, as well as a commitment to oneself and to other human beings (Watson, 2012). Overall, the nurse-patient relationship is developed not only on the basis of fulfilment of the physical needs of patients, rather, it includes the integration of clinical skill and empathy.

Sister Mary Simone Roach (1985/1992) identified five features of caring: compassion, confidence, competence, conscience, and commitment. She added a sixth C, comportment, in the early 1990s. Roach (1992) described compassion as ‘a sensitivity to the pain and brokenness of the other, quality of presence which allows one to share with and make room for the others’ (p.58). It is quite clear that having compassion leads nurses to be empathetic to their patients. Sethi (1997) believed that ‘with compassion one becomes a colleague in humanity’ (p.184). Roach (1992) viewed confidence as a crucial attribute as it can encourage mutually trusting relationships. A confident health worker can assist the patients to cope in difficult circumstances and empower them to achieve their goals (Sethi, 1997). Competence is also important for the caring relationship. According to Roach (1992) ‘while competence without compassion can be brutal and inhumane, compassion without competence may be no more than a meaningless, if not harmful, intrusion into the life of a person or persons needing help’ (p.61). It is therefore arguable that combination of competence and compassion may facilitate the provision of humane nursing care.
Conscience, as part of Roach’s 6Cs, reflects caring in a person who has moral awareness or moral understanding (Roach, 1992). Conscience guides the nurse to respond appropriately to the moral or ethical issues that may arise during nursing care (Sethi, 1997). Roach (1992), described commitment as a ‘complex affective response characterised by a convergence between one’s desires and one’s obligations, and by a deliberate choice to act in accordance with them’ (p.65). Lastly, comportment reflects on the professionalism, self-awareness and responsibility required in the healthcare industry. Comportment relates to the impact that health care workers may have on their patients. To ensure a positive impact, nurses’ behaviour, attitude, appearance, dress and language should all communicate a caring presence.

Roach’s work has been adopted widely in many countries and has been extended by some nursing researchers concerned with the provision of patient care. One example is the concept of the eight Cs of caring for terminally ill patients developed by Pusari (1998). Pusari proposed three Cs beyond Cummings’ original five; these included courage, culture and communication. Cummings also adapted the original 5Cs, adding a sixth, when setting out the 6Cs of nursing. NHS England launched the use of the 6Cs in December 2012 as part of ‘Compassion in Practice, the Vision and Strategy for Nurses, Midwives and Care Staff’ (Department of Health of UK, 2012). Though the strategy has been integrated in the NHS’s vision and mission statement, it is lacking in terms of supporting evidence.

These ‘Cs’ of caring may articulate the values necessary for the provision of excellent nursing care. However, it seems obvious that the attributes of caring are merely a framework of care provision. Political interest in caring seems limited. Caring has typically been undervalued in society, potentially as it is considered as a ‘motherhood’ issue (Morse et al., 1991) or as a universal human attribute (Fine, 2007; Procter, 2000). According to Morse et al. (1991), ‘some
Theorists argue that caring is not unique to nursing because it is embedded in the work that women in Western society do, both inside the home and in the paid labor force (p.119). The historical devaluing of so-called ‘women’s work’ is discussed later in this chapter. Roach (1985) believed caring not to be unique to nursing or other health professions but rather a primary characteristic of being human. While some aspects of caring work in health care have been professionalised within legislative and policy frameworks, caring is often related to assumptions about gender roles and responsibilities (Procter, 2000).

Morse et al. (1991) performed a review of nursing articles describing the concept of care, analysing theorists’ perspectives on caring. The authors identified five conceptualisations of caring. These included caring as a human trait, caring as a moral imperative, caring as an effect, caring as an interpersonal interaction and caring as a therapeutic intervention. Outcomes of caring were categorised as the patient’s subjective experience, the patient’s physical response and the nurse’s subjective experience. Morse et al. (1991) acknowledged that the analysis of the literature on caring was extremely difficult to carry out. This was ‘due in part to the paucity of definitions of caring and a lack of clarity in describing caring’ (p.126).

Similarly, Brilowski and Wendler (2005) examined the evolution of the concept of caring within the context of nursing beginning in 1988. They identified five attributes of caring: relationship, action, attitude, acceptance and variability. They suggested that factors including trust, understanding of self and others, rapport and commitment must be present for caring to occur. According to Brilowski and Wendler (2005), ‘the consequences of caring include an increased ability to heal for patients and an increase of sense of personal and professional satisfaction for nurses’ (p.648). The authors acknowledged the presence of limitations in their review, such as the exclusion of certain seminal works and articles that did not appear in English. As a result, whilst their results may have
enriched the body of knowledge, their findings may have presented an incomplete picture of the evolution of the concept of caring. The inclusion of literature from non-Anglophone countries, and most specifically those from outside the West, is critical to this thesis.

The aim of the present study is not to review the concept of caring. Rather, it focuses on its nurse participants’ experiences of caring for patients. Using a phenomenological approach, this study explores how nurses defined the term ‘caring’ and how their experience in caring for patients informed their everyday work. Benner and Wrubel (1989), who adopted a phenomenological perspective from Heidegger and Ponty, described caring as ‘knowing and being as it fuses thought, feeling and action’ (p.1). Brenner and Wrubel (1989) also noted that caring enables nurses to take note of which interventions are effective, with the nature of caring considered central to the success of most nursing interventions. According to Heidegger (1962), an individual’s essential relation to the world is present in the experience of care. To be is to care. Care means relating to human existence.

According to Cheung (1998), Heidegger viewed caring as the source of the will and the motivating force of human existence. This view is consistent with the human science approach regarding the meaning of life experiences. Human science reflects on the nature or meaning of being in the world. Ray (2010) stated that ‘reflection helps us to understand who we are and how we live in relationship to others and the environment. Reflection also helps us to live in a world where a lot is uncertain and to recognise that life is unfolding as we are living it’ (p.42). It seems that reflection constitutes empathy, previously noted to be the core element of caring action.
The present study follows a similar line of thought to that of previous theorists, arguing that caring is a primary source of human existence. In this study, caring is viewed as a major element of nursing in which nurses are aware of the importance of their bodies, minds, spirit, knowledge and attitudes in establishing a reciprocal nurse-patient relationship.

Discussions related to caring have been presented in the context of various approaches; these include the sociological, psychological, ethical and political perspectives. In providing nursing care, nurses as the frontline members of the healthcare staff may be affected by socio-psychological aspects as well as by their ethical-political environment. As a result, a discussion of these important elements is included in the subsequent section.

1.2 Sociological and psychological perspectives on caring

According to Taylor and Field (2007), ‘instead of focusing on factors within the human body, sociology explores the social contexts in which people live and their relationship to health issues’ (p.22). Fine (2007), in a critique of the emergence of caring as a public concern, clarified the meaning of caring from a broad sociological perspective. He argued that care refers ‘not just to action and activity, but to relationships, value, and attitudes about our responsibility for others and our own being in the world’ (p.4). This implies that the protection of life is a universal responsibility, with caring thus transposed from private concern to public issue. According to Parsons and Smelser (2003) in their study which integrate both economic and social theory, wealth, income and welfare can be attained by an individual through the social systems. Individuals’ welfare, wealth as well as health do not only depend on individuals’ independence, but it also relies on individuals’ social relationships.
Such attitudes can be strongly linked to how we label people or how we perceive certain illnesses, for example stigma about people with leprosy or HIV/AIDS. Stigma was articulated in the 1960s by the sociologist Erving Goffman (Kleinman and Hall-Clifford, 2009). Goffman (1963) explained stigma as a situation when an individual is being discredited and rejected by his/her community due to a stigma attributed to him/her. Care, therefore is understood to be a social ideal. Fine (2007) also noted that the responsibility of providing care and support does not fall to a single individual and that wider social accountability should be acknowledged. Care has also been broadly defined as an aspect of the social role of women or their unpaid responsibility towards their families (Fine, 2007). Accordingly, the relative position of nurses and women in healthcare has been attributed to gendered organisational structures (Procter, 2000, p.78). In health care, patients, as those being cared for, must perform the ‘sick role’ in order to be perceived as legitimately ill. It is the role of healthcare workers, as care-givers, to provide instructions or interventions which must be followed by the patient (Barkan, 2011).

From a psychological perspective, caring has been defined by Hall (1990) as a long-term and enduring series or chain of interactions between two or more people with the objective of protection, prevention, help, support, or alleviation (p.141). It is often accompanied by strong positive or negative emotions. Furthermore, Hall (1990) argued that care is a mutual process, with the carer and the cared-for either actively or passively engaged in the caring encounter or interaction, which may be non-verbal, verbal, or behavioural. Treatments or interventions, when occurring alongside care, are embedded in a matrix of far more numerous care events, often of greater personal meaning to the cared-for (Hall, 1990).
Hall (1990) described care in a psychological sense by positing four components of the interpersonal encounter: first, a set of beliefs or philosophies which guide care, second, a set of goals or objectives which enable specific goals to be set for a caring act, third, a set of practices and acts which emphasise what actually happens in the caring encounter, and fourth, the emotions and feelings which accompany care.

1.3 Ethical and political perspectives on caring
Ethics, linked to morality, are considered crucial to an understanding of the essence of caring. Collins (2015) argued that caring attitudes are shaped by moral values. Further, Tronto (2013) noted that caring practices involve the interrelation between thought and action. According to Collins (2015), care ethicists present the following general claims: ‘that responsibilities derive directly from relationships between particular people rather than from abstract rules and principles; that deliberation should be empathy-based rather than duty-based; that personal relationships have a moral value’ (p.5).

Caring practices were described by Iphofen and Poland (1998) from a political point of view. The authors defined politics as power, noting that in order to care for others, people must have power and authority: ‘anyone who works in healthcare systems has to learn how to recognise, acquire and use power, both for themselves and for their clients’ (Iphofen & Poland, 1998, p.18). Such power is believed to be required in order to work effectively within healthcare. Political issues relating to caring are often associated with the gender issues previously discussed. Procter (2000) stated that ‘the position of nursing within health care, it is argued, mirrors the positions of women in society. A change in the status of nurses in health care will only come about if it is accompanied by a change in the status of women in society’ (p.75).
Overall, the above concepts and theories of caring appear to be linked and supportive of one another. Several close links were also found between these components of caring and the themes identified in the literature review performed as part of the present study. This brief overview of the concept of caring in nursing underpinned the author’s understanding of the concept of caring.

1.4 Culture and Caring

Whilst the term ‘culture’ has been variously defined in the literature, the present study uses the term as defined by Leininger, McFarland and Ray. Culture has been defined as encompassing the social and structural elements in society including kinship, religion, politics, law, economics, technology, ecology, and health care (Leininger & McFarland, 2006; Leininger, 1991). A later view presented culture as ‘dynamic complexity which is a foundation for co-creating cultural unity within diversity’ (Ray, 2010, p.13).

It has been noted that cultural aspects need to be taken into account in the provision of nursing care. Human caring which values cultural diversity may avoid subjective assumptions regarding patients’ behaviours, beliefs or values. Ideally, nurses would identify what patients do, say or think as being part of their culture (Henley & Schoot, 1999). Therefore, in order to enhance others’ wellbeing through knowledgeable caring actions, Ray (2010) agreed that caring requires an understanding of the holistic aspects of the patient, including body, mind, spirit and human relationships, as well as the cultural differences between nurses and their patients.

Moreover, Pergert et al. (2008) concluded from their study that in order to ensure the provision of high-quality care, healthcare staff would need to overcome obstacles to transcultural caring relationships. According to Leininger’s (1988) theory, human caring is derived from a cultural perspective.
Leininger’s theory was based on her premise that people of different cultures not only know and define the ways they experience and perceive their nursing care, but also relate these experiences and perceptions to their general health beliefs and practices. This concept allows nurses to be aware of the similarities and differences in health care and nursing practices within diverse cultural contexts and societies (Omeri, 2008). Wikberg and Eriksson (2008) noted that the concept of caring differs across cultures and is unique to each patient due to differences in culture and context. Thus, nurses ought to maintain an awareness of the possibility of culturally diverse behaviour among their patients in order to maintain a holistic approach to caring with respect for the uniqueness of each patient, including their culture, beliefs or customs.

A lack of understanding of specific cultural, religious and spiritual beliefs and customs can lead to inappropriate or unfair treatment of those who are from minority ethnic groups (Samanta, 2012). Within the hospital community, racial, cultural and religious matters cannot be entirely avoided by nurses. Accordingly, members of the health care team who are not indigenous to the area in which they work need to apprehend and accept the values, customs, and beliefs of the patients and staff members with whom they are working (Sampson, 1982). Ray (2010) suggested that, in a multicultural society, ‘nurses must examine both good and harmful patterns of behaviour and choose to seek understanding of the meaning of differences in cultures and negotiate change toward a new order’ (p.13). Similarly, Cortis and Kendrick (2003) suggested that cultural awareness is of great importance to nurses in establishing the nurse-patient relationship. This cultural and religious awareness is particularly critical in a country with a community as religiously and culturally diverse such as Indonesia. Indonesian nurses might encounter challenges every day as they work with their particularly diverse patient set.
Based on the studies reviewed, it can be summarised that caring is a means to providing nursing care. Quality nursing care is achieved through the provision of holistic care, where nurses show concern for the bio-psycho-social-cultural-spiritual aspects of their patients’ health. Nurses are aware of differences in health care beliefs among those of different cultural or spiritual backgrounds, particularly in heterogeneous populations. An understanding of patients’ cultures and spirituality is believed to contribute to the implementation of holistic care. Nurses have attempted to create some strategies to provide qualified nursing care and to avoid unfair treatment of patients. Such issues are discussed further in the literature review.

1.5 Indonesia, a multicultural and religiously diverse country

Indonesia is a pluralistic nation consisting of various ethnic groups, religions and languages. This pluralism is intertwined in one Indonesian nation as a whole and sovereign nation. The unity of the Indonesian nation is based not only on its socio-cultural, geographical and historical background, but also on the unification of the various viewpoints, ideologies and philosophies of life across the nation. The views, ideologies and life philosophies of the Indonesian people are holistically reflected in the principles of Pancasila, which form the basis of the Indonesian state; the unity of the Indonesian nation’s views, ideologies and life philosophies are explicitly stated in the symbol of the country which reads Bhinneka Tunggal Ika, which means ‘unity in diversity’ or ‘We are of many kinds [ethnicity, religion, language], but we are one [Indonesian]’ (Statistics of Indonesia, 2011). This motto is a founding principle of the modern Indonesian nation and declares the essential unity of its members despite its ethnic, regional, social and religious differences (Memory of Majapahit [online], 2014). Indonesian pluralism is one of Indonesia’s national treasures, and it is possessed by few other countries. Each ethnic group in Indonesia has its own special customs and culture which constitute its identity (Statistics of Indonesia, 2011).
Pancasila as the foundational philosophy of the Indonesian state (Dasar Negara). Pancasila was promulgated by the first president of Indonesia, President Soekarno, in 1945 to unite the diverse archipelago of Indonesia into one state. Soekarno declared Pancasila to be a philosophy of Indonesian indigenous origin that he developed under the inspiration of Indonesian historical philosophical traditions. The term Pancasila derives from the Sanskrit language and consists of two roots: Panca, meaning ‘five’; and Sila, which translates as ‘principles’. These five principles are: 1. Ketuhanan yang Maha Esa (“Belief in the one and only God”); 2. Kemanusiaan yang adil dan beradab (“A just andcivilised humanity”); 3. Persatuan Indonesia (“A unified Indonesia”); 4. Kerakyatan yang dipimpin oleh hikmat kebijaksanaan dalam permusyawaratan perwakilan (“Democracy, led by the wisdom of the representatives of the people”); and 5. Keadilan sosial bagi seluruh rakyat Indonesia (“Social justice for all Indonesians”). These philosophical elements embody a harmonious society based on religious tolerance, humanity, unity, democracy and social justice (Bajoria, 2011).

Indonesia is known as an archipelagic country. It is located between the two continents of Asia and Australia and between the Pacific and Indian Oceans. In terms of geographical position, Indonesia’s boundaries are as follows. In the north, it is bordered by Malaysia, Singapore, the Philippines, and the South China Sea; in the south, by Australia and the Indian Ocean; in the west, by the Indian Ocean; and in the east, by Papua New Guinea, Timor Leste, and the Pacific Ocean. Indonesia is the largest archipelago in the world; it consists of 17,504 islands, of which 6,000 are inhabited. Two of the islands are shared with other nations: Kalimantan (known in the colonial period as Borneo, the world’s third largest island) is shared with Malaysia and Brunei, and the province of Papua shares the island of New Guinea with Papua New Guinea. Indonesia has 33 provinces spread over five main islands and four archipelagos. These are Sumatera Island, the Riau Archipelago, the Bangka Belitung Archipelago, Java
Island, the Nusa Tenggara Archipelago, Kalimantan Island, Sulawesi Island, the Maluku Archipelago and Papua Island (Statistics of Indonesia, 2013).

The number of ethnic groups in Indonesia as a whole is more than 1,300. The sizes of the populations of each ethnic group vary greatly. Javanese people are scattered around almost every territory of Indonesia, with a population of 95.2 million people constituting approximately 40.0 percent of the Indonesian population. Other ethnic groups, such as the Bantik, Wamesa, Una, Lepo Tau and Halmahera have a population of fewer than 10,000 people. In general, Indonesian ethnic groups are determined based on the paternal line (father/male), for example, the Javanese, Madurese and Batak tribes. However, there are several ethnic groups in Indonesia that follow maternal (mother/female) lines, such as the Minangkabau tribe (Statistics of Indonesia, 2011).

Before the growth of official religions in Indonesia, the various tribes in Indonesia believed in animism and dynamism. Animism refers to the belief that objects on this earth, such as the sea, trees, and forests, have souls that must be respected. Dynamism is the worship of ancestral spirits. Animism and dynamism are considered as the oldest part of Indonesia’s religious history, falling in the period before the advent of the six religions of Indonesia (Haris, 2013). Though animist and dynamist beliefs are considered to belong to primitive civilization (Haris, 2013) and have existed for many generations, even in the modern era some ethnic groups in Indonesia still believe in animism and dynamism; these include the Buru, Bauzi, Toraja, Tengger, and others. There are approximately seven million members of the Dayak tribe in West Kalimantan who continue to hold animist beliefs (Haris, 2013). Some of the Buru tribes in the Maluku Archipelago also maintain traditional beliefs that worship things and spirits. The highest God for Buru is called Opo Hebe Snulat and his trusted messenger is
Nabiat. However, some of the Buru people have adopted modern religions such as Islam and Protestantism.

On Java Island, animism and dynamism are still actively practiced by certain groups of Javanese. Their belief is called Kejawen or Javanism, which is a Javanese religious tradition that amalgamates animistic, Buddhist, Hindu and Islamic beliefs. Kejawen followers practice their beliefs with such traditions as tapa (meditation), fasting, animistic worship and other rituals. Animism, dynamism and Kejawen beliefs are not recognised as religions in Indonesia; in 1973, the Indonesian government determined these beliefs to be part of Kepercayaan kepada Tuhan Yang Maha Esa, or ‘Belief in One Mighty God’. Because they are classified as beliefs (Kepercayaan) and not religions, they fall under the jurisdiction of the Ministry of Education and Culture rather than that of the Ministry of Religion (Lee, 1999). Thus, in the modern era some segments of the Indonesian population still hold strongly to their ancestral heritage and may not be interested in modern life. This can clearly affect the relationships between health staff and patients and their families who continue to practice their ancestral religious customs. Some patients might prefer to consult a shaman or other traditional healer instead of a physician or a nurse, and some people might choose to use herbal remedies rather than modern medicine. In certain situations, their beliefs might run contrary to the health treatments that are prescribed by medical staff, which are influenced by modern scientific ideas and technology.

Given the cultural diversity in Indonesia, culture clashes might emerge between two individuals who have different ethnicities and customs. Such a culture clash may occur between nurses and patients who have different cultural identities or between nurses who do not share the same ethnicity. This affects nurse-patient therapeutic relationships as well as the professional relationships among nurses. Therefore, it is important to explore the ways in which cultural diversity in
Indonesia influences nurse-patient connections, as well as to consider whether cultural difference affects nurses’ attitudes as they care for their diverse patients.

Indonesian pluralism is clear not only from its variety of ethnic groups, but also from the diversity of religions adopted by the population. Indonesia has six official religions. Based on information from Statistics of Indonesia (2011), the representation of religious groups in Indonesia is reflected in the following percentages: Islam 87.18%; Protestant 6.96%; Catholic 2.91%; Hindu 1.69%; Buddhist 0.72%; Confucianist 0.05% and ‘Other’ 0.13%. Indonesia is the world’s most populous Muslim nation. However, it is not an Islamic state. Indonesia does not adopt political Islam, nor does it proclaim Islam as its official religion. As the first *Sila* is belief in the one and only God, atheism might have no place in Indonesia. The first *sila* was criticised by The International Humanist and Ethical Union (IHEU) as it does not provide a right to atheism. People who do not identify with any of the official religions of Islam, Catholic, Protestantism, Buddhism, Hinduism, and Confucianism might experience discrimination in Indonesia (Osman, 2012).

The atmosphere of a harmonious religious life in heterogeneous communities with various religious backgrounds exists because of the tolerance of the people who respect others’ differences. Various socio-cultural activities in Indonesian communities, such as mutual cooperation (*gotong royong*) activities, are carried out jointly by all members of the community regardless of class, ethnicity or religion (Statistics of Indonesia, 2011). It is also common for places of worship to be built adjacent to each other. People with different ethnicities, religions and languages can live together peacefully and respectfully.
The tolerance of different religions in society is supported by the Indonesian government’s commitment to guarantee the freedom of every citizen to embrace religion according to his or her own beliefs; this commitment is explicitly stated in Undang Dasar 1945, the 1945 Constitution, Article 29, Paragraph two, which reads: ‘The State guarantees the independence of every citizen to embrace their religion and to worship according to their religion and belief.’ However, several religious conflicts have emerged between followers of different religions or among the followers of certain religions. For instance, in the past two decades, Indonesia has experienced several conflicts among religions triggered by the dissatisfaction of minorities and provoked by certain social organisations in Indonesia (Nahrowi, 2006). The inter-religiously Harmony Forum (FKUB) was established to build dialogue among religious leaders, accommodate the aspirations of religious organisations and communities, and give recommendations to the government about the feasibility of erecting places of worship (Nahrowi, 2006).

Religious tensions that sometimes arise in certain regions and communities might affect religious tolerance at the national level. Social media and technology contribute to the rapid spread of information regarding any conflicts that may exist in a particular region. Religious conflicts that occur in certain regions may have an effect on the lives of people in other diverse regions. It is therefore pertinent to consider whether the attitudes of nurses and other health staff towards religious diversity is affected by religious tolerance in other regions. The current study also investigates nurses’ attitudes toward this religious diversity itself.

1.6 Nursing care in health care systems of Indonesia

The number of hospitals in Indonesia is 2,776. This number includes 2,198 public hospitals and 578 specialty hospitals. There are several classes of hospitals including VVIP, VIP, first class, second class and third class, which may be chosen
according to patients’ preferences. The number of primary health centres (PHCs) in Indonesia is 9,825, including 3,454 with inpatient services and 6,371 with outpatient services only. There are 3,410 PHCs that provide traditional health services; health workers in these PHCs are trained to prepare traditional concoctions and to provide acupuncture and acupressure (Kementerian Kesehatan Republik Indonesia, 2017). In 2017, the number of health staff in Indonesia reached 1,143,494 and the number of nurses was 345,276. According to former Minister of Health Nafsiah Mboi (2014), the ratio of the number of nurses to the number of people in Indonesia is sufficient. However, the distribution of nurses throughout Indonesia may be unbalanced. Nurses are generally inclined to work in big cities rather than in the countryside.

Generally, Indonesian communities use a PHC (called *Puskesmas*) as their basic health care provider. The PHC provides first-level services and focuses on health promotion and the prevention of ill health. A primary health centre is located in each sub-district, providing access to health professionals including a doctor, nurses, and midwives. A patient can be referred to the hospital from the health centre if further intervention is needed.

As Indonesia is a multicultural, multi-religious country, nurses in all regions may experience caring for patients with beliefs, ethics, customs, values and norms that differ greatly from their own. The diversity in Indonesian society as a whole may affect the Indonesian nurses’ delivery of human caring for patients having the same or different cultures and religions. Therefore, Indonesian nurses ought to provide nursing care and an atmosphere that reflects respect for the cultural values, customs and religious sensitivities of the client group (Indonesian National Nurses’ Association, 2000).

On the basis of several published studies which are presented in Chapter Two, it has been noted that in a multicultural society, nurses might encounter a variety
of challenges in caring for patients of differing cultures. However, these studies were undertaken in multicultural societies in which indigenous nurses cared for patients from immigrant communities or those from minority ethnic groups. Nurses’ experiences in a multicultural, multi-religious society where indigenous nurses and indigenous patients come from a variety of cultures and religions remain largely unknown to date.

Therefore, given the diversity of patients for whom nurses in Indonesia are expected to care, it seems pertinent to consider how such diversity is experienced in nursing work and how the nurses themselves understand these experiences. Tension may arise during the provision of nursing care for diverse patients, and this may also affect nurses’ feelings about caring for certain individuals. The question as to whether Indonesian nurses are capable of caring for patients from all backgrounds despite the obvious challenges and barriers to doing so remains unexplored; investigation into the nature of such challenges and barriers themselves is also required.

1.7 Summary

The importance of this study derives from several aspects of the issues that it considers. Firstly, on the basis of the literature review in Chapter Two, it appears that all relevant previous studies of nurses’ caring experiences had been conducted in heterogeneous populations but were focused on caring for patients from immigrant and minority ethnic groups. Though numerous studies on nurses’ experiences of caring can be found in the literature, most have been conducted in Europe and the United States. Such studies are very different in character to the present study. This study was conducted in a heterogeneous population of indigenous nurses and patients with very diverse cultures and religions. Indonesian inhabitants share a nationality but have diverse backgrounds in terms of ethnicity, religion, customs, and local languages. The major differences between the heterogeneous population of Indonesia and the
populations of Western countries would likely result in different responses to diversity.

Secondly, it has been suggested by Watson (2012) that ‘a serious study, reflection, action, and searching for new knowledge and new insight are required to discover new meanings and understanding of the person and human caring process during health-illness-healing experiences’ (p.38). Thus, a study of caring for patients in a multicultural, multi-religious country such as Indonesia is useful in that it is capable of providing deeper insight into caring, particularly in heterogeneous societies. Thirdly, both hospitals and primary health centres will be able to use the present study’s results to optimise supporting factors and overcome inhibiting factors, thus providing an improved environment to enable nurses to best implement caring behaviour.
A review of evidence in the available literature of caring in nursing practice, particularly in multicultural and multi-religious societies, was carried out to assimilate the information objectively and to reach new insights on the topic of caring. A literature review has a pivotal role in accessing the latest ideas and information on any topic. Undertaking a literature review means investigating and examining appropriate literature (Aveyard, 2007). A systematic method was applied in this review, using a critical appraisal tool. It is noted that critical appraisal skills enable people to interpret evidence, to determine the quality of research evidence and to decide the suitability of the evidence presented in a published paper for their own work. In the area of health care, investigating the strengths and weaknesses of previous research findings allows a researcher to determine whether the evidence found is valid and useful for health care practice (Young & Solomon, 2009).

Given the range of databases used for the literature review and the specificity of the research focus, that of nurses’ caring experience in heterogenous populations a narrative review approach was considered to be the most appropriate method. It is acknowledged that the lack of a systematic search in selecting and appraising evidence might cause bias and diminish the trustworthiness of the review (Egger et al., 2003). Narrative reviews are more interpretive in nature, informing about and providing new perspectives on the current state of an issue (Uman, 2011). It has also been argued that narrative reviews play an important role in interpreting and describing up-to-date knowledge (Rother, 2007). The intention of the present literature review was to establish the field of study to which the current research would correspond, to identify any gaps in the body of knowledge within the synthesised papers.
examined, and to address the gaps by means of performing the research presented in this study. The literature review was conducted to address the question: ‘What are nurses’ experiences of caring for patients in a multi-cultural and multi-religious society?’

This chapter offers the results of the literature review in two sections. The initial section of this chapter outlines a first review that was performed using a systematic method. This first section consists of an explanation of review’s search strategy, the inclusion and exclusion criteria applied, specifics of data management, data extraction, and quality assessment, results of review, and a discussion of narrative review. The second section of this chapter consists of a review of studies on caring in Indonesia that are related to findings of present study.

2.1. First narrative review

2.1.1 Search strategy

This review was undertaken on the basis of a comprehensive and systematic approach by screening articles through databases and hand searching (snowballing). Studies reviewed were identified through an online search of four databases, namely CINAHL, PsycINFO, Web of Science, and Google Scholar.

Although discussion about caring in nursing practice has been taking place among renowned theorists such as Watson and Leininger since the 1970s, this review includes newest published articles. Seminal articles and monographs on caring were considered important to enhance my understanding of caring in nursing practice; these were presented in chapter one above. The reviews of the seminal works are not included in this chapter as process of review only focused on current studies. Relevant articles from reference lists in retrieved studies were also analysed in order to find secondary studies that met inclusion criteria (snowballing or hand searching).
2.1.2 Inclusion and exclusion criteria

In advance of the in-depth analysis of this review process, articles were screened through both abstracts and full texts. A comprehensive search method and clear inclusion criteria contribute to mitigate selection bias (Aveyard, 2007; Rumrill & Fitzgerald, 2001). The search was performed by combining the following key search terms:

(nurses’ experiences of caring OR nurses’ perception of caring) AND (cultural diversity OR ethnic diversity) AND (religious diversity) AND (multicultural society) AND (multi religion society).

Inclusion criteria were:

1. Studies which examined nurses’ experiences of caring;
2. Studies in which the participants were nurses;
3. Studies which were conducted in heterogeneous populations;
4. Studies undertaken in either hospitals or the community;
5. Studies employing qualitative, survey quantitative or mixed methods;
6. Studies printed in English. From the databases in the first review, the author did not find published studies about caring in the Indonesian language (Bahasa Indonesia). However, several studies on caring in Indonesia can be found in Indonesian journal papers and dissertations which are not available online. Therefore, I reviewed the Indonesian literature when I returned to that country for data collection; information on these works is presented in the second review in this chapter.
7. Studies published between 2000 and 2018, in order to gather data from the newest published articles.
Exclusion criteria were:

1. Studies which were not relevant to topic being reviewed;
2. Studies which did not present a discussion of nurses’ encounters with the diversity of patients in multicultural and multi-religious society;
3. Literature review-based studies.

2.1.3 Data management
The initial literature review in this study was undertaken towards the end of 2014 and early 2015, which included papers published between 2000 and 2015 and considered 18 papers (see figure 1). Then, prior to PhD submission in 2018, I undertook a further literature search to discover any new papers in this area which gave rise to a further five papers (see figure 2).

The initial literature search was undertaken from December 2014 to May 2015. A total of 299 published studies were retrieved. The articles were screened to identify whether the studies fitted the inclusion criteria. On the basis of a detailed reading of the abstracts, out of 299 retrieved papers, 274 studies were excluded. Of these 274 excluded studies, 271 were eliminated based on focus and/or language, and four were excluded because they were duplicates.

Out of the 24 remaining relevant articles, ten papers were removed from consideration. A study by Forssell, Torres, and Olaison (2013) was excluded as the authors did not provide information regarding the educational background of the study’s participants. The participants were health care professionals, but the study did not specify whether the participants were nurses, physicians, or other health workers. One study by Kirkham et al. (2012) was likewise excluded as the study employed patients, family members, and administrators as participants, whereas the current review aimed specifically to capture nurses’ experiences. Three studies by Tay, Ang, and Hegney (2012), Rytterstrom, Cedersund, and Arman (2009), and Yam, Rossiter, and Cheung (2001) were
excluded as the studies did not explain caring in the context of a culturally and religiously diverse population. Five studies by Morse et al. (1990), Arritt (2014), Blackford (2003), Daly and Lewis (2000) and Josipovic (2000) were also excluded as the studies were literature reviews. Screening the reference lists of the 14 remaining studies led to the identification of four further papers. A total of 18 articles were therefore included in the in-depth review. The evidence map of relevant studies is depicted in figure 1. The reasons for excluding papers are illustrated in table 1.
Figure 1. Evidence map of the included studies

Articles retrieved
(n = 299)

Eliminated based on focus and/or language
(n = 271)

Duplicates
(n = 4)

Included studies
(n = 24)

Excluded
(n = 10)

Retained studies
(n = 14)

Included studies from snowballing
(n = 4)

Included studies for in-depth review
(n = 18)
### Table 1. Reason for excluding papers

<table>
<thead>
<tr>
<th>Reasons for exclusion</th>
<th>Studies excluded</th>
<th>Number of studies excluded</th>
<th>Number of studies retained (from 24 studies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not provide educational background of participants</td>
<td>Forssell, Torres, and Olaison (2013)</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Involved patients, family and administrators as participants</td>
<td>Kirkham et al. (2012)</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>Does not explain caring for culturally and religiously diverse patients</td>
<td>Tay, Ang, and Hegney (2012); Rytterstrom, Cedersund, and Arman (2009); Yam, Rossiter, and Cheung (2001)</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Literature reviews</td>
<td>Morse et al. (1990); Arritt (2014); Blackford (2003); Daly et al. (2002); Josipovic (2000).</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>10</strong></td>
<td><strong>14 retained</strong></td>
</tr>
</tbody>
</table>

Four additional studies were gathered from reference lists and included. Thus, a total of 18 studies were included in the original review.
Then, prior to thesis submission, a total of 41 further published studies were retrieved. The papers were screened to identify whether studies fitted the inclusion criteria. On the basis of a detailed reading of abstracts, out of 41 retrieved papers, 19 studies were excluded. Of these 19 excluded studies, 18 were eliminated based on focus and/or language, and one was excluded because of duplication.

Out of the 22 remaining relevant papers, 17 papers were removed from consideration. Six studies were excluded as the studies employed patients, family members, and administrators as participants, whereas the current review aimed specifically to capture nurses’ experiences. Those were studies by Higginbottom et al (2015), Ebot (2014), Ahaddour and Broeckaert (2018), Lucchetti et al (2016), Balakrishnan and Claiborne (2017), Saleem et al (2018). Seven studies by Sharma and Kirkham (2015), Napier et al (2014), Cooper and Chang (2016), Cura (2015), Eastwood et al (2016), Shelley (2015), and Ware (2017) were excluded as the studies did not explain caring in the context of a culturally and religiously diverse population. Four studies by Ahmed et al (2016), Bassett and Baker (2015), Brunger (2016) and Johns et al (2018) were also excluded as the studies were literature reviews. A total of five papers were therefore included in the in-depth review. The evidence map of relevant studies is depicted in figure 2. The reasons for excluding papers are illustrated in table 2.
Figure 2. Evidence map of the included studies

- Articles retrieved (n = 41)
  - Eliminated based on focus and/or language (n = 18)
    - Duplicates (n = 1)
  - Included studies (n = 22)
    - Excluded (n = 17)
      - Included studies for in-depth review (n = 5)
Table 2. Reason for excluding papers

<table>
<thead>
<tr>
<th>Reasons for exclusion</th>
<th>Studies excluded</th>
<th>Number of studies excluded</th>
<th>Number of studies retained (from 22 studies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved patients, family and administrators as participants; did not include nurses as participants</td>
<td>Higginbottom et al (2015); Ebot (2014); Ahaddour and Broeckaert (2018); Lucchetti et al (2016); Balakrishnan and Claiborne (2017); Saleem et al (2018)</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Does not explain caring for culturally and religiously diverse patients</td>
<td>Sharma and Kirkham (2015); Napier et al (2014); Cooper and Chang (2016); Cura (2015); Eastwood et al (2016); Shelley (2015); Ware (2017).</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>17</td>
<td>5 retained</td>
</tr>
</tbody>
</table>

A further five studies were included in the literature review prior to submission of the final thesis. Thus, a total of 23 papers were included for the in-depth review.


2.1.4 Data extraction
The author extracted all relevant data provided in the included studies. The data extraction presented a broad overview of the included papers. In this process, the author performed the extraction of the relevant data and the interpretation of the synthesised studies concurrently. The results of the data extraction are provided in Appendix 1.

2.1.5 Quality assessment
A number of critical appraisal tools exist to aid in quality assessment. These include CASP, SURE, AMSTAR, and PRISMA. However, in the current review, studies that met the inclusion criteria were assessed for methodological quality using criteria from the appraisal tool developed by Hawker et al. (2002). There are two reasons why Hawker and colleagues’ appraisal tool was chosen to assist in the assessment of the methodological quality of the studies included in this literature review. Firstly, Hawker and colleagues’ tool enables researchers to conduct a systematic review of studies that involve a variety of research methods (Hawker et al., 2002). The tool is thus suitable for all qualitative and quantitative studies included in this review. Secondly, Hawker and colleagues’ tool provides continuum criteria to categorise empirical studies into four ranges: good, fair, poor, and very poor. On the basis of the continuum criteria, I can determine the quality of each study reviewed. By contrast, CASP tools provide separate checklists for each type of study and can therefore not compare studies that utilised different methods.

The quality criteria in Hawker and colleagues’ assessment tool address the rigour of nine components: abstract and title, introduction and aims, method and data, sampling, data analysis, research ethics and bias, findings/results, transferability/generalisability, and implication and usefulness. Based on the evaluation of these components, studies are rated ‘very poor’, ‘poor’, ‘fair’ or ‘good’ on the provided scale with scores ranging from 10 to 40 (10 = very poor;
20 = poor; 30 = fair; and 40 = good). However, in the assessment process, no studies were excluded based on the resultant quality ratings because the findings in the included studies were considered necessary as part of the review process. A description of the first review on the basis of the appraisal tool by Hawker et al. (2002) is provided in Appendix 10. Subsequent to the initial review, the studies were re-read to synthesise the data gathered and to attain a detailed understanding of their findings, theories and concepts. The interpretive reading of the themes chosen resulted in the following section.

2.1.6 Results of the literature review
On the basis of the research reviewed, six themes emerged from the synthesised studies, these are, communication problems, cultural issues, attitudes toward diversity, and problem solving, minority nurse experience and culturally competent care. These themes were generated from the analysis process of reviewed studies.

Communication problems
Language barriers appear to be the major concern in caring for diverse patients in multicultural societies. Several studies examined this concept and argued that nurses encounter communication challenges when interacting with patients and families from backgrounds that differ from their own. The presence of language barriers results in limitations in the conversations between health staff and patients and their families. A phenomenological study undertaken by McCarthy et al. (2013) about conversation across barriers of language and interpretation, which scored 20 on Hawker and colleagues’ tool (hereafter HT), stated that nurses felt that the communication process between themselves and their patients was often strained and that conversations were limited. Consequently, the nurses had difficulty to assess the patients’ needs. The study made use of good inclusion criteria to establish good samples for the study. This study involved nursing students in a post-registration BSc nursing studies programme.
in Ireland. The participants had 30 years of working experience in different settings across the health services spectrum within Ireland’s South-West region. Seven nurses volunteered to participate in the study. The data were elicited from only one region in Ireland. Thus, the findings might not represent nurses’ experiences in Ireland as a whole.

According to a quantitative study carried out by Ayaz et al. (2010), differences in dialect and pronunciation were considered as a major issue encountered by nursing students in providing care for patients with different cultural backgrounds in Turkey. The study was good in rigour as it had a high HT score of 40. The study used a questionnaire adopted from the Transcultural Assessment Model (Giger & Davidhizar, 2002). The questionnaire was pre-tested to determine the validity and reliability of the data collection tool. The study involved 622 senior undergraduate nursing students from three Turkish universities that shared a similar curriculum. Due to the significant number of participants and the study’s broad scope, the results of the research might be representative of nursing students’ experiences throughout Turkey.

Communication problems, then, increase the likelihood of undelivered messages and misunderstandings. When nurses and patients do not share a common language, the patients cannot express their concerns to the nurses. As a result, nurses are unable to provide appropriate support to the patients. This finding was generated by Jirwe et al. (2010), who studied nursing students’ experiences of communication in cross-cultural care in Sweden; the study scored 40 on the HT. The qualitative investigation was conducted using a framework analysis approach and employed ten final-year nursing students as participants. The students had experience in clinical education in multi-cultural settings and were able to speak English and Swedish. Thus, the results might parallel the literature regarding communication in cross-cultural care encounters. The first author, as interviewer, was a nursing lecturer but was not involved in teaching any of the
participants. The problem of power distribution between the nursing students as interviewees and the author as interviewer might have arisen. This circumstance might affect the students’ responses to the questions in the questionnaire. Their responses therefore, might not reflect their true answers.

Additional resources are considered necessary to solve the communication challenges in nursing care of patients and families in multicultural settings. Two phenomenological studies included in the present literature review were concerned with the use of interpreters. These studies were carried out by Nielsen and Birkelund (2009) and by Jones (2008). In both studies, formal or informal interpreters were considered essential in providing care for patients in culturally diverse societies as the interpreters help to facilitate nurse-patient communication. However, the presence of interpreters might also lead to problems. It might become a barrier to nurses’ engagement with the patients and could result in inadequate implementation of holism. A study which earned an HT score of 30 (Jones, 2008) examined emergency nurses’ caring experiences with Mexican-American patients and emphasised the accuracy of translation as a major concern in nurse-patient relationships, particularly when using a telephonic interpreting service. Concerns about the accuracy of translation and the lack of personal contact were considered to influence the care relationships. This qualitative study was poor in rigour as the study involved only five nurses as participants and took place in a single location with a low Hispanic population as compared to the national population.

A phenomenological study by Nielsen and Birkelund (2009), which aimed to explore nurses’ experiences of caring for patients from minority ethnic groups in Denmark and scored 30 on the HT, identified that nurses perceived that involving family members as interpreters could be problematic as the family might uncover issues that related to themselves. Another major concern was the intimate nature of some healthcare conditions, especially in cases in which the
patient is a parent of the interpreter. In addition, family members may not translate what has been said, but rather what they think the patient wants to hear. However, Nielsen and Birkeland (2009) found that nurses considered the presence of family members as interpreters to be particularly helpful when patients were admitted at night and it was not possible to contact an interpreter immediately. Although this study employed both interview and observation to gather the data, it involved a very small sample size consisting of four nurse participants. Hence, the findings might not reflect the experiences of other nurses in Denmark. It seems that the two studies described above supported and agreed with one other. The studies depicted their nurse participants as primarily concerned with two things: the accuracy of information delivered by the interpreters and the impact of using interpreters. Overall, it is clear that nurses experience communication challenges in the provision of caring for their patients in culturally diverse settings.

Cultural issues
The studies considered in the present literature review consistently reported that nurses were aware of the prevalence of cultural and spiritual issues in nursing when caring for patients with cultural and religious backgrounds different from their own. Four studies identified concerns among nurse participants regarding the roles of patients’ families. In the studies undertaken by Cioffi (2005) and Ekblad et al. (2000), it was revealed that family involvement was considered important in health care. Ekblad and colleagues (2000), whose study of cultural challenges among hospice staff in Stockholm scored 30 on the HT, noted that gaining an understanding of a family’s culture could enable the nurses to attain useful information regarding the reasons for which patients from minority cultures might respond to their illnesses differently to patients from the host culture. Nurses viewed family as playing a positive role in hospice care. Similar conclusions were also reached by Cioffi (2005), who studied nurses’ experience of caring for patients from culturally diverse backgrounds in acute
care settings in Australia. According to Cioffi (2005), nurses perceived family involvement as an essential resource in the provision of health care. The presence of family can eliminate the feelings of loneliness that patients experience. In a grounded theory study conducted by Cortis (2004), nurses also acknowledged that the presence of families was important to help meet certain patient needs such as personal hygiene and privacy.

The abovementioned studies support each other in the assertion that family involvement is of great import for nurses providing health care. Three of the studies maintained rigour in the analysis of data and earned high HT scores. While the settings and data collection methods employed in the studies were different, the studies all maintained the trustworthiness of data. The analysis of data from focus groups interviews of 19 participants in Ekblad and colleagues’ study (2000) was carried out thoroughly. The researchers returned to the hospice staff members to check the accuracy of the data gathered. Similarly, the studies by Cioffi (2005) and Cortis (2004) were both assigned HT scores of 40. Cioffi’s study (2005) also performed a final validation that involved five out of the study’s ten participants. The validity and reliability of data were also maintained by Cortis (2004). The participants were involved in transcription checking, and a colleague was asked to independently check the codes identified.

A different result was identified in a participatory study conducted by McKinley and Blackford (2001). The study, which investigated nurses’ experiences in caring for families from culturally and linguistically diverse background when they have lost a child, identified that family involvement creates distressing events. The nurses had difficulties working with patients’ families. For instance, when a discussion about a patient’s prognosis was called for, the family preferred the presence of extended family. Although a private room had been prepared for the discussion, the room was unable to accommodate the whole family. This study’s
results appear to contrast with those of the two studies discussed above. While the participatory method employed in the study allowed the nurses to become co-participants in the study, a limitation was found in this study. Namely, with such a small sample size (six nurses in one paediatric intensive care unit), the study might not reflect the nurses’ experiences of caring for patients from culturally and linguistically diverse backgrounds in different settings. The study is less rigorous than the three studies by Cioffi (2005), Cortis (2004) and Ekblad et al. (2000) as McKinley and Blackford’s study earned a relatively low HT score of 20. Generally, the nurses perceived that families had an important role in providing health care for the patients. However, the presence of extended family might create a distressing situation for nurses.

Two additional studies also took up the issue of family visitation. In the studies by Nielsen and Birkeland (2009) and by Jones (2008), it was identified that family visits to patients in hospital could involve many relatives at one time. Nielsen and Birkeland (2009) found that nurses perceived this phenomenon in different ways. When families came and brought food for the patients, some nurses viewed it as a good idea, while other nurses argued that the food’s smell might be annoying to other patients. The nurses also reported that when many relatives come into one room, it was bothersome to other patients. Similarly, this phenomenon was discussed in Jones’s study (2008). One nurse informed the researcher that many people (families) usually visit the patients.

Issues surrounding gender in nursing also arise in connection with some patients. These phenomena were reported in two studies. Nurses reported that some members of certain ethnic groups consider men to be superior to women. It was also expressed by nurses that male family members were often impolite to the nurses as the male family members only respected the male doctors to the exclusion of other health staff members. Englund and Rydström (2015), in their grounded theory study which scored 40 on the HT, involved health care
professionals who cared for children with asthma who came from immigrant families. The majority of the participants were nurses (11 of 17 total participants). The two authors participated in the entire process in order to enhance the trustworthiness of the data.

Similarly, in their study about intensive care nurses’ experiences with families from various cultural backgrounds in Norway, which scored 30 on the HT, Hoye and Severinsson (2008) indicated that their nurse participants had reported that the patriarchal opinions prevalent in some families from minority backgrounds affected their attitudes towards nurses. The nurses in the ICU felt that their role was considered to be subordinate, particularly when the nurses perceived a lack of respect from members of diverse ethnic groups. With 16 nurse participants in a multi-stage focus group interview, this study maintained rigour by using verification strategies such as using a strict recruiting procedure, providing summaries of previous meetings of the focus groups, and performing peer debriefing of the data. However, the possible dominance of one head nurse involved in a multi-stage focus group might affect others in the expression of their views. Regarding the gender issue, in a study by Cortis (2004), nurses argued that patients from ethnic minority groups in the UK preferred to be cared for by nurses of their own gender because of their spiritual beliefs. These related particularly to the patients’ need for help in meeting personal hygiene needs.

Another cultural issue that emerged in the study of Birkelund (2009) and Hoye and Severinsson (2008) related to the ways in which patients responded to disease and coped with dying. Nurses experienced incidents with patients and families who engaged in loud expressions of pain and grieving. Nurse participants informed Nielsen and Birkelund (2009) that the patients had ‘ethnic pain’ (p.434). The patients from minority ethnic groups in Denmark often expressed their pain more strongly than the majority population. This caused a dilemma for the nurses as they were unable to assess whether patients were in
as much pain as they seemed to be expressing. Nurses also needed to anticipate the fact that loud expressions of pain could be irritating to other patients. A similar finding was reported in the study carried out by Hoye and Severinsson (2008), in which nurses perceived the issue of how patients respond to their illnesses as comprising two challenges: challenging conversations with families from minority cultural backgrounds and challenges in preventing distress.

Dietary needs were also acknowledged as a cultural and spiritual issue for nursing in a multicultural society. Two studies reported nurses’ awareness of particular dietary requirements among patients who come from some ethnic groups. In a quantitative study about providing transcultural care for children and parents (Festini et al., 2009) which scored 20 on the HT, nurses reported that eating habits and breastfeeding patterns were regarded as a problem for immigrants in Italy. Hospitals have strict rules and provide insufficient food choices for people of some cultures. Patients from some ethnic groups were also reported to have refused human breast milk provided by hospitals from donors, even in cases when the babies needed it. As this study was carried out using a quantitative approach with 129 nurses as respondents, it examined only the frequency of problems in providing care, but did not measure the quality of the problems encountered by nurses. A problem with dietary requirements also appeared in another study. According to Cortis (2004), nurses reported that Pakistani patients, who are members of a minority ethnic group in the UK, required certain foods as they were vegetarians. Nurses perceived that special dietary needs might affect the provision of nursing care as the patients might need more variation and nutrition than the hospitals were providing.

**Attitudes toward diversity**

It is noted from the studies reviewed here that nurses have a variety of attitudes towards diversity. Their positive and negative responses may arise when nurses encounter patients who might be different from themselves. Four studies
concluded that most nurses show positive responses to the diversity of patients for whom they cared. Two studies about caring in multicultural society in Australia (Cioffi, 2005; Cioffi, 2003) found that nurses showed themselves to be flexible, empathetic, respectful and willing to try to reduce marginalisation. Flexibility was usually shown in accommodating family involvement. Both studies were undertaken rigorously. Using sufficient sample sizes of 23 and 10 participants, respectively, Cioffi (2005, 2003) involved the participants in the process of verifying the themes that emerged. In Cioffi’s study (2003) about acute care nurses’ experiences caring for patients with culturally and linguistically diverse backgrounds, bilingual health care workers were involved in reading the findings in order to establish the credibility of the study.

Similarly, a phenomenological study about nursing people from different cultures in Ireland conducted by Tuohy et al. (2008) emphasised that nurses demonstrated an awareness of ‘being understood and being able to understand’ in terms of both language and cultural sensitivity, thereby enhancing care (p.167). A similar finding was presented by Ekblad et al. (2000). In this qualitative study, nurses argued that an awareness of one’s own culture enriches nurses’ understanding of others’ cultures. The two studies concurred that nurses showed a concern for cultural sensitivity.

However, two studies by Hoye and Severinsson (2008) and Vydelingum (2006) found that nurses respond negatively toward patients from culturally diverse backgrounds. Nurses reported that nursing procedures were hindered by the crowding of family members in wards and corridors, creating a stressful situation (Hoye & Severinsson, 2008). Similarly, in the grounded study of nursing experiences in caring for patients of South Asian ethnicity in England (Vydelingum, 2006), focus group interviews with nurses revealed that the participants perceived the relatives of ethnic minority patients as ‘deviants and a nuisance’ as they often asked many questions and stayed much longer in the
wards than other patients’ families (p.27). In this qualitative study, an adequate sample size and maximum variation sampling were demonstrated. Forty-three nurses volunteered to participate in the study. However, information regarding the rigour of the study was not reported. Based on the review process, both studies discussed here focused on only one aspect of cultural differences, which was the behaviour of patients’ relatives.

Overall, this review indicates that nurses respond differently in providing nursing care for their culturally and spiritually diverse patients. They might have either positive or negative attitudes towards patients from cultural backgrounds that differ from their own. However, cultural awareness overall does appear to be a concern for nurses working with patients with various cultural backgrounds.

**Problem solving**

Three studies revealed that nurses attempted to deal with the communication problems that may stem from diversity. Studies carried out by Jones (2008) and Nielsen and Birkelund (2009) found that interpreters became a main channel for overcoming communication problems. However, a phenomenological study conducted by Cioffi (2003) suggested that multiple communication strategies might need to be developed when caring for patients from minority linguistic groups; these strategies might include involving family members, bilingual nurses if available, and the use of charts, signs or body language. The studies support one another in positing that nurses ought to use all available resources to facilitate nurse-patient communication and thus maintain the continuity of care.

It appears that the availability of relevant resources on clinical areas, such as translators or interpreters is considered significant in improving nursing care for people from various cultures (Tuohy et al., 2008). In addition, in two studies by Jirwe et al. (2010) and Cioffi (2003), nurse participants described situations in
which they had to make deliberate efforts to facilitate communication, for instance, when an interpreter was not available. In order to prepare for such cases, the nurses reported that they preferred to learn a few key words and phrases in their patients’ languages.

A grounded theory study by Berlin et al. (2008) aimed to develop a theoretical explanation of primary child health care (PCHC) nurses’ assessments of health risks in children and parents of ‘foreign origin’ in Sweden (p.118). Face-to-face interviews with 15 PCHC nurses revealed that nurses generally applied active and/or passive strategies to establish relationships with the parents. The active strategies performed included home visits and more frequent contacts. Nurses attempted to create trust and improve their relationships with the parents. The nurses also actively collected information from organisations that had contact with the children and parents such as day nurseries, family centres and social services. Passive strategies such as a ‘wait-and-see strategy’ (p.123) were also employed. The nurses believed that the children’s health improved with time. The fit between data and theory was tested and the theoretical model was validated by the participants in the study. Overall, the studies reported that the nurses generally used several strategies to surmount the problems that might arise during the provision of health care. The strategies were used to establish both nurse-patient and nurse-family relationships.

**Minority nurses’ experiences**

A qualitative study undertaken by Keshet and Popper-Giveon (2016) explores ethnic minority Arab nurses’ experiences of caring for patients in Israeli public hospitals. Nurses convey a number of career advantages of the nursing profession, such as job security, professional development and promotion. However, nurses also experience challenges associated with their personal identity as an ethnic minority. They perceive Israeli patients stereotype minority Arab nurses; for example, patients were seen to give a disapproving glance at
nurses, refuse to be cared for by Arab nurses, and demonstrate unfriendliness and hostility towards them (Keshet and Popper-Giveon, 2016). Therefore, their study recommends policy makers to take action to overcome the difficulties encountered by ethnic minority Arab nursing staff in hospital in order to optimize the working environment (Keshet and Popper-Giveon, 2017).

Ethnic minority Arab health professionals perceive healthcare settings as egalitarian working places, where medical knowledge and practice are relatively impersonal and universal. Despite this supposed ethos of neutrality, the nurses are reported as being subject to discrimination and racism from Israeli patients (Keshet and Popper-Giveon, 2017). Their study demonstrates that the ethos of neutrality in health service and tensions related to ethnicity are relevant to the work of ethnic minority health practitioners (Keshet and Popper-Giveon, 2017).

**Culturally competent care**

Education and training related to cultural competence has been shown to be important in a multicultural environment. Four reviewed studies (Debesay et al., 2014; Jirwe et al., 2010; Cioffi, 2005; Ekblad et al., 2000) described the need for education or training in cultural competence. Most of the nurses interviewed admitted that their education had been inadequate in terms of training them to provide nursing care for culturally diverse patients. A phenomenological study conducted by Debesay et al. (2014) in Norway, showed that most community nurses expressed a perceived need for opportunities to develop their skills in working with heterogeneous patient groups in the hospice care setting. This study aimed to explore the challenges encountered by community nurses in nursing patients from ethnic minority groups in Norway. The study included 19 community nurses from four city districts in Oslo and employed semi-structured in-depth interviews. A qualitative study by Ekblad et al. (2000) also reported that the majority of hospice staff interviewed considered it important to learn about cultural issues in a multi-cultural society and believed that this would become
even more crucial in the future as the diversity of patients’ cultural backgrounds was expected to increase.

These findings were supported by a quantitative study by Lim et al. (2004) that aimed to investigate nursing students’ self-efficacy in providing transcultural care. According to the results, the students demonstrated the lowest perception of self-efficacy in the cognitive domain, as compared with the practical and affective domains. This study indicated the importance of theoretical education and clinical experience in providing transcultural care in order to establish nursing students’ self-efficacy with their patients. Of the 199 nursing students who participated in the study, 109 were first-year students and 90 were fourth-year undergraduate nursing students. The transcultural self-efficacy tool (TSET) was utilised as a questionnaire to collect the data. SPSS was employed in the data analysis process. While the data analysis followed the statistical approach, the fact that the participants’ lecturer was involved in supervising the completion of the questionnaires might have affected the findings of the study.

An ethnography study undertaken by Fortin and Maynard (2018) in three Canadian paediatric hospitals reveals that the recognition of diversity between health practitioners, patients and members of family, is considered vital to diminish conflict that might emerge in the pluralist space of a hospital. Fortin and Maynard (2018) view hospitals as a place of cultural mixing, conflict and recognition. The process of healing, hope and loss all take place in hospitals. Diverse values and norms constantly interact among the hospital community. Hospitals also serve as a place of negotiation between health care providers and patients and family. Therefore, an understanding of diversity is crucial in hospitals (Fortin and Maynard, 2018).
A descriptive qualitative study conducted by Abudari et al. (2016) that investigates non-Muslim nurses in caring for terminally ill Muslim patients indicates three factors affected nurses’ lived experiences, including cultural values, religious practice and family matters. Their study also found that in the nurses’ experience, the availability of staff members’ in palliative care is crucial. Abudari and colleagues’ study (2016) also demonstrate that nurses have a lack of cultural understanding, a general lack of awareness of cultural differences and that formal cultural education is frequently not provided. Therefore, Abudari et al (2016) emphasise the importance of the provision of cultural education in the nursing curriculum to enhance culturally competent care.

A qualitative study undertaken by Mollah et al (2018) indicates that cultural competencies are of importance for all health practitioners and in all health settings, either in rural or urban area. They interviewed 20 mental health professionals, including counsellors, psychologists, psychiatrists, nurses and social workers, all of whom cared for immigrant patients in Australia. Mollah and colleagues’ study (2018) reveals health practitioners understand cultural competence. However, cultural competences are applied differently within different professions, health settings, localities and years of work experience. A health professional’s own cultural background and cultural experiences affect different methods of operationalisation of cultural competence (Mollah et al., 2018).

2.1.7 Discussion
The synthesised studies described nurses’ experiences and perspectives regarding nursing care for patients from culturally and religiously diverse backgrounds. It is noted that in a multicultural population, an understanding of patients’ verbal and nonverbal communication is important (Leininger & McFarland, 2002) to maintain the quality of the care provided (McCarthy et al., 2013). Some strategies are considered important to enhance nurse-patient
communication; these include ensuring the availability of hospital interpreters, involving patients’ family members as interpreters, and using additional resources, such as charts, signs and body language. It may appear obvious that nurses and patients feel more satisfied when they can communicate well with one another, thus supporting the use of interpreters where there are difficulties in verbal communication because of the inability to speak each other’s language. However, the presence of a formal interpreter may result in a dilemma. Interpreters can in some cases become a barrier to the development of a nurse-patient therapeutic relationship and inhibit nurses from obtaining information about patients’ cultures, which are particularly pertinent in terms of their health care beliefs (Nailon, 2006).

A number of issues relating to cultural knowledge arise in the provision of health care. The need for understanding the cultural aspects of patients’ backgrounds, including the manner of responding to the situation of illness, particular dietary needs, family involvement, gender issues, perceptions of treatments and religious practices. This means that nurses need to acknowledge that their ability to understand patients’ cultures influences the effectiveness of communication (Nielsen & Birkelund, 2009). Nurses should be aware of health practices in other cultures to promote health and well-being (Snyder & Naiska, 2003), which in turn enables them to accept the variety of behaviours that may stem from differences in cultural background.

Cortis (2004) pointed out that an inadequate understanding of patients’ cultures and spirituality leads to a limited implementation of holistic care. Quality nursing care is achieved through the provision of holistic care. Nurses should view each patient as a whole human being who comprise many aspects, biological, psychological, social, cultural and spiritual. Based on their considerations of each of these facets, nurses can accept each of them and respond positively to both the patient and the situation.
Education or training in order to enhance nurses’ capability to provide equitable nursing care might be important in some situations. Cultural competence enables the health care staff to be more receptive to and more flexible with patients from diverse cultural backgrounds. However, cultural and spiritual knowledge is not always obtained through formal education or training. It is possible for nurses to learn on their own through their interactions and their experiences with patients from culturally and spiritually diverse backgrounds.

The possibility of dominance on the part of a particular member of a focus group interview was found in two studies (Hoye & Severinsson, 2008; McKinley & Blackford, 2001). In the study by Hoye and Severinsson (2008), the possible dominance of a head nurse involved in focus group interviews might have affected others in their expressions of their own views. In the study by McKinley and Blackford (2001), the first author’s presence as a participant might have influenced the discussions in the focus group sessions. In addition, the findings in four studies might not be capable of representing the lived experience of all individuals due to their small sample sizes in single locations with small populations in comparison to the national populations of the countries in which the studies took place. These studies were carried out by McCarthy et al. (2013), Nielsen and Birkelund (2009), Jones (2008), and Tuohy et al. (2008).

The application of quantitative methods in three of the studies on caring made it impossible to offer further descriptions of the results. The researchers were not able to explain why certain variables affected other variables. Hence, a qualitative approach is considered the best approach when investigating human lived experiences as this approach enables researchers to obtain richer and deeper information from the individuals participating in the studies.
The differences in the heterogeneous populations in Indonesia and in Western
countries might result in nurses responding differently to the diversity they
encounter. Indonesian inhabitants share the same nationality but have very
diverse backgrounds in terms of ethnicity, religion, customs, and local language.
Indonesians live together in diversity. However, the dynamism of life in
Indonesia may sometimes lead to tension.

Most of the studies reviewed were concerned with cultural issues. Spiritual
aspects were scarcely discussed in the research. The studies were conducted in
multicultural populations and particularly related to immigrant and minority
societies; as such, these studies were very different in character from the
present study. Thus, this study of caring for patients in the multicultural and
religiously diverse country of Indonesia is expected to improve the insights of
nurses around the world, particularly in settings with heterogeneous
populations.

2.2 Second narrative review
2.2.1 Research on caring in Indonesia
The review of Indonesian literature on nurses’ experiences of caring in Indonesia
was based on information obtained from two sources. These sources were
journal papers garnered from an online search and master’s dissertations from
the University of Indonesia, which are not available online. When I returned to
Indonesia to undertake data collection, I visited the central library of the
University of Indonesia to access dissertations about caring in Indonesia. My
reason for choosing the University of Indonesia to obtain academic papers or
dissertations related to nurses’ caring experiences was that the University of
Indonesia is the oldest in the country as well as the first university in Indonesia
to offer a master’s degree from a Faculty of Nursing as well as a major in nursing
management that would provide the opportunity for studies related to
experiences of caring in nursing settings in Indonesia. Master’s students in the
Faculty of Nursing at University of Indonesia generally come from all regions in Indonesia. Research on caring is often carried out by master’s students in their regions of origin; thus, the available studies on caring represent descriptions about caring around all areas in Indonesia. Due to time constraints, I did not visit other university libraries in Indonesia. These, too, might provide dissertations related to the topic of caring. This constitutes a limitation of the present literature review.

This second search for literature resulted in the location of two journal papers and nine dissertations on the subject of nurses’ experiences of caring for patients in Indonesia. The majority of the studies were undertaken using quantitative methods. Only one study was conducted using a qualitative approach, and it was a grounded theoretical study. Six out of 11 of the reviewed studies included nurses as participants, four studies involved patients as participants, and one study involved both nurses and patients as participants. As stated in the first review of the present study, this literature review excluded studies that did not involve nurses as participants, therefore, only seven studies met the inclusion criteria. Brief descriptions of those studies are presented in the following paragraphs.

A grounded theory study conducted by Dedi and colleagues (2008) found seven themes related to nurses’ caring behaviours in one hospital in Bandung, Indonesia. The nurses’ concerns were, the fulfilment of patients’ needs, responsibility for the fulfilment of patients’ needs, friendliness and hospitality, calm and patience while helping patients, readiness and willingness to help patients, providing patients with motivation, and empathy for patients and their families. Dedi and colleagues (2008) suggested the importance of the development of a culture of caring behaviour among nurses with the assistance of continuing education and effective direction and supervision.
A quantitative study investigating the relationship between performance factors and nurses’ caring behaviours in Abepura Hospital in Jayapura, Indonesia (Walli, 2013) indicated that there is a significant relationship between performance factors (including job design, perception, attitude and motivation) and nurses’ caring behaviours. The most influential factors were job design and attitude. A quantitative research paper (Koswara, 2002) explored the correlation between nurses’ caring knowledge and nurses’ caring attitudes in a public hospital in Tasikmalaya, Indonesia. The author found a significant correlation between nurses’ caring knowledge and their caring attitudes.

Though many of the nurses’ personal characteristics, including age, gender, marital status and length of work experience were investigated, only gender appeared to be a factor affecting caring attitudes. This study demonstrated that male nurses had more caring attitudes than female nurses. The author posited that males are more likely to express their opinions, including articulating their attitude regarding the questions contained in the questionnaire about caring attitudes (Koswara, 2002).

Sobirin (2006) conducted a cross-sectional study on the correlation between workload and motivation and nurses’ caring behaviour in a public hospital in Subang, Indonesia. The results indicated that nursing workload and motivation both have a significant correlation with caring behaviour. Nursing workload was considered to be the dominant factor in the application of caring behaviour among nurses. The author suggested that nurse managers need to determine the factors that might influence nursing workload, thus providing nursing staff with the opportunity to offer more compassionate care to their patients (Sobirin, 2006).
A similar quantitative study conducted by Supriadi (2006) demonstrated a significant relationship between job characteristics, including the emotional meaningfulness that the nurses experience at work, autonomy and feedback, and the implementation of caring behaviour. The meaningfulness experienced in their professional practice was concluded to be the most pertinent factor in the implementation of caring behaviour among the nurses interviewed (Supriadi, 2006).

2.3 Summary

The first review includes 23 studies consisting of 20 qualitative studies and three quantitative studies. The studies took place both in hospitals and in the community (primary health centres). Most of the studies were conducted in Europe (Denmark, Ireland, Italy, Norway, Sweden, Turkey and the UK). Nurses and nursing students were involved as participants in the studies. On the basis of the reviewed studies, six themes emerged from the synthesised studies which were communication problems, cultural issues, nurses’ attitudes toward the diversity encountered, problem solving, minority nurse experience and culturally competent care. The reviewed studies were conducted in multicultural populations, with particular attention to patients from minority groups and with immigrant backgrounds.

The second narrative review is a review of Indonesian literature on nurses’ experiences of caring in Indonesia. Seven studies using Bahasa Indonesia were involved in this review as they met the inclusion criteria. The second review was conducted in Indonesia while I undertook my data collection. This review involved journal papers gathered from an online search and master’s dissertations from the library of the University of Indonesia, which are not available online. Based on reviewed studies, it appears that nurses recognised the importance of various values of caring, such as empathy, readiness, hospitality, calm, patience and fulfillment of patients’ needs. Nurses considered
that workplace conditions and nursing workload influence their capability to apply caring values in their daily practice. Nurses also acknowledged the importance of cultural understanding in caring for very diverse cultural background of patients. Finally, it appears that culturally competent care was considered crucial for nursing education.
CHAPTER THREE
RESEARCH METHODOLOGY AND METHODS

As discussed in the literature review, caring captures numerous essential elements of nursing. The study of caring requires consideration of nurses’ knowledge, attitude and experience of dealing with complex issues associated with the body, mind, soul and spirit. A qualitative approach was determined to be best suited to explore a topic of this nature.

As outlined below, phenomenological, ethnographical and grounded theoretical approaches might all be utilised to investigate caring in nursing. However, as the current project focuses on nurses’ experiences, phenomenology was determined to be the most appropriate methodology in this instance. In addition to a discussion of the chosen methodology, this chapter also comprises the aims of the study, ethical considerations related to the inquiry, the rationale for selecting a hermeneutic-interpretive approach to the data analysis, and the approaches used to enhance the methodological rigour of the investigation.

3.1 The aims of the study
The study aims to investigate Indonesian nurses’ experience of caring in a multicultural, religiously pluralistic country. There are four objectives:
1. To determine how Indonesian nurses to define caring;
2. To explore Indonesian nurses’ experiences in caring for patients from all backgrounds (patients with a variety of cultural and religious backgrounds);
3. To explore Indonesian nurses’ views regarding barriers encountered when caring for such a diverse patient group; and
4. To identify how Indonesian nurses to break down such barriers or resolve any other difficulties faced when caring for members of a particular patient group.
3.2 Methodology

Qualitative research is generally carried out to reveal social phenomena in a thorough manner (Watkins, 2012). The goal of most qualitative studies is to present a dense, contextualized understanding of human experience through intensive study (Polit & Beck, 2010). Latimer (2003) views qualitative methodologies as studies of a lived space in which a qualitative researcher intends to uncover naturally occurring phenomena. The emphasis is on subjective data gathered through talking directly with, seeing, and interacting with the people being studied in a natural setting (Creswell, 2007). In contrast, quantitative research is principally conducted to gather numerical details. The major aim of quantitative studies is to test a hypothesis and predict an event under investigation (Begley, 2008). It offers an objective stance. Quantitative researchers assume that everything in the world is amenable to investigation through measurement (Watson & Keady, 2008).

To study nursing phenomena, a researcher needs an in-depth understanding of nurses’ perceptions, experiences, beliefs, intentions and motivations. Due to the fact that some phenomena might be not amenable to measurement and are not always quantifiable using quantitative approaches, qualitative methods may be useful in addressing such issues. According to Parahoo (2014), to understand people, rather than handing out questionnaires and relying strictly on a scale, researchers are able to learn more by interacting with the participants, as well as by giving attention to their experiences through listening and observation.

Holloway & Wheeler (2002) specifically highlight that a qualitative approach would be of great significance for health professionals who focus on caring, communication, and interaction. As underscored by Munhall (2012), the major aim of qualitative research is to understand the meanings of individuals’ experiences and to understand how the individuals are experiencing what they
have encountered, in both a positive and negative sense. Qualitative studies place emphasis on the interpretation of how behaviour is bound to social/cultural contexts, including questions of how people interpret human problems and how social life is shaped (Watkins, 2012; Crowe & Sheppard, 2010).

The current study examines the lived experience of nurses who care for patients in a multicultural, religiously pluralistic country. This involved exploration of elements such as the personal challenge involved in caring for patients from diverse backgrounds. The investigation also revealed the differences in the nurses’ experience when caring for people from their own culture or religion compared to people with other backgrounds. After much deliberation, phenomenology was considered as the most appropriate approach for the study. I acknowledge that the choice not to use ethnography in the current study could be seen as a problematic decision. Therefore, a more detailed analysis of the methodology is presented here in the context of a comparison to other methodologies. The following section conveys why and how the abovementioned decision was made.

Ethnography is a qualitative method which aims to probe the culture of group of people in their own environment using a range of data collection methods such as observations, interviews and supplementary data sources such as written documents, paintings, sculptures, historical accounts, photographs or visual records, poems and songs; ethnography emphasises culture as including the habits, customs, rituals, values and goals of individuals (Parahoo, 2014; Roper & Shapira, 2000). The primary feature of ethnography is the fieldwork involved, which allows the ethnographer to observe, ask, hear, write, re-check, compare, reflect, and to triangulate the information garnered before generating a description of the group of people being studied (Fetterman, 1989).
Ethnography was originally attributed to cultural anthropology, in which studies are conducted in remote areas, with researchers living with their subjects and immersing themselves in the daily activities of the tribes. This practice was known as traditional ethnography. However, the concept of ethnography has broadened to include the study not only of distant places but also those closer to the researcher’s home. Studies that take place in hospitals, schools, prisons, nursing homes or clinics can also be termed ethnographic (Parahoo, 2014). The emphasis of ethnography is on the study of individuals sharing characteristics in terms of their beliefs, activities, work, interests, leisure or rules. For example, Margaret (2012) conducted an ethnographic study in an emergency unit to explore the impact of belief systems on triage nursing practices. Ethnographers benefit from a contemporary interpretation of ethnography that does not require them to be in faraway places or to remain on site during the entire fieldwork period. The researcher may, rather, visit the relevant site(s) on several occasions over a period of time. This is sufficient to allow ethnographers to view people’s behavioural patterns (Fetterman, 1989).

Ethnography has been widely utilised in social science, though it remains less employed in nursing research than grounded theory and phenomenology. Ethnography could make a significant contribution to nursing research because nurses as a professional group might have different notions and attitudes within their own area. Each clinical setting may have its own culture, including particular beliefs, values, goals, activities, work, interests, leisure and rules. The culture in the emergency unit and the inpatient unit of a single hospital may, for example, differ significantly (Parahoo, 2014). However, an explication of such cultures is not within the scope of the current research.

Robertson and Boyle (1984) assume that ethnography has the potential to contribute to the development of nursing practices and knowledge. Ethnographic study is considered necessary to reveal the salient cultural
components associated with nursing care. Parahoo (2014) underlines that ethnography could be utilised as a beneficial means for exploring the cultural contexts of phenomena of health and illness. Since nurses work with clients from a wide variety of cultural backgrounds, ethnography is capable of helping nursing professionals achieve greater cultural sensitivity in providing care. Understanding the culture of a patient may assist nurses in offering appropriate care interventions (Robinson, 2013). However, patient culture is less applicable if the ethnographer is a nurse academic as the time required to collect data in ethnography is generally extensive (Creswell, 2007). Researchers need to spend adequate time in their participants’ environments, gaining confidence, building relationships and immersing themselves in the culture in order to obtain in-depth data (Parahoo, 2014). Such research could be conducted by the nurses in charge of units as those nurses may spend prolonged periods talking with, living with, and learning from patients as well as participating in activities in the setting where they interact with the patients as participants (Munhall, 2012).

Ethnography was also determined not to be a practical methodology for the present study due to time constraints and certain skills that might be needed. Ethnographic methods involve a prolonged engagement in on-site fieldwork (Munhall, 2012). For example, an ethnonursing study of caring for long-term psychiatric patients in Finland conducted by Nikkonen (1992) involved 11 years of data collection including observation and interviews. Furthermore, immersion in any setting and building trust with the participants is time-consuming and is likely to require considerable skill in order for the results to be accepted in the field (Parahoo, 2014).

Overall, an ethnographic approach serves to explicate the ways of living of people in particular cultures (Burns & Grove, 2001), emphasizing the role of culture in shaping experience rather than the meaning of the experience (Dickson, 1995) and exploring the beliefs, language, behaviours and social
dynamics of a particular cultural group (Creswell, 2007). If such aspects of nursing care were to provide the main focus of the study, ethnography would prove to be a useful methodology. However, ethnography places less emphasis on exploration or interpretation of the meaning of the participants’ lived experience. It was therefore judged to be less useful in this instance than phenomenology, which explores ‘individuals’ experiences without necessarily connecting these to a particular cultural identity’ (Gill, 2014, p.12).

There are other methodologies that could have been used in the present study, and they will be considered in turn. However, as is readily demonstrated, they would not have been helpful for this study. Grounded theory, for example, is an inductive qualitative research technique (Burns & Grove, 2005), aiming to generate, develop, or discover a theory (Creswell, 2007), clarify a concept and develop one’s own theories through field observation and interviews (Parahoo, 2014). The intent of the present study is not to create a framework or theory. The goal is to understand individuals’ lived experiences. According to Munhall (2012), the grounded theory method is most useful when ‘little is known about the area to be studied, or when what is known is from a theoretical perspective that does not satisfactorily explain what is going on’ (p.230). As is known in the theory of caring, the concept of caring in nursing practice has been widely discussed, and the goal of the present study is not to create a framework or theory; for this reason, as well, it was determined that the employment of grounded theory would be less useful for the present study.

A discourse analysis is an analysis and elucidation of written and spoken texts and any documents relating to human conversation and interaction (Traynor, 2006). The analytical process involves consideration of socio-political, psychological and historical contexts (Parahoo, 2014). This approach was determined not to be directly relevant to the aim of the current study. The present study does not intend to analyse written data or documents; rather, the
The aim of the study is to uncover the subjective experiences of nurses and interpret them.

A case study could be employed to investigate an individual case or a set of cases in nursing care (Toles & Barroso, 2014), for instance, nurses’ experiences in caring for patients with particular illnesses. However, a case study would not have been appropriate in the context of the current study as this research does not focus on particular cases in nursing care. The study is intended to enrich understanding of phenomena by obtaining differing perspectives or experiences in nursing practices (Cioffi, 2005, 2003).

Feminist research would have been relevant for a study focusing on gender relations; one of the purposes of feminist research is to uncover women’s experiences of oppression or exploitation (Kralik & Van, 2008; Sigsworth, 1995; Webb, 1993). Although the majority of nurses participating in this study were female, women’s experiences as such were not of concern to me. Male nurses’ experiences were also considered. A feminist approach was therefore determined to be inapplicable for the current research. Other alternative qualitative methods such as participatory research, historical research and evaluation research (Toles & Barroso, 2014; Watson et al., 2008) were likewise considered unsuitable for the present study, which intended to reveal and to interpret the meaning of human lived experiences.

Whilst it is therefore acknowledged that there are other methodologies, most particularly ethnography, that could have been seen as appropriate for the present study, in view of the principal aim – to comprehend the experience of the nurses – a phenomenological approach was chosen. This method was employed to explore and interpret the lived experiences of the nurses in the study (Boyd, 2001; Dickson, 1995). According to Van Manen (2007), phenomenology is a project of intensive thought on human lived experience. As
stated by Heidegger (1962, p.58), phenomenology means ‘to let that which shows itself be seen from itself in the very way in which it shows itself from itself’. Phenomenology enables researchers to attain a very natural, genuine sense of participants’ perceptions and ideas. As posited by Sokolowski (2000, p.14), ‘phenomenology recognizes the reality and the truth of phenomena, the things that appear’, in which every individual experience has its own meaning and could be attributed to the phenomenon under study (Paley, 2016).

The use of phenomenological research in nursing could make a worthwhile contribution to nursing science and practice. Nursing is principally a human relationship including interactions between nurses and patients, nurses and families, nurses and nurses, or nurses and other professionals. According to Beck (1994), nursing theories which are established through phenomenological inquiry are considered more appropriate to nursing as phenomenological inquiry is developed through close attention to the lived world of nursing. One of the best ways of knowing and describing nursing practice is phenomenology (Taylor, 1993). Phenomenological researchers can explore the lived experiences of people in nursing areas, including patients, nurses, physicians and other health professionals. As its focal point is the experience of individuals, a phenomenological approach can aid researchers in revealing how a patient experiences illness, how a nurse experiences caring for a patient, and how a nurse approaches issues in nursing practice (Parahoo, 2014).

According to Crotty (1996), a phenomenon is the synthesis or elaboration of the essence of individuals’ experiences, with phenomenology being a technique used to identify, describe and understand subjective experience. Hence, phenomenology was determined to be the most useful methodology for the purposes of this study as it enables me to uncover nurses’ lived experiences through their authentic stories in an in-depth investigation.
Interpretive phenomenology, based on the work of Heidegger and Gadamer, has been chosen as the research methodology best suited to meet the research aim. A more detailed explanation of the use of Heidegger’s and of Gadamer’s work in this study is presented in the following section. Mackey (2005) suggested that nurse researchers who intend to employ a phenomenological approach must demonstrate insight into the work of the original phenomenological philosophers due to differences in the approaches of those philosophers. I therefore consider it is important to examine the basic concepts of phenomenology according to three renowned scholars of the phenomenological tradition: Husserl, Heidegger and Gadamer. The work of these three philosophers underpins the later usage of phenomenology as a research methodology.

Husserl’s text *Logical Investigations* outlined a phenomenological method through which phenomena could be described. Husserl began to develop his work on phenomenology as he assumed that in the development of science and theory, there were many things that remained unanswered. He argued:

‘I still saw all around me only undeveloped, ambiguously iridescent problems and deep-delving but unclear theories. Weary of the confusions and fearing lest I sink into the ocean of endless criticism, I felt myself compelled [...] to look for problems which were immediately accessible’ (Husserl, 1975, p.18).

Husserl’s motives for developing a phenomenological philosophy included a desire to use science to be as beneficial as possible to the lifeworld (Dahlberg, 2006). Husserl believed that a science constructed from nature would be more beneficial to nature. Phenomenology is the analysis of essence related to any form of consciousness. Husserl viewed the investigation as a sphere more than the meaning of words, which might include fantasy, perception or image-conceptualisation (Husserl, 1975). Husserlian phenomenology is concerned with developing a description of the essence of the human lived experience (Tufanaru & Attard, 2013; Smith, 1996).
Husserl described a phenomenon as being the ‘thing’ itself, with his philosophy being related to epistemology, the ‘study of knowing’. As stated by Husserl (1975, p.22), ‘the “being-in-itself” [Ansichsein] of the ideal sphere in its relation to consciousness brings with it a dimension of puzzles which remain untouched by all such argumentation and hence must be solved through special investigation through phenomenological ones’. Husserl emphasised that all mysteries could be resolved with a phenomenological mindset through viewing the phenomena as a phenomenon in itself. According to Miles et al. (2013), Husserl’s focus was to establish a science by means of a comprehension of why things are the way they are. We need to see phenomena comprehensively.

Suggesting that all kinds of experiences or phenomena which contribute to the description of a phenomenon should be considered, Husserl (1975) underlined:

‘what is important is to look at the thinking and knowing itself, to bring to clarity the “relation to objectivity” which belongs to it and which is the very thing to be grasped, as well as the sense which it finds in itself (with its relation to this objectivity)’ (p.23).

Husserl stressed the need for objectivity in seeing the phenomenon or the thing itself. Husserl emphasised the objectiveness of the investigator as crucial to ensure that the true essence of the studied phenomenon emerges through the concept he called phenomenological reduction. Phenomenological reduction is a term used to describe the process of bracketing, which is an effort to isolate our preunderstanding and all outside influences in order to reveal a phenomenon or experience itself in its ‘pure’ condition (Parahoo, 2014). As stated by Husserl (1975), ‘The entire being and life of phenomenology is nothing more than the most radical inwardness in the description of purely intuitive givens’ (p.58).

Husserl stressed that we must be free of interpretation. Phenomena must be described without prejudice or pre-suppositions (Dowling, 2007). In order to succeed in doing so, phenomenological researchers must engage in bracketing, or dismissing their own pre-understandings or preconceptions, in order to
generate the pure essence of the examined experiences (Creswell, 2007). As explained by Husserl (1975):

‘one reads, one intuits, one follows the descriptions and the comparative reflections. But during the reading, one [should] abstain both from all philosophies either acquired from others or developed by oneself as also from every judgment which is not won in its own active seeing and describing’ (p.60).

In practice, such an approach doubtless proves challenging, as researchers are likely to find it difficult to suspend all of their preconceptions in order to describe a lived experience without contamination (Jasper, 1994).

Following from the work of Husserl, Heidegger offered a distinct concept of how to study human consciousness of phenomena. The interpretive-hermeneutic approach of Heidegger tended towards the ontological, with a focus on the meaning of ‘being in’ or ‘presence in’ the world (Dowling, 2007). Heidegger’s concept is viewed as an expansion of Husserl’s ideas, appending meaning and interpretation to description without bracketing our previous experiences and knowledge (McCance & McIlfatrick, 2008). Heidegger felt that our comprehension has always been already present and cannot, nor should it, be separated from our thinking (Smythe et al., 2008). Heidegger (1962) highlighted that ‘this presupposes inevitably that we must have an insight into the meaning of the formal conception of phenomenon’ (p.55). This demonstrates that prejudices and preconceptions are a legitimate part of Being and cannot be bracketed (Miles et al., 2013, p.274).

The central concepts of Heideggerian phenomenology include Dasein and authenticity. The term ‘Dasein’ can be translated as ‘being in the world’ or ‘being there’, the way in which the world is disclosed to each individual through being and experience (Heidegger, 1962). As detachment from the world is impossible, lived experience can only be studied from the perspective of a fellow being-in-the-world (Moran, 2000). As described by Heidegger (1962):
‘an entity present-at-hand within the world can be touched by another entity only if by its very nature the latter entity has Being-in as its own kind of Being – only if, with its Being-there [Dasein], something like the world is already revealed to it, so that from out of that world another entity can manifest itself in touching, and thus become accessible in its Being-present-at-hand’ (p.81).

Heidegger believed that our own existence in the world, or our ‘being-in-the-world’ has significantly affected our understanding of how we experience things (Parahoo, 2014). How people see and interpret their lived experience is influenced, consciously or unconsciously, by their previous perceptions and experiences.

Another Heideggerian concept, authenticity, refers to being ‘whole’ and is related to the concept of ‘ownership’, meaning that beings-in-the-world have the capability to think about themselves and to express their own feelings (Moran, 2000). An understanding of the meaning of lived experience can be attained through ‘being in the world’ combined with an interpretive process (Smith, 1996). Heidegger underlined that when we explore the experience of others, we also interpret what they say, bringing our own prejudices and perceptions to the phenomenon (Parahoo, 2014). If interpretive phenomenology is understood in these terms, bracketing is not relevant as part of the methodology for the present research. It is clear that Heidegger’s concepts of Dasein and authenticity stand in opposition to Husserl’s notion of bracketing.

Heideggerian phenomenology is fundamentally concerned with understanding the meaning of lived experience through interpretation (Bergum, 1989). Heideggerian phenomenology does not serve merely to generate description; rather, it is seen as an interpretive process (Creswell, 2007). In the Heideggerian approach, the researcher’s presupposed understanding of the phenomena under examination is considered to be an essential contribution to the interpretive process (McCance & McIlfatrick, 2008). The process of phenomenological
interpretation involves reciprocal activity in the hermeneutic circle (Van Manen, 1990).

Following the work of Heidegger, Gadamer further developed hermeneutic phenomenology in his work *Truth and Method*. Gadamer (1976) highlighted that hermeneutics refers to situations in which interpretive effort is needed to overcome the difficulty of obtaining an immediate understanding. He developed the concept of the ‘circle of understanding’, the process by which people bring their own prejudices and preconceptions into their understanding of experience by means of reading and interpreting (Gadamer, 1976). A hermeneutic circle is a reciprocal activity of interpretive process (Earle, 2010). The hermeneutic circle is so called due to the need to move back and forth between viewpoints in order to formulate further questions, to engage with and to understand the meaning of experience (McCance & McIlfatrick, 2008; Koch, 1996). The process therefore appears to be circular (Moran, 2000, p.235).

Gadamer’s concept of ‘the fusion of horizons’ implies that a new perspective may be developed by combining our old views with new views (Vessey, 2009). Gadamer viewed each individual as having his or her own understanding of the world, called a ‘horizon’, which is built by the individual’s personal history and culture (Parahoo, 2014). Our understanding of the phenomena we encounter is shaped by our previous experiences and our present circumstances. As posited by Gadamer (1976), understanding is not reconstruction but mediation, in which the researchers are the transmitters of the past into the present. When two individuals begin to engage with one another and discuss a certain issue or phenomenon, they also bring their ‘horizons’ together into the conversation. Gadamer viewed this as a ‘fusion of horizons’ (Parahoo, 2014). Gadamer (1976) believed that a successful dialogue would lead to a fusion of horizons; he emphasised that this fusion is useful for establishing our understanding of experiences and phenomena because the conversation between researcher and
participant in an interview situation contributes to the generation of a new knowledge of the issue under investigation (Parahoo, 2014).

As the above brief introduction highlights, an understanding of the main concepts of phenomenology is vital to determine the research methods to be used in the present study. As the study is interpretive in nature, a Husserlian approach is not considered appropriate, and as has previously been noted, the concept of bracketing can be problematic (McCance & McIlfatrick, 2008; Dowling, 2007). Interpretive phenomenology emphasises an understanding of the subjects being studied along with the nature of their experience and therefore of the nature of the phenomena in question; such an approach is seen as ideal to answer the research question posed: How do Indonesian nurses experience caring for patients from all backgrounds (patients with a variety of cultural and religious backgrounds) in a multicultural and religiously pluralistic country. As an Indonesian nurse, it would not be possible for me to enter into the dialogue of an interview without bringing my own perceptions of the interaction the nurse and their patients from multi-cultural or multi-religious backgrounds.

Overall, the three phenomenologists discussed above were philosophers, not researchers. Though they presented their work on phenomenology as philosophers, their ideas and concepts in the field of phenomenology are able to guide researchers in developing their own phenomenological research methods (Parahoo, 2014). The philosophical principles under consideration here have been divided into two types: descriptive phenomenology, which is based on the work of Husserl, and interpretive phenomenology, which is based on Heidegger’s and Gadamer’s ideas. Husserl’s notion of descriptive phenomenology was adopted by Giorgi (1985) and by Colaizzi (1978), who were concerned with the importance of bracketing to describe participants’ experiences in their own way without any prejudice on the part of the researcher (Parahoo, 2014). Colaizzi’s
procedure involves participants in final validation, while Giorgi’s relies solely on the researcher for data analysis (Polit & Beck, 2012). On the other hand, interpretive phenomenology was adopted by Van Manen (1990) to provide understanding of the meaning of human lived experiences through rigorous description and interpretation (Zalm & Bergum, 2000). Van Manen’s work was influenced by Heidegger’s and Gadamer’s ideas of phenomenology (Paley, 2016). In accordance with those principles, Van Manen also rejected the concept of bracketing as dialogical processes taking place in interviews between researchers and participants would contribute to the interpretation of the meaning of the experiences (Earle, 2010).

The use of phenomenology in nursing research has been criticized by several scholars. Crotty (1996, p.17), in a critique of phenomenology in nursing research, noted a ‘confusion of thought regarding the nature and the relationship of experience and phenomenon’ among nurse researchers; according to Mackey (2005), this may be due to differences in understanding of phenomenological philosophy and methodology. Malacrida (2007) therefore proposed that an understanding of methodology, along with an understanding of the various phenomenological philosophical traditions, is crucial to ensure accountable research findings; similarly, Kakkori (2009) emphasised the importance of researchers’ comprehension of the philosophical traditions on which their chosen methodologies are based. Specifically, an understanding of phenomenological philosophy plays an essential role in the use of phenomenology as a research method (McCance & McIlfatrick, 2008; Creswell, 2007).

Paley (2016), however, posited that it is not necessary to understand phenomenology as a philosophy in order to adopt phenomenology as a qualitative research method. Phenomenology as philosophy (PP) has been comprehensively set out in the work of philosophers such as Husserl, Heidegger
and Gadamer. Phenomenology as qualitative research method (PQR) is a phenomenological research method developed by researchers such as Colaizzi, Giorgi and Van Manen based on the work of those philosophers. According to Paley (2016), there is no connection between PP and PQR, and phenomenological researchers should focus on what they do to distinguish phenomenology from other qualitative methods. However, Mackey (2005) argued that research that adopts or adapts the phenomenological approach without mention of the philosophical underpinnings from which the method was developed might ‘[lead] to the misuse of methodological notions’ (p.180). Hence, phenomenological researchers need to clarify which philosophical approach underpins their chosen research method.

Learning about phenomenology as a philosophy has enabled me to understand its basic concepts. The philosophical underpinnings of phenomenology have permitted me to think, undertake and analyse in a phenomenological manner. While some challenges were encountered, for example with regard to the complexity of the philosophical concept itself, the philosophical comprehension garnered has supported me in using phenomenology as a research method. As translated versions of texts considerably affect the meaning of philosophy itself (Parahoo, 2014), several secondary sources were used to assist me to understand a number of ideas and concepts. However, to establish a more profound comprehension of phenomenology, I referred to the original texts.

The current study employed interpretive hermeneutic phenomenology in order to examine not just the nature of caring, but also the nurses’ lived experience of caring for various patients. The interpretive approach enables ‘a research which aims for understanding, rather than explanation’ (Mackey, 2004, p.179). Analysis is conducted through use of the hermeneutic circle in order to best interpret the meaning of the nurses’ lived experience. As suggested by Creswell (2007), an investigator needs to decide in what way his or her pre-understandings will be
incorporated into the study. A reflexive approach is undertaken in considering my preconceptions, developed through my background as an academic and researcher, in order to gain a deeper understanding of the phenomena under investigation. This is of particular relevance during the process of data collection and analysis. As I am conducting the present study is being undertaken as a novice researcher, any preunderstandings are considered useful in developing potential questions for the interviews as well as to attain the depth of information required in such interviews. It is clear that my previous understanding of the phenomena under examination has the potential to contribute greatly to the hermeneutic circle in this instance.

3.3 Sampling
3.3.1 Sampling method
The research was undertaken in East Java Province, one of the largest provinces in Indonesia, with an area of 47,963 square kilometres over 74 islands. The province population in 2010 was 37,476,757 inhabitants (Statistics of Indonesia, 2013). East Java is administratively divided into 29 regencies and nine cities, 662 sub-districts and 8,523 villages. The tribes represented in East Java include Javanese, Madurese, Tengger and Osing. Javanese and Madurese people are spread over almost all of the East Javan mainland, while most of the Tengger and Osing people live in separate regions in East Java. However, through movement due to marriage or employment, members of other ethnic groups, including Batak, Minang and Ambon, also reside in East Java. The majority of the East Javan population follows the Islamic religion. The representation of religious groups in the province is: Islam 96.3%, Protestant 1.6%, Catholic 1%, Hindu 0.6% and Buddhist 0.4%. In addition to these ‘official’ religious groups, animistic religious beliefs and practices are still prevalent, especially in the more rural communities, creating a more religious pluralist culture than is immediately obvious.
There are 2,381 hospitals in Indonesia. East Java has 319 hospitals, both public and private. The province also has 960 primary health centres, including 504 with inpatient services and 456 with outpatient services only (Ministry of Health of Indonesia, 2014). In 2013, there were 288,405 nurses in Indonesia and 32,833 in the province of East Java; the number of nurses per 100,000 inhabitants in the province was 85.2 (Statistics of East Java, 2013).

The present study included two public hospitals from two cities in East Java Province: Surabaya and Malang. Two primary health centres in the cities of Jember and Banyuwangi were also sampled to capture the experience of community nurses, thus ensuring a culturally and socially diverse population (Debesay et al., 2014).

Sampling has been defined as a technique of selecting the participants who will be invited to participate in a study (Parahoo, 2014). In qualitative research, the sampling process is concerned with the appropriateness and adequacy of information (O’Reilly and Parker, 2012). The richness of data must be taken into consideration as the aim of the study is not to calculate ideas or opinions but to investigate a phenomenon or issue (Gaskell, 2000). Some terms borrowed from sampling methods, such as selective, criterion, and purposive and theoretical sampling, are often applicable in the context of qualitative studies (Creswell, 2007; Coyne, 1997).

Parahoo (2014) posited that all sampling approaches in qualitative research are similar in that they all involve the researchers’ subjective judgement during the selection process. Purposive sampling is defined as a method of deliberately selecting people as they have experience with the phenomenon under study: they either are living the experience or have lived the experience in the past, and they have the ability to communicate their experiences (Palinkas et al., 2015; Wood & Haber, 2014). According to Wood and Haber (2014), phenomenologists
view participants’ stories as a dimension of the present, in which a past experience exists in the current moment. Purposive sampling is frequently used in phenomenology. Theoretical sampling is often used in grounded theory, in which the participants are selected as they can contribute to the generation of a theory (Creswell, 2007; Coyne, 1997).

Purposive sampling was employed in this inquiry; the participants were selected purposively based on defined criteria. This form of sampling requires the identification of a group of participants who have the lived experience necessary for the investigation (Berg & Lune, 2012; Groenewald, 2004; Polit & Beck, 2004). The present study adopted three aspects of sampling in phenomenology (McCance and McIlfatrick, 2008; Creswell, 2007): the participants had encountered the phenomenon under study, had a willingness to share their lived experience, and had the capability to articulate the experience under investigation. Thus, the main criterion for this phenomenological study was that nurses have experience of caring for culturally, religiously and linguistically diverse patients.

3.3.2 The number of samples

This study recruited 20 nurses, ten of whom worked in hospitals and ten of whom worked in the community. Sampling in phenomenological studies tends to depend on very small samples, typically ten or fewer participants (Polit & Beck, 2012; Groenewald, 2004; Burns & Grove, 2001). However, with a purposive sampling method, the researcher must decide to increase the sample size if not enough data are obtainable, or even to stop the sampling process if no new data have emerged (Parahoo, 2014).

Based on the literature reviewed, it was noted that the sample size in phenomenological studies ranged from four to 23 participants. Several authors provided detailed rationales for using a specific sample size, with sample size
differing between studies with varying scopes, inclusion criteria and data collection methods used. Research that investigates broader areas of study may require maximum variation sampling, which serves to reflect differing perspectives in order to enrich understanding of the phenomena (Cioffi, 2005, 2003). For example, research into nurses’ experiences in Australia by Cioffi (2003) and in Norway by Debesay et al. (2014) used sample sizes of 23 and 19 respectively. By contrast, phenomenological studies employing small sample sizes are generally characterised by the use of very specific inclusion criteria. For instance, a study about minority ethnic patients in the Danish healthcare system by Nielsen and Birkelund (2009) established very specific inclusion criteria: nurses with an ethnically Danish background working in the same hospital department, having at least five years of professional experience as well as experience caring for minority ethnic patients in Denmark.

In determining the sample size for the present investigation, a number of elements were considered. Because individual interviews were used as the data collection method, it was indeed a time-consuming process. According to Yeo et al. (2014) and Bauer and Gaskell (2002), an hour-long interview must be undertaken for each participant to obtain adequate qualitative data. In the present study, in addition to transcription, it was also necessary to take into account the process of translation as this study employed two languages (English and Bahasa Indonesia). The duration of each interview was approximately 90 minutes. The shortest interview lasted 20 minutes and the longest lasted 128 minutes. The transcription of each interview required approximately ten hours, while the process of translation of the transcripts took approximately 200 hours. It was therefore determined that twenty would be a manageable number of participants for this study.
3.3.3 Recruitment

The data collection process, which included the recruitment process through the interviews, was conducted from December 28, 2015 until April 2, 2016. Informal communication with gatekeepers in the public hospitals and primary health centres in East Java Province was established before I arrived in Indonesia. I sent the letter of research permission and attached the letter of ethical approval from the University of Manchester.

I approached the heads of the primary health centres in Jember and Banyuwangi and the heads of the public hospitals in Surabaya and Malang. The authorities at the primary health centres accepted the letter of research ethical approval from the University of Manchester. For this reason, it was not necessary to perform an ethical review in the primary health centres. Once approval was secured, the recruitment process was begun. This took place in the first week of January 2016. Participant information sheets, personal contact sheets and consent forms were distributed. Ten nurses from the two primary health centres approached agreed to participate in the study. All interviews in the primary health centres were performed in January 2016.

An ethical review was required to obtain research approval from the public hospitals in Malang and Surabaya. The study was reviewed by the Research Ethics Committee at the public hospitals in both locations. Approval from the public hospital in Malang was granted on February 12, 2016. The ethical review in the public hospital in Surabaya was held on February 25, 2016. Once research approval had been granted, I approached the head of nursing in each hospital to share the details of the project, including the inclusion criteria and the number of participants required. As per the bureaucracy in government hospitals, the nurse managers were the individuals able to give me access to all nurses at each hospital.
After both nurse managers agreed to give access to the nurses and gave me a list of potential participants’ names, I contacted them to ask whether or not they would like to participate in the study. Five names of nurses from the public hospital in Malang were given by the nurse manager there, and five names of nurses from the public hospital in Surabaya were given by the nurse manager in that location. All interested participants were given participant information sheets, personal contact sheets and consent forms. Ten nurses were chosen from two hospitals as they met the inclusion criteria for the study. All interviews of the nurses working in hospitals were performed from February until April 2016.

The inclusion criteria for the study were:

1. Approximately five or more years of experience working as a nurse. A period of five or more years of experience is linked to individual proficiency (Cioffi, 2005).

2. Working as a nurse in any area of care. This ensured that the study involved nurses with a relevant diversity of views and perspectives (Polit & Beck, 2004). Ideally, the study could achieve maximum variation through the purposive involvement of nurses from diverse settings and backgrounds. Maximum variation has been recognised as a popular and ideal mode in qualitative studies (Creswell, 2007).

3. Having cared for patients from a variety of cultural and religious backgrounds within the previous six months. In accordance with the limitations of human memory, Foddy (1993) noted that people generally memorize salient events for up to one year and non-salient events for up to one month. Thus, I considered that events having taken place within the previous six months would be adequately present in the nurses’ memories.

4. The ability to provide informed consent.
The exclusion criteria for the study were:

1. Working as a nurse apprentice
2. Studying nursing
3. Working as a nursing assistant

These groups were excluded from the study. Nurse apprentices are recent graduates and are thus considered to be nurses who have less experience caring for culturally and religiously diverse patients. In Indonesia, nursing assistants do not have a nursing education background and may be employed upon graduation from senior high school.

Demographic data of participants were collected through participant information sheets given to participants prior to interview process. Participants’ demographic information were also gathered during the process of individual interviews with participants. Demographic information of participants include age, gender, ethnic group, religion, length of work, clinical role, area of specialism, hospital or primary health care class, and ward class.

Based on Peraturan Menteri Kesehatan Republik Indonesia Nomor 56 Tahun 2014 (The Regulation of the Minister of Health of the Republic of Indonesia, number 56), the classification of general hospital is determined based on the health service, human resources, equipment, building and infrastructure. The health services provided by the Class A general hospital at the very least should include medical services, pharmaceutical services, nursing and midwifery services, clinical support services, non-clinical support services and inpatient services.

The medical services in the Class A general hospital should at least consist of emergency services 24 hours, basic specialist medical services (internal medicine, child health, surgery, and obstetrics and gynecology services),
supporting specialist medical services (anesthesiology, radiology, clinical pathology, anatomical pathology, and medical rehabilitation services), other specialist medical services (eye care, ear / nose / throat, nerves, heart and blood vessels, skin and genitals, mental, pulmonary medicine, orthopedics, urology, neurosurgery, plastic surgery, and forensic medicine), subspecialty medical services (subspecialty services in the fields of specialization in surgery, internal medicine, child health, obstetrics and gynecology, eyes, ear nose throat, nerves, heart and blood vessels, skin and genitals, psychiatry, pulmonary medicine, orthopedi, urology, neurosurgery, plastic surgery and mouth / teeth, and medical services for dental and oral specialists.

The pharmaceutical services include the management of pharmaceutical preparations, medical devices and medical consumables, and clinical pharmacy services. Nursing and midwifery services cover generalist nursing care, nursing specialist and midwifery care. Clinical support services include blood bank services, intensive care for all age groups and types of diseases, nutrition, instrument sterilization and medical records. Non-clinical support services include laundry / linen services, food / kitchen services, engineering and maintenance facilities, waste management, warehouses, ambulances, information and communication systems, mortuary management, fire prevention systems, medical gas management, and clean water management.

There are two kinds of Class A general hospitals, which are Class A general hospital belongs to government and Class A general hospital belongs to private health care or belongs to non-government. There are specific requirements of Class III ward beds for the Class A general hospital. At least 30% Class III ward beds must available in the Class A general hospital belongs to government, 20% of Class III ward beds must be available in the Class A general hospital belongs to private health care, and 5% must be intensive care beds in both Class A general
hospital belongs to government and Class A general hospital belongs to private health care.

The Class A general hospitals have a broad range of practitioners and specialists including medical staff, nurses, pharmacists and other allied health care workers. Medical subspecialties consist of at least 18 General Practitioners, four dentists and six basic specialists (medical/surgical consultants) and at least three consultants for each individual medical specialty (i.e. neurology).

The human resource requirements for the Class A general hospital consists of medical personnel, pharmacy staff, nursing staff, other health workers and non-health workers. The specific requirements for medical personnel include at least 18 general practitioners for basic medical services, four general dentists for oral dental medical services, six specialist doctors for each type of basic specialist medical service, three specialist doctors for each type of medical specialist support services, three specialist doctors for each type of medical service for other specialists.

The nursing staff requirement is allocated based on the number of beds in the inpatient ward. The qualifications and competencies of nursing staff are determined based on the hospital service. The number and qualifications of other health workers and non-health workers are decided based on the hospital requirements.

The medical services in the Class B general hospital should at least consist of emergency services 24 hours, basic specialist medical services and supporting specialist medical services are equal to health services in the Class A general hospital. However, for other specialist medical services in the Class B general hospital, they are only required to have eight out of 13 services, which include eye service, ear / nose / throat, nerves, heart and blood vessels, skin and
genitals, mental medicine, lung, orthopedics, urology, neurosurgery, plastic surgery, and forensic medicine.

Medical personnel in the Class B general hospitals include at least 12 general practitioners for basic medical services, three general dentists for oral dental medical services, three specialist doctors for each type of basic specialist medical service, two specialist doctors for each type of medical specialist support services, one specialist doctor for each type of medical service other specialists, one subspecialty doctor for each type of subspecialty medical service and one specialist dentist for every type of medical services for oral dental specialists. The number of nursing staff, other health workers and non-health workers are the same as for the Class A general hospital.

The demographic data of participants is provided in table 3. The participant codes within the table are the same as those used to refer to specific participants throughout the thesis.
### Table 3. Demographic data

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Ethnic group origin</th>
<th>Religion</th>
<th>Length of work (years)</th>
<th>Migrant/ local nurse</th>
<th>Clinical role</th>
<th>Area of specialism</th>
<th>Ward class</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary health centre 1: class A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>P1</td>
<td>42</td>
<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>20</td>
<td>Migrant</td>
<td>Clinical nurse</td>
<td>Adult and TBC care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td>P2</td>
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<td>Male</td>
<td>Javanese &amp; Sundanese</td>
<td>Islam</td>
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<td>Clinical nurse</td>
<td>Emergency care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td>P3</td>
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<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
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<td>Clinical nurse</td>
<td>General ward</td>
<td>Ward Class 3, 2 and 1</td>
</tr>
<tr>
<td>P9</td>
<td>38</td>
<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>11</td>
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<td>Clinical nurse</td>
<td>Adult and child care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td>P10</td>
<td>30</td>
<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>6.5 (was in hospital &amp; now in PHC)</td>
<td>local</td>
<td>Clinical nurse</td>
<td>Dental care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td><strong>Primary health centre 2: class A</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>P4</td>
<td>34</td>
<td>Male</td>
<td>Javanese</td>
<td>Islam</td>
<td>9 (was in hospital &amp; now in PHC)</td>
<td>local</td>
<td>Clinical nurse</td>
<td>Adult care and diabetic care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td>P5</td>
<td>47</td>
<td>Female</td>
<td>Osing</td>
<td>Islam</td>
<td>23 (was in hospital &amp; now in PHC)</td>
<td>local</td>
<td>Clinical nurse</td>
<td>Adult care and elderly</td>
<td>Outpatient service</td>
</tr>
<tr>
<td>P6</td>
<td>33</td>
<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>12</td>
<td>Migrant, now local</td>
<td>Clinical nurse</td>
<td>Adult care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td>P7</td>
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<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
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<td>Outpatient service</td>
</tr>
<tr>
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<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>18</td>
<td>Local</td>
<td>Clinical nurse</td>
<td>Adult and child care</td>
<td>Outpatient service</td>
</tr>
<tr>
<td><strong>Public hospital 1: class A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
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<td>Javanese</td>
<td>Christian</td>
<td>29</td>
<td>Local</td>
<td>Clinical nurse and head of ward</td>
<td>Adult care</td>
<td>Stroke unit</td>
</tr>
<tr>
<td>P12</td>
<td>45</td>
<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>23</td>
<td>Local</td>
<td>Clinical nurse and head of ward</td>
<td>Adult care</td>
<td>Haemodialysis unit (HD)</td>
</tr>
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<td>Sundanese</td>
<td>Islam</td>
<td>14</td>
<td>Migrant</td>
<td>Clinical nurse</td>
<td>Adult care</td>
<td>Was in ward class 3 and 2. Now in class 1</td>
</tr>
<tr>
<td>P14</td>
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<td>Kalimantan</td>
<td>Islam</td>
<td>12</td>
<td>Migrant</td>
<td>Clinical nurse</td>
<td>Adult and child care</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>P15</td>
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<td>Javanese</td>
<td>Islam</td>
<td>25</td>
<td>Local</td>
<td>Clinical nurse</td>
<td>Emergency care</td>
<td>Emergency unit</td>
</tr>
<tr>
<td><strong>Public hospital 2: class A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>P16</td>
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<td>Female</td>
<td>Madurese</td>
<td>Islam</td>
<td>30</td>
<td>Local</td>
<td>Clinical nurse and head of ward</td>
<td>Adult care</td>
<td>Was in ward class 3,2 and 1. Now in oncology unit</td>
</tr>
<tr>
<td>P17</td>
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<td>Female</td>
<td>Javanese</td>
<td>Islam</td>
<td>29</td>
<td>Local</td>
<td>Clinical nurse</td>
<td>Adult and child care</td>
<td>Ward class 1, 2 and 3</td>
</tr>
<tr>
<td>P18</td>
<td>46</td>
<td>Female</td>
<td>Balinese</td>
<td>Hindu</td>
<td>23</td>
<td>Migrant</td>
<td>Clinical nurse</td>
<td>Adult care</td>
<td>Was in ward class 3,2 and 1. Now in HD unit</td>
</tr>
<tr>
<td>P19</td>
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<td>Female</td>
<td>Manado</td>
<td>Christian</td>
<td>30</td>
<td>Migrant</td>
<td>Clinical nurse</td>
<td>Adult care</td>
<td>Ward class 1, 2 and 3</td>
</tr>
<tr>
<td>P20</td>
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<td>Female</td>
<td>Sundanese</td>
<td>Islam</td>
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<td>Migrant</td>
<td>Clinical nurse and head of ward</td>
<td>Adult and child care</td>
<td>Critical care unit</td>
</tr>
</tbody>
</table>
3.4 Interviews in qualitative research

An interview is a means of entry in qualitative inquiries to capture the perceptions of respondents and to apprehend how participants give certain meanings to phenomena or situations (Berg & Lune, 2012). In-depth interviews have been considered as a superior data collection method in qualitative research such as phenomenological studies (Whorton, 2009; Munhall, 2001). In hermeneutic phenomenology, the interview has two benefits: building an in-depth understanding of the phenomenon under study and creating a communication relationship between the researcher as the interviewer and the participants as the interviewees (Van Manen, 1990).

There are three broad categories of interview techniques divided according to synchronous/asynchronous communication in time and/or space; they are: a) the face-to-face interview, b) the telephone interview, and c) the computer-assisted interview (Berg & Lune, 2012; Opdanakker, 2006). A face-to-face interview is characterised by synchronous communication in time and place: both the interviewer and the interviewee make conversation at the same time and in the same place. Telephone interviews are classified as synchronous communication in time, but asynchronous communication in place (Opdanakker, 2006). A telephone interview is considered to provide the best source of information if the researcher is not able to meet with participants face-to-face (Creswell, 2007). However, the researcher should consider drawbacks such as the expense of telephone calls and loss of non-verbal communication. Computer-assisted interviewing may involve computer-assisted telephone interviewing (CATI), computer-assisted personal interviewing (CAPI), email and MSN Messenger interviewing.

Computer-based conversations such as those conducted in real-time chat rooms and over instant messenger services are categorized as synchronous communication as they allow the researcher and participants an almost real-
time face-to-face interaction. However, computer-based communication using email or forum posts is characterised as asynchronous communication in both time and place (Berg & Lune, 2012; Opdenakker, 2006). Interviewing using a computer may generate some advantages, including cost savings on transcription, travel and time, as well as providing greater convenience and anonymity (Jackson, Daly & Davidson, 2008).

This study used two considerations in selecting face-to-face interviews as the data collection method rather than alternative techniques such as telephone interviews or computer-assisted interviewing. Firstly, a face-to-face interview enables me to capture nonverbal signs such as facial expressions or gestures that emerge during the interview process, and the interviewer and the interviewee can make conversation in the same time and place. It has been noted that the taking of notes during the interview is important in order to gather data that cannot be gleaned from an audio recording. Groenewald (2004) argued that taking descriptive and reflective notes during the interview enables the investigator to reflect on the interview process.

Secondly, face-to-face interviews provide the opportunity to develop rapport and trust (Jackson, Daly & Davidson, 2008). Establishing and maintaining rapport with respondents is vital to the gathering of information of the richness required for phenomenological research (Polit & Beck, 2004). Admittedly, however, using face-to-face interviews in the present study entailed travel expenses and travel time during the data collection period (Opdenakker, 2006). Strategies have been developed to address these issues, whereby I prepared a schedule for collecting data in each setting including the expenses required. I also checked transportation timetables and fare information before travelling to avoid waiting for long periods at bus stops or train stations.
Group interviews have been used by some qualitative researchers. According to Brinkmann (2013), group interviews ‘dominate consumer research’ and are ‘increasingly common in the social sciences’ (p. 26). The researcher’s role in such interviews is to be a moderator and to lead the group of (normally between six and ten) participants in a discussion around the specified themes (Morgan, 2002). A focus group interview is likely the best approach if interaction among the participants is to be considered in the study and if interviewees are similar to and co-operative with one another (Creswell, 2007). The aim of group interviews is to explore differing viewpoints regarding an issue rather than to achieve consensus concerning the themes discussed (Brinkmann, 2013). Within the focus group approach, however, all participants are encouraged to talk, with the researcher monitoring for individuals who may dominate the conversation (Creswell, 2007). The possible dominance of the conversation by certain individuals may limit other participants’ expression of their own perspectives and may present difficulty for the group as a whole as it attempts to address the questions as intended (Sewell, 1999).

Individual interviews were applied in the present study as they have several advantages over focus group interviews. Firstly, in phenomenological inquiry, in which human lived experience is the topic of the study, the goal of an individual interview is to establish in-depth conversation (Munhall, 2012). It is clear that this aim is more likely to be achieved through individual interviewing than in focus group interviews. In a focus group, the interviewer must obtain responses from the entire group to ascertain the fullest coverage of the topic (Fontana & Frey, 2008). Secondly, individual interviews are well suited for exploratory studies of aspects of people’s lives which may be personal and sensitive. Individual interviews allow for greater confidentiality and development of an atmosphere of trust (Brinkmann, 2013). Thirdly, the phenomenological researcher is the primary instrument for access to the subjects’ experience of the phenomenon (McCance & McIlfatrick, 2008; Burns & Grove, 2005). Individual
interviews enable the interviewer to lead the conversation, which might be useful depending on the interviewer’s purpose (Brinkmann, 2013). However, as the present study is of a phenomenological nature, I attempted to avoid one-way dialogues and monopolising the conversations (Creswell, 2007). Rather, I encouraged the interviewees to talk freely and assisted them in clarifying or expanding their own views about the issues discussed. The research process demonstrated that these points could be achieved more easily through individual interviews. The participants were able to share their experiences freely over a relatively long period of time with a stranger (they were meeting me for the first time at the interviews). The interviews generally took approximately 90 minutes. The longest interview was 128 minutes. Only one participant seemed in a hurry during interview. It took only 20 minutes.

Open-ended questions were employed in the semi-structured interviews in the current study. Interviews are classified into three types according to their structure: a) structured, b) unstructured, and c) semi-structured (Brinkmann, 2013). In the structured interview, the participants are all provided with the same series of predetermined questions, with the assumption that the questions to be asked are comprehensive enough to elicit all information required for the study (Berg & Lune, 2012). This type of interview is commonly used in telephone as well as face-to-face interviews. The structured interview was not felt to be appropriate for the present study as structured interviews typically employ closed-ended questions with a pre-planned range of possible responses. Such structured interviews are generally referred to as quantitative interviews. The structured interview approach leaves very little room for the interviewer or interviewee to express judgment or to respond beyond the specific questions being asked (Jackson, Daly & Davidson, 2008). A structured interview does not allow the investigator to explore the individual’s perspective or elucidate the meaning of the lived experience of participants. Brinkmann (2013) argued that structured interviews do not facilitate dialogical conversation between the
investigator and the participants. As a consequence, structured interviews would not have allowed me as a researcher to reveal the human lived experience required for the present study. It was therefore determined not to apply the structured interview approach.

In unstructured interviews, researchers do not prepare a series of predetermined questions because they do not have a clear idea of the exact nature of the data to be collected, with such interviews being more intuitive, conversational and interactive (Polit & Beck, 2004). Brinkmann (2013) argued that in order to investigate a participant’s life story, the interviewer cannot be bound by a list of specific questions, but should instead concentrate on the means by which to facilitate the telling of the story. Jackson, Daly and Davidson (2008) described the unstructured interview as an in-depth qualitative interview involving an initial open-ended question with no predetermined response to be provided to the interviewee. It appears that, in such interviews, emphasis is placed on the researcher’s ability to guide the interview process to elicit the data required.

Lastly, semi-structured interviewing allows researchers to drive and guide the interview (Chan, Fung & Chien, 2013). Silverman and Seale (1997) suggested the use of open-ended questions as being the most effective way of ascertaining an individual’s experience. Compared to unstructured interviews, semi-structured interviews give interviewers a greater opportunity to focus the conversation on the issues that they feel are essential in relation to the aims of the study (Brinkmann, 2013). Foody (1993) suggested asking general questions first, followed by more specific questions. In semi-structured interviews, the interviewer knows that data will be collected during the interview but cannot predict what the information will be (Fontana & Frey, 2008; Jackson, Daly & Davidson, 2008). In addition, Berg and Lune (2012) argued that in semi-structured interviews, the interviewer can adjust ‘the level of language of
planned questions’ if necessary to elicit data from the subject (p.113). In the present study, I prepared a broad topic guide related to the nurses’ experience of caring for patients. The use of this interview schedule facilitated me in the exploration of the participants’ experiences.

There are both strengths and weaknesses involved in using interviews in the data collection process. Sewell (1999) believed that interviews facilitate participants’ expression of their perspectives using their own words. Participants ideally feel relaxed and are able to interpret and respond to questions in the way intended by the interviewer. Hence, responses in such interviews are generally truthful. Credibility and face validity are also guaranteed in that the researcher has an opportunity to ask for more detailed data if required, thus verifying that the participant’s explanation and demeanour fit the description and situation (Whorton, 2009; Tobin & Begley, 2004).

Nevertheless, there are some drawbacks to using interviewing in a qualitative study (Sewell, 1999). These may involve personalities, moods and interpersonal dynamics between the researcher and participant. The participant may describe his or her experience excessively or take the interview flow beyond the research question. Field and Morse (1985, p.66) used the term ‘dross rate’ in defining the irrelevant information given by the interviewee. Therefore, Field and Morse (1985) suggested to keep interviewees on topic, asking broader, open-ended questions at the beginning of the interview to diminish the dross rate. Use of the topic guide prepared for the present study enabled me to encourage the interviewees to speak freely during the conversations.

The present study was conducted in a multicultural, religiously pluralistic country where I belong to the majority religious and ethnic groups (Islamic and Javanese). Further, I am a nurse educator conducting research in healthcare settings as part of a PhD study in a country where only a very small number of
nurses have PhDs. I acknowledged that such circumstances might influence the participants’ willingness to divulge their experiences. Creswell (2007) noted some potential challenges faced in qualitative interviewing as the problems of power and resistance, the problem of consent and the projection of the interviewer’s own self.

One of the key issues anticipated in this study was related to the power gradient between the interviewer and the interviewees. My position as a nurse educator and a PhD student had the potential to affect the interviewer-interviewee relationship. Nunkoosing (2005) posited that the problem of power in interviews derives from the interviewer’s authority as a knowledge-seeker and methodological expert with the interviewee as a more or less privileged knower. The participants might consider my evaluation of them, leading them to say what they feel I wish to hear rather than what they actually want to say. For example, nurses say that they treat everyone the same, but through phenomenological interpretation and discussion of certain ethnicities (e.g. Madurese), it is possible to interpret that they may not in fact do so. Collins et al. (2005) argued that participants may have an unconscious desire to make a favourable impression during the interview process. Therefore, in the current study, the interview situation was developed on an egalitarian basis to allow the participants to share deeply personal thoughts and feelings (Collins, Shattell & Thomas, 2005). I attempted to demonstrate a neutral attitude and made participants aware that there were no correct answers to the questions posed.

Regarding truth and authenticity in interviews, resistance could potentially have arisen. According to Charmaz (1995), participants are likely to be reluctant to reveal certain things about themselves. Interviewees may choose particular aspects of their lives which they are most interested in narrating, despite the researcher as interviewer preferring to hear other stories than the one being told (Nunkoosing, 2005). In phenomenological interviews, Creswell (2007)
emphasised, asking appropriate questions and relying on participants to discuss the meaning of their experiences requires patience and skill on the part of the researcher. According to Nunkoosing (2005), the interviewer should wait, negotiate and build an enabling relationship with the interviewee, thus allowing him or her to reveal the aspects required to develop insight into the situation. In the present study, I did not push the interviewees to reveal things they did not wish to disclose; the interviews were carried out in a comfortable situation to avoid giving participants the feeling that they were being interrogated. Most participants preferred to meet for the interview in a publicly accessible private space at their workplaces. The participants claimed that they could speak more freely in a private sphere at the workplace than at home as they felt they would be very busy with domestic activities at home, such as taking care of their children, preparing dinner for their families, and the like. However, two participants preferred to be interviewed in their own homes due to time constraints they were encountering at the times we arranged the interviews.

The potential problems of interviewing at work place might emerge related to confidentiality. As the nurse managers are the only access to obtain participants for this study, the participant’s identity cannot be disguised from the nurse manager. However, to ensure the confidentiality of what participants revealed in researcher-participants’ conversation, I did not involve nurse managers in the interview process, I convinced participants that the conversations are secured and the interview narrative will not be delivered to nurses managers. I also found some feminist issues in the interview process. It was difficult to interview female participants at home because of child-care and domestic roles.

3.5 The transcribing process and the translation of transcriptions
To transcribe means to convert speech or other data into written form. In the present study, all interviews were audio recorded and transcribed by myself. This allowed me to immerse myself in the data and to identify some important
emerging issues. According to Nikander (2008), the process of transcribing accords the investigator multiple hearings and viewings of data. I can benefit from the transcribing process as an initial part of data analysis. All transcriptions for the current study were made in Bahasa Indonesia as the interviews were conducted in Bahasa Indonesia. Though in the data chapters there is much about communication in local language as an important adjunct to care, however in the interview process nurses being interviewed in Bahasa Indonesia rather than using local language. Bahasa is normally used in a formal conversation. However, in some occasions nurses use local language and they translate into Bahasa.

Though transcribing may be a time-consuming, messy and exhausting process, transcriptions generate textual versions of the original interactions between interviewees and interviewers (Nikander, 2008). The transcription of each interview for the present study took an average of 10 hours as the length of interviews was varied. Each interview generated approximately 17 pages of transcribed text; the shortest interview generated five pages and the longest 23 pages. All transcriptions were checked by the participants to ensure accuracy. This process enabled participants to clarify or rectify their answers if required and prevented me from misinterpreting the data (Chan et al., 2013). Some participants requested maintenance of the anonymity of the patients’ ethnicities (tribes) and places mentioned in the interviews. For instance, one participant describes a Madurese patient’s behaviour who lives in one rural in Banyuwangi. This participant wanted to disguise the patient’s identity.

As the research project was undertaken in a non-English-speaking country, a process of translation and transliteration was undertaken as part of the data analysis. Translation is the process of translating words from one language to another language. Transliteration is the written transposition of a word into a similar-sounding word in a language that uses a different alphabet. I decided to use one-way translations, which are translations from the original version into
the target language made by a bilingual person (Weeks et al., 2007). This involved forward translation, from Bahasa Indonesia to English, and backward translation, from English into Bahasa Indonesia. These processes were conducted by myself due to considerations of time efficiency and cost. Further, in order to become more familiar with the data (Spencer et al., 2003), the researcher him- or herself should be considered as the most appropriate person to translate transcriptions. Eighteen of the interviews in the present study were transcribed by myself. Only two interviews were transcribed by a professional bilingual translator. Confidentiality of the transcripts was maintained through a confidentiality agreement between the translator and me. The interpretive process was built simultaneously during this process, including interviewing, transcribing and translation.

3.6 Data Analysis
The present study utilised hermeneutic phenomenology for data analysis. Hermeneutic phenomenology employs an interpretive approach to investigate the participants’ everyday life as they experience a particular phenomenon (Miles et al., 2013). As previously discussed, Heidegger felt an understanding of the meaning of lived experience could only be achieved through the interpretive process (Smith, 1996). The five phases of the hermeneutic circle as elucidated by Crist and Tanner (2003) and based on a Heideggerian philosophy is used to guide the process of data analysis. Lee and Lau (2013) agree that Crist and Tanner’s circular process of hermeneutic interpretive phenomenology is the most appropriate to develop an experiential interpretation of a phenomenon. During the analysis, all transcriptions were read line by line and analysed in Bahasa Indonesia.

The five phases of hermeneutic analysis according to Crist and Tanner (2003) are: Phase 1: early focus and lines of inquiry, where the first few transcripts are examined in an interpretive process; Phase 2: central concerns, exemplars and
paradigm cases, where central concerns, important themes or meanings are identified and the relationship between each informant’s earlier experiences and the current situation are explored; Phase 3: shared meanings, where the researcher identify the connection between meanings found within and across narratives; Phase 4: final interpretation, the development of in-depth interpretations, summaries of central concerns and interpretive summaries; Phase 5: dissemination of the interpretation. Manuscripts reporting the interpretations were refined with input from the interpretive team (my supervisory team). Creation of the final text is an iterative process between examination of the narratives and field notes along with supervisory team input. As noted by Crist and Tanner (2003) the above phases may overlap as the process of hermeneutic interpretive analysis is not linear. As ‘hermeneutic phenomenology seeks to capture such events in the form of stories of what happened’ (Smythe, 2010, p. 1475), the hermeneutic circle can be viewed as ‘an unending process’ (Crist and Tanner, 2003, p. 205) and the interpretation is built simultaneously.

3.7 The trustworthiness of study

In order to establish rigour in this phenomenological study, validity and reliability (trustworthiness) are maintained. Seale and Silverman (1997) argue that rigour is important in qualitative health research. The concept of trustworthiness (Lincoln & Guba, 1985) is adopted, including the four aspects credibility, authenticity, transferability and dependability. Confirmability, though a further criterion of trustworthiness, is not involved in this study as confirmability is related to objectivity, a concept antithetical to phenomenological study where the investigator’s preconceptions become part of the analysis process (Morse et al., 2002).
Credibility is related to the notion of whether the final interpretation is believable and fits with the participants’ narration of their experience (Tobin & Begley, 2004). Credibility is demonstrated in this study through member checking and peer debriefing. Firstly, the transcript or raw data were checked for accuracy by participants. This procedure allows participants to determine whether their answers need to be clarified and avoids investigator misinterpretation of the data (Chan, Fung & Chien, 2013). Secondly, peer debriefing is a process of external checking. For the purpose of this study, my supervisors are the peer debriefers in order to maintain researcher’s honesty and ensure that method, meaning and interpretation are appropriate (Creswell, 2007).

Authenticity relates to my ability to accurately interpret the experience of participants. Tobin and Begley (2004) argue that authenticity may be demonstrated by ‘showing fairness’ to a range of participants through ‘depiction of their associated concerns, issues and underlying values’ (p. 392). In this study, authenticity is demonstrated through understanding the phenomenon under study, appreciating the viewpoints of the participants and empowering them to convey the phenomena (Creswell, 2007).

Transferability is regarded as the generalisability of the inquiry, comparable with external validity (Tobin & Begley, 2004). Lastly, dependability is comparable with reliability. Dependability is demonstrated through creation of an audit trail and a continuing process of reflexivity to be established during the study (Tobin & Begley, 2004). Reflexivity refers to the self-awareness of the researcher through evaluation of his or her own feelings and experiences which might influence the study (Burns & Grove 2001). Documentation of data, method, and results are audited by the supervisors. Reflexivity is achieved through self-criticism and evaluation of my feelings towards the study process.
3.8 Ethical considerations

This study obtained research ethical approval from the University of Manchester and the research settings in Indonesia. Ethical approval from the Research Ethics Committee at the University of Manchester was granted on August 26, 2015. Approval from the Public Hospital of Malang was granted on February 12, 2016 and from the Public Hospital of Surabaya on February 25, 2016. The authorities at the primary health centres in Jember and Banyuwangi accepted the letter of research ethical approval from the University of Manchester and did not require further ethical review.

Regarding ethical issues in phenomenological inquiry, informed consent is a vital aspect of the research interview (Jackson, Daly & Davidson, 2008). Informed consent refers to consent received from a participant who has received sufficient information regarding the research to make an informed decision as to whether to participate (Fontana & Frey, 2008). Once the nurse manager gave me the names of potential participants, I approached each participant to explain the purpose of the research; further, the Participant Information Sheet (PIS) was handed out. I emphasised that participation was entirely voluntary and that a decision not to take part would not affect the nurses’ future careers. I also explained that anyone deciding to participate would be free to withdraw their data from the study at any time up to the point at which the research was published without giving a reason and without detriment to themselves. However, none of the participants withdrew their data. Once each individual agreed to take part, the participant and I arranged a suitable time and place for the interview based on the participant’s preferences. On the day of the interview, prior to the interview process, consent forms were signed by both the participant and me as a researcher, with one copy to be kept by the participant and the other by me.
Another ethical concern in phenomenological study is participants’ right to privacy, confidentiality and data security. Since qualitative research generally uses a small sample size and rich description, it can be difficult to maintain anonymity (Holloway & Wheeler, 2002). Participants may be concerned that they can be identified, and participants in the current study were therefore assured that their anonymity would be maintained by means of the use of participant reference numbers should data be reported or published in journals. I used reference numbers to disguise the real names and identities of all participants. However, it is acknowledged that anonymity could not be fully maintained in the current study as the nurse managers gave me access to the nurses. Therefore, it was confirmed that the head nurses of all four of the hospitals and health centres from which interviewees were drawn remained uninvolved in the interview process. It was not possible for the head nurses to match the interviews with any of her or his nurses.

Regarding confidentiality, the participants were informed that the research subject’s data would be stored securely. Data such as digital audio recorded materials, as well as papers such as signed consent forms and the master list of subject’s names and code numbers, were stored in locked desk in my room. Electronic data were stored on my personal encrypted laptop equipped with a password. Such data have also been stored on the protected server at the University of Manchester, accessed through a password-protected university computer. Sending data by email between my supervisors and me was unavoidable due to the fact that the research was being conducted in Indonesia. Any such data was sent through the University of Manchester link as the university servers are secured.

The digital audio files will be stored for up to one year after the end of the PhD project as they may be required for further analysis. Other data will be stored for up to five years after completion of the PhD project as I may need to return
to it during the process of dissemination or for the purpose of future studies regarding nurses’ caring experiences in other provinces in Indonesia.

I ensured the confidentiality of participants by using no participant names in any written reports created as part of the study. I used reference numbers to disguise the real names and identities of all participants. Any information which might identify participants was removed. Confidentiality was maintained during the translation process by means of a confidentiality agreement between the professional translator and me.

### 3.9 Summary

Hermeneutic-Interpretive phenomenology, based on the work of Heidegger and Gadamer, was chosen as the research methodology for this study. Employing a purposive sampling method, 20 nurses were involved as participants. Ten nurses were from two public hospitals and ten other nurses were from two primary health centres. Individual semi-structured interviews were used to explore participants’ stories.

Data were analysed using five phases of the hermeneutic circle as elucidated by Crist and Tanner (2003) based on a Heideggerian philosophy. Four aspects of credibility, authenticity, transferability and dependability were maintained to enhance trustworthiness of study. This study gained research ethics approval from the University of Manchester and the research settings in Indonesia. Permission to conduct the research was obtained from hospitals and primary health centres. Permission to record interviews was obtained from each participant. All participants were assured that all information would be treated in confidence.

This chapter has elaborated the research methodology used in this current study. Through process of data analysis, this study has generated three themes:
barriers to caring a heterogeneous society, attitudes towards differences and similarities in patients’ cultural and religious identities and strategies in addressing cultural and spiritual issues. These themes will be outlined separately in Chapter Four, Five and Six.
CHAPTER FOUR
BARRIERS TO CARING IN A HETEROGENEOUS SOCIETY

This chapter aims to elucidate nurses’ views of barriers in caring for patients in Indonesia, a multi-cultural, religiously pluralistic society. Analysis of interviews revealed that nurses’ experiences of barriers to caring for patients from a multi-cultural, multi-religious population can be placed into three major categories: barriers related to cultural issues, barriers related to spiritual issues and barriers related to workload issues. The first two of these will be considered as ‘shadowing’ the work of nurses and the barrier to workload is understood as an actual barrier.

This chapter provides results obtained from conversations between participants and me in the interview process. Analysis of findings in this study indicated that participants expressed concern about manifold barriers which affect nursing care. Various barriers are revealed and grouped into the three categories. Each barrier is outlined in following section.

4.1 Nurses’ views of barriers related to cultural issues
In caring for diverse patients, nurses identified a range of obstacles associated with cultural customs in society. These are family, language barriers, perceptions of illness and treatment, and traditional beliefs.

4.1.1 Family
Family was one of the issues discussed most frequently by participants. According to participants, in caring for patients in a multi-cultural and multi-religious country, family can be a hindrance but can also play an important role in health care. Family involvement is therefore a complex combination of hindrance and help, with some family members hindering and helping.
simultaneously, but the presence of the family in the healthcare environment shadows the patient. Nurse participants explained that in some situations, the presence of families around patients was considered as a barrier to caring for patients, though family might also serve to bridge nurse-patient communication. Nurses in this study viewed patients’ families from both positive and negative perspectives, but this chapter focuses only on hindrances to patient care. Discussions of family as a helpful element in patient care are to be found in Chapter Six. These phenomena are similar to those found in previous investigations (Nielsen & Birkelund, 2009; Jones, 2008; McKinley & Blackford, 2001) in which nurses revealed that family involvement can create distressing events and that extended family visits can be disturbing to other patients. During discussions about nurses’ experiences relating to the family, participants in the present study mostly spoke of family attendance and family visits in hospital, strong family bonds and families as decision makers. These issues are outlined in this section.

Family attendance and family visits in hospital

Participants experienced an uncomfortable situation associated with families’ presence in hospital. The habits of family members bringing several items from home and staying close to patients in a hospital or primary health centre can lead to difficulty for nurses. While nurses were concerned about cross-infection, they also claimed that the presence of a large number of family members obstructed their performance of their nursing activities and forced nurses to work in cramped spaces. Several nurses commented on these issues as follows:

‘This is Madurese custom, the patient is only one, but the family who drive are many; they take a pickup. They also do not comply with the visitation schedule…. There are also family members who wait for the patient in the room, too many people. They stay at the primary health centre (PHC). Some sleep inside the room, some sleep outside. If there are too many people inside, I tell them and ask them to leave. However, sometimes they are grumpy: “I am here paying for the service,” they say. In the afternoon, visitors sometimes bring a lot of food, they eat together at the PHC. The family, not the patient. The majority of them are from the village, the
countryside. I have told them, “If you want to visit the patient, bring enough food and wrap it up.” It is their culture. People bring a large basket filled with food, they also roll out a mat. Those who live far, sometimes they stay and shower at the PHC’ (P 3).

‘Generally, there are many visitors. They often come inside the room all together. We have told them to go inside one by one, but they ignore us. Particularly in the afternoon, probably because they are working in the morning. It inhibits nurses’ activities. Sometimes, other patients complain because the rooms become crowded with people’ (P 10).

‘When families want to enter the room, but the room must be sterile, then I say that the patient’s condition is very prone to infection, especially infection from the outside, you do not know, maybe if we use a microscope, we would see a lot of germs on your clothing or skin. [...] Families who wait for the patients, they sit outdoors. We feel disturbed because it is difficult to move when performing nursing interventions for patients in the room’ (P 11).

‘They just sat outside the room, in front of the patient’s room. So, it didn’t bother me when caring for patients. I just felt less comfortable’ (P 8).

‘The patient was only one, but the visitors were so many. Sometimes they would stay and sit on the floor in front of the terrace. We told them to not sit there, and they went away for a while, but they would come back afterwards. It was crowded. We felt uncomfortable’ (P 9).

Participant 3 felt that family members from certain ethnic groups often crowded into a ward. They came in large groups and stayed in the hospital or PHC to accompany a patient. Some family members accompany their ill loved one in the room and some others sit outside the ward on the floor in front of the terrace. This situation was described by participants 8 and 9 as an uncomfortable condition as the patient’s room becomes crowded with family members. This finding is relatively similar to those of other studies regarding family attendance in hospital. One study undertaken by Nielsen and Birkelund (2009) identified the presence of relatives in a ward as a disturbance to other patients. This shows that family presence can make other patients feel less comfortable. Further discussion of this issue can be found in Chapter Seven.
Participants 3 and 9 link the family behaviours mentioned above to the customs of a particular ethnic group, Madurese. Madurese families often bring items from home such as mats and foods; they roll out their sleeping mats on the floor next to patient’s bed or outside the room. The behaviour of family members who mar the cleanliness of the room is also of concern to nurses. Nurse participants interviewed had informed family members that the number of family members permitted to accompany patients in the ward is restricted and that family are not allowed to sit on the floor of the ward’s terrace.

However, family members comply with nurses’ requests only temporarily, and they often return to sit on patient’s bed or on an unoccupied bed next to patient’s bed. Based on my observations, PHCs do not provide waiting rooms for family. A spacious terrace is available in front of patients’ rooms. As a result, family members use this space to sit and sleep while they accompany patients in the PHC. Some hospitals provide waiting rooms for family; however, family members often do not use these waiting rooms. According to participants in the present study, family members prefer to sit on the floor in front of patient’s room as they want to be close, shadow and give attention and support to the patient.

Participant 11 spoke of concern with the risk of transmitting infection that resulted from family behaviour when visiting patients or accompanying patients in the unit. According to an observational study by Cohen et al. (2012), some patients received as many as 18 different visitors per hour. This may increase the risk of infection transmission from patients to visitors or from visitors to patients. Therefore, nurses should develop a strategy to heighten family awareness of the risk of cross-infection. In certain conditions, such as when patients are suffering from communicable diseases or when outbreaks of disease occur, nurses may apply a ‘temporary suspension of visiting’ (TSV) to diminish transmission of the disease. It was indicated that the possible advantages of TSV
application outweigh the disadvantages during norovirus outbreaks (Currie et al., 2016, p.124). TSV is a strategy that can be applied to reduce the risk of transmitting infection. Further discussion is provided in Chapter Seven.

Family attendance and family visits in health care areas sometimes cause other problems, for instance in the case of smoking. One participant working in a PHC reported:

‘A few years ago, the PHC provided a smoking room for visitors to eliminate smoking around patients’ rooms. However, this smoking room is very rarely used as visitors usually smoke outside the PHC’ (P 2).

This phenomenon demonstrates that a few years ago, family and visitor awareness of the smoking prohibition in the PHC area remained low. Though they smoked outside the patients’ rooms, doing so endangers passive smokers and even patients in the room.

Physical and non-physical violence also emerged as an issue in the present study. Participant 3 described a family who visited a patient at the PHC in a large group. Family members accompanied their loved one at the PHC; some of them slept in the patient’s room, while some slept on the terrace of the room. When the nurse told the family members that they were not allowed to stay at the PHC in a large group, one family member became grumpy and said that he was paying for the service at PHC and that family deserved to stay there. Another participant in the present study experienced physical violence in the emergency unit. One participant from a hospital said:

‘There was a male patient delivered to the emergency room due to a traffic accident. He was grabbing and yelling at me and other health staff in the emergency unit’ (P 15).

This participant understood that the physical and non-physical violence perpetrated by this patient was due to his loss of consciousness. Along with the perception of family presence in health care settings as a barrier, the quotations and descriptions above depict nurses’ emphasis on completion of their nursing
tasks rather than on showing a caring attitude in providing nursing care. Nurses treat the patient’s family as if they were not part of the patient, whereas patients and families cannot be separated because prior to entering the hospital, the patient lived with the family.

In another case, the participants mentioned it was difficult to handle visitors when the patient was a prominent figure or religious leader as the ward would become very crowded with people. Many visitors would arrive continuously. Nurses also voiced their feeling of being disrupted by a very crowded room, as shown in the excerpts below:

‘There is a certain culture, when a family member is hospitalised, usually the extended family comes, many visitors come. Especially when the patient is an influential person such as the head of a village, many visitors would come to the hospital’ (P 16).

‘When the patient is a religious figure, there are many visitors and families who wait for the patient. They sit outdoors.’ (P 11).

In Indonesia, some figures are respected by society as influential leaders. These influential figures are regarded as people who have power or influence and who are capable of giving good advice and guidance in social life. Such important figures are known as *tokoh masyarakat* (community notables). Each region or tribe has different names for community notables. For Madurese and Javanese, the titles of community notables include *tokoh desa*, *sesepuh desa* and *kiai*. *Tokoh desa* comprise important figures of a village, whereas *sesepuh desa* are village elders, though they are not very old; *kiai* reflects a religious authority, religious teacher or religious leader (Nooteboom, 2015; Pribadi, 2013; Sukimi, 2009).

When community notables are ill and/or hospitalized, the rural population visits to show their great respect for the influential person. This phenomenon is very similar to that of Roma. Roma people (also known as gypsies) live in a large extended family, usually called a clan. When a family member is ill, family
attendance is considered crucial to show respect and concern. Galanti (2007) argued “when the ill one was a king of a clan, the presence of the all members of clan was almost mandatory” (p.99). The entire clan came in the evening and stayed all night. Therefore, the nurses should be aware of people’s loyalty to their important figures. As the community notables are still regarded as important figures in rural society in Indonesia, cultural knowledge is pivotal for Indonesian nurses as they care for patients from very diverse cultures.

**Strong family bonds**

Based on the interview analysis, family visitation and family attendance have a close association with strong family ties in Indonesia. Participants described several family behaviours in a ward and connected them with the power of family ties. According to the participants, families often stay 24 hours a day in the hospital to accompany the patient and take items from home to the hospital for themselves such as pillows, blankets, floor mats, and rugs. They also take food for themselves and the patient. A large number of relatives visit the patient, as depicted in the following excerpts:

‘A certain ethnic group has strong family ties. We sometimes have difficulty to make them understand. For example, when I was asking them to wait outside for a moment as we needed to examine the patient, it took a lot of energy to explain this to them. Sometimes we need to explain firmly and ask them to leave the ER. Otherwise, they would crowd inside the ER’ (P 15).

‘The families bring floor mats, bring food from home. The food is not for the patient, but for them (family), to eat together. In addition, guyub [Javanese for friendliness, togetherness, closeness among family members] is a characteristic of theirs. If someone is ill, then many people come, they are guyub. Their culture is guyub’ (P 2).

‘It is rather difficult to tell them to wait outside and that only two people are allowed to accompany the patient in the room. Perhaps it is their culture, called guyub. When we’re not able to deal with this situation, sometimes I even call security to ask the visitors to leave the room’ (P 18).
Participants in the present study depicted the strength of the family ties described as guyub. Family members come to visit and accompany patients as an expression of the family’s attention and support. Nurses sometime feel it is difficult to overcome a situation in which many family members and visitors remain around a patient’s room. In the current study, participants identified the family behaviour of accompanying patients in health care settings as related to Indonesian cultural traits. The rational explanation for this phenomenon is that the sense of family togetherness in Indonesian family culture is very strong.

According to Goodwin and Giles (2003), Indonesia is one of the most collectivist societies in the world. Goodwin and Giles (2003) also cited Hofstede’s ranking of individualism across nations, in which Indonesia was ranked 47th out of the 53 countries assessed, whilst Britain was ranked 3rd on this dimension. Another previous study on individualism and collectivism across cultures found Indonesia to be the least individualist country of the nine studied and placed it third in terms of family integrity (Trandis et al., 1986). Although the study was conducted in the 1980s, the culture of family members taking care of one other has remained a tradition in Indonesian (Effendy et al., 2015). As a result, instead of being alone, Indonesian society prefers being together, and likewise, a family always wants to be close to the patient.

Family is central to the lives of the Javanese and Madurese. The essential nature of family for Javanese is depicted in the proverb ‘mangan ora mangan waton kumpul’, which means that even if there is no food to eat, being together is the most important thing (Subandi, 2011). Whatever situation they may encounter, as long as they live close together, their lives are peaceful enough to help each other. Similarly, in Madurese family culture, the entire extended family traditionally live in the same area, called a tanean lanjang (vast land with long yard), consisting of a main house surrounded by other houses, a prayer room, a storehouse, a family tomb, and at the centre, a long yard.
The *tanean lanjang* is normally occupied by three generations of family. All family members have the same responsibility to maintain the extended family and help each other (Noer, 2012). Although in modern urban Indonesia the extended family do not always live close by, the value of togetherness is expressed on certain occasions such as ceremonies in general (*hajatan*), childbirth ceremonies (*syukuran*), pilgrimage ceremonies (*selametan*), and Eid or Christmas celebrations (Rainy et al., 2017). Family who live far away return to their home towns to celebrate these occasions; this is called *pulang kampung* (‘back to home town’). They arrive at their parents’ house or at the home of the older generation of the extended family. Clearly, most ethnicities in Indonesia possess a tradition of being united or congregating. Therefore, it is reasonable that the family tradition of being together should also be found in the health care environment. The nurses in the present study referred to these behaviours as *guyub*. Although *guyub* is a Javanese term, the nurses did not connect this behaviour solely to Javanese families. *Guyub* represents a trait of Indonesian families beyond the Madurese and Javanese population in East Java Province.

Several papers describe differences in the characteristics of family ties between Asian and Western countries. In Asian countries, most people live with their extended family and have strong family ties. For example, in Taiwan, family members are usually regarded as a whole body, and society’s cultural tradition includes collectivism, familial interests, and filial piety (Chang, 2013). Traditionally, for most Asians, the family of orientation (the individual, parents, and siblings) is placed above the family of procreation (the individual, spouse, and children) (Galanti, 2008). This means that the parents and siblings are accorded more value than the spouse and children. The extended family is viewed as a centre of social and financial support. In contrast, Western societies value the family of procreation above the family of orientation. They live in
nuclear families. Once their children marry, parents allow their sons and daughters to have their own lives (Galanti, 2008).

In Western populations, which usually have small families and live in a nuclear family, privacy is of vital importance. They generally visit their ill loved ones only for a while as they want the patient to rest in order to get well (Galanti, 2008). Patients do indeed require privacy and rest to get better. No hindrance is produced when this concept is applied in urban areas, where people tend to live more individualistically and local traditions are beginning to vanish due to modernisation (Effendy et al., 2015). However, when it is applied in Indonesia, in which more than 50 percent of population lives in countryside and cultural traits are still preserved, the resulting phenomena differ. In a society with strong family bonds, it is not easy to tell the entire family not to accompany the patient for a long period of time. Nurses, as part of the cultural community, should be aware of the cultural tradition of familism in Indonesia. Nurses should understand that, the closer the relationship, the more frequently family members visit a patient (Ryan and Scullion, 2000). While the most frequent visitors are generally the nuclear family, patients may also be visited by the entire extended family.

Galanti (2008) underlined that it is common for Asian patients be accompanied by family members at their bedside throughout the day. Therefore, in order to provide privacy and sufficient rest time for patients, nurses should facilitate family visits while allowing families to maintain their societal traditions. As suggested by Galanti (2008), in cases in which a patient is visited by a large number of family, nurses could ask the family members to choose one person to see and have a chat with the patient for a specified amount time, e.g. one hour. The family members could take turns sitting with the patient. In this way, all family members would have an equal chance to be with the patient, without
ignoring the patient’s need for time to rest. This scenario is one example of a strategy for applying a concept of nursing that respects local culture.

Families as decision makers

The nurses interviewed in the present study revealed that family members have a powerful position in decision-making processes for patient hospitalisation or getting medical treatment. Even when the patients are adults, the family serves as the decision maker for people of a certain ethnicity, as illustrated by an interviewee’s statement:

‘I think the patient’s family has a dominant position in the decision. Once a patient needs hospitalisation, the extended family come. Then, there is a debate among the family. Some agree to hospitalisation and some others disagree with it. This often happens. In such a case, I defer to the family; it is up to them. I sometimes suggest that they discuss it among the family’ (P 2).

Indonesia is characterised by strong family ties and primarily patrilineal system. Traditional Indonesian families tend to rely on their extended paternal families to make decisions in all aspects of life, including hospitalisation. Extended family members are regarded as a source of moral and monetary support (Riany, et al., 2017). Indonesian residents exhibit ‘relatively high’ interdependence (Macdonald & Jessica, 2006); families sometimes consult ‘second-layer’ family members, such as cousins-in-law or cousins of parents, when deciding whether a patient should or should not remain in hospital.

In certain family groups with low incomes or little experience with hospitalisation, the directions of other family members – those perceived as educated or wealthier – are followed. The family would depend on these individuals to communicate with health care providers or to organise the payment of medical expenses. Problems may arise in cases of disagreement between first- and second-layer family members. The decision-making process can then be protracted, even if the patient requires immediate treatment. This also creates a difficult situation for the nurses taking care of the patient as family
This finding is consistent with some studies investigating family disagreement in decision making about treatment. A previous survey of family members of deceased lung cancer patients found that family conflict could be divided into four types: disagreements or arguments among family members, resentment among family members, feeling anger toward one another and yelling among family members. Almost one-third of families reported disagreements or arguments among family members (Kramer et al., 2009). Another study, conducted by Siminoff et al. (2012), found a relatively low incidence of family conflict; approximately eleven per cent of patient-family caregiver dyads reported the presence of decisional conflict. It was also revealed that family disagreement about care and treatment decisions is significantly related to depressive symptoms, feelings of overburdening, and physical health symptoms (Koerner & Shirai, 2012). Furthermore, Koerner and Shirai (2012) discovered that those who hold strong familistic beliefs may demonstrate frustration with internal conflicts arising among family members regarding patient treatment and care.

According to the statement of participant 2 above, participant 2 merely focuses on a family’s role as decision maker. This nurse was not concerned about patient autonomy, whereas the (adult) patient is the person legally entitled to make decisions about his/her own life (Nistelrooij et al., 2017). While it is challenging for nurses to navigate the cultural family system described here, nurses should be patient advocates. To facilitate family involvement in decisions regarding patient hospitalisation, nurses could ask the family to select primary people in the family to be primary decision makers (Quinn et al., 2012).
On some occasions, nurses are disappointed with family decisions, as shown in the following excerpt:

‘If the family refuses, we cannot do anything. Then, they sign a rejection form. It is their right. However, [in this case], I was disappointed, very disappointed, because we cannot do anything when we know the conditions require a particular intervention, such as CPR or resuscitation, but the family refuses. I was very disappointed; perhaps the patient should be alive. I was very disappointed because [the patient’s death] happened for a non-technical reason’ (P 15).

The quote above also illustrates the nurse’s expression of unhappiness with family decisions that not meet expectations. To deny a patient’s autonomy and enable a family member to decide whether to administer CPR is ethically problematic. According to Sudore et al. (2014), in some cases, a patient may designate a close family member as the decision maker in such a situation. However, nurses should pay attention to decisions that might harm the patient. A study undertaken by Sharma et al. (2011) found that family members were often unable to generate decisions accurately related to treatment options, where to seek care, and advance care planning. The authors suggested that nurses and family need to consider a patient’s will or preference in making decisions.

Alternatively, nurses can ask family members to choose one person as the family spokesperson. A spokesperson has a role as a bridge of communication between the extended family and the health providers. Choosing a spokesperson can facilitate consensus and agreement within families (Quinn et al., 2012). Overall, though nurses seem to struggle with Indonesian ideas of familism, in a country like Indonesia, with a very heterogeneous culture and many tribes, nurses should understand societal family traditions. Indonesia’s tradition of strong family ties must be kept in mind; the patient, as a person, belongs to the family. If one family member is suffering from disease, the entire family is affected.
4.1.2 Language

Communication is another barrier in caring for Indonesia’s very diverse patients. Language can be a major obstacle for Indonesian nurses as they share a nationality but have diverse backgrounds in terms of ethnicity and unique, complex local languages. The participants in the present study recognised their limitations in communicating with patients who speak local languages and do not speak Bahasa Indonesia, as reflected in the following quote:

‘Sometimes patients cannot speak using Bahasa Indonesia. Consequently, we have to use their local language. However, I do not understand their language. My weakness is about the language’ (P 12).

The majority of the Indonesian population predominantly utilise a local language for daily communication. Approximately 79.5 percent of the population aged 5 years and older use their local languages for daily communication, with 19.9 percent using the national language and 0.3 percent using foreign languages (Statistics of Indonesia, 2011). This demonstrates the Indonesian preference for local languages over Bahasa Indonesia as the colloquial language. Nurses in Indonesia meet patients speaking a wide range of local languages. Nurses who have long lived in an area with a local language not their own usually understand what people say but lack the confidence to reply in the local language. As one nurse said:

‘I cannot speak Madura. I actually know what they mean, but I could not give feedback, I could not respond to it’ (P 6).

Like the very diverse types of ethnic groups in Indonesia, the types of regional languages also vary. Overall, the local languages in Indonesia number approximately 2,500, or almost double the number of ethnic groups in Indonesia (Statistics of Indonesia, 2011). Madurese and Javanese, like some other local languages such as Balinese and Sundanese, use different words depending either upon status or upon the relationship between the two speakers. There are six levels in Madurese, ranging from kasar (coarse), biasa (ordinary), and tengah (middle) to alus (refined), alus tinghi (low refined) and alus mandhap (high refined) (Stevens, 1965).
In the Javanese language, likewise, there are two main levels of speech, namely *Ngoko* and *Krama*. There are two further levels within *Ngoko*, including *Ngoko lugu* (ordinary) and *Ngoko alus* (low refined). There are also two further levels within *Krama*: *Krama lugu* (refined) and *Krama alus* (high refined) (Trahutami, 2016; Indrayanto & Yuliastuti, 2015). A previous study indicated that manner of speaking and local accent discrepancies can be a major barrier in providing care for people of different cultural backgrounds in Turkey (Ayaz et al., 2010). Therefore, it is understandable that nurses attempting to communicate in a complicated local language would be very careful. As revealed by participants 2 and 10:

‘Actually, I knew what they were talking about and I wanted to communicate with them, but I worried they will perceive me as a disrespectful or impolite person due to my language. It happened often. Yes, this is the obstacle in communication’ (P 2).

‘I understand the Madurese language, but only superficially. I could not speak the highest level of Madurese language. I am not confident to speak Madurese’ (P 10).

The quotes illustrate that participant 2 and 10 were not confident to speak patient’s local language as there are several levels of speech of local language. Language barrier is one of principal obstacles encountered by participants in providing care. Given that language serves as a tool of communication, this situation presents an obstacle to communicating with and to examining patients.

The presence of a language barrier can impact on communication between health staff, patients and their families. This, in turn, can give rise to the possibility of misunderstandings and fearfulness on the part of patients to fully reveal their emotions (Maesschalck, et al., 2011). When patients can convey their concerns, ask questions and receive clear answers from health care providers, however, patient safety improves considerably (Ashton, 2012). One phenomenological study found that nurses felt nurse-patient conversations were
often strained and that communication was limited due to language problems. Consequently, nurses had difficulty in assessing the patients’ needs (McCarthy et al., 2013).

Nurse participants in the present study also spoke of the worries they had as they did not understand local languages. They expressed concern about the accuracy with which non-Bahasa-speaking patients understood the information they were given, as well as about misinterpretation due to language problems, as expressed in the excerpt below:

“When I was working at the hospital, the problem was communication. Sometimes, I couldn’t understand what they said. I asked them to speak in Bahasa, but some patients couldn’t speak Bahasa. Thus, sometimes it became a problem as I couldn’t speak their local language. I doubted whether or not patients understood what I had explained. I was worried that they might misinterpret what I said” (P 5).

This finding supports other studies that show language hindrance to be a potential contributor to either misunderstandings or undelivered messages. As a consequence, nurses experiencing language barriers are unable to provide appropriate support to the patients as the patients cannot express their feelings to the nurses (Jirwe et al., 2010). The language barriers act as a ‘fog’ through which nurses must pass before they can engage with the patient and their family, especially when so many do not speak the same language as the nurse. Language barriers can also result in a greater chance of delayed communication about diagnosis, treatment and prognosis, misunderstandings regarding instructions and advice, and missed follow-up appointments, as well as the experiencing of adverse drug reactions (Ashton, 2012; Karliner et al., 2011).

According to nurses, patients who speak local languages and not Bahasa Indonesia are generally people of the older generation who live in the countryside. However, some young people are also unable to speak Bahasa. Some always use their local language in daily life, as mentioned in the following illustrations:
‘Sometimes there are patients who really do not understand the national language. They do not understand at all. Generally, they are from rural areas. Only some people. The old generation, but the young people as well sometimes’ (P 15).

‘Some patients do not speak Bahasa and do not speak Javanese; they only speak Madura. They typically are elderly patients, but some are youth with non-formal educations from, for example, traditional Islamic boarding schools [Pesantren education]. Probably, they are used to speaking using the local language instead of Bahasa’ (P 6).

The majority use of Bahasa Indonesia as a language of daily communication is only seen in five provinces, namely DKI Jakarta (90.7 percent), West Papua (69.7 percent), Riau Islands (58.7 percent), North Sumatra (55.6 percent) and East Kalimantan (53.5 percent). Meanwhile, the majority of the population in Indonesia’s other 28 provinces use local languages as the vernacular (Statistics of Indonesia, 2011). Consequently, Indonesian nurses, both in hospitals and primary health centres around Indonesia, care for patients speaking their vernacular languages.

Given the fact that many nurses are unable to use the various levels of Javanese or Madurese, the complexity of the local languages can be seen as a hindrance to communication with patients and families. For instance, there are several factors that influence the use of speech levels in Javanese and Madurese, including gender, age, social status, kinship, positions and roles (Samsiyadi et al., 2016; Indrayanto & Yuliastuti, 2015). The following example from Indrayanto and Yuliastuti (2015) pertains to the use of levels in the Javanese language related to gender. In Javanese culture, a wife speaks to a husband using a level of Krama, but not vice versa:

Wife: Bapak mangke sonten kundur jam pinten? (What time will Daddy come home this evening?).

Mangke and mengko both translate as ‘later’. Mangke is Krama (refined), while mengko is Ngoko (coarse). However, errors in lexical use often occur due to non-native speakers’ lack of knowledge of the concept of levels or to limited Javanese vocabulary. Consequently, the use of the Ngoko level is more widespread because it is more easily understood in conveying information (Indrayanto & Yuliastuti, 2015). A study conducted by Trahutami (2016) found that in Klapadhuwur society, the Ngoko level of Javanese is used in informal communication; in formal situations, though, Krama and Bahasa Indonesia are used concurrently.

While it is known that the language barrier is a major issue in caring for patients in a heterogeneous population, nurses in Indonesia, with its more than two thousand local languages are presented with an extraordinarily complex language challenge. The complexity and very broad range of the Javanese language provides an example of the value of courtesy in communications and relationships among Javanese people (Trahutami, 2016). Nurses who are not native speakers of Javanese may believe that if they use the language levels improperly, they will be considered impolite. Nurses who speak a different local language to that of their patients are at greater risk of communication problems with their patients, particularly with those who rarely utilise Bahasa Indonesia in daily conversation. As a result, nurse-patient therapeutic relationships are sometimes stymied by communication barriers. Patient-nurse interactions are considered very complex in term of language as most patients do not speak Bahasa when going about their daily activities.

4.1.3 Perception of illness and treatment

The nurses interviewed realised the challenges of local perceptions of health and illness and of medical treatment. Some communities have their own strong perceptions, and these are quite difficult to influence. One participant stated
that some people think someone is healthy if they can eat, even when symptoms of illness are present:

‘Her son had had a fever for 10 days, but he still could eat, so the parent considered her son to be healthy. But when her son did not want to eat, it meant he was ill’ (P 8).

This phenomenon reflects a lack of understanding of health and illness. In some East Javanese communities, prolonged illness is often perceived as resulting from a personal fault, either of the patient or the family; having offended either a spirit or a person, or having failed in balancing social and spiritual surroundings (Weesing, 2010). This belief may be influenced by perceptions of the older generation that remain strongly preserved in society (Demartoto, 2013). Indian parents’ attitudes towards certain symptoms of disease can reflect cultural attitudes to child rearing (Cruz, 2016). Their perceptions shape their beliefs regarding illness and healing. Beliefs also impact the ways in which people seek healthcare support (Anania, 2014). As a consequence, it may be difficult for nurses to encourage members of some communities to demonstrate help-seeking behaviours. As described by participant 8, some families still believe in their parents’ and older generations’ perception.

Nurses also mentioned that patients tend to conceal stigmatised diseases such as HIV/AIDS and leprosy. Nurse participants in the current study felt that an obstacle is presented by the fact that social perceptions may impact patients’ decisions regarding care:

‘The stigmatisation of HIV patients is still extensive. HIV patients tend to cover up the disease. They do not want anyone else to know. They do not want their family to know about their illness. They are worried about being rejected by the community’ (P 5).

‘Leprosy is still perceived as a stigma in Indonesia. The patients feel embarrassed’ (P 2).
In addition, people from certain ethnic groups think of injections as a powerful health treatment, as illustrated in the excerpts below:

‘They always ask for an injection. According to them, without an injection, they will not get well. They believe that if they are not injected with drugs, they will not recover. According to them, not to receive an injection means to remain untreated, even if they are examined and given oral medication’ (P 6).

‘Patients from a certain tribe are generally pleased to get injections. They always ask for an injection. The patients have said that no injection is like being untreated’ (P 8).

Participants 6 and 8 described a misunderstanding of the uses of injections that exist in a certain ethnic group. Injections are perceived by some patients as the best medication. In a previous study of nurses in Madurese society, Mulyadi (2015) found that Madurese have a particular perspective of professionalism. Madurese generally assume that health service is excellent if they receive an injection. They consider the injection to be the core of health services. If an injection has not been given, they are disappointed and consider the health provider to be unprofessional (Mulyadi, 2015). According to participants in the present study, patients seem focused on treatment rather than compassionate care. This behaviour or attitude is passed down from the experiences of their parents.

In certain communities, medical treatment is sometimes believed to be harmful to the patient. Nurses may be required to provide a detailed explanation of the treatment given:

‘The treatment that a patient need is sometimes incorrectly perceived by the patient’s family. Resuscitation is considered by a particular ethnic group to hurt the patient because we compress the chest. If we do not explain beforehand, they consider that we are torturing the patient’ (P 15).

Inadequate health literacy and insufficient knowledge about health services lingering from generation to generation can shape people’s perceptions of illness and treatment (Anania, 2014). Clearly, this affects the ways in which people seek
health care support. Indonesian nurses, as health care workers, need to understand social perceptions of disease and treatment and must provide accurate information to counteract the misperceptions that may arise in the community.

4.1.4 Traditional beliefs

As evidenced in the interviews, nurses also faced a handicap in relating to traditional beliefs. Nurses reported some superstitious beliefs that clearly affected the health beliefs of patients:

‘Sometimes there are patients who have a belief that if they are sick, they should not cut their fingernails because it will cause bad luck, and their fingernails become dirty and long. Another traditional belief is related to the day of discharge, which is considered as a bad day. When one patient was allowed to leave the hospital because his condition was healthy, he refused to go home because it was the same day on which his father had died ten years ago. He believed it was not a good day for him to go back home’ (P 13).

‘Even now, there are a lot of people who maintain traditional beliefs. There are patients who refuse to cut their nails or do not want to wash their hair due to their beliefs. Sometimes I have found patients keeping amulets in their pockets, wallets, belts, or on necklaces. They believe in these objects’ (P 15).

Participants 13 and 15 described superstitions among patients and families. According to participants, some patients and families believe in superstitious practices to avoid bad luck to patient. Cutting fingernails and washing or cutting hair during an illness are believed to bring bad luck to patients. Some patients also trust in good and bad days. Based on participants’ reports, patients are sometimes reluctant to be sent back home on the day or date when a parent who had been an in-patient died, for fear that they too would die.

Participants in the present study referred to the practice of some patients of wearing amulets (sikep) to protect them from calamities; these patients believe that the amulets will bring them good luck. Amulets are worn by some people to
prevent them from misfortune, from spirits that could make them ill, or even from others’ evil intentions. The amulet is usually placed around the neck or wrist, above the door to one’s house or inside the wallet (Wessing, 2010). Cultural constructs such as personal hygiene-related misfortune, special days and amulets or other objects as protectors may influence their beliefs about illnesses and healing processes. This may be another hindrance associated with cultural issues experienced by Indonesian nurses in caring for their culturally diverse patients.

Nurses also reported that some patients and families choose traditional healing practices. Some villagers prepare herbal remedies as traditional medicine, as discussed in the following examples:

‘They went to a traditional healer, were massaged there. Whereas, to reach the dhukun’s house (shaman’s house), they must pass through the PHC. They went to the shaman first, and if they did not immediately recover, they would come to the PHC. Sometimes, the shaman or healer is the grandmother of the patient. So, it is quite difficult to tell them. Generally, they prefer to go to traditional healers. But it was many years ago, now only some still go to shamans. Now, shamans do not open practices. Shamans only serve their own families’ (P 8).

‘...a factor related to customs. It is often against the programme of care that we provide. When [haemodialysis] patients go to traditional healers (tabib/kyai), they are usually told to drink plenty of water and drink coconut water as well. Whereas coconut water should not be given to patients with renal failure as coconut water contains high levels of potassium’ (P 12).

Participant 8 spoke of a mother who took her ill child to a shaman (dhukun) to get help. She eventually took the child to the primary health centre as the child did not improve with the treatment from the shaman. Even when the PHC is closer than the shaman’s house, patients prefer to be treated by a shaman. Participant 12 also reported that some patients received traditional healing from tabib. These patients are given water that has been prayed over or paper on which a prayer has been written; they then drink the water or wipe it onto the patient’s body.
Participants conveyed that patients often go to the hospital only when traditional therapy has not been effective. As revealed by participant 16:

‘A patient told me that she had gone for alternative treatment, gotten a white turmeric herb. It was expensive, and she had to go many times for the sessions. They spent a lot of money, but the lump broke and pus came out. Finally, they came to the hospital because the hospital is free of charge. If she had come to the hospital from the beginning, she might not be in such bad condition’ (P 16).

Participant 16 further reported that lack of information about health treatment results in patients being afraid of receiving medical treatment. As conveyed by participant 16:

‘Almost all ethnicities believe in alternative treatment. They do not immediately come to the hospital because they fear chemotherapy or surgery. They have been informed that chemo or radiation will damage the body. They went to alternative treatment. It turned out that the lump had grown back, and eventually she returned to the hospital and were willing to undergo chemotherapy’ (P 16).

According to participants, patients sometimes ask for a combination of traditional healing and medical therapy. Patients follow the medical instructions, but they also ask to use an object obtained from a tabib or shaman. Participants in the present study stated that they tell patients that they can follow traditional healers’ suggestions as long as they do not go against medical instructions. Participant 15 reported:

‘As long as it does not harm the patient or run contrary to medical instructions, we still allow them. But if the patient has kidney failure and brings water [from a cleric], he or she is not allowed to drink the water; for washing or wiping the patient’s skin, it does not matter’ (P 15).

Some patients also use herbal remedies to replace medical therapy. Participant 8 revealed that patients from rural areas generally use and make herbal remedies as traditional medicine. Participant 8 stated:

‘People in rural communities barely use drugs. They prefer herbal remedies. They make their own herbal remedies’ (P 8).
4.2 Nurses’ views of barriers related to spiritual issues

Nurse participants also spoke consistently of barriers connected with spiritual beliefs. The nurses mentioned that individual religious beliefs could affect nurse-patient relationships. Nurses and patients might have different perspectives of religious concepts. It can be seen in nurse-patient interactions between those who share a religion and those whose different religion, as exemplified below:

‘To be honest, a conflict arises in my heart. According to sharia, I know I should help. If I do not do it [help], I am actually committing a sin. However, perhaps they have a different understanding. I felt more comfortable when caring for a cleric. There was a cleric’s wife, I remember it well. The lady had many female students (followers). They accompanied the lady. At that time, I had to perform an urinary catheterisation. Her students refused to allow me to perform the procedure as I am a male nurse. Finally, the lady explained to them that it was allowed according to sharia. Then, I was permitted to perform it. Generally, the clerics do not refuse, they even understand it. Those who refuse are usually those who have partial knowledge, perhaps, and this is often a constraint. I think they are not fanatical, but they do not understand. I finally explained it, sometimes I also recite an Ayat from the Holy Quran. They usually have no strong foundation, because their understanding is only based on the textbook, probably’ (P 15).

‘It is better for me not to say that I am a Christian. It is better if the patient does not know my religion as some people [Muslims] might not willing to be cared for by a Christian nurse. I worry that if they know that I am Christian, they will not want to be treated by me. Therefore, it is better if I do not let patients know that I am a Christian, so I can care for them’ (P 11).

Having different points of view may impact human relationships, even among those who share a religion, as expressed by participant 15. The nurse assumed that the discrepancy in perspectives he described became a barrier to his ability to take care of the patient. Even though both nurse and patient have same religion, this study indicates different religious beliefs may exist among those with same religion. Nurses might unable to perform a clinical activity for patient when the patient or family consider this activity against patient’s religious beliefs. This would be problematic for patient care, whether the patient is an adult or a child. A family’s refusal of treatment related to religious dilemma can
be harmful for the patient. Antommaria and colleagues (2013) underlined that religious exemptions related to parental refusal of treatment should be rejected in cases in which the treatment is considered necessary to prevent the child from a severe condition or death. Therefore, health care staff should provide clear information about the consequences of refusing treatment in relation with spiritual or religious beliefs.

In other cases, individuals may be concerned by differences in religious identity. Participant 11 does want to tell her patient that she is a Christian. Participant 11 thought that some Muslim patients, particularly those with a quite profound religious belief, might be reluctant to be cared for by Christian nurses, although this phenomenon might require a clarification from patients’ viewpoints. As this study is focused on nurses’ experiences, however, patients’ perceptions of care were not included and their views were not obtained.

The above data clearly demonstrate that nurses’ attitudes toward the religious beliefs of patients might be influenced by their own spiritual views. This finding is consistent with a survey in Taiwan conducted by Chiang et al. (2016) in which the spiritual well-being of nurses was shown to potentially affect their attitudes toward caring and to significantly contribute to nurses’ professional commitment and caring. Kaur et al. (2015) posited that nurses’ spiritual intelligence had a notable effect on their caring behaviours, finding a positive relationship between two dimensions of spiritual intelligence (those of critical existential thinking and transcendental awareness) and caring behaviour (the dimension of assurance of human presence). Overall, good spiritual health can generate a positive attitude.

The participants in the current study also mentioned that patients who have ‘strong beliefs’ asked that some requirements, such as a private room and a nurse of the same gender, be met:
‘Patients who are fanatic, they are different. They [women] usually do not want to be treated by a male nurse. They just want to be examined and treated by a nurse of the same sex’ (P 6).

‘There was a Muslim, wearing hijab and burqa [covering her face]. It was the first time she was receiving dental treatment in the PHC. She wanted me to close the doors [front and back]. She wanted to be treated by female doctor. Fortunately, the female dentist was in charge that day. All of the males in the room were asked to leave. Then, when she came back for dental care, we [female nurses] recognised her. Honestly, I feel less comfortable than when I care for patients who do not cover their faces. I feel bit awkward. When we talk to each other, she seems to keep a distance’ (P 10).

According to the reports above, nurses experience obstacles related to the religious or spiritual beliefs of patients when providing nursing care. The nurses linked patients’ requirements of privacy with the patients’ spiritual beliefs. As there are many different beliefs, values and ways of life within Islam, there are many distinct points of view as well. Not all Indonesian Muslims act as described by the participants in this study. However, for those who firmly adhere to Islamic tradition, there are customs which must be followed, such as eating only halal foods, practicing modesty and avoiding some forms of touching (Lawrence & Rozmus, 2001). Cortis (2004) reported that some Pakistani patients request particular diets, such as vegetarian diets, related to their religious beliefs. Another Islamic way of life can be seen in some Muslim women’s covering of their bodies, arms, legs and hair with long dresses and scarves (Ali, 1996). In the provision of nursing care for a Muslim female patient, female nurses might be required as the patient may not be allowed to touch or be attended by anyone of the opposite sex except her husband, muhrim, or close family members (Lawrence & Rozmus, 2001; Ali, 1996).

Requests for privacy may be not always related to religious concerns. Privacy can be associated with an individual’s dignity. Patients might prefer single-sex wards or a single room in order to protect their privacy. Williams and Gardiner (2015) highlighted the desire for privacy as one of the reasons patients prefer single
rooms; others might prefer a shared room as it provides the opportunity to communicate with other patients. Aitken (2008) pointed out that patients’ privacy and dignity should be respected and maintained to prevent patients from unpleasant experiences such as embarrassment, annoyance, disgust, or worry about their bodies being exposed or seen by others. However, this can create a dilemma when female patients are reluctant to be treated by male nurses, particularly during the night shift, when only a few nurses are on duty and a nurse of the patient’s gender may not be available. In such cases, some strategies can be applied to maintain patients’ privacy (Hairon, 2007). For instance, in mixed-sex wards, the beds of male and female patients can be separated; the wards are equipped with separate toilets for male and female patients, and at least one male and one female nurse is provided in each ward to honour the requests of patients who want to be treated by nurses of their own gender (Hairon, 2007).

4.3 Nurses’ views of barriers related to workload issues

Participants in this study who worked at primary health centres recounted that a large part of their jobs related to documentation of nursing activities. Participants reported being responsible for the documentation of outpatient and inpatient PHC nursing care and of the PHC programmes they ran, as expressed by participants 9, 4, and 3:

‘In the PHC, while we have to serve patients, we also need to make a report, which is much more work than in the hospital. At the hospital, we only do a shift report. In the PHC, we do daily reports as well as reports of the work programmes that we manage. I am responsible for managing several programmes for elderly’ (P 9).

‘We are implementing a PHC health programme in the community and reporting on the programme. Together with a local midwife, we provide treatment for local people at the local mosque. We run a programme and report on our achievements each month’ (P 4).

‘Another thing that also takes a lot of time and energy is writing reports. This activity takes up a lot of our time, really. We have to hand in the report monthly, including the number of patient hospitalisations, lengths of stay,
the patients’ ages, genders, etc. However, that is my job. It is very essential for daily and monthly reports. If we do not report, we will not know the prevalence of diseases in this city’ (P 3).

Participants described their activities in nursing registers. They felt that the documenting of activities caused them to be very busy in the PHC. They believed that their workloads at PHCs were not lighter than in hospitals as they also were responsible for implementing PHC programmes in the community. The workload of PHC nurses could impact nursing care quality at the PHCs. In addition, the workload could influence the quality of documentation at the PHCs. As shown in a qualitative study conducted by Shihundla et al. (2016), PHC nurses’ workload may affect the documentation of patients’ information, including the unavailability of patient information and documents as well as illegible, inaccurate and incomplete patient information (Shihundla et al., 2016, p.6). However, nursing workloads have not consistently affected the quality of nursing documentation. In a prospective observational study, Bailey and colleagues (2015) indicated that nurses’ workloads were unlikely to influence the quality of the basic note-keeping and programme documentation between day and night shifts. They did find, however, that tiredness might result in substandard documentation (Bailey et al., 2015). Therefore, the Head of primary health centres should be aware of nurses’ workloads. Managers need to facilitate the easing of nurses’ workload in several ways, such as providing computers for electronically based documentation, arranging scheduled breaks to enable nurses to improve documentation quality, and recruiting volunteers from the community to join in community PHC programmes (Shihundla et al., 2016; Bailey et al., 2015).

Hospital-based nurse participants in the current study also admitted that they could not provide the best care to patients as they were responsible for so many nursing tasks; in particular, these were related to the delegation of duties such as medication administration, intravenous therapy, urinary catheterisation, and
dressings and wound care. Participants realised that their workloads impacted the quality of nursing care:

‘I feel I cannot give optimal support to patients. I talk about it honestly. Why? Because it’s too much work. We do more of the “job of doctors”. It is delegation. The doctors just check out and write down the intervention. All the work is done by nurses. Maybe if the nurses simply carried out the nursing work, then the patients would be doing better. For example, when I did an injection, I did not see the patient’s satisfaction. When I work as a nurse, I see that patients seem happy when we talk or chat with them. When I greet patients and mention their names, the patients look very happy’ (P 17).

‘I cannot lie, between Class III and Class I, it was definitely different, definitely different. Why was it different? The number of patients in Class I is smaller than in Class III. When I was in charge of Class III, the number of nurses on the night shift was only two, while the number of patients we treated was 40. Can you imagine it? How could we provide excellent service, how could we satisfy the patients, it would be impossible. I am now in charge of Class I, and there are nine patients treated by four nurses on the morning shift’ (P 13).

Participant 17 expressed the opinion that delegating affected the amount of nursing time available to provide patients with the best care. Participant 17 often saw patients looking happy when nurses had time to talk with them. However, nurses often lack the time to provide emotional support to patients as there are many things to be done, including completing medical tasks, completing documentation, and performing other nursing activities. Participant 17 felt dissatisfied with the situation.

Participant 13 described differences in the quality of patient care at a Class III inpatient unit and a Class I inpatient unit. A Class III inpatient unit is a ward consisting of 30 to 40 beds. A Class I inpatient unit comprises three to five rooms. Each room contains one or two beds. Participant 13 conveyed that the quality of care in Class I was generally better than in Class III as the workload in Class III is higher than in Class I. This is related to nurse-to-patient ratios. Four nurses in Class I cared for nine patients during the morning shift, while in Class
Ill, only two nurses were available to take care of 40 patients during the night shift. Participant 13 believed that nursing workloads affected the quality of patient care.

The excessive duties of nurses can cause nurses to seem uncaring. Participants in this study emphasised task achievement and the need to manage a large number of patients. Nurses’ workloads are a common problem in almost all hospitals around the world. Workloads affect many aspects of nursing care. One survey in an NHS hospital undertaken by Ball et al. (2014) identified several nursing care activities ‘left undone’ due to insufficient time in the last shift, such as comforting or talking with patients, providing health education to patients, and managing nursing care plans. Additional activities undertaken by the nurses included pain management, treatment and procedures, which were very rarely left unaccomplished. The study also found a significant correlation between nurse staffing levels and the amount of care not being provided (Ball et al., 2014, p.116).

Studies have also identified that health staff workloads even have an impact on hand hygiene. According to an observational study carried out by Scheithauer et al. (2017), there is an inverse association between hand hygiene compliance and workload. The study found that the higher the workload, the lower the compliance with hand hygiene regulations (Scheithauer et al., 2017). Overall, it is clear that the findings of the present study are consistent with those of previous studies, supporting the fact that workloads can become actual barriers to the provision of care for patients in healthcare settings. The issue of nursing tasks that emerged in the current study needs to be taken into consideration. Further discussion of this topic is provided in Chapter Seven.
4.4 Summary

Three categories of barriers to patient care have been presented and thoroughly discussed in this chapter. Based on an in-depth analytical process, I have classified these categories into two types of barriers: actual barriers and shadow barriers. Barriers related to nursing workload issues are considered as actual barriers, while barriers related to cultural and spiritual issues are considered as shadow barriers. Workload issues constitute an obvious barrier in this study as they are directly related to the carrying out of nursing work. The term ‘shadow barrier’ is used in this study to describe all barriers that shadow nurses’ activity. Nursing care was shown in this study to be consistently shadowed by some circumstances which may affect nurses’ ability to take care of their patients. Nurses have much to overcome in order to be able to provide care. The barriers are universal; nurses across the globe carry out nursing tasks and complete additional work such as written nursing documentation. However, whilst nurses worldwide need to consider culture and religious beliefs, these barriers taken on a particular resonance in a culturally and religiously diverse country such as Indonesia. These factors are always present; as such, they shadow nurses’ work constantly and without respite.

Taken together, these results provide important insights into the barriers encountered by participants in caring for diverse patients. Actual barriers and shadow barriers are part of nurse participants’ everyday life activities. The results show that shadow barriers shadow nursing care activities every day and everywhere. These issues constantly detract from nurses’ ability to do their job; they must be passed through like fog or a dense shadow in order for the nurses to reach the patients. Consequentially, these barriers may impact on nurses’ attitudes in questions of diversity and uniformity. The next chapter, therefore, moves on to discuss the attitudes of participants towards differences and similarities in patients' cultural and religious identities.
CHAPTER FIVE
ATTITUDES TOWARDS DIFFERENCES AND SIMILARITIES IN PATIENTS’ CULTURAL AND RELIGIOUS IDENTITIES

The previous chapter discussed barriers to nurses’ performing nursing care. Three kinds of barriers were outlined, including barriers related to cultural issues, those related to spiritual issues, and those stemming from workload issues. These barriers may affect nurses’ views on subjects of patient diversity such as ethnicity, religion, belief, language, and behaviour.

This chapter considers participants’ attitudes towards differences and similarities and how they impact on care. Participants in the present study displayed a variety of attitudes towards diversity and similarity. Four types of attitudes emerged from interview analysis, including describing-stereotyping, feelings of shared cultural ties with people from same ethnicity or same local origins, trying to be fair and respecting differences. These attitudes are depicted and elaborated below.

The phrase ‘describing-stereotyping’ used in this chapter developed as part of data analysis. The phrase is used to refer to the description of different peoples in a stereotypical manner. In this thesis, the term ‘implicit bias’ is also used, it reflects attitudes and stereotypes that unconsciously influence an individual’s understanding, actions and decisions.

5.1 Between describing and stereotyping
The sub-theme of describing-stereotyping indicates that participants’ attitudes towards diversity and similarity were twofold. While participants described the characteristics of patients, participants also maintained stereotyped views based on the patients’ cultural backgrounds. A stereotype is defined as an individual
opinion of a specific population which generally consists of details of a particular group of people and a common trait that characterises people in the group (Ruble & Zhang, 2013).

Pauker et al. (2010) highlighted that a stereotype is compiled by a consensus of understanding, presumption, and expectancy about a particular group of people. It may yield either positive or negative consequence for a single specific group. For example, when Madurese people are described as rude people, it generates an opinion that all Madurese are rude, although Madurese individual with whom one is communicating may not be rude.

Participants in the present study unconsciously gave stereotyped descriptions of patients. This is evidenced in following quote:

‘The way they [ethnic group Osing] speak, it is quite similar to the ethnic group Madurese. Their dialect sounds like they are angry, but actually, they are not. They speak in loud voices and bit rudely’ (P 7).

Two ethnic groups, Osing and Madurese, are portrayed by participant 7 based on the local accent of the people. Initially, participant 7 seems to express a positive perception of Osing and Madurese patients by saying that the patients are in fact not angry. However, participant 7 also explains that patients from ethnic groups Osing and Madurese have a rough accent with loud voices and coarse language:

‘Some ethnic groups, such as Madurese and Batak, their attitudes are similar, they are a bit aggressive, stubborn and rude’ (P 2).

Participant 2 easily recounted others’ ethnic characters, though the question posed to participant 2 regarded his approach to patients and how he cares for patients with different characters. This indicates that participant 2 unconsciously describes others using cultural stereotyping. Based on data, participants 7 and 2 provide descriptions of patients in a stereotypical view.
The phenomenon of describing-stereotyping is even displayed by a participant sharing the ethnicity of the patients she describes:

‘They often speak bluntly. They are also impatient. Indeed, it is characteristic of ethnic group Osing. I am from ethnic group Osing, and I know about people from ethnic group Osing. They talk bluntly. It’s their way’ (P 5).

Though participant 5 admits that her treatment of patients is sometimes determined by their ethnicity and culture, she also acknowledges a range of behaviours among patients from her own ethnic group that might influence other nurses caring for members of that group. However, participant 5 does not link this to how nurses may care for them. Participants in the current study might not be conscious that their interpretations of patients’ cultural identities can lead to the emergence of a stereotyped perception.

Cultural stereotyping is related to people’s perceptions of other cultures and groups, positive or negative, that are based on their beliefs about that culture; these beliefs are formed without interacting with or knowing people from that culture (Ruble & Zhang, 2013; Operio & Fiske, 2003). Cultural stereotyping can cause the emergence of racial attitudes according to which one group is continuously appraised more positively and another more negatively (Pauker et al., 2010). This phenomenon appeared in present investigation and can be identified in following excerpt:

‘Sometimes, what they said was a bit harsh. Madurese are usually not like the Javanese. Javanese, they are calm. Madurese, they are not like Javanese’ (P 3).

Participant 3 was a Javanese who was caring for a Madurese patient. By repeating the statement about distinction between Madurese and Javanese’s behaviour, participant 3 emphasises her interpretation that her culture is better. This expression shows the ethnocentrism of participant 3. An individual’s cultural perceptions might lead to becoming an ethnocentric person. Almutairi et al. (2015) defined ethnocentrism as the tendency of individuals to consciously or
unconsciously evaluate other cultures according to their own cultural perspectives. In the context of nursing care, this could give rise to a cultural conflict related to a cultural or ethnic issue. An ethnocentric nurse could utilise his or her own cultural perspective to appraise and judge the character or the culture of other ethnic groups (Almutairi et al., 2015). An ethnocentric perspective could in turn affect nurses’ attitudes toward and strategies in caring for culturally diverse patients.

While participant 3 perceived her own culture as superior to that of another group, she simultaneously described others both positively and negatively:

‘The Madurese, their accent was rough. They would get angry when they were not satisfied [with our service]. However, if we are kind to them, they will be nicer to us. The nicer we are to them, the better their attitude toward us’ (P 3).

The quotation above denotes participant 3’s acknowledgement of her two opposing viewpoints about Madurese patients: on the one hand is her negative perception of them as rough people, but on the other hand is her view of them as individuals who are kind when nurses are kind to them. Participant 3 stated that she needed to engage kindly with the patients to bring out their own kindness. This divulges a belief that Madurese behave positively only when Javanese are kind to them. In fact, Madurese patients might have had negative attitudes because they were discontented with nursing care they received. It might also be the case with members of other ethnic groups when nurses’ service does not meet the patients’ expectations. Participants in the current study may have false interpretations of Madurese.

The phenomenon demonstrated above indicates that participants’ attitudes towards others with different ethnic backgrounds are affected by their personal justifications as well as by stereotypes of Madurese in society. While some negative stereotypes have been assigned to Madurese, they are also known as friendly, hospitable, loyal, open and sociable (Nootenboom, 2015). Participants’
understanding of both the positive and negative manners of Madurese could have an impact on participants’ perceptions of their Madurese patients. As a result, participants do not realise that they might ignore patients’ needs for care. Participants were overly focused on their personal perceptions of Madurese.

Presumption-based stereotypes refer to attitudes towards individuals who belong to particular social groups (Yzerbyt & Demoulin, 2010). As highlighted by Koenig and Eagly (2014), when people behave towards others according to stereotypes, it makes it difficult to diminish stereotype itself. For instance, some people ascribe weak and emotional traits to female employers or strong and protective traits to male employers. Such stereotypes of female and male employers might influence both the assumptions and behaviours of employees towards their managers.

The present study concludes that stereotypes also affect the behaviour of the stereotyped group members themselves. Members of groups tend to justify their actions based on stereotypes used against them. They receive a stereotype, internalise it and become what they are. They perpetuate the stereotype attributed to them, with the potential result that others experience difficulty in knowing if behaviours reflect a person’s actual personality or an ‘acted out’ personality. This phenomenon is exemplified in following quote:

‘It is quite difficult to tell them [visitors/ families] not to crowd in or be noisy. Then, I usually talk with the patient’s family. I usually approach the nuclear family. I cannot talk directly to the visitors as usually they would say: yes, we are Madurese, everywhere the Madurese are like this. Finally, I approach the patient’s family to tell the visitors not to make noise so as not to bother other patients’ (P 8).

Participant 8 described the behaviour of members of a particular ethnic group who are giving justification for their behaviour based this a stereotype of their ethnic group. In working with Madurese people, participants’ perceptions and attitudes towards Madurese patients, families and visitors have constantly been influenced by the stereotype of Madurese that continues to exist in community.
Consequently, the stereotype cannot be eradicated with ease; on the one hand, people might treat the member of the social group based upon the stereotype, and the other hand, the individual belonging to the group might give justification for their actions based upon the stigmatisation. As a result, the chain of the stereotype may be difficult to break.

A multicultural experience can have a remarkable effect on people’s behaviour when communicating with a culturally diverse population; it can also have a strong influence on their viewpoints of stereotypes about particular ethnic groups:

‘I was thinking a lot. I was worried because, as we know, people from ethnic group B speak firmly. It turned out they preferred to be cared for by me. The patient’s mom said that she wanted me to become her family [laughing]. I just realized that they were very kind. I thought people from Medan were different from Javanese’ (P 10).

Participant 10 was a local Javanese nurse living in Jember regency with six years of working experience. She had only interacted with local people (Java and Madura) until the event described above. Thus, when she first met Batak people, her preliminary understanding of Batak people, obtained from a stereotype extant in her environment, influenced her opinion of Batak society. Once she interacted with Batak patient and family, she recognised that her perception of them was false.

Participants 8 and 10 revealed that as nurses, they struggle with the fact that stereotypes are so profoundly embedded in the public mind. As a Javanese, I am aware that I sometime have similar prejudices. I admit that I feel the same as participants do about Madurese and Batak people, but I make a consistent effort not to be prejudiced and discriminate against Madurese and Batak. It is relevant for me to make use of Heidegger and Gadamer’s phenomenological approaches here, given that bracketing in the current study was impossible due to the fact that I live in the culture under investigation.
As exemplified below, a different attitude was shown by another participant, one who had experience of living in diverse cultural settings:

"It means we must be jembar atine [open-minded, patient, tolerant]. We must understand that many things like that [religious understanding], they are a patient’s right. Even though they contradict my beliefs and might differ with our perceptions, we must understand them" (P 20).

"The character [of the ethnic group], we must understand it. It means certain behaviours, certain cultures, as well as their views, are things we have to learn, because from that, we will eventually understand, and then we can interact with patients. I am open to all. I want to live peacefully everywhere. As I am a migrant, I am a guest, so I must be able to appreciate them so they will be willing to interact with me" (P 20).

Participant 20 was a Sundanese nurse with 40 years of working experience who had been working as a nurse in various regions with people from diverse ethnic and religious groups. The expressions of participant 20 reveal nurse’s openness to diversity. As participant 20 had been exposed to various culture and behaviour, she had become more tolerant of, and flexible with others.

The responses of participant 20 are in sharp contrast to those of participant 10. Participant 10 admitted that she had limited experience of caring for those from disparate backgrounds and cultural groups. Therefore, when she was confronted with someone from a different ethnic group, she based her knowledge of that person on pre-existing stereotype. Participant 20 was a far more experienced nurse, having been in the profession for over 40 years. Furthermore, she had a wealth of experience in caring for patients from a wide variety of cultural, religious and ethnic backgrounds. Her general attitude was more peaceful and open to other people.

The results of the current investigation reveal that working experiences can raise an individual’s levels of understanding and receptiveness. They indicate that a person’s multicultural living experiences may influence his or her attitude.
towards social and ethnic differences. Buchtel (2014) posited that knowledge of cultural disparities enhances cultural sensitivity, thus improving intercultural relationships and decreasing negative presumptions about other groups. Emotional intelligence may also affect an individual’s ability to control negative feelings and be more flexible (Leung & Chiu, 2010). Hence, cognitive structures formed by such multicultural experiences, combined with emotional maturity, could prevent people from stereotyping or labelling other groups of people.

5.2 Cultural and ethnic ties

The feeling of a strong cultural bond also emerged in the current investigation as an element in the attitudes of nurses towards human differences and similarities. This second sub-theme arose from nurses’ explanations and interpretations of their personal feelings. Phenomena of cultural/ethnic ties existed in the nurse-patient relationship when they belonged to the same ethnicity:

“When I met a patient who coincidentally has the same ethnicity, I felt like I miss Sundanese. I felt like I was meeting an old friend. It was like graduating from college and then meeting each other after many years. So we could speak using our native language. It is probably because I have been here for a long time, I have been living in Java for many years. There was a patient of my ethnicity. However, I did not give him special treatment due to our membership in the same tribe” (P 13).

Participant 13 was a Sundanese nurse who worked as a nurse in Javanese population. She seemed pleased to meet patients who shared the same culture. However, this positive response to members of her own ethnicity suggests a deeper and, for the purposes of this thesis, more concerning issue than responses to those of a different culture. In maintaining closeness to those of her own ethnicity, she may inadvertently feel less close to those of a different ethnicity, thereby negatively affecting the therapeutic encounter. The participant might treat patients differently. Similarly, another participant expressed a happiness when encountering a patient from her place of origin,
although they did not share an ethnicity or religion. The participant revealed that their meeting evoked nostalgic memories, as demonstrated in data below:

‘I met a patient. He looked like he came from the eastern part of Indonesia, not from this town. Because my origins are in the eastern part of Indonesia, I asked him where he came from, what his religion was. I also said that I was from the eastern part of Indonesia as well. We were happy to meet, even though our religion is different. We met here and instantly felt so close. I lived in the eastern part of Indonesia. Because my parents are originally Javanese, when I meet people from Java, I feel happy. But after I moved here, meeting the people from eastern part of Indonesia, it feels nostalgic. I feel more caring because I feel like we are a family’ (P 1).

Participant 1 was a Javanese nurse who had worked as a nurse for several years in Ambon (a city in eastern Indonesia, not on Java island) and was living and working in Java at the time of the interview. A similar phenomenon was experienced by participant 18. She said:

‘When meeting Balinese in this city, I feel I am meeting my relatives. We can speak in the Balinese language. Sometimes they ask where there is a place of worship [temple], asking about their diseases and complaints in Balinese. Sometimes I spontaneously give my mobile phone number to patients; it might be of benefit to them’ (P 18).

Based on the above quotes, it is clear that a feeling of nostalgia arises in the participants when they meet anyone who has the same geographical origins or shares the same ethnicity. Participants became more easily acquainted with these patients. This situation can facilitate communication as well as develop nurse-patient relationship. However, I also considered the possibility that nurses could be unfair to those of different ethnic backgrounds. While the nurses’ feeling of cultural ties emerge as a natural response when meeting people whom they consider ‘similar’, this feeling may or may not lead nurses to treat some patients differently and thus result in unfair treatment. Even if the treatment is fair, there is less natural kinship with patients who do not share the nurse’s background, so therapeutic relationship is more difficult to develop. If a therapeutic relationship is more difficult to create, given the barriers discussed in the previous chapter, nurses may not have a time or indeed an energy to create these more challenging relationships. Thus, a therapeutic relationship
that supports healing may not develop, and patient health outcomes may be poorer.

5.3 Trying to be fair
As outlined in the presentation of previous sub-theme, a sense of cultural similarity helped some participants to build trust and create therapeutically useful communication with patients, though this could potentially give rise to inequitable nursing service. The sub-theme of trying to be fair reveals that participants affirmed their commitment to take care of patients equally.

5.3.1 Nurses attempt to see everyone the same and treat all patients equally
Participants in the current research explained that they tried to care for all patients similarly. Participants emphasised that the religions and ethnicities of patients did not affect the way they cared for patients. This can be seen in following excerpts:

‘I have a principle not to differentiate according to who they are or which group they come from. I accept them all and I try my best to do whatever I can do for them’ (P 5).

‘All people are same. The difficulty or ease of caring for the patient is not because of what ethnicity he/she belongs to’ (P 1).

Participants 5 and 1 conveyed that their feelings about all patients from all backgrounds were equal. Participants considered all patients deserving of equal nursing care. The finding of the present investigation was consistent with other previous studies related to patients’ opportunity to obtain equal health services. Fairness in gaining healthcare services is of concern among health service providers in many countries. For example, the South African health system has paid attention to the implementation of justice and equity in health services, mainly linked to equitable access to healthcare for rich and poor and also between public sector and private sector health facilities (Rensburg, 2014).
In the case of a multicultural population, inequitable healthcare amenities across ethnic groups ought to be considered seriously. An exploratory study conducted by Salway et al. (2016) indicated that equity among all ethnicities needs to be considered within UK healthcare commissioning. Attention to racial diversity should not be seen only as a legal responsibility. An understanding of diversity is also necessary to meet the patients’ expectation of care, which may vary among people of different cultures (Salway et al., 2016). This also applies to Indonesia, which has great variety in its population. As recommended by the Indonesian National Nurses’ Association (2000), Indonesian nurses need to provide an atmosphere that is respectful to the cultural values, customs and religious sensitivities of all in the provision of nursing care. Indonesian nurses must maintain equity of health care for diverse patients, though many aspects may affect nurses in caring for their patients.

Several factors can contribute to disparities in healthcare quality, including different cultural backgrounds, cultural beliefs and behaviours, language and other individual characteristics such as education, gender, income, age and sexual orientation (Clancy et al., 2014; Akhavan, 2012). According to Johnson et al. (2016), implicit bias on the part of health staff could negatively influence patient care. Implicit bias is defined as a set of ‘attitudes and stereotypes that affect our understanding, actions, and decisions in an unconscious manner’ (Johnson et al., 2016, p.12). Therefore, health professionals need to be capable of recognising and minimising the effects of implicit bias.

A number of strategies can be applied in nursing care to prevent implicit bias. Nurses should have a basic knowledge of the culture of patients and see all patients individually, avoiding stereotypical attitudes. Maintaining good emotions and a positive mood when interacting with patients also reduces implicit bias (Johnson et al., 2016). Similarly, in managing culturally diverse patients in Indonesia, one of the most culturally diverse nations in the world,
cultural understanding and competencies should be taken into account as conscious or unconscious cultural prejudice and discrimination could generate unfair treatment in nursing care (Samanta, 2012; DHHS, 2004).

5.3.2 Understanding of patients’ characteristics is important

Participants in the present study pointed out that a knowledge of various behaviours and the nature of diverse cultures is considered crucial in nursing care. This is indicated in the following excerpts:

‘As we meet a wide range of people with different characteristics, we must understand them’ (P 2).

‘Since I have been working here, I know a few customs of other religions such as Christianity and Islam. Christian families who pray for the patient usually pray by singing with a rather loud voice. So I usually put them in a special room so they can pray without disturbing other patients. There are some Muslim patients who refuse to be assisted by a nurse of the opposite sex when bathing and urinating. Finally, the male nurse helps a male patient, a female nurse helps a female patient. Since then, I was learning how to care for patients of diverse religions and cultures’ (P 18).

These quotes show that participants admitted that understanding the religious beliefs and cultural behaviours of others is of great importance. Participants considered that different patients and those of different ethnicities require a different approach to the fulfilment of their healthcare needs. This can be seen in the following excerpts:

‘I have lots of experience caring for patients from different cultures, from the east to the west. In my opinion, to deal with people of different cultures, we have to use a different approach. Encountering people with a strong cultural character and a smooth character, we indeed need to use a different approach. So, the approach is different, the basic need remains the same’ (P 15).

‘Actually, we serve all patients the same, with patience, gentleness, knowledge of how to keep the patient comfortable, and they can accept nursing care. However, the most important thing we have to understand is the nature or characteristics of the person. As we all know, Javanese generally are rather soft, Madurese are rather loud. So we should be able to understand them. For example, when we treat Javanese patients we
should not talk loudly, because the patients would be offended. So we need to know the character of people’ (P 12).

Participants in the current study believed that fairness is not the same as equality. Providing equitable nursing care does not mean giving the same service to each patient, but rather using one’s cultural knowledge to provide appropriate nursing care for each unique patient. As shown in the quotations of participants 12 and 15, nurses might need to use different approaches to communicate with Javanese and Madurese patients as they have different ways of communicating with others. As discussed above, however, the application of stereotypes to different ethnic groups needs to be taken into consideration; therefore, differing cultural backgrounds might require that nurses use different strategies to take care of patients.

Cultural comprehension on the part of nurses is beneficial in enhancing equitable nursing care for diverse patients. However, cultural proficiency cannot be achieved simply by relying on nurses’ willingness. Cultural competence for nurses should form part of a programme for nursing performance development, which can be delivered through professional education and training programmes for the healthcare workforce (Almutairi et al., 2014).

Participants in the present study also expressed concern about equality of treatment for the diverse population of Indonesia:

‘Personally, all the differences in background such as ethnicity, culture, or religion have no effect on me. In my mind is only that the patient needs to live, that's all. As nurses, we care for our patients. We meet their basic needs. I think, at any time, in any country, basic human needs remain the same. The difference is understanding, clothes, culture. When we are dealing with emergency patients, whether baby or adult, with a faith or no faith, they are just the same; the patient needs to live’ (P 15).

‘All is the same when we care for patients. The treatments are not different. When we care for Javanese patients or Madurese patients, nothing is different, all is the same’ (P 3).
'For me personally, I have never looked at the religion, what is his religion. For me, the important issue is that I am working based on the SOP [Standard Operating Procedure]' (P 11).

These quotations demonstrate that participants felt responsible to provide equitable treatment. However, the focus of participants’ concerns appears to be solely the patients’ physical needs and activities of daily life. Participants did not mention other facets of caring, such as psychological and spiritual aspects. In quotations above, participants talk about their work in relation to the completion of nursing tasks, including operating procedures and ensuring that patients survive. The quotations demonstrate little of the therapeutic and caring engagement of a nurse with a patient. This phenomenon is explored in further detail in discussion chapter.

Regarding nurses’ great effort to provide equitable nursing care, Salway (2016) underscored the fact that attention to fairness to people of all ethnicities could be sustained through improving the skills of health staff and managers, along with generating a national policy to support strategies to eliminate ethnic inequalities within the healthcare sphere. Culturally diverse healthcare staffing has been considered crucial to ensure the adequate provision of culturally sensitive health services (Akhavan, 2012). Patients tend to prefer and to more closely connect with health staff with whom they share the same cultural background (Skaggs & Kmec, 2012; Ferguson & Candib, 2002). Though the current study does not investigate patients’ experiences of care, it was identified that participant 13 had encountered patients who preferred staff who shared their ethnic background, as shown in the example below:

‘There was a patient who has the same ethnicity as I do, a Sundanese. He and his family seemed to prefer to be treated by me. Though there were many nurses in the room, the patient and family were always looking for me. This might be because we share the same culture; they might have felt more comfortable talking with me. However, I personally do not discriminate against patients based on ethnicity. All are the same’ (P 13).
According to participant 13’s narrative, some patients might prefer staff from their own ethnic background. Though this phenomenon might not always emerge in a ward, nursing managers must consider this important issue to ensure the provision of good nursing service. As highlighted by Williams et al. (2014), a culturally diverse workforce can facilitate access to healthcare resources for all patients from various cultural backgrounds.

Not all hospitals and primary health centres in Indonesia are able to recruit members of the country’s diverse cultural and religious populations. In the capital or in other urban centres where the population is more heterogeneous in terms of ethnicity, language, customs and religious beliefs, healthcare facilities have greater access to a more diverse nursing workforce, enabling greater variety on an establishment’s staff. For example, one of General Hospital in Surabaya (Surabaya is the capital of East Java Province) is a referral hospital for the eastern region of Indonesia. The hospital accepts patients from East Java Province as well as from other areas such as Bali, Kalimantan, Sulawesi, and Papua. The hospital employs nurses from a wide range of ethnic and religious backgrounds. One participant in the current investigation who worked in Surabaya stated that her cultural identity as Balinese and Hindu enabled her to help Balinese patients to obtain health treatment:

“When they [Balinese patients] did not understand something about their medical treatment, I would help them to ask the doctor and explain to the patients and their families in Balinese” (P 18).

The presence of culturally diverse nurses has a positive impact on the equity of healthcare service as well as nursing care. The work of Williams et al. (2014) evidenced that a diverse nursing staff serves as a significant vanguard to decrease health disparities and reach equity in health care across the population. However, creating such a situation in a small town may prove difficult. Hospitals and other health care centres in small cities or rural areas are not always able to provide culturally diverse health professionals, particularly in the case of caring for ethnic minority groups. For example, a majority of
population in Jember, a small city, are Javanese and Madurese. Most of healthcare staff are Javanese, and some are Madurese. It would be not easy for a Papuan patient living in Jember to find nurses sharing the same cultural background. A similar issue might also arise when a nurse works in a region in which the population does not share his or her culture and language, for example, in the case of a Javanese nurse who works in Sulawesi. Patients might be afraid or reluctant to seek health services and interact with nursing staff due to language barriers, differing beliefs or different cultures. This circumstance can lead to an inadequate or unequal health service. Therefore, cultural knowledge should be considered when managers in Indonesia recruit and employ health staff.

5.4 Respecting differences
The sub-theme of respecting difference emerges in working with patients of varied backgrounds; the interview analysis showed that participants demonstrated respect for patients’ beliefs and that both nurses and patients respect one other.

5.4.1 Respecting patients’ beliefs
The following are two examples of nurses’ expressions regarding their attitudes concerning patients’ spiritual beliefs:

‘Some of them [the patients] still refused. They said they would cut their fingernails at home. I finally just said, okay. We respect patients’ beliefs’ (P 13).

‘Sometimes suddenly I found there was water with Arabic writing on the patient’s table. I never asked why, because everyone has their individual beliefs. I never forbid the patient’s family to bring water because I am afraid of having a misunderstanding. I do not ever forbid them to bring the water because I do not want to interfere in someone’s beliefs. When someone is convinced and believes in something, no matter how much we talk, he or she will not listen to us, because he already believes in it. This is not our domain. It is difficult to influence someone’s beliefs. However, I keep checking the patient’s condition to make sure it will not endanger him. Sometimes the patient drinks the water, sometimes it is simply wiped onto the patient’s body. As long as the patient does not have diarrhoea or..."
vomiting, immediate effects may not exist. I once saw that the amount of water in the bottle had not reduced. Perhaps the patient just drank a little bit of it, but he did not feel anything; finally, he took the drugs and felt the results. Finally, he believed in medical treatment’ (P 16).

Participants 13 and 16 expressed that, as nurses, they respect their patients’ beliefs. Based on interview analysis, it was found that while participants permitted patients to adhere to their beliefs, participants still attempted to ensure the safety of the patients. In addition, participants respected patient beliefs in order to prevent a misunderstanding as they might have different perspectives or assumptions.

In a multicultural environment, patients may bring their beliefs, lived experiences and personal preferences to bear on their expectations of nursing care; these may be affected by various common traits such as cultural background, gender, ethnicity, age, education, or family matters (Sherrod, 2013). As experienced by participants in the present study, nurses encounter a wide range of patient characteristics. As outlined earlier in this chapter, the uniqueness of patients often influences the participants in their provision of appropriate nursing care. Sherrod (2013) proposed that, in order to fulfil patient expectations, nurses learn to recognise and manage the dynamics of diversity through identifying, investigating and exploring the cultural contexts of individuals and communities in the service area. As participant 16 stated in the quote above, she did not interfere with the presence of water from outside the hospital in the patient’s room, nor did she proscribe its use for drinking or cleansing purposes, but she did monitor the patient. She specifically stated: ‘I keep checking the patient’s condition’ in order to ensure that patients do themselves no harm while following cultural practices.

It has been outlined in previous paragraphs that multicultural living can enhance a person’s awareness of diversity. Respect for cultural diversity can be generated from an individual awareness of heterogeneity. As stated by Martin and Shao
(2016), people may or may not experience early immersion in multicultural experiences. Roaten and Schmidt (2009) argued that multicultural awareness can be stimulated from school age through experiential activities designed to help students confront and overcome bias, stereotyping, and exclusionary behaviour. These learning activities can encourage students to gain awareness, discover beliefs and attain knowledge and skills about their own culture and the cultures of others (Roaten & Schmidt, 2009). This can also be applied to nursing education. Nursing students can learn about cultural diversity either in class or in healthcare settings. The nursing students’ awareness of cultural diversity can be heightened because they are at a level of education that is enriched through real working experiences. This awareness is central to increase nurses’ competence in respecting diversity.

Whilst it is important to respect patients’ beliefs as part of the acknowledgment of cultural diversity, such acceptance of cultural differences may result in problems for nurses and their patients. Nurses and other healthcare professionals may find that they struggle to make the most appropriate decisions from an ethical standpoint in terms of their patients’ health and well-being. For example, whilst respecting the autonomy of the patient to use water as part of the healing process, there may be instances in which such a practice causes harm to the patient, thus negating the principle of non-maleficence.

As mentioned by participant 16, patients and families may believe in using water as part of the healing process, although she herself doubted its value. Participant 16 argued that the water might affect a patient’s health. She attempted to respect patients’ cultural beliefs, but she found it difficult to understand the use of water. Participant 16 showed her respectfulness by allowing the patient to use the water as a complementary therapy, not as the main treatment or medication. Chattopadhyay and De Vries (2013) underlined the fact that respect for cultural diversity can be shown through acknowledgment and appreciation.
for diverse moral values. Therefore, it is considered necessary for nurses to enhance their cultural knowledge as different patients may have different beliefs, attitudes and moral codes (Mbugua, 2012). Nurses’ cultural knowledge enables them to be confident in providing culturally sensitive nursing care, which serves as a form of respect for the patient’s belief or culture.

5.4.2 All respect each other

In the current study, it was also found that participants received respect from others, both patients and colleagues. One participant in the current study stated that she had never been treated in an unpleasant manner by her colleagues or patients, though she came from a minority ethnic group in her workplace:

‘As a minority here, I have never been bullied or harassed, not ever. Sometimes just a joke, because some of the terms in Bali have a different meaning here. For example, ‘feet’ in the delicate Balinese language is cokor, whereas in the Javanese language, the meaning of the term cokor is insulting. I just laugh when we joke about terms in our local languages. I have never met a patient who refused to be cared for by me because I am Balinese; no one insults my culture. They even share their experiences of holidays in Bali, the beauty of nature, the habits of the people, the holy days and more. I think this is because we always respect each other, respect our cultures in our country’ (P 18).

Participant 18 revealed feeling appreciated by everyone, though she is a migrant nurse and a member of a minority in her environment. Participant 18 portrayed a respectful atmosphere in her nursing wards and her community. However, data from members of other ethnic groups have not been explored. Further investigation is recommended to uncover additional phenomena.

Respect is a fundamental value in healthcare professions. Respect, as frequently expressed in the nursing code, focuses on respecting individuality, autonomy, dignity, privacy and other values and responsibilities (Papastavrou et al., 2012). Respect can be defined as an attitude that exhibits esteem, regard, and honour to others (Branch, 2006). Respect is considered as a pivotal value in nursing, one which must be adopted by all nurses as part of a proper attitude toward all
individuals (Koskenniemi et al., 2012). As a fundamental attitude, respect can be
demonstrated through being polite, being patient when listening to others,
being responsive, supportive, and exhibiting other valued behaviours
(Koskenniemi et al., 2012). As posited by Papastavrou et al. (2012), we must
create a reciprocally respectful nurse-patient relationship through not only
considering the patient’s rights but also the patient’s duties in the healthcare
sphere. This mutual respectfulness can enhance a therapeutic nurse-patient
relationship in the healthcare system.

5.5 Summary
This chapter has demonstrated nurses’ attitudes towards their patients’ various
cultural backgrounds. Nurses respond differently to patients of different
cultures. Taking care of patients from diverse ethnic and religious backgrounds
can be challenging. Nurses’ presumptions and stereotyping of patients from
cultures other than their own can affect the care that they are able to provide. A
cultural stereotype that is perpetuated in the community may also have the
potential to influences nurses’ attitudes towards others who do not share their
ethnicity or religion.

This study has also demonstrated that, regardless of religious and cultural status,
having the same place of origin can also facilitate nurses’ constructing of a nurse-
patient relationship. Cultural identity, language, and customs all help nurses to
build trust and communication between themselves and their patients. While
participants in the current study stated that they felt close to patients with
whom they shared common ground, they did not say how they felt about those
patients with whom they had no common ground. It was also evident that
nurses seemed to focus on the patients’ physical needs. Caring engagement did
not appear in their descriptions of their provision of care. These phenomena
figure further in the discussion chapter.
Multicultural life experiences increase nurses’ awareness of cultural diversity. The present study has demonstrated that cultural knowledge is of significance to prevent unfair treatment, as individuals with different ethnic backgrounds may respond best to different approaches. Nurses’ cultural awareness and understanding can be improved and increased through individual effort. Cultural awareness should also be sustained by nursing managers in the healthcare setting. Further, cultural competence, that is, competence in understanding cultural, religious and ethnic differences and accepting that these are part of the diversity of our communities, is essential to the provision of good nursing care.
CHAPTER SIX
STRATEGIES IN ADDRESSING CULTURAL AND SPIRITUAL ISSUES

The previous chapters have outlined barriers to nursing care and participants’ attitudes towards other people’s cultural identities. Three barriers to carrying out nursing care were revealed. It was evident that the barriers affected participants’ opinions about their patients’ diversity; in addition, participants exhibited a variety of attitudes which may have emerged consciously or unconsciously as responses toward culturally diverse patients.

This chapter elaborates participants’ strategies in approaching cultural and spiritual issues. Participants in the current study shared several methods that they employed to treat very diverse patients in their healthcare settings. The three major strategies that emerged in this study – communication strategies, cultural approaches and spiritual support – are detailed and discussed in the text that follows.

6.1 Communication strategies
The sub-theme of communication strategies captures the ways in which participants cared for patients with a variety of cultural and religious backgrounds. Seven communication techniques arose from the participants’ narratives; these included clear explanations, rectifying mistaken opinions, suggesting without coercing, non-verbal communication, engaging a translator or interpreter, involving community leaders, and making jokes or employing irony.

Communication has long been acknowledged as a vital component in nurse-patient relationships (Bowles et al., 2001) and as an indispensable component of patient-centered care (Jones, 2003). The significance of communication in
nursing has been recurrently elucidated by nursing scientists since the era of Florence Nightingale in the 1900s (Fleischer et al., 2009) and can be found in the work of several nursing theorists such as Imogene King, Ida Jean Orlando and Hildegard Peplau (Cypress, 2011). Communication comprises the speaker and subject as well as the environment, which influences the process of communication (Park & Song, 2005). Despite the presence of language barriers in caring for various patients with varied local languages, as revealed in Chapter Four, participants in the present study also recognised the pivotal role of communication in nursing care. The following excerpts reflect participants’ points of view about the importance of communication:

‘There might be a language barrier; however, the most important thing is that we need to build good communication and there will be no problem [in caring for patients]’ (P 5).

‘We should be able to approach each patient individually. Each patient, each individual is different. Without communication, we would not be able to find out patients’ complaints. The more we approach and communicate with patients, the more we can see the uniqueness of each patient. Even when we simply give meals to the patients, we need communication, we need to have a chat with patients. There was an elderly patient, he did not eat the meals for days in the hospital. I asked him why he did not want to eat. I also explained why he needs to eat the meals. Finally, after a long conversation, he agreed to eat. Without initiative and communication, we cannot solve problems’ (P 17).

These quotations show that communication helped participants to handle their difficulties in caring for diverse patients. Participants 5 and 17 conveyed that communication served as a significant strategy to deal with the problems that arise during nurse-patient interactions. Both participants posited that problems can be diminished through communication. Participant 5 used communication as a method or technique to solve the problems.

Similarly, participant 17 suggested that, as nurses, we need to have conversations with patients in order to learn about the patients’ complaints. Through communication and initiative, she was able to persuade an elderly
patient to eat his meals. According to participant 17, approaching means being there and being close to the patient. Although participant 17 used a psychological aspect of communication in her persuasion of the patient, her sole concern was the physical health of the patient. The term ‘problem’ appears in participants’ narratives, indicating that all things which hinder nursing activities are considered as problems. It is also evident in the above quotations from participants 5 and 17 that they did not involve feelings in nurse-patient communications. They did not describe their feelings either during or after communicating with the patients.

Several of the participants in the study view communication as a strategy to overcome problems, which in turn is a means to merely perform nursing tasks. Bowles and colleagues (2001) highlighted that nurses’ conceptions of nursing as a practical, work-oriented profession can lead to ineffective communications in which nurse-patient conversations may focus solely on a patient’s medical treatment. By contrast, in a communication, a process of exchange of thoughts, feelings and information can take place between the speakers (Kourkouta and Papathanasiou, 2014). Communication is not only about how to dispatch messages; rather, the process of communication also involves the transmission of feelings between nurse and patients, where feelings are delivered and recognised by the speakers (Sheppard, 1993). There should be a reciprocal communication between nurse and patient.

The participants ought to let patients know that they as nurses understand the patients’ feelings. Nurses who are able to acknowledge patients’ feelings are able to recognise patients’ needs comprehensively rather than focusing solely on physical needs. McCabe (2004) posited that nurses do not communicate well because they are a) unaware of the meaning and importance that patients attach to the nurse-patient relationship and b) focused on the administrative
and practical aspects of their jobs. Communication in nurse-patient interactions is further examined in the discussion chapter.

Communication is also related to a person-to-person relationship. According to participants 1 and 7, communication enables nurses to build interpersonal relationships. This is consistent with Sheldon and colleagues’ (2006) position that communication serves as a ‘cornerstone’, or basic foundation, of nurse-patient interactions. Nurse-patient relationships can be developed through communication. Participants 1 and 7 revealed that nurse-patient connections are easier to build if nurses employ good communication, as shown in the quotations below:

‘Good communication creates good relationships’ (P 1).

‘If we are good at communication, then the interactions will be easier. The main thing is communication’ (P 7).

The narratives of participants 1 and 7 reveal that good communication includes a capability on the part of nurses to use several strategies to develop conversation and to interact with patients. These strategies are outlined in the following paragraphs.

6.1.1 Clear explanation

The participants considered clear information about health and interventions to be of primary importance for all patients. Informational explanations should be understandable for patients and families, particularly in working with certain ethnic groups. Communication about health and treatments aims to avoid misunderstandings between the nurse and the patient or family:

‘Sometimes they do not understand our explanation. We have to explain it slowly and explain many times to make them understand’ (P 9).

‘When I give an explanation to the family of a patient, sometimes I need to explain a few times and I also ask questions related to my explanation to ensure they really understand it. If they have other family members who
are considered more educated and have a better understanding, they may ask their relatives to listen to the explanation from the nurse’ (P 14).

According to participants 9 and 14, nurses may need to explain things more than once to ensure that patients and families understand the information they are being given. Based on the interview analysis, language barriers and the educational levels of patients and families are considered to be the causes of this situation. The issue of language barriers was outlined in Chapter Four. Some Indonesians use only their local languages in their daily communications and do not use Bahasa. This can have an impact on patients’ and families’ understanding of the health information delivered by health staff. The participants’ purpose in repeating their explanations was to help patients and families to comprehend the information. Jain and Krieger (2011) suggested repeating information as a communication strategy when encountering intercultural differences. It is evident that misunderstandings can be lessened through repeated explanation.

Nurses also need to use common terms instead of medical terminology. Patients’ ability to understand explanations are likely also affected by the differences in the language used by patient and nurse. For instance, ‘fever’ in Bahasa is demam. Madurese who are not used to speaking Bahasa would not understand the word demam. Madurese speakers usually use the word panas instead of demam. Panas in English means ‘high temperature’. Nurses need to determine and choose suitable terms to help patients understand their explanation and to establish effective communication. Jain and Krieger (2011) found that differences in language due to cultural differences between staff and their patients can lead to difficult situations in nurse-patient relationships. The use of appropriate language and common terminology in nurse-patient communications is therefore pertinent.

Patients’ educational levels were also of concern to participants in this study. Even when patients and families are literate and speak Bahasa, sometimes a
patient or family member has asked a family member with more knowledge to help communicate with participants, as described by participant 14. This family member serves as a spokesperson who helps patient and family to understand a nurse’s explanation. The specific rationales for involving a spokesperson in patient-nurse relationships in Indonesia have remained largely unexplored to this point. According to the process of hermeneutic-interpretive analysis in the present study, high interdependence in Indonesian families has a considerable influence on this phenomenon, as described in Chapter Four.

Among some Madurese, as well as among some patients from the countryside, patients and families tend to rely on a family member who is perceived as an educated or wealthy person to facilitate their communications with healthcare staff. Patients may feel that their educated family members, as people who care for them, have greater access to professional knowledge, information or other sources (Johnson, 1997). Madurese and people from the countryside may seem to lack the confidence to talk with healthcare staff due to their level of formal education. They may also consider the difference in educational level between them as patients and the participants as health staff. As stated by Klimova and Semradova (2012), educational or professional differences and different views of the world are considered as basic barriers to communication. The results of the current study also indicate that a patient’s perception of a knowledge gap and a difference in social status between nurse and patient may inhibit nurse-patient communication. Further study is required to explore the extent to which patients’ feelings about healthcare staff’s social status contribute to patients’ perspectives of patient-nurse relationships.

Some participants stated that they themselves sometimes decided to invite one family member with a higher educational level to participate in nurse-patient communications. A spokesperson can serve as a communication intermediary between nurses and patients. However, spokesperson involvement in nurse-
patient communications, particularly when the spokesperson is a second-layer family member, might affect the decision-making process regarding the health treatment required by the patient. The findings of this study indicate that participants’ only concern was delivering messages and explanations clearly, without considering that the way a spokesperson delivers information can influence the patient’s and the family’s understanding and, in turn, the making of decisions.

As highlighted by Ashton (2012), health professionals need to be cognisant of the accuracy of the information delivered by a family spokesperson. The information dispatched by a family spokesperson may be biased, and some secret information may be concealed to protect the patient (Ashton, 2012). The nurse wants the patient to have but that the spokesperson decides is not good for the patient to have (i.e. bad news that might upset the patient). To minimise this adverse impact of spokesperson involvement, the language of communication should be understood by the patient and all those surrounding the patient as an ill person (Kourkouta & Papathanasiou, 2014). Therefore, providing clear and detailed explanation in delivering information to patients and family is of great importance. Overall, participants in this study underscored that in nurse-patient communications, participants need to speak slowly, repeat their explanations and use common terminology to facilitate patients’ and families’ understanding of the information.

6.1.2 Rectifying poor health literacy
As explored in Chapter Four, participants were aware of lack of understanding about health, illness and health interventions. People from some Indonesian localities perceive a person as being in good health as long as he or she can eat normally, even if symptoms of disease have appeared. This phenomenon was revealed by participant 8 in Chapter Four. She said:
Her son had had a fever for 10 days, but he still could eat, so the mother considered that her son was not sick. But when her son did not want to eat, it meant that he was ill’ (P 8).

Previous research has also shown that, in certain populations in East Java, people who suffer from a chronic disease for a very long time believe that their illness is caused by a mistake made by either the patient or a family member, interfering spirits, or a wrong done to another person (Weesing, 2010). This phenomenon is related to local beliefs in which the population has been immersed from generation to generation.

Some other poor health literacies were found regarding medication. A particular ethnic group perceives injection therapy as the best intervention. As presented in Chapter Four, an erroneous assumption about medication sometimes emerges in the Madurese community. Madurese strongly believe in injection therapy. They consider that health treatment is not complete and comprehensive if an injection of medication has not been received (Mulyadi, 2015). This phenomenon was discussed by participant 6:

‘They would always ask for an injection. According to them, no injection means that they will not get well. They believe that if they did not get an injection, they will not recover from their illness. According to them, not being injected means being left untreated, even if they have been examined and given oral medication’ (P 6).

Another participant cared for a patient from a certain ethnic group with the belief that resuscitation, or compressing the patient’s chest, is harmful for the patient. Participant 15 revealed this situation as shown in the following extract:

‘The treatment that need to be done for the patient, sometimes incorrectly perceived by the patient’s family. Resuscitation, by a particular ethnic group it is considered as an act which would hurt the patient because we compress the chest. If we do not explain beforehand, then they would consider we are torturing the patient’ (P 15).

Regarding these barriers, participants in the present study recognised that it is not easy to change misperceptions about health, illness and treatment in situations in which a perception has been held over time by people from a
particular ethnic group. Cultural distinctions can contribute to distinctions in perception (Ji & Yap, 2016). In addition, as highlighted by Jain and Krieger (2011), cultural differences can result in difficulties in communication.

Participant 6 admitted that this situation entailed strenuous effort in therapeutic communication to influence and amend patient and family beliefs as well as to rectify false perceptions. Effective communication is indispensable in overcoming barriers related to local beliefs. Nurses should understand that effective communication necessitates an understanding of the patient and the experiences they reveal (Kourkouta & Papathanasiou, 2014). Listening and heeding patient needs are also considered important to the development of therapeutic relationships (Shattell et al., 2007). In cases in which patients express limited understanding regarding health and illness, nurses must identify appropriate methods to rectify their understanding.

To rectify poor health literacy and ensure that patients and families have correct information, participant 6 explained subtly until the patients understood and agreed with the explanation. Participant 15 gave clear explanations to patients and families prior to performing a nursing intervention to assure them that the intervention would not be harmful to the patient:

‘The nurses were struggling to give an explanation. I explain to [the patients] that injection is not the only treatment for their illnesses. We cannot directly say “I cannot give an injection, Sir”. We cannot do it like that. I have to explain to them until they understand and accept. The nurses will not follow their wishes. The most important is to give an explanation to them’ (P 6).

‘It is very important to give information including the purpose and the urgency of our intervention. Misunderstanding and misperception can be minimised. We have to give an explanation before carrying out a health intervention’ (P 15).

Based on participants’ narratives, since health treatment is sometimes perceived by certain ethnic groups as a harmful intervention, a clear and detailed
explanation of the treatment should be provided by health staff to reduce misunderstanding and misperception about health and illness. Through clear explanations, patients and families can obtain health education. Further, they can use their understanding of health interventions to correct false perceptions of others in their communities where health treatments are concerned.

6.1.3 Suggesting without coercing

In nurse-patient communications, participants sometimes met patients who had very strong, even obstinate opinions about health and treatment. Patients may be reluctant to accept new concepts or ideas. This is related to their personal beliefs. Participants made concentrated efforts to persuade patients to follow health staff suggestions:

‘Patients sometimes act as if they know everything. Sometimes I find it difficult to give them health information. They argue when we give them some information. For example, there was an elderly patient with hypertension. We asked him to reduce his intake of certain foods such as petai, salt, fat, durian. He did not follow our suggestion and said, “I usually eat this food and I am fine.” Finally, I said to him, “You can try to eat it if you don’t believe me. Later on, after eating that kind of meal, please have your blood pressure checked at the PHC.” In the end, they believe our explanations’ (P 8).

Participant 8 was treating an elderly patient who did not believe that his diet affected his blood pressure. The patient did not follow the nurse’s recommendation. In this situation, participant 8 used a ‘try it and let’s see’ strategy. Participant 8 suggested that the patient act according to his beliefs and return to the primary health centre to re-check his blood pressure. The patient eventually returned to the primary health centre and agreed with participant 8’s suggestion to restrict his intake of certain foods that can raise blood pressure. This phenomenon reflects that the potential harms and problematic nursing practice present in this study. The nurse knows the harm that will come from eating such foods, yet she/he encourages the patient to do so. However, the nurse still involved members of family to observe the patient when the patient eats those meals at home.
Participant 8 attempted to suggest without coercing. Through the ‘try it and let’s see’ strategy, participant 8 was able to persuade the patient without patronising him. This strategy is useful for communication with elderly patients. According to participant 8, it is not easy to influence the lifestyles of people from the countryside and encourage them to adopt healthier habits. They might not always obtain proper health information, as their lifestyle is mainly influenced by their upbringing or the customs of prior generations. They may believe more strongly in traditional healers than in healthcare staff. They usually seek health staff only when they feel very ill.

Patients’ ways of living affect participant 8 in building trust and communication with people from countryside populations. It is not effective for health staff to simply give straight instructions; rather, they must use appropriate approaches that show appreciation for patients’ local wisdom. For instance, in having conversations with older people, nurses need to show respect. In this case, participant 8 used a ‘try it and let’s see’ strategy, knowing that she had to show her respect to the elderly patient and that it would not be easy to change his opinion, particularly as he came from the countryside, where obtaining health information might not be of concern. However, a ‘try it and let’s see’ strategy might not applicable in some situations and settings. In an emergency, this strategy may be not appropriate and could be harmful for the patient as rapid action may be required.

Another situation was encountered by participant 12. Participant 12 struggled with patients’ lack of adherence to health regimes. Some patients do not comply with standards of water intake and diet. Participant 12 also applied the ‘try it and let’s see’ method, allowing the patient to do what he wanted to do, but she warned the patient to stop if he suddenly felt out of breath and to go to the hospital immediately:
‘I always explain to the [haemodialysis] patients about the rules of water intake and diet. Initially, they usually do not comply with our suggestions. They drink lots of water, eat a lot of bananas and oranges, and drink coconut water, which must be limited because it contains large amounts of potassium. I finally said, “If you do not believe us, you may try it, but if you have difficulty breathing, please stop eating and drinking these things.” Finally, the next day, the patient came back to the HD unit and told me that he would stop, that he gave up [“kapok’ in Javanese”] (P 12).

Participant 12 felt that this strategy is useful when communicating with obstinate patients, though this method may endanger the patient and potentially unethical. Participant admits that there must be more supportive and less harmful ways to show patients the potential harm they inflict upon themselves when they drink too much. Therefore, participant 12 tried to suggest to patients without coercing. Some patients still use traditional healers or adhere to traditional customs whose treatments run contrary to those of healthcare programmes. Some people in East Java believe that coconut water is the most potent traditional medication for all diseases. While coconut water is considered beneficial for heart and musculoskeletal health (Lewin, 2017) due to its richness in nutrients and minerals, the potassium in coconut water is not appropriate for patients with renal failure:

‘The other thing was a factor related to customs, this often goes against the programme of care that we provide. Sometimes, patients with haemodialysis try to use traditional healers. Healers usually tell patients to drink plenty of water and to drink coconut water as well, whereas coconut water should be avoided by patients with renal failure as it is high in potassium. In addition, water intake for patients with renal failure must also limited. The amount of urine in 24 hours plus 500 cc, that is the proper amount of water consumption for a patient with renal failure’ (P 12).

When encountering strong beliefs and customs, participants in the present study used a strategy of suggesting without coercing in order to build communication with patients. Participants in the current study conveyed that through the use of subtlety, providing good reasoning and respecting patients’ beliefs, they were able to build trust in their communications with their patients. The ‘try it and let’s see’ method may also be beneficial in persuading some patients who have
strong personal beliefs. This communication strategy enables participants to help patients understand and accept their explanations.

I consider that this phenomenon is one of negotiation method. Johnson (1997) with his idea of negotiating, posits that ‘negotiating is common to most forms of social interaction between persons involved in the delivery and the receipt of health care’ (p.128). In the nurse-patient interaction, a negotiation can be one of several communication strategies in health care:

*The important thing is how we speak. If we speak subtly and give a good reason, they will listen to us. They finally understand and accept it’ (P 11).

Overall, participants reported needing this communication strategy to manage several barriers when caring for patients with diverse personal beliefs and customs. Though the aim of this strategy seems solely to perform nursing tasks, participants in the present study used this communication method to persuade patients to follow their suggestions and health instructions. As suggested by Richardson and Ovens (2016), nurse-patient communication during routine procedures enables nurses to develop nurse-patient intimacy and facilitates the performance of more difficult procedures or interventions. Nurse-patient closeness, which can be developed through being there for the patient, along with suggestion as a communication strategy, makes it easier for nurses to invite patients to comply with healthcare programmes. However, certain circumstances might require different communication strategies.

### 6.1.4 Non-verbal communication

Non-verbal communication was a significant component of the communication methods used by participants in the present study. As explained in Chapter Four, language barriers contribute to difficulties in caring for diverse patients; some patients from some ethnic groups, as well as patients from the countryside use their local languages in everyday communication. They might know Bahasa, but they do not speak Bahasa in daily conversation. This circumstance can affect
patients’ ability to comprehend explanations from health staff. Therefore, nurse participants described sometimes using non-verbal communication when they conducted patient assessments and carried out nursing interventions:

‘I usually use non-verbal language; I use body language as sometimes older Madurese cannot speak Bahasa’ (P 7).

Participant 7 stated that she used non-verbal communication with Madurese patients, many of whom do not speak Bahasa. Though some Madurese know and understand Bahasa, they usually prefer to use the Madurese language in communication; this is particularly true among elderly Madurese or those who are illiterate. Health staff who understand Madurese can speak with Madurese patients in their own language. When Madurese patients understand Bahasa, there are no difficulties in nurse-patient communication. However, some health staff are not Madurese and do not understand the Madurese language. In this situation, health staff might use non-verbal communication to enable them to take care of patients, as expressed by participant 15 in the quotation below:

‘I often use non-verbal language, especially when we face a language barrier. We use the language of Tarzan [laughs]. For example, when I ask the patient whether he is dizzy, I hold my head; whether he has chest pain, I hold my chest. We often speak using Bahasa and also using non-verbal language. I am asking while holding or moving certain body parts’ (P 15).

Participant 15 described using non-verbal communication when conducting physical assessments or assessing a patient’s complaint, touching or moving body parts as a way of asking the patient which area is affected. This communication method helped him to evaluate patients’ complaints. Another participant used a different technique in engaging in non-verbal communication. Participant 11 used body language and certain tools such as toiletry items. Participant 11 conveyed the opinion that, though a patient might not understand her explanation in Bahasa, the use of certain equipment or devices in communication allowed the patient to understand the information she was giving:
‘I use body language. For example, when I was going to bathe the patient, I said, “Miss., it’s bath time.” I was carrying toiletries, so she understood that it was bath time’ (P 11).

This phenomenon demonstrates that non-verbal communication can involve both body language and instruments to support the communication. Non-verbal language is used not only by healthcare staff; sometimes, patients also use body language to describe their complaints. Patients signal toward a body part to express their complaints, as illustrated in the quotation below:

‘Patients try to use non-verbal signs to convey what they feel, for instance pointing to a part of the body’ (P 5).

In such a circumstance, both nurse and patient can use non-verbal communication to overcome language barriers. This communication strategy is considered beneficial when no translator is present. However, the accuracy of information delivered via non-verbal cues should be of concern.

6.1.5 Translators and interpreters

According to the nurse participants in the present study, translators or interpreters sometimes facilitate nurse-patient communications, particularly when language problems emerge related to language differences. This finding is consistent with a previous study conducted by Cioffi (2003) that suggested the use of a multiplicity of communication strategies, such as body language and the assistance of translators or interpreters, when caring for diverse patients. Local language diversity in Indonesia sometimes results in communication problems. Some people prefer speaking their local language in daily communication rather than Bahasa. Some patients are also unable to speak Bahasa, and some health staff cannot speak others’ local languages. This circumstance can inhibit nurse-patient communication. Therefore, the presence of a translator enables healthcare staff to communicate with patients and families. Participants in the present study indicated that they usually involved patients’ family members, other nurses or staff, and even other patients to help translate a patient’s local language into Bahasa, as shown in following excerpts:
'If the patient is accompanied by family, I ask for help from the family in translating. However, if the patient comes alone, I ask for help from my colleague who speaks Madurese or I use non-verbal communication’ (P 7).

‘I usually speak to the family when I experience a language hindrance. Family members help me to translate. The family is really helpful. The presence of family is helpful in terms of translation’ (P 10).

Though family members’ behaviour sometimes becomes a barrier to nursing care, as outlined in Chapter Four, family attendance is considered helpful in the case of a language problem. For patients who cannot speak Bahasa and health staff who cannot speak a patient’s local language, the presence of a family member who can speak both the local language and Bahasa is considered essential to support and facilitate nurse-patient communication. The family can help patients convey what they are feeling or what their complaint is and inform health staff. Family members can also assist nurses in delivering information or explanations in the patient’s local language.

Family members can serve as translators or interpreters; however, the accuracy of the information delivered by family can be an issue. A family translator who speaks Bahasa may not be familiar with medical terminology. Healthcare staff who involve patients’ family members as translators or interpreters need to consider this possibility. As highlighted by Ashton (2012), a family translator may be unable to reliably deliver the information given by healthcare staff as the translator may have a limited understanding of medical terms. This situation may result in a greater chance of inaccurate translation and information.

A family translator may also choose to withhold some of the information given by the healthcare staff, wishing to protect the patient from that information (Ashton, 2012). This can result in the patient receiving biased information. Involving other health staff or colleagues is considered preferable to ensure greater accuracy in the translation process. Karliner and colleagues (2011) suggested the use of professional interpreters rather than family members, who
are usually not familiar with medical terminology and are generally less skilled as interpreters. Participants in the present study often asked other staff to help them to interpret patients’ local languages, particularly when the family were not present at the patient’s bedside, as shared by participant 7. This is confirmed in the quotations below:

‘I usually ask my colleagues or people who speak the language of ethnic group M and Bahasa Indonesia. Sometimes I ask for help from the family or from other patients next to the patient’ (P 3).

‘When there are patients who cannot speak using Bahasa Indonesia, I ask another nurse who can speak Madurese to help me as a translator’ (P 14).

Participants 3 and 14 do not speak Madurese. They need other nurses who can speak Madurese to help them translate from Madurese into Bahasa and vice versa. Other patients may even be involved as translators and interpreters, as revealed by participant 3. The accuracy of information can be ensured when health staff serve as translators. As health staff and translators, they do not withhold information from either patients or nurse participants. However, patients may not always feel free to convey their feelings or complaints to health staff. Patients may feel too hesitant, fearful or anxious to share their emotions or feelings with staff. Patients may also be reluctant to share their complaints as they may consider staff members as strangers. Therefore, health staff may need to be aware of patients’ emotions (Maesschalck et al., 2011). When there is a language barrier and a patient attempt to communicate on his or her own, preferring not to ask for an interpreter, greater misunderstandings may occur. Patients may also feel fearful to fully express their emotions (Maesschalck et al., 2011). Health staff serving as translators or interpreters need to be supportive and to encourage patients to convey their feelings and complaints. Health staff translators may need to speak their patients’ local languages subtly and with compassion:

‘I usually ask the family to translate the language. There must be people who help me to translate the local language’ (P 8).
An interpreter or translator is considered beneficial to support staff-patient communication. Hospitals in some countries provide professional interpreters (Ashton, 2012; Kale and Syed, 2010). However, some hospitals may not provide professional interpretation services due to issues with reimbursement policies (Karliner et al., 2011). In Indonesia, professional interpreters are only provided for foreign languages such as English. There are no professional translators for local languages in Indonesia. Professional translators are not provided in public hospitals in Indonesia.

As outlined above, family, colleagues and health staff are often involved to help as translators or interpreters when required. Other hospital staff who speak local languages who are on duty and available may become involved in the translation process and help with the care of patients (Ashton, 2012). Though the provision of translators or interpreters can improve clinical care (Karliner et al., 2011), the accuracy of the information conveyed must also be taken into consideration. This communication strategy can serve as an option in cultivating the nurse-patient relationship.

6.1.6 Involving community leaders

One participant in this study revealed that nurses involve community leaders to disseminate health information around the community. Participant 4 stated that, as a PHC health staff member, he often met community leaders and requested their participation in health information dissemination for community in their region:

‘We usually approach community leaders (prominent people), give them health information and encourage them to share health information with the public’ (P 4).

As explained in Chapter Four, community leaders in Indonesia are influential figures. They usually are respected by people as they are able to provide guidance in such areas as social and spiritual life. As people are usually obedient
to community leaders, information and suggestions given by community leaders are likely to be followed.

The purposes of health information dissemination are more readily achievable when community leaders are involved. However, nurses need to be careful to select and appoint the community leaders as they may have different opinions about health; it is important to anticipate the possibility that contrary or false information may be delivered by community leaders.

6.1.7 Humour and irony

Participants in the present study also discussed the use of humour, jokes or irony as communication strategies in caring for culturally diverse patients. The study's findings indicate that humour is used to persuade patients and family to comply with nursing interventions; this is the case both for patients of the same culture as that of the nurse and for those from different cultures. Participants mentioned using local slang, local languages and the national language as components of humour-based communication. Participants recognised that humour serves as one strategy in caring for patients in a multicultural population. Several quotations form the participants relate to this sub-theme:

‘I joke with patients to distract them from their concern about their diseases. Sometimes it is effective in reducing their tension’ (P 9).

‘Communication with joking reduces the patient's tension. Initially. A female patient did not want to be treated by a male nurse, but after we worked to persuade her and we joked, the patient ended up being willing to be treated. It [humour] was effective; there was even a cleric who was eventually also willing to be cared for by a female nurse’ (P 11).

Participants 9 and 11 revealed that humour and jokes can help to reduce patient stress. Participants discussed their attempts to diminish patient stress through expressions of humour. This study demonstrates that humour can distract patients from concerns about their illnesses. As expressed by participants 11 and 13, through joking and humour, nurses can also persuade patients and families
to follow medical instructions. Humour is believed to be a way to help individuals deal effectively with stress and to cope effectively with life in general (Kuiper and Martin, 1993). Humour can also help to reduce tension and break down barriers between individuals. According to Martin (2002), humour can intensify the level of an interpersonal relationship:

I tried to persuade her using irony. “Miss, look, your fingernails are long and dirty; these nails look very dirty, which can also affect your health. There are germs hidden in your fingernails.” Sometimes patients eventually cut their nails in the hospital’ (P 13).

‘As I used to joke while I examined the kid, they were happy with me. When they came back, they would ask me to care for them’ (P 7).

Participant 7 stated that she included some jokes in her conversations with patients, particularly paediatric patients. This strategy helped participant 7 to become closer to her child patients. As highlighted by Beck (1997), humour has multidimensional benefits including physiological, psychological and social aspects. Therefore, communication with some humour or jokes can facilitate the building of relationships between health staff and patients and families:

I sometimes talk using jokes. It was very effective. Communicating with slang language, people will feel much closer. But it is not for everyone. We see their age. Sometimes we use their local language. Using some jokes with slang and local language, we can build trust with patients. With the communication approach, in any case, generally people prefer joking, that’s my experience. With jokes and slang, it is easier for me to communicate with patients. They become more trusting of me as a nurse, it effectively relieves stress, and it helps them face obstacles like gender, age constraints, and language barriers’ (P 15).

Based on this study, it is clear that humour can help deepen nurse-patient relationships. Participants have successfully applied humour-based communication to begin open communications with patients. This facilitates the building of a trusting relationship between nurse and patient. Humour is also essential for persuading patients and family to comply with nursing interventions. By using local cultural approaches such as local slang and local language, participants in this study were able to use humour as a powerful way
of caring for culturally diverse patients. Humour is recognised as one strategy in caring for patients in a multicultural population.

The nurses are trying to use humour-based communication, but because of the cultural differences frequently run into potential danger. It is therefore considered important to learn and to understand aspects of the cultures that are part of a heterogeneous population. Jain and Krieger (2011) recommended that nurses learn culturally appropriate language, including the use of slang words and colloquial terms as communication strategies in intercultural encounters. However, different countries may have different senses of humour or ways of joking. Different regions and ethnicities may also have different senses of humour as they have different local languages and behaviours. Humour may also be perceived as patronising. Health staff need to be careful when using humour, jokes, and irony in nurse-patient communications.

6.2 Cultural approach
Different cultural approaches were also applied by the nurse participants in this study to overcome the barriers they encountered in caring for culturally diverse patients. While in Chapter Five found that participants respected differences in culture, behaviour, customs and beliefs while engaging in nurse-patient interactions, the study’s nurse participants also acknowledged the benefits of cultural approaches through speaking local languages with patients. This study demonstrates that participants used culturally based communication to establish nurse-patient relationships, as expressed in the quotations below:

‘I know that as nurses we need to learn the language, because all activities of nurses start from communication. Even though we have a national language, we also have to learn local languages, because patients come from everywhere, from many ethnicities’ (P 12).

‘When I can speak using the local language of my patients, I feel so much closer to my patients. I felt more united. I think when I speak Bahasa with patients, it might seem too formal. When I speak Javanese or Madurese, I feel one step closer to the patient than when I speak Bahasa. That is what I
feel. I think it is important to learn the local language. Just in case, when we find patients who cannot speak Bahasa Indonesia and we do not know their local language, then what are we to do? If there is a friend who can help, maybe there will not be a problem. If there is nobody who can translate, then what? In a remote area, there is usually only one nurse on duty; therefore, it is very important to learn the patients’ local language’ (P 13).

‘I think it is very important to learn the local language so that we can communicate with patients. Then our activities and actions can be easily understood by patients’ (P 18).

Based on the narratives that emerged from the interviews, participants recognise the importance of utilising local languages in nurse-patient communications. Participants attempted to learn patients’ local languages, particularly to aid in communication with elderly, rural patients or patients who prefer to speak their mother tongue. This is consistent with Jain and Krieger’s suggestion (2011) that health professionals can use colloquial language or common slang to facilitate intercultural nurse-patient communication.

6.3 Spiritual support

Another strategy used by the nurse participants in the present study is approaching patients from a spiritual perspective. Participants revealed the importance of spiritual support in caring for patients. Participants stated that they believed that all patients have spiritual beliefs, and they therefore encouraged patients not to rely solely on medical treatments or health professionals, but also to believe in God. The following quotations relate to questions of spiritual support as viewed by participants:

‘I usually give spiritual advice to patients. If they have the same religion as I do, I’m more likely to suggest prayer and dhikr to them, but if they are of a different religion, I usually advise them to pray according to their beliefs. I always convey to the patient to keep praying to God for healing; we as nurses in hospitals are only intermediaries. I give spiritual advice because I think the psychological impact on the patient, physically, toward healing, is huge’ (P 13).
'I usually use a spiritual approach to the patient’s family to calm them and not make them more frantic. They eventually become more accepting of the situation’ (P 15).

‘I give spiritual encouragement. I remind them to pray according to their beliefs, that everything will come back to God’ (P 1).

‘Drugs are indeed important, but the expensive drugs, the sophisticated and smart doctors, the caring nurses, if not accompanied by prayer then it all vanishes. The one entitled to determine the age of man is not a doctor, but God’ (P 11).

‘Thank God, so far no one showed a sense of discomfort or displeasure. They even look comfortable and happy when I remind them to pray for the recovery of their loved ones’ (P 16).

‘It seems so far no one does not believe in God. All believe in God’ (P 12).

The findings of this study show that participants seem to integrate their own spiritual beliefs into the concept of caring for patients, which is likely coloured by their own religious upbringings. It has been underlined by Cohen and Varnum (2016) that religious beliefs affect a person in terms of cognition, work ethic and moral judgment. An individual’s cognitive capacities, which are influenced by religious capacities, have an effect on the individual’s capabilities ‘to solve adaptive problems like managing social relations and avoiding disease’ (Cohen and Varnum, 2016, p.7). Participants’ religious capacities apparently also have an impact on their capabilities to manage nurse-patient relationships, particularly in difficult situations or encounters.

**6.4 Summary**

This chapter elaborates various strategies used by nurses in addressing cultural and spiritual matters in caring for very diverse patients. Seven communication methods were found in this study, including clear explanation, rectifying poor health opinions, suggesting without coercing, non-verbal communication, engaging a translator or interpreter, involving community leaders, and making jokes or employing irony. This study also indicates that nurses use cultural
approaches and spiritual support in dealing with culturally and religiously
diversity of patients.

Though nurses describe a wide range of strategies in dealing with patients’
diversities, this study indicates a number of problems that are inherent in the
nurses’ responses to certain points. For instance, nurses’ narratives about not
only depending on medical treatments, but also believing in God. This statement
might give rise to problems when nurses care for patients who do not believe in
God. Using a humour in a nurse-patient communication might cause
misunderstanding, resentfulness or offence if patients think nurses’ humour or
irony are not appropriate to the patients’ belief, value or culture.

To conclude all themes discussed in the findings chapters are presented in the
table below.
Table 4. Overarching themes

<table>
<thead>
<tr>
<th>Barriers to Caring in a Heterogeneous Society</th>
<th>Attitudes Towards Differences and Similarities in Patients’ Cultural and Religious Identities</th>
<th>Strategies in Addressing Cultural and Spiritual Issues</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Nurses’ views of barriers related to cultural issues</strong></td>
<td><strong>1. Between describing and stereotyping</strong></td>
<td><strong>1. Communication strategies</strong></td>
</tr>
<tr>
<td>a. Family:</td>
<td></td>
<td>a. Clear explanation</td>
</tr>
<tr>
<td>- Family attendance and family visit in hospital</td>
<td></td>
<td>b. Rectifying poor health literacy</td>
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<tr>
<td>- Strong family bonds</td>
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<td>c. Suggesting without coercing</td>
</tr>
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<td>- Families as decision makers</td>
<td></td>
<td>d. Non-verbal communication</td>
</tr>
<tr>
<td>b. Language</td>
<td></td>
<td>e. Translator and interpreter</td>
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<tr>
<td>c. Perception of illness and treatment</td>
<td></td>
<td>f. Involving community leaders</td>
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<tr>
<td>d. Traditional beliefs</td>
<td></td>
<td>g. Humour and irony</td>
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<tr>
<td><strong>2. Nurses’ views of barriers related to spiritual issues</strong></td>
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<td><strong>2. Cultural approach</strong></td>
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<td><strong>3. Nurses’ views of barriers related to workload issues</strong></td>
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<td><strong>3. Spiritual support</strong></td>
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<td></td>
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<td>a. Nurses attempt to see everyone the same and treat all patients equally</td>
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<td>b. Understanding of patients’ characteristics is important</td>
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<td><strong>1. Communication strategies</strong></td>
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<td>g. Humour and irony</td>
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CHAPTER SEVEN
DISCUSSION

The data chapters in this thesis have identified several critical issues. Some of these issues have been acknowledged in previous studies that have considered caring for patients from minority groups in a homogenous population; however, there are significant differences between caring for patients with immigrant or minority backgrounds in a homogenous population and caring for such patients in a heterogeneous population. In this chapter, the key themes identified in the data chapters are considered in greater depth. These major issues are the barriers to nurses’ provision of health care, nurses’ attitudes toward complexity and the strategies nurses employ in working in PHCs and hospitals in their heterogeneous communities.

The section of this chapter that focuses on barriers elaborates a wide range of barriers encountered by nurse participants in caring for members of a diverse society. In-depth analysis of the research findings of the present study indicates that a number of barriers affected and shadowed nurse participants in caring for patients with various cultural backgrounds. The nurses encountered actual barriers related to workload issues as well as shadow barriers related to cultural and spiritual issues. The existence of these barriers exerts a constant influence on nursing activities as nurses care for patients; consequently, the barriers impact nurses’ responses to the plurality that characterises their patients. This study indicates that participants’ attitudes towards patients’ diversity vary widely. The findings of the current study demonstrate four types of participant attitudes in response to patient diversity. These are describing and stereotyping, cultural ties, trying to be fair and respecting difference.

This chapter also elaborates participants’ strategies in managing to overcome a wide range of cultural and spiritual barriers. The present study reveals three...
major strategies undertaken by participants. These are communication strategies, cultural approaches and spiritual support. Through analysis of the interviews undertaken as part of the present study, seven methods of communication have been identified. These include clear explanation, rectifying mistaken opinions, suggesting without coercing, non-verbal communication, using translators or interpreters, involving community leaders, and making jokes or using irony. Cultural approaches have also been identified in the present study. Nurses may speak using local languages to improve culturally based communication. This study indicates that a cultural approach can be beneficial in building the nurse-patient therapeutic relationship. Also evidenced in the current study is that a spiritual approach was applied by participants to circumvent barriers to caring for diverse patients.

7.1 The barriers influencing nursing care

Nurse participants in this investigation explained some of the complexities inherent in caring for patients with various backgrounds. In-depth analysis of the research findings indicates that a number of barriers affected and shadowed nurse participants in caring for their varied patients. The researcher has classified these barriers into two types, namely actual barriers and shadow barriers. The barriers cannot be obliterated; rather, they are obstacles that nurses must learn to overcome. Both actual and shadow barriers influenced the perspectives of nurse participants towards patients’ diverse backgrounds as well as the way they approached their patients from various cultural groups. The term ‘shadow barrier’ was established in this study to depict persistent circumstances that shadow nurses’ activities and influence nursing care. The actual barrier that emerged in this study was nursing workload, while the shadow barriers identified were cultural and spiritual issues. Barriers related to cultural issues include family, language, perceptions of illness and treatment, and traditional beliefs. This section discusses all of the barriers discovered, including issues related to workload, culture and spirituality.
7.1.1 Workload issues

As one of the objectives of this study was to investigate participants’ experiences regarding the barriers encountered when caring for a culturally and religiously diverse patient group, this study might be predicted to yield simple facts about barriers related to cultural and spiritual issues. However, the findings of this study indicate that nursing workload was also a major concern of participants in caring for their diverse patients. Although this study explored diverse cultural and spiritual aspects of nurses’ experiences in caring for patients with varied backgrounds, I discovered during the process of analysis that workload issues constitute an actual barrier which influences nurses’ experiences. Information about nursing workloads emerged through the individual interview process. Participants in the present study revealed that excessive workloads significantly influence the quality of nursing care.

Nursing workload is a common term used to describe the sum of all nursing activities that take place in a health care setting. These involve direct patient care, indirect patient care, and non-patient care. Alghamdi (2016) provided a description of the differences between nursing work and nursing workload. According to Alghamdi (2016), nursing work refers to all actions that nurses undertake for patients, while the nursing workload is defined as the quantity of nursing work that a nurse is required to undertake. The nursing workload is often divided into three types of workloads: the unit-level workload, the job-level workload, and the task-level workload. Holden and colleagues (2011) outlined these workloads as follows: *Unit-level workload* refers to the patient-to-nurse ratio; in other words, it is related to the sufficiency of the workforce. Unit-level workload is determined by the adequacy of nursing staff resources, which influences the nurse-to-patient ratio (Holden et al., 2011). For example, as mentioned by participant 13 in Chapter Four in pages 125-126, when she was in charge of a Class III inpatient unit, there were only two nurses caring for 40
patients during night shifts. In contrast, when she was in charge of a Class I inpatient unit, there were four nurses caring for nine patients during morning shifts. Participant 13 felt the difference in the nursing workloads between Class III and Class I inpatient units. This phenomenon indicates that the unit-level workload is affected by the nurse-to-patient ratio. The nursing workloads in Class III inpatient units are considerably higher than in Class I inpatient unit. As a result, nurses in Class III inpatient units might not be able to provide as much caring as nurses in Class I inpatient units.

The term ‘job-level workload’ refers to the specific requirements of a job. These include the quantity and types of jobs performed in a day as well as the time and tools required to do the job. Job-level workload is related to the total amount of work that needs to be done in a day, the difficulty level of the job and the level of attention required to do the work. Some of the required resources considered are the number of hours given to do the job, break time and staff and technology resources (Holden et al., 2011). For example, a nursing job in an intensive care unit might include checking vital signs every four hours, giving parenteral nutrition every eight hours, taking blood samples, working with heparin drips, insulin drips, and restraints’ performing bladder irrigation and nasogastric tube irrigation (Giammona et al., 2016).

Task-level workload refers to the requirements and sources for a particular nursing task, including the difficulty level of the task to be done, the level of concern about the work required and the specific training required to do the task. For instance, for the performance of several tasks such as intravenous therapy installation, medication administration, and complex dressings, nurses might require training, electronic resources or support from experienced senior staff (Holden et al., 2011). There are five main attributes of nursing workload as underlined by Alghamdi (2016). These are the quantity of nursing working hours, the nursing competency level, the weight of patient care, the level of physical
effort, and the complexity of care (Alghamdi, 2016). Based on the interview analyses in the present study, nursing workload involved all of these characteristics, including nursing workforce resources and the number of nursing tasks, particularly work related to ‘doctors’ jobs’ or medical interventions.

Participants in this study understood the wide range of their workloads. The majority of participants felt that routine nursing tasks required a great deal of time all throughout the workday. The nurse participants were responsible for such tasks as the administration of medication, intravenous therapy, routine dressings and wound care, and paper-based and/or electronic nursing documentation. Nurses perform not only nursing jobs; most nursing activities include ‘medical jobs’ or ‘doctors’ jobs’. One participant explained that new nurses and freshly graduated nurses are generally happy to do ‘doctors’ jobs’.

I view this phenomenon as stemming from the fact that new nurses who have recently graduated may feel pride in their expertise and ability when they have an opportunity to turn their knowledge and competencies into the performance of actual health services, either in hospitals or in primary health centres. This is actually beneficial for their competence development as they can perform clinical skills with real patients (Roberts and Johnson, 2009). Whereas as a nursing student they may have mainly experienced clinical skills in a simulated setting (Roberts and Johnson, 2009). Nevertheless, this present study indicates newly qualified nurses frequently focus merely on performing clinical task and do not involve component of caring in their nursing activities. I believe that the nursing curriculum in Indonesia is partially responsible for this phenomenon. There is no particular subject in the nursing curriculum that covers the topic of caring in nursing. Though the topics of compassionate care and therapeutic care are involved in the subject of communication in nursing practice, I posit that it is important to understand the development of caring theory in nursing science as well as the elements of caring that have been established by several nursing
scholars. In such a way, nursing students can gain a broader knowledge base regarding caring as the essence of nursing practice.

Nurses might be proud when they receive praise from patients or family members who are pleased with the nurse’s ability to perform a painless intravenous administration. A previous study I conducted in 2010 revealed that, though patients expect to be cared for compassionately, they also require a competent nurse who is able to take blood samples from an intravenous line and to insert urinary catheters or nasogastric tubes without causing the patient pain. The majority of patients and families lack knowledge about nursing education and may thus often assume that nurses are doctors’ assistants. My previous study also indicated that some patients perceive that nurse competency in performing medical skills and procedures is of great concern, given that such competency ensures the minimisation of patient discomfort. Patient and family complaints often emerge when a patient is dissatisfied with a nurse’s competency rather than with a nurse’s compassionate care. Therefore, it is considered that patients’ expectations do affect nurses’ perceptions regarding their nursing work. Nurses attempt to demonstrate high competency in order to meet patient and family expectations.

Arguably, the assessment of nursing performance in hospitals and primary health centres also influences nurses’ perceptions of nursing jobs. One of the items on nursing performance evaluations is based on nursing work, including the performance of ‘doctors’ jobs’. Nurses obtain normal wages and additional salaries as compensation for the performance of ‘medical tasks’. As far as I am aware, there is in Indonesia no specific measurement on nursing performance rubrics that assesses or evaluates nurses’ provision of compassionate care. This lends credence to the sense that nurses are more appreciated for their performance of ‘medical tasks’ rather than for their caring attitudes. Nurses’
technical skills are more valued than the compassionate care they provide. This situation might also influence nurses’ performance in caring for patients.

Therefore, I suggest the development of assessment tools to measure caring and demonstrate the value of nurses’ caring attitudes. Although a caring attitude should come from sincerity of heart, a caring assessment tool could encourage nurses to be more caring towards patients as nurses would then receive compensation for demonstrating caring attitudes. There are several measurement tools for caring in nursing. These include Nelson and colleagues’ caring factor survey (2008), the caring behaviour assessment tools used by Duffy (1992), the caring behaviour checklist and client perception of caring established by McDaniel (1990), and the caring behaviour assessment tools developed by Cronin and Harrison (1988). I consider that it is important to establish a caring assessment tool which includes aspects of cultural diversity typical of Indonesia in order to ensure that the caring assessment tool is appropriate and applicable in Indonesia. I plan to engage in such a project as a postdoctoral scholar.

The findings of this study are in line with those of previous studies which indicate that nursing workloads often influence the quality of nursing care. A cross-sectional survey conducted by Ball and colleagues (2014) found a significant association between nurse staffing and the amount of ‘missed care’. Their study demonstrated that care is often left unfinished by nurses in hospitals in the UK due to the inadequacy of nursing time in the last shift. Several nursing care activities that may be neglected have been identified; they include comforting or talking with patients, providing health education to patients, and managing nursing care plans. Other nursing activities, including pain management, treatment and the performance of procedures were very rarely left undone (Ball et al., 2014). This study shows the impact that insufficient time resources can have on the amount of work that can be completed by nurses.
Moberly (2017) presented the results of polling and focus group work, conducted by Anastasia Knox, which revealed that members of the public believed that doctors and other staff in the NHS were overworked and wanted to provide better care but had no time to do so. Anastasia Knox is a research director at Britain Thinks, a consultancy agency that uses polling and focus group work to gauge public opinion. The public in the UK are concerned about staff shortages, and they also wonder whether new, younger staff members offer the same commitment as older staff to practicing caring values in patient-staff relationships (Moberly, 2017).

These phenomena are also reflected in the findings of the present study, in which participants reported that they felt they had insufficient time to talk with their patients due to the many nursing tasks that they were required to accomplish. Participant 17 conveyed that she, as a nurse, felt more satisfied when she could also provide emotional and spiritual support to her patients rather than solely offering technical support. Participants in the present study also expressed concern about the shortage of nursing personnel, particularly in the night shift in Class III inpatient facilities, where participant 13 reported that three nurses cared for 40 patients. Participants acknowledged that they could not provide optimal care due to the need to manage many patients with a wide range of medical needs. Participants felt that they lacked the time to sit beside patients and to talk with them. They understood that, this being the case, they might not be able to meet patients’ expectations in terms of receiving compassionate care.

Cremasco (2012) found that nursing workload has been identified as one of the risk factors linked with pressure ulcer incidents in intensive care units (ICU), with other factors including severity of illness, sex and length of stay in the ICU. However, the study also indicated that higher workload serves as a protective factor for patients with high dependency; though nurses’ workloads are
increased when they care for patients whose conditions demand more attention, these patients are obtaining sufficient care to reduce the incidence of pressure ulcers (Cremasco, et al., 2012). Health staff workload has also been shown to affect hand hygiene. As Scheithauer and colleagues (2017) indicated, there is an inverse correlation between hand hygiene compliance and staff workload. The authors explained that the higher the workload, the lower the compliance with hand hygiene regulations (Scheithauer et al., 2017). The findings of these two studies also support the present study’s finding that nursing workloads have an impact on patient safety to the extent of becoming an actual barrier to caring for patients.

Excessive nursing workloads can increase the possibility of pressure ulcers in intensive care patients, and nursing workload is also related to lack of staff compliance with hand hygiene regulations. Nevertheless, Cremasco’s study (2012) did identify some anomalies in the evidence that workload is necessarily a risk to patient care. The study also found that workload can serve as a protective indicator. As nursing workload and pressure ulcer incidents had become a concern, the circumstances led nurses to provide additional care for patients with high dependency levels, i.e. patients who require particularly intensive nursing work and attention. Although this finding might contradict the findings of the current study, it has a place in the present discussion chapter as it may contribute to the body of knowledge regarding nursing workload. As a result, it may not only help nurses to understand the impact of nursing workload on nursing care, but also provide information about the protective factor of nursing workload.

The importance of findings that are contradictory and/or not entirely clear is that they acknowledge the complexity of nursing work and the impact of that work on patient care. However, Cremasco (2012) did not identify whether the provision of additional care for the patients with pressure ulcers caused other
patients to experience missed care. Cremasco (2012) did not identify the missed opportunities in patient care which might be experienced by other patients when additional attention was given to patients considered to exhibit high dependency levels.

This present study also indicates that nursing workloads related to documentation activities significantly affect the quality of nursing care. Nurses admitted that their activities in completing both paper-based and computerised documentation detracted from the time available for them to provide the best patient care. However, this study also indicates that several spiritual and cultural issues such as family, language barriers, and traditional beliefs affected nurses’ ability to care for patients from certain cultural backgrounds. Based on the data gathered for this study, I suspect that nurses might be unable to manage optimal patient care due to documentation work. However, it is also important to consider that as a result of the barriers which arise due to cultural and spiritual issues, nurses might not in fact want to do the work of caring for some of their patients. This is further discussed in the next section.

The finding that nurses may actually seek to avoid caring work is in line with an ethnographic study conducted by Johnson and colleagues (2015) in three hospital sites in England. Their study underscores that nursing tasks and roles have changed significantly. Nurses often delegate their caring works to health care assistants as nurses have an increasing task regarding documentation. Though this would enable health care assistants to obtain the real experiences of caring for patients, however this situation prevents nurses from doing ‘the real care of patients’ (Johnson, et al., 2015, p. e33). Nursing workload and roles obviously increase as nurses’ focus is not only on documentation job, but also supervise health care assistants to enhance a safety care. Therefore, Johnson et al. (2015) highlight the importance of effectiveness of delegation and supervision nursing task to health care assistants. This aims to ensure the care provided by
nurses and health care assistants as a collaborative team work is safe, effective and efficient.

Another previous study demonstrated that an elevated workload can also influence the quality of documentation. An explorative survey undertaken by Shihundla et al. (2016) indicated that increased nursing workloads affect the documentation of patient information in primary health centres in Vhembe District, Limpopo Province. The documentation of patient information was found to be both incomplete and inaccurate. Nurses felt that it was difficult to manage their increased workload related to the need to document patient information in multiple formats in primary health centres. While there is an association between nursing workload and nursing documentation, the finding of Shihundla and colleagues’ study is not entirely relevant to the present study. The authors found that nursing workload can influence the quality of nursing documentation. Their study showed that nurses were unable to manage optimal documentation of patient information due to their nursing workloads and that, as a result, nursing documentation was often inaccurate and left incomplete.

The phenomenon in Shihundla’s study (2016) is not mirrored in the current study, in which nurse participants considered completing nursing documentation to be part of the workload itself. For example, participant 3 felt that nurses were unable to provide the best care for their patients due to a massive amount of work in documentation. Working in a primary health centre, nurse participants not only care for patients in outpatient or inpatient units but also manage several primary health centre programmes in the community; these include TBC, hygiene and sanitation, vaccination, and the like. Nurse participants are required to document all activities undertaken both in the primary health centre and in community.
The correlation between nursing workload and patient length of stay also requires consideration. A study conducted by Elliot and colleagues (2014) indicated that increased workload can lead to increased length of stay and care cost. The length of patient stay may rise significantly as increased workload rises, particularly at lower hospital occupancy. Increased nursing workload can prolong the length of stay of patients, thus also increasing the cost of care (Elliott et al., 2014). Elevated nursing workload increases the possibility that patients may experience adverse events. Kang and colleagues (2016) found that four types of patient adverse events resulted from the elevated nursing workloads that resulted from the need for nurses to perform non-nursing tasks. These patient adverse events comprise medication errors, nosocomial infections, patient falls, and pressure sores (Kang et al., 2016). None of these issues were raised by nurse participants in the present study. However, based on the interview narratives, it could be the case that these events occur with more frequency when nurses strain under heavy workloads.

Certainly, given the shadow barriers that need to be moved through before appropriate care can be given, there is a chance that some patients must stay in hospital longer; therefore, this possibility needs to be taken into consideration. It also offers additional information about the impact of nursing workload on nursing care quality. This information can help nurses to understand the risk of prolonged length of stay due to patient adverse events which are caused by excessive nursing workloads. Awareness of this study can raise nurses’ and nurse managers’ appreciation of the importance of managing nursing workload so as to ensure the delivery of best care for patients.

Several strategies can be applied to manage nursing workloads in health care settings. An experimental study undertaken by Giammona (2016) developed and evaluated the Nursing Care Score (NCS) system in the electronic health record. It significantly optimised nursing work and allocation of staff. This system enables
nurse managers to allocate nursing staff. The study also indicated that nurses were satisfied with the NCS system as the system both allowed them to provide adequate care and convinced them that workloads were being equitably distributed (Giammona, 2016).

A similar strategy was offered by Goh and colleagues (2017), who found a weak positive association between patient satisfaction and nursing workload. Goh and colleagues (2017) suggested that nurse managers should develop positive work environments through optimising efficient staff resource allocation and providing adequate staffing to improve patient safety. Shihundla et al. (2016) and Bailey et al. (2015) offered strategies related to nursing documentation in primary health centres. The manager of a primary health centre may provide a computer for electronically based documentation and recruit local residents as volunteers in community primary health centre programmes (Shihundla et al., 2016; Bailey et al., 2015).

Holden (2011) suggested making staffing determinations based on multiple measures of workload rather than relying solely on the number of patients, staff personnel or patient classification systems. Further, Holden (2011) underlined that when nurse managers are unable to increase the number of staff required, nursing staff adequacy can be maintained through better allocation of tasks in the wards, better interpersonal communication and better teamwork in the unit. Similarly, Johnson and colleagues (2015) in their study suggest the importance of professional nurses to make a priority in performing nursing tasks and nurse should capable to manage their time.

No data in the current study were found to relate to strategies for managing nursing workload. None of the participants in this study described methods for managing their workloads, despite the fact that some of the participants in this study were nurse managers. Perhaps the absence of data on this subject
resulted from a limitation imposed by my choice to conduct semi-structured individual interviews. Therefore, a number of the strategies suggested by other researchers as discussed here may be important. It is for this reason that they are provided in this discussion chapter. This information can help nurse managers either on a ward or in a primary health centre to overcome nursing workload issues in their units. Nurse managers can choose the best strategies for their particular units, considering several factors such as staff resources, electronic device resources, type of work, time required, etc.

The findings of this study broadly support those of previous studies which indicate that, as detailed in the previous paragraphs, nursing workloads have a significant impact on nursing care quality. Nursing workload issues were determined to be the single actual barrier in this study. Several factors can contribute to an explanation of this analysis. Firstly, nursing shortages and nurse-population ratios in Indonesia appear to be related to nursing workload issues in this study. The description of Indonesia’s nursing workforce outlined in the following paragraphs explains why nursing workload issues emerged as an actual barrier in the present study.

According to the Data and Information Centre of the Ministry of Health of the Republic of Indonesia (2017), the total number of nursing personnel in Indonesia in December 2016 was 296,876, or about 49% of the total number of health staff in Indonesia. The nurse-to-population ratio in Indonesia in 2016 was 113.40/100,000. This figure is far below the Ministry of Health’s target for 2019, which is 180 nurses per 100,000 populations; moreover, the 2016 figure is below the 2014 target of 158 nurses per 100,000 populations (Data and Information Centre of the Ministry of Health of the Republic of Indonesia, 2017). In 2013, there were 32,833 nurses in the province of East Java, where the nurse-to-population ratio was 85.2/100,000 (Statistics of East Java, 2013).
Based on the membership report recorded in the information system of Indonesia’s professional nursing organisation (PPNI), the number of Indonesian nurses registered as of April 2017 was 359,339. A total of 256,326 nurses (71%) were female and 103,013 were male (29%). A total of 652 (0.18%) nurses were working abroad. A total of 58.26% of the nation’s nurses were assigned to work in hospitals, 29.46% in PHCs, and 12.22% of nurses in underdeveloped, outlying and border regions (tertinggal, terdepan dan terluar or 3T). The majority of nurses are permanent employees. In Indonesia’s 970 public and private hospitals, approximately 70% of nursing staff are permanent personnel, while 30% are non-permanent employees (contract workers, volunteers). Of the total number of nurses working in primary health centres, as many as 78% are permanent employees and 22% are non-permanent employees (Data and Information Centre, MoH, 2017).

According to the regulations of the Health Minister in 2014, the minimum standard number of nurses in an inpatient primary health centre is eight, while that in a non-inpatient primary health centre is five. In 2016, 26.17% of the country’s primary health centres lacked a number of nurses, with the majority of the shortages in Java and Bali. Overall, the number of nurses is large, but the ratio of nurses to population in most parts of Indonesia has not met the target outlined in the health strategic plan, and the number of nurse experts and specialists is still relatively low (Data and Information Centre, MoH, 2017).

The health staff shortfall is also a serious problem globally. Nursing personnel shortages also occur in both developing and developed countries around the world. According to Global Health Observatory (GHO) data from the World Health Organization (WHO) (2017), about half of WHO member countries have fewer than three nursing and midwifery staff per 1000 population, including Indonesia, which has only 1.303 nursing and midwifery personnel per 1000 population. According to GHO-WHO data, nearly 27% of WHO member states
have fewer than one staff member per 1000 population. GHO of WHO (2017) also estimate the needs-based shortage of health care staff to be roughly 17.4 million globally. Of these, more than nine million are nurses and midwives. South-East Asia and Africa are the two regions experiencing the largest needs-based shortages of human resources in health care (GHO of WHO, 2017). The nurse shortage in China, for example, is less serious than that in Indonesia. In China, the nurse-to-population ratio in 2013 was 2.05 nurses per 1000 population (You et al., 2015). Indonesia’s shortage is relatively severe: in 2014, Indonesia had only 0.94 nursing personnel per 1000 population (Data and Information Centre, MOH, 2017). Bigbee (2008) reported that data from the U.S. Department of Health and Human Services (2006) reflected a 2004 nurse-to-population ratio of 825 nurses per 100,000 population or 8.25 per 1000 population.

NHS UK also face problems related to retaining nurses. BBC News UK health correspondent Triggle (2018) revealed that 33,000 nurses leave NHS each year. Based on figures sourced from NHS Digital, in the past three years, more than 10 percent of the nursing staff left NHS and more than half of those were nurses aged under 40 (Triggle, 2018). Campbell (2018) wrote on guardian.com (2018) that several English hospitals were experiencing desperate nursing shortages. Triggle (2018) concluded that more nurses were leaving than joining the NHS in England. The nurse attrition rates have also been surging in Northern Ireland, Scotland and Wales. As a result, the nurses who remain face higher nursing workloads as the shortage of nursing staff becomes more acute. Nurses are becoming too busy as they have many things to do, as expressed by one nurse who finally left the NHS (Triggle, 2018).

NHS managers are also experiencing difficulties in recruiting new nurses for the workforce. According to NHS Digital’s figures, hospitals in London struggle with the recruiting of new nurses; of 2,545 nursing and midwifery positions they
wished to fill, only 42 new staff were hired. Similarly, the fill rate of new NHS nurses in north, central and eastern London is only 3.3 % (Campbell, 2018). Vacancies for nurses and midwives advertised in 2017 have been more numerous compared to those offered in 2015, with a total of 133,660 positions open. However, the number of applicants fell by 12.2 per cent over the two-year period between 2015 and 2017 (Wilson, 2018). This means NHS is increasingly struggling with the recruitment of new health staff. There were 103,826 applications for nursing and midwifery position at the end of 2015, but the number of applications dropped significantly to 91,189 applicants (Wilson, 2018).

Rafferty (2018) highlighted the fact that the shortage in the UK nursing workforce does influence the quality of patient care and threaten patient lives. On theconversation.com (2018), Rafferty opined that the number of nursing staff in the NHS of England has declined over a ten-year period during which the demand for care has risen due to the increasing elderly population and the number of patients with multiple long-term illnesses. Further, Rafferty argued, government have rescinded the student nurse bursaries which are crucial to supporting nurses’ education and training. This policy has caused a 23 per cent decrease in nursing degree applicants (theconversation.com, 2018 [online]).

Rafferty underscored two of the factors that are considered to have resulted in the nursing shortage in the NHS: Brexit and the English test of the Nursing and Midwifery Council. The number of EU nurses joining the NHS UK has fallen by 89 per cent due to Brexit. As a result, nurses in England have higher workloads and burnout rates as compared to the rates in EU countries (theconversation.com, 2018 [online]). The length of working hours will be longer, reaching 12 hours per shift, perhaps without breaks. According to Rafferty, this condition will affect patient care, threaten patient lives, and cause increases in both the risk of complications and the number of readmissions to hospital. Rafferty, together
with Aiken and colleagues (2017), indicated that a larger professional nursing workforce contributes to better outcomes for patients and nurses as it diminishes the number of patient deaths and increases the quality and safety of hospital care. Rafferty in the conversation.com (2018) describes her study with her colleagues which indicates that if hospitals in the nine EU countries they studied had at least sixty per cent degree-professional nurses with a 1:6 nurse-to-patient ratios, this would avoid 3,500 patient mortalities per year. This clearly indicates that a sufficient number of staff members on the nursing workforce can enhance safety, care and outcomes.

This global picture of the nursing shortage in many countries gives an idea of the nursing workload issue as experienced in countries other than Indonesia as well as the influence of these circumstances on the provision of nursing care. The adequacy of the nursing workforce should be considered not only to ensure that care is acceptable, but also to facilitate the provision of therapeutic care. Nursing staffing figures are therefore central to the ability to provide therapeutic care rather than merely to maintain safe levels of care.

Richardson and Ovens (2016) suggested that the therapeutic relationship should be developed and improved through embedding values of empathy, care and compassion into nursing intervention skills as therapeutic care relationships can enhance patient outcomes. Therefore, through a discussion of nursing workloads in the current study, I have highlighted three benefits of maintaining a sufficiently staffed nursing workforce: one, to overcome nursing workload issues; two, to ensure patient safety; and three, to enable nurses to provide the best possible therapeutic care.

Overall, the uneven distribution of nurses in Indonesia and the low nurse-to-population ratio causes the number of nurses in Indonesia to be disproportionate to the population. Thus, nursing workloads due to nursing
shortages and low nurse-population ratios are obviously high, as shown in this study. This factual information confirms participants’ expression that an imbalance in nursing tasks and nursing staff resources causes inadequacy of provision of the best compassionate care for patients with diverse backgrounds. Based on several papers as outlined in the previous paragraphs, it appears that nurses in Indonesia experience the same problems as nurses around the world; however, these findings may help nurses to better understand nursing workload as one of the barriers in caring for patients with diverse backgrounds. No studies thus far have considered and included the aspects of patients’ cultures, languages and spirituality as a prior assessment in nursing work. Therefore, further investigations are required to determine whether it is possible to include all aspects of the spiritual, cultural, and linguistic identities of patients as an initial activity in nursing work. Human resources, electronic resources, cultural training and education, and the time required to examine those aspects might need to be considered.

7.1.2 Cultural issues

Several reports have shown that aspects of the cultures of both patients and nurses can influence the nursing care process. The most obvious finding to emerge from the analysis within this study is that in caring for very diverse patients, the nurses encountered some obstacles associated with the cultural customs of society. The research findings demonstrate that family, language, perception of illness and treatment, and traditional beliefs are barriers related to cultural aspects. Although similar barriers in caring for diverse patients might have been revealed in previous studies, which, as outlined previously, were mostly conducted in Western countries (see for instance Englund & Rydstrom, 2015; McCarthy et al., 2013; Jirwe et al., 2010), the present study indicates barriers of a different nature as this study was conducted in a heterogeneous population of indigenous nurses and patients with very diverse cultures, religions and local languages.
The next question that might arise is the reason for which cultural and religious issues are termed shadow barriers rather than actual barriers. According to my analysis, as a nurse and a person who lives in the culture being studied, a possible explanation for this is that the nurse participants have grown up and lived in an environment with diverse cultures and beliefs (Crisp & Turner, 2011; Leung & Chiu, 2010). The ways in which nurses have been brought up, which might also be affected by the cultural and spiritual aspects of their families, have also influenced nurses’ views on diversity. The nurse participants were already familiar with the cultural and spiritual diversity of their environments. Nurse participants might have considered cultural and spiritual aspects to be less problematic than their workloads. This might affect participants’ perspectives of the cultural and spiritual issues that normally appear in nursing care, as expressed by the majority of the nurse participants. Therefore, this study has found cultural and spiritual barriers not to be a major obstacle in nursing care, but rather shadow barriers that shadow and influence the care that nurses are providing. The nurse participants in this study viewed nursing workloads as the main problem in caring for patients.

Family
Family attendance and family visitations are of concern to nurses when caring for patients in all units. Family members may have a strong desire to keep an eye on and to provide the best protection for their relatives. Nurses are required to be able to ensure the balance of the provision of family visiting time, manage the care of patients and maintain inter-professional relationships in the unit (Agard & Lomborg, 2010). The current study found that nurse participants were concerned with the risk of cross-infection between patients and family members or other visitors; however, they were also aware of the benefits of family presence due to the emotional and spiritual support that family members provide for the patients. The results of the present study corroborate the
findings of many previous works which concern the risk of infection related to visiting patients, as outlined in the following paragraphs.

Nurse participants in the current study expressed their awareness of family and other visitors’ behaviour when family visited or accompanied their loved ones, knowing that their presence might increase the possibility of the transmission of infection from family or other visitors to patients. Members of the family or other visitors often visit in large groups and bring food and personal belongings as they stay overnight at the hospital. According to participants, members of patients’ families and other visitors did not pay attention to the risk of bacterial transmission, which might be heightened by their behaviour when visiting or accompanying patients in the room. This finding is consistent with that of Hobbs et al. (2016), who also found that visitors paid little attention to the risk of cross-infection in hospital. Hobbs and colleagues’ (2016) observational study indicated that the awareness of visitors of the need to maintain hand hygiene by using alcohol-based hand sanitiser was low at under four per cent. They found visitors more likely to follow alcohol-based hand hygiene practices when the sanitiser was placed in a clearly visible and reachable area such as in the middle of the lobby.

Hobbs et al. (2016) also found that the visitors preferred to use alcohol-based hand sanitiser in the afternoon rather than in the morning. Younger visitors and visitors who arrived in a group more frequently used alcohol-based hand sanitiser. Therefore, managers must consider the best locations to place alcohol-based hand sanitiser to enhance the following of alcohol-based hand hygiene practices and to minimise the transmission of bacteria that come with visitors. Younger people and school-age groups can be target groups to campaign the importance of hand hygiene when visiting patients in a hospital (Hobbs et al., 2016).
In the present study, nurse participants seemed to focus only on visitor behaviour when visiting in a large group and family members who accompanied patients in their rooms with large numbers of belongings around the patients’ beds. Though nurse participants in this study did not discuss family and visitors’ hand hygiene practices, this does not mean that nurse participants did not devote their attention to family or other visitors’ hand hygiene practices. The nurses may also be concerned with the hand hygiene practices of family and other visitors; however, the lack of the provision of alcohol-based sanitiser for visitors in patient rooms may be one of the reasons for which hand hygiene regulations are not followed. Although the current study provides no data about family and other visitors’ maintenance of hand hygiene, Hobbs and colleagues’ study provided a similar result in showing that family attendance and family visits can raise the risk of bacterial transmission as family and other visitors’ awareness of the risk of cross-infection remains low.

The possibility of bacterial transmission, which may result from the presence of family members or other visitors, can be reduced by cleaning mobile phones frequently. Though participants did not mention phones specifically, I extrapolated the risk of pathogens on the objects that may be taken into the hospital from home by relatives; these objects may include mats, fans, pillows, blankets, and the like. Therefore, it is considered essential to begin a discussion about the relationship between the use of mobile phones in clinical settings and the risk of bacterial transmission in this chapter as doing so significantly supports the description of the phenomena that relate to family attendance and family visitation as found in this study.

There are a number of studies which indicate that the use of cell phones in health care settings, whether by patients, family, other visitors, companions or health staff, can transmit pathogenic and non-pathogenic bacteria (Zakai et al., 2016; Ali et al., 2010; Tekerekoglu et al., 2010; Ramesh et al., 2008). In a cross-
sectional study undertaken by Ali and colleagues (2010), it was found that almost 50% of health staff mobile phones carried pathogenic microorganisms and that this could increase the risk of nosocomial infection. Therefore, to diminish the possibility of the transmission of infective microorganisms from health care providers’ cell phones to patients, Ali and colleagues proposed the regular disinfection of phones to decrease the bacterial count on the phones and in turn minimise the development of healthcare-associated infections (Ali et al., 2010).

However, in another study, it was indicated that the numbers of pathogenic bacteria on patients’, companions’ and visitors’ mobile phones were higher than on health staff phones, which means that the risk of the transmission of pathogenic microorganisms via the mobile phones of patients, companions and visitors is higher than the risk of transmission from the phones of health care providers. Higher counts of multidrug-resistant pathogens were also found on the patients’ mobile phones (Tekerekoglu et al., 2010). The authors recommended several protocols to reduce the risk of infection from visitors or companions, such as wearing gowns, gloves or masks when entering the unit. They also proposed some strategies to diminish pathogen colonisation on health staff phones. These included regular handwashing, staff education, the use of alcohol-based disinfectant wipes, and restriction of the use of mobile phones in high-risk areas (Tekerekoglu et al., 2010).

Another similar study conducted by Zakai et al. (2016), which investigated bacteria count on preclinical medical students’ mobile phones, indicated that their phones can be a port of entry for both pathogenic and non-pathogenic bacteria. Approximately 96% of medical students’ phones were contaminated by bacteria. Therefore, Zakai et al. also recommended restriction of the use of mobile phones in clinical settings, the following of hand hygiene protocol, and the use of bacterial decontamination wipes on mobile phones (Zakai et al.,
A study carried out by Chang and colleagues (2015) named ten high-touch items that can be reservoirs of bacteria in patients’ room, comprising cleanliness: bedside rails, bedside tables, patients’ bodies, patients’ files, linen, bed curtains, bed frames, lockers, drinking cups and reusable water bottles.

In the current study, participants revealed that family members or other visitors sometimes sat down on patient beds despite the presence of a chair provided for family and that some visitors even decided to sleep on unoccupied patient beds next to the bed of the patient being visited. Nurse participants claimed that they always informed family and other visitors that a maximum of two people were permitted to enter patient rooms at one time and that they also reminded family and other visitors to maintain the cleanliness and tidiness of the beds and the rooms. Overall, mobile phones used by patients, family, other visitors, health care staff and pre-clinical students, as well as all items around patients in a room, can be reservoirs and ports of entry for pathogenic and non-pathogenic microorganisms. The presence of family members and family visitations also have an impact on the risk of the transmission of infection in the unit. The risk of cross-infection results not only from the presence of family members and other visitors but also from the presence of the belongings used by patients, family or other visitors and placed around patients’ beds and bodies.

Visitors’ smoking behaviour was also a concern of participants in this study. It is not easy to manage this phenomenon as some health care providers are smokers as well. Smoking behaviour on hospital grounds or in PHCs is a public concern as people may consider smoking to be inappropriate behaviour in a health care area, whilst others might perceive that people have the right to smoke as long as the smoke does not disturb other people. In a cross-sectional study about people’s points of view regarding smoking on the grounds of a hospital in Yorkshire (Serafin et al., 2014), it was demonstrated that all participants, including hospital staff, visitors and patients, perceived smoking on
the grounds or at the entrance of the hospital to be socially unacceptable. This study found two different groups related to smoking policy in hospital; some participants suggested providing separate areas for smokers and non-smokers and creating a smoker shelter or smoker space located at a distance from the entrance of hospital. Other group participants assumed that a no-smoking policy must be applied, with total prohibition, fines and monitoring (Serafin et al., 2014).

According to participants in the present study, PHCs do provide smoking areas; however, this solution has not been effective in decreasing anti-social smoking behaviour as smokers continue to smoke outside PHC entrances. Therefore, nurses should control family attendance and family visits as visitors might exhibit anti-social smoking behaviours. As smoking might be considered as an individual right, it might be difficult to diminish smoking behaviour, even in the hospital. Strategies might be applied to control this behaviour related to the presence of family members and other visitors in health care settings. Regulations regarding smoking prohibition must be clearly communicated to family and other visitors. A separation of smoking and non-smoking areas can reduce the effect of smoking on non-smokers.

Family attendance and family visits in the unit can be one of cause of violence to which nurses may be exposed. A retrospective survey conducted by Speroni and colleagues (2014) on the subject of workplace violence against nurses indicated that most nurses working in hospitals, particularly in emergency departments, had experienced workplace violence perpetrated by patients and visitors. This included verbal and physical abuse such as yelling, swearing, scratching, kicking and grabbing. The culprits were most often adult males who were losing consciousness or under the influence of drugs or alcohol. A similar study carried out by Wei et al. (2016) in hospitals in Taiwan found that the incidence of non-physical violence was higher than the incidence of physical violence against
nurses; in addition, the results showed that violence in emergency units occurred more often than in intensive care units and that younger nurses were particularly vulnerable to workplace violence. Hahn and colleagues (2012) recommended the provision of staff training related to aggression management and communication skills as the occurrence of verbal violence is higher than physical violence.

In the present study, participants reported family behaviours related to workplace violence. One participant from a PHC, participant 3, conveyed that sometimes family members from certain ethnic groups displayed unexpected attitudes. When the nurse told the family members that they were not allowed to stay too long in the PHC in a large group, a family member was grumpy and said that he was paying for the service at the primary health centre and that the family deserved to stay there. While the nurse participant did not describe this as an incident of verbal violence, such behaviour is related to non-physical violence. Another participant in the present study, participant 15, had also experienced physical violence in the emergency unit. Overall, patients as well as family and other visitors may commit acts of physical and verbal violence against nurses in health care settings. Although this might occur principally in certain situations, nurses are a vulnerable group of health staff who may experience workplace violence. Therefore, the possibility of violence committed by patients’ family members should be of concern of health staff in hospitals and primary health centres.

The present study also demonstrates that nurses felt that the presence of family members in a unit can get in the way of the nursing work that must be performed in order to care for the patients. Family who often come in large groups of five to ten people, place their belongings around the patients’ beds, remain around patients’ rooms and use loud voices when chatting with other family members around the ward were all of concern to nurses who participated
in this study. Nurse participants stated that they felt uncomfortable with family members’ presence around patients’ rooms.

Nurse participants also revealed the difficulty of overcoming the problem of family visitors when the patient was a prominent figure or religious leader. Nurse participants understood that some prominent figures or religious leaders are respected as influential figures. Many people visit such influential patients, with continuous coming and going, to show their respect to the person or leader. In such a case, the patient’s room may be crowded with visitors. Nurse participants felt that the presence of visitors can disrupt nurses’ activities and might also bother other patients in the unit. Nurses conveyed a feeling of discomfort when patients’ rooms were crowded with people. Even when visitation policies have been communicated to all visitors, visitors sometimes fail to comply with visitation rules.

The results of this study are in agreement with those obtained by Voncina and Newcomb (2016) and Walls (2009). In a project regarding implementation of a formal visitation policy in a postanaesthetic care unit (PACU) conducted by Walls (2009), it was demonstrated that despite the fact that the majority of staff would like family to visit in the PACU, about 53% of staff felt that it was not appropriate for families to visit patients in the PACU. They described several reasons for this, including privacy and space issues, the risk of exposure to infection, staff anxiety, the possibility of families witnessing resuscitation processes, and family education issues (Walls, 2009).

Voncina and Newcomb (2016), in their study, found similar results regarding family visitation in the PACU. A number of barriers to family visitation remain unchanged, including space, noise, privacy, compliance with visitation rules and family presence getting in the way of nurses trying to perform their work. According to Voncina and Newcomb’s study (2016), almost 75% of participants
in 2009 felt that their work was hampered by family attendance; four years later, 37% of respondents still felt that their jobs were hampered by presence of family members. Birkeland (2009) also posited that the presence of family members might disturb other patients in a shared room as it might become crowded and noisy in the room and as result make other patients feel less comfortable.

Several strategies for family attendance and family visitation can be applied to manage family members who accompany patients in the room, to control visitors and to reduce the risk of cross-infection. Currie et al. (2016) recommended the application of ‘temporary suspension of visiting’ (TSV) for patients with communicable diseases or during outbreaks of disease, for instance, during norovirus outbreaks. The strategy of TSV provides the benefit of diminishing the risk of the transmission of infection. However, nursing staff might be unable to restrict family members or other visitors from visiting patients as their presence can add emotional support for patients; in addition, family might want to provide the best possible support for their loved ones. Though some nurses might feel less comfortable with the presence of family member or other visitors, some studies have found that family visits can enhance patient and family satisfaction.

A study undertaken by Whitcomb and colleagues (2010) demonstrated that a less restrictive family visitation policy in adult intensive care units effectively increased patients’ and families’ levels of satisfaction. Through applying a more open visitation policy, health staff can facilitate patients’ physical and emotional contact with their families, and this can also decrease the anxiety of the family members (Whitcomb et al., 2010). Voncina and Newcomb (2016) also suggested several strategies related to family visitation programmes in the PACU; these included providing family members with preoperative information about visitation guidelines and facilitating staff training to encourage nurses and other health staff to be compassionately assertive during family visits.
Overall, nurses in all units might relate family attendance and family visits with space issues, noise and privacy; however, the descriptions of family behaviour while visiting patients in the present study seem to differ with those from previous research. In this study, participants described struggling to manage family members who were visiting or accompanying patients as family and other visitors often arrived in large groups, bringing many items along, sitting down on the terrace and blocking access to patients’ rooms; family behaviour was reported to often fail to comply with nurses’ instructions regarding family attendance and visitation regulations in the hospitals and PHCs. Nurse participants found family attendance and family visits to be a barrier as the presence of family with their belongings often got in the way of nurse participants attempting to perform their nursing work, such as monitoring the vital signs of patients, monitoring infusion therapy, caring for wounds, administrating medication, and the like.

These instances show nurses to seemingly be focused only on the completion of their nursing work. Nurses viewed family members as if the family were not part of the patient, whereas a patient is part of a family network (Whitcomb et al., 2010) and lives with the family before being cared for in a hospital or PHC. This study indicates that nurse participants viewed family attendance and family visits as a barrier in caring for diverse patients. Nurse participants related the behaviour of family members in visiting and accompanying patients with the Indonesian idea of togetherness, particularly within certain ethnic groups. This raises the issue of contradictions in their narratives as to the value placed on the emotional engagement with patients as opposed to physical care activities. As previously argued, several participants voiced their concern over the emotional care left undone. Yet, when family members were present to undertake this work to support their patients, the nurses were unhappy with their presence.
As mentioned in previous paragraphs, family attendance and family visits have a significant connection with the tradition of strong family ties in Indonesia. A number of recent studies have provided discussions on phenomena of family attendance and family visits in hospitals, as well as their impact on patient care. However, very little was found in the literature on the question of whether family attendance and family visits have an association with strong family ties. As stated in Chapter Four, strong family ties, or guyub, are related to the tradition of togetherness among family members in Indonesia. Guyub is loosely translated as ‘togetherness, closeness, friendliness and care for one another’. Participants experienced caring for patients in situations in which many family members visit and accompany the ill loved one in health care units as a form of guyub.

Members of patients’ families and other visitors are present to show their attention and togetherness. This result may be explained by the fact that Indonesia is one of the few collectivist countries in the world.

As explained in Chapter Four, Indonesia is classified as a collectivist society in which people have high interdependence among the members of society and in which people’s behaviours are often anticipated to correspond to the vision of their society (Hofstede Insights, 2017). In a collectivist culture, family and society or in-groups to which people belong have significant roles in people’s lives, and individuals are expected to be helpful to each other, generous, dependable, and attentive to the needs of others (Cherry, 2018). It is therefore likely that such connections exist between the cultural trait of strong family ties and the fact that Indonesia is a collectivist society. When one member of a family is ill, another member of the family might be expected to adhere to the values of family to help, support, protect and give attention to the patient. A number of relatives and even neighbours may come together without prompting to show that they sympathise what the patient and family are feeling.
The debates regarding Indonesia as a family-friendly country and the nurses who wish for the family to leave because they are hampering nursing activities with their presence is a critical element of this study that warrants discussion. The difference in family ties between Indonesia and Western countries is considered to influence the way in which Indonesian nurses encounter the family members of their patients. Most of the nursing references and literature used in Indonesian nursing education are generally sourced from Western studies, in which differences in culture and customs become evident and pertinent. Nurses in Indonesia might have adopted and imposed the values of the Western health care system and they might ignore their own country’s ideas and values. The nurses have been living in the culture and have been inculcated with values and ideas about family ties, but once they become nurses and they are at their workplaces, they appear to transform quickly and take on Western values that differ significantly in terms of family orientation.

Although nurses might want to be professional, they might not realise that their professionalism is overlooking Indonesian cultural values of family orientation. This phenomenon appears at odds with the upbringing of Indonesians who later become nurses, as they seem to completely abandon the traditional ideas of their country about the nature of family once they become part of the Western scientific society. It seems counterintuitive that nurses who have grown up in an environment and culture that is so family oriented could change so quickly once they become nurses. They become like Western people, as if they had never lived in the Indonesian environment and culture. I acknowledge that this might seem odd, though nurses might believe that it is completely normal in Indonesia with its very diverse population. This is a phenomenon that is taking place in Indonesia.

Thus, I raised a question regarding the adoption of Western attitudes by Indonesian nurses: given the entirety of their cultural upbringing, it may have
been expected that they would be sensitive to *guyub*. However, the predominance of Western scientific practice in the training and education of nurses might supersede the national impulse. It seems that even in countries in which the nurses share cultural values with their patients, they quickly dispense with them and become part of the Western hegemony with its Western scientific approach to nursing. Therefore, I suggest further research to determine how Western nursing science has influenced and changed Indonesian nurses’ attitudes toward Indonesian ideas and values, to study whether Indonesian nursing education has adopted a completely Western method of nursing education, and to investigate how Indonesian ideas and values can contribute to a nursing education system that is sensitive to the ideals of Indonesia.

Another possible explanation of this finding is related to cultural viewpoints. Though family networks are very strong among all ethnicities in Indonesia, some nurses constantly connected family behaviours regarding the activities undertaken while accompanying and visiting patients with cultural traits of certain ethnic groups, such as Madurese. For instance, Javanese nurses compared Javanese families with Madurese families and described Madurese families as often failing to comply with nurses’ instructions. Even Madurese nurses acknowledge this Madurese family behaviour. Nurses might adopt Western nursing science, but they might also have personal cultural views towards certain groups. Nurses might not realise that their personal points of view have abandoned their country’s ideas regarding family ties. Nurses might describe people, but they might also unconsciously stereotype particular ethnic groups. This is further discussed in the next section.

Another barrier found in this study is related to family members as decision makers. The data show that nurse participants in this study reported experiencing difficulty in making decisions regarding patient care. Disagreement among members of patients’ families regarding medical treatment for their ill
loved ones can result in delayed intervention and cause dilemmas. On one hand, nurses wish to take care of patients immediately, but on the other hand, the family has the dominant role in deciding whether the patient will be cared for in the unit or not. Though the patient is an adult and has the right to decide about his or her own life, adult patients in Indonesia generally ask the opinions of family members when there are questions related to the family’s overall well-being such as who will manage the home or take care of children at home when the parent, usually the mother, is ill, and who will make a living when the person earning the family income, usually the father, is hospitalised. Questions also arise as to who will accompany the patient in the ward and who will pay the medical expenses.

Patients tend to rely on family to decide whether they will be hospitalised or not, and patients also ask for their family’s opinions and suggestions regarding medical interventions. This finding might be explained by the fact that in Indonesia, the family has a major role in the life of an individual. Trandis and colleagues (1980) placed Indonesia third out of nine countries assessed in terms of family integrity, which means that children and adults in Indonesia have high levels of dependence on their parents and elderly family members as family is central to their lives.

In Indonesia, living together with extended family is completely normal. Strong family networks and a patrilineal family system are adopted by most ethnic groups in Indonesia. Family with three generations often live together in one big house or in different houses that are near one another, particularly in rural areas or in the countryside. The family has an economic and a moral role in Indonesia (Riany, 2017). The members of a family have a responsibility to follow the moral values of the family and to ensure that family members have no financial difficulties. Members of extended family help each other and exhibit ‘relatively high’ interdependence (Macdonald & Jessica, 2006).
In Indonesia, the oldest, the wealthiest or the best educated people in a family are often regarded as decision makers in the family. They are the most powerful members of the family. When a family member is ill, decisions regarding patient care involves these family members who are older, wealthier or more educated. However, in some cases, agreements cannot be reached as members of the family have differing opinions regarding the patient’s condition. As a result, nurses are faced with a difficult decision. Clear information regarding patient care and interventions should be provided to allow the families to make the right decisions for their ill loved ones.

In accordance with the present results, previous studies have demonstrated that family disagreements related to decisions about patient care and medical interventions often occur in families with strong family beliefs (Koerner & Shirai, 2012). According to a study conducted by Kramer et al. (2009), approximately 30% of family experience disagreement among the members of the family in the process of decision-making regarding patient medical treatments. Another previous study undertaken by Siminoff et al. (2012) indicated that 11% of patient-family caregivers experience a conflict in the decision-making process. Though the present study cannot provide statistics regarding disagreements in making decisions about patient care, it is clear that nurses around the world have similar experiences in working with family members who are involved in decision-making processes. This phenomenon might occur in population with strong family values, such as Indonesia and other Asian countries.

Generally, nurses participating in this study faced such situations particularly when taking care of patients from rural areas with traditional family values. In urban areas and cities, this phenomenon does not appear often as families are less reliant on extended family and tend to live as a nuclear family. Decisions might only involve parents and siblings. The extended family might live in the
countryside and modernisation might also influence urban patients in making
decisions about their health care. However, some urban families sometimes still
consider the extended family’s suggestions regarding health decisions as they
preserve traditional family ideas and values.

Overall, Indonesian nurses generally experience dilemmas regarding family
members’ roles as decision makers because family is central for most of the
Indonesian population. Though family involvement in making medical decisions
for patients might create problematic situations, nurses should consider the
benefit of family involvement in a medical decision-making. A cross-sectional
study conducted by Itzhaki et al. (2016) indicated that family should be involved
in decision-making, particularly when a patient is unable to make a decision;
family involvement in decision-making should also consider financial and
emotional support for patients. However, shared decision making (SDM), which
includes both patient and clinician in health care decisions, might also require
enhancing the benefits of health care decisions for patients’ conditions (Itzhaki
et al., 2016).

Nurses in this study viewed family involvement in health care decision-making as
closely related to family culture in Indonesia. Nurses, as part of the culture,
acknowledged this phenomenon. Family plays an important role in patients’
health care decisions, and patients also rely on family as family is considered
central for Indonesian families. This finding is consistent with that of Laidsaar-
Powell et al. (2016), who posited that family involvement in making health care
decisions can be affected by cultural factors. Other similar studies found that
family involvement in decision-making is closely related to the factor of culture;
these studies were mostly conducted in Asian countries. This might be the case
because most Asian countries consider family to be essential in life in general;
Asian families provide financial and social support for other members of the
family (Galanti, 2008).
As revealed in a qualitative study undertaken by Lin et al. (2012) in Taiwan, family is central in decision-making processes. Patients view family involvement in decision-making processes as very important for patients. Similar to the Indonesian population, Taiwanese patients have strong and reciprocal relationships among family members, and they are concerned with all family members’ well-being when making health care decisions for their ill loved ones (Lin et al., 2012). However, Lin et al. (2016) found that cultural factors are not the only reason for family involvement in decision-making. The authors demonstrated three other aims of family involvement as perceived by family, including the sharing of responsibility among family members, confirming that the medical information is correct, and ensuring the safety of the patient. Families’ roles as decision makers in health care can be influenced by cultural factors and other individual factors. However, families as decision makers were perceived by nurses in the present study as more affected by the cultural values of family in Indonesia.

Nurses in this study also acknowledged that, though they are living in the culture and the environment, they felt unhappy with family involvement in decision-making when the decisions did not meet the nurses’ expectations. As reported by participant 15, one family disagreement regarding resuscitation for their ill loved one resulted from the family’s assumption that the intervention would hurt the patient’s body; the family members perceived that a dying person should die in peace. This study demonstrated that factors of knowledge and cultural significantly influence family behaviour in decision-making. While nurses must understand these factors of knowledge and culture in family involvement, nurses should also consider patient autonomy. An adult patient has the right to decide to choose the best care for him- or herself as the adult patient is the one who is legally entitled to decide about his or her own life (Nistelrooij et al., 2017).
Therefore, nurses should be able to balance the patient’s right to autonomy and the family’s right to be involved in decision-making regarding the patient’s health care (Laidsaar-Powell et al., 2016). In addition, the patient’s preference and the hope of health decision-making should be taken into consideration (Sharma et al., 2011). Nurses must also ascertain that family involvement in decision-making does no harm and does not worsen a patient’s condition. Clear information and explanations regarding a patient’s disease and medical and nursing interventions are required to enhance the family’s knowledge about the patient’s care and to diminish cultural barriers to patient care. The choice of a spokesperson from the family is considered beneficial to strengthen and facilitate communication between nurses or health staff and patient and family (Quinn et al., 2012). Families can select one member of the family as a family spokesperson to ease nurse-patient and nurse-family communication. A spokesperson serves only as a communicator, because decisions about medical treatment and patient care are determined by members of the family, although the patient might involve only relatively close family members in decision-making (Sudore et al., 2014).

To summarise, the problem with family revealed in this study exemplifies the difficulties experienced by Indonesian nurses. Indonesian nurses are caught between their Western health care education and their Indonesian cultural identity. This creates a dilemma for nurses, because they know that family culture is important and they also want to be professional in their nursing careers. Nurses exist in the space between their cultural upbringing and their professional education. This study manifests the difficulty that individual nurses may encounter between cultural identity and patient care. Their difficulties may help people from around the globe to understand the difficulties that nurses from different cultural backgrounds may experience in their adopted countries.
Language

Language is another cultural barrier to patient care that emerged in this study, particularly when patients cannot speak the national language and nurses cannot speak the patients’ local languages. Indonesia has one national language: Bahasa Indonesia. However, more than three-fourths of the population speak their native languages in daily communication (Statistics of Indonesia, 2011). Given the wide range of local languages in Indonesia, nurse participants in this research had ample opportunity to take care of patients from linguistically diverse backgrounds. Living in a heterogeneous population where more than one thousand local languages are spoken and where most people prefer to speak their local languages in everyday situations rather than Bahasa, it was a complex challenge for nurse participants in this study to maintain therapeutic communication. Nurse-patient connections can be influenced by language impediments.

There have been many studies investigating the effects of language barriers on patient care. In accordance with the present results, previous studies have demonstrated that language barriers can result in lack of communication, misinterpretation and misunderstanding. McCarthy and colleagues (2013) found that language problems can limit nurse-patient communication and, as a result, can cause nurses to be unable to determine the health care needs of their patients. Patients might also unable to convey what they feel due to language barriers (Maesschalck, 2011), and this lack of communication also gives rise to human errors (Pedersen, 2012); thus, the safety of patient care can be threatened by language barriers (Rose et al., 2016).

The data in the present study also indicate that misinterpretation caused by language problems is a concern for nurses. Information received by patients and families is perhaps not perceived accurately as patients and families might incorrectly understand the information they receive. Nurses may not understand
a patient’s local language and at the same time, the patient may be unable to speak Bahasa, Indonesia’s national language. In this situation, language barriers can also detract from patient safety. Participants in this study expressed concern with the safety of patient care provided by nurses who cannot communicate well with their patients as a result of language problems.

Participant 5 spoke of having explained the administration of medication to the family members of a patient so that the medication could be given to the patient at home. Members of the family, who were unable to speak Bahasa, only replied ‘yes’ every time the nurse asked a question or gave information about the medication. The nurse participant wondered whether the family members had understood the nurse’s explanation or not. If members of the family misinterpret the information they receive, the language barrier endangers the safety and care of the patient. There may be mistakes in the family members’ interpretation of the information. This result seems also to be consistent with another study undertaken by Rose et al. (2016), which found that patient safety can be affected by language barriers that emerge among health staff and patients or families.

The safety of patient care in daily nursing work such as pain management, medication administration or fluid balance management can be threatened by language problems when they arise between nurses and patients (Rose et al., 2016). Nurses in such a situation are unable to ensure the patient’s and family’s understanding of the patient care that must take place. As a result, nurse-patient communication concerning the provision of health information might be delayed due to language problems. These communications may involve, for example, information about diagnosis, prognosis, treatment, suggestions, follow-up appointments and adverse drug reactions (Ashton, 2012; Karliner et al., 2011); communication between medical staff and patients or family members might be also influenced in acute situations (Rose et al., 2016).
Overall, a patient may feel worry and reluctance to reveal his or her emotions or feelings due to language barriers; as a result, the patient’s needs cannot be assessed in detail. Language problems might also lead to a misunderstanding as a message may not be delivered properly, possibly impacting the safety of patient care. Thus, the quality of patient care can be significantly affected by language barriers. A study conducted by Jirwe et al. (2010) indicated that the best care and support of patients might not be provided when patients cannot express their emotions and feelings to nurses. Bernard and colleagues (2006) also found that language problems were felt by acute care medical staff to be a hindrance to maintaining the quality of health care.

Cultural differences are also a source of communication barriers (Klimova & Semradova, 2012). This notion concurs with the findings of the present study. One of the participants stated that, although she (a female nurse) understood the patients’ local language, which is different from hers, she felt no confidence to speak in that local language because she worried that she would be perceived as impolite if she spoke using the wrong level of the language. As outlined in Chapter Four, there are a number of grades of different native languages in Indonesia which are used based on age, relationship, and social status. Thus, therapeutic relationship can be hindered by language barriers, particularly when nurses communicate with patients who prefer speaking their own local language. Even in a country in which people speak one language with variations of dialect and pronunciation, communication problems might also arise.

As revealed in a quantitative study conducted by Ayaz et al. (2010), dialect discrepancies and disparities in pronunciation were felt by nursing students in Turkey to be an obstacle to the provision of care for patients from various cultural backgrounds in Turkey. A study undertaken by Al Khatami et al. (2010) also demonstrated that language differences presented a barrier to communication between the participants (Arabic patients) and non-Arabic-
speaking nurses (NANS). Almost two-thirds of participants felt that they were unable to build communication with NANS as most NANS often avoided contact or ended conversations prematurely due to language problems. This demonstrates that cultural distinctions along with language differences can limit nurse-patient communications and relationships. Language barriers have long been obstacles in every country where health staff and patients or families do not speak the same language. As a consequence, the staff are unable to provide appropriate, safe, adequate and effective care that meets the expectations of staff and patients (Ali & Watson, 2017). Overall, language hindrances, either resulting from different languages or different dialects and pronunciations, can restrict nurse-patient conversations and affect the quality of patient care.

Globally, healthcare staff, including nurses, face language barriers in providing care to patients. Language problems are encountered by nurses in developed countries such as the United Kingdom, Australia, and the United States, as well as in other Western countries where the multicultural population is increasing significantly. This is taking place because people can move to other countries with ever greater ease, either to gain international work experience or to relocate as immigrants. For instance, overseas nurses who work in the United Kingdom must meet a compulsory English proficiency requirement called the International English Language Testing System (IELTS). Though based on European Union law, it is not permissible to examine the English proficiency of nurses from the European Union and European Economic Area who work in the United Kingdom; all nurses who work in the UK, from both within and outside the European Union and European Economic Area, are required to have enough English competency to be able to communicate effectively with patients, family and colleagues (Allan & Westwood, 2014).

Communication might also be difficult to develop between British and non-British speakers who might have different accents and dialects (Allan &
Differences of dialect and style in English between British and non-British nurses and patients might present a barrier to the development of communication. British patients and family members who speak to non-British staff might not be as comfortable as they are speaking to British health staff. Language barriers might also be encountered by British nurses who provide care for patients who are unable to speak English or who speak English as a second language.

Misunderstanding or misinterpretation might arise during their conversations, whereas it is essential to build nurse-patient communication from the beginning to obtain a patient’s baseline data. McCarthy et al. (2013), in a phenomenological study, also highlighted that nurses felt that language barriers led to limited nurse-patient conversation as both nurses and patients felt uncomfortable developing communication due to the barriers presented by differences in language. Therefore, Allan and Westwood (2014) suggested that nurses from overseas receive help and support to ensure a successful and smooth transition in practicing English communication skills, particularly as related to the academic, clinic and nursing context in the host country. It is crucial for nursing staff from overseas to understand and accept the distinctions between various dialects, accents and pronunciations which might be considered significantly different from those commonly encountered in the host country. On the other hand, language barriers are not only encountered by overseas nurses who work in a host country where people speak a language that differs from their own.

Whilst language barriers are not new and have long been a significant problem in caring for patients in diverse populations, the communication barriers encountered by Indonesian nurses are more complex and challenging compared to those found in other countries. Indonesia has thousands of tribes and each tribe has its own customs, culture, and native languages (Statistics of Indonesia,
Pluralism in Indonesia is one of Indonesia’s treasures and is rarely found to such an extent in other countries. Indonesia has one national language, called Indonesian or Bahasa Indonesia; however, there are thousands of local languages or native languages spoken by people of different ethnicities throughout Indonesia. As explained in Chapter Four, Indonesia has 2,500 kinds of local languages (Statistics of Indonesia, 2011), and each native language has different levels of speech which are used according to criteria such as gender, age, social status, kinship, positions and roles (Samsiyadi et al., 2016; Indrayanto & Yuliastuti, 2015).

Bahasa Indonesia was developed from the language of Melayu, which has been used as a language of communication (lingua franca) not only in Indonesia, but also throughout most of Southeast Asia since the 7th century (Ministry of Education and Culture, 2018). Bahasa Indonesia was declared the national language on 28 October 1928, at which time Indonesian youth gathered and gave pledges. This pledge was known as the Youth Pledge; it consisted of three parts: (1) uphold one motherland, the land of Indonesia, (2) uphold one nation, the nation of Indonesia, and (3) uphold the language of unity, Bahasa Indonesia. This pledge was a form of resistance of the Indonesian youth against colonialism at that time. The third element of the Youth Pledge is a statement of determination that Bahasa Indonesia is the language of national unity (Ministry of Education and Culture, 2018).

The Proclamation of Independence of the Republic of Indonesia on 17 August 1945 constitutionally affirmed the status and function of Bahasa Indonesia as the state language of Indonesia (Ministry of Education and Culture, 2018). However, the majority of the Indonesian population do not use Bahasa Indonesia as their everyday language. Approximately 79.5 per cent of the total population aged five years and older speak a local language when engaging in daily communications at home; only 19.9 per cent of the population use Bahasa
Indonesia as an everyday language at home, and 0.3 per cent use a foreign language (Statistics of Indonesia, 2011).

Generally, Bahasa Indonesia is used in the formal communication that takes place in such places as schools, government buildings, or offices. Bahasa Indonesia is also used as the language of communication between two speakers from different ethnicities who do not understand the local language of their interlocutors or of the other speaker. For instance, the Javanese and the Sundanese speak Bahasa Indonesia in their conversations when the Javanese speakers do not understand the Sunda language and the Sundanese do not understand the Javanese language.

According to Statistics of Indonesia (2011), the percentage of the Indonesian population speaking Bahasa Indonesia in daily communication increased from 10.7 per cent in 1990 to 19.9 per cent in 2010. This indicates that, over the past two decades, the percentage of the population of Indonesia using Bahasa Indonesia as a colloquial language has almost doubled. However, only in five provinces does most of the population speak Bahasa Indonesia in everyday communication, including Jakarta (90.7 per cent), West Papua (69.7 per cent), Riau Islands (58.7 per cent), North Sumatra (55.6 per cent) and East Kalimantan (53.5 per cent). The majority of the population in the other 29 provinces generally use their native local languages as their colloquial languages. However, this does not mean that people from these 29 provinces do not understand Bahasa Indonesia. They might understand Bahasa, but they might also prefer to speak their local languages when they communicate with health care staff.

According to the nurse participants in the present study, patients who are unable to speak Bahasa and prefer to speak their native languages are generally elderly people, people from villages or the countryside, or adults who did not have a formal school education, as explained in Chapter Four. Therefore, the
history of Bahasa Indonesia and the existence of thousands of native languages in Indonesia can explain the complexity of the communication problems encountered by Indonesian nurses.

Nurses and other health staff in Indonesia have the opportunity to provide care for patients from a variety of linguistic backgrounds, either those who can speak Bahasa Indonesia or those who prefer to speak a local language due to their inability to understand Bahasa Indonesia. As nurses do not always understand patients’ local languages, nurses use Bahasa Indonesia as the language of communication with their patients. However, nurses who understand a patient’s local language usually use that local language to communicate with the patient.

Nurses sometimes understand two or three of the local languages that are most commonly spoken by the population in the region. For instance, the majority of the population in East Java Province speak Javanese and Madurese. Nurses in East Java usually understand Javanese and Madurese. Though nurses might understand Javanese or Madurese, they might be unable to speak or lack the confidence to speak Javanese or Madurese as people are spoken to using different levels of address in each local language in Indonesia, such as levels of Ngoko and Krama in Javanese (Trahutami, 2016; Indrayanto & Yuliastuti, 2015), as discussed in the previous paragraph.

This illustration describes language barriers in only a single province. Nurses in Indonesia might also experience different communication problems when they move from one province to another province or other region with different ethnicities and local languages. Hence, nurses tend to speak to patients using Bahasa to develop the nurse-patient relationship. This may be the reason for the determination of Bahasa Indonesia, as the language of unity; Bahasa Indonesia does not use various levels of speech and is thus easy to understand compared to local languages that do entail different levels of speech.
The phenomenon of language barriers as encountered by Western nurses and Indonesian nurses might be similar; however, the complexity of language as a barrier in caring for diverse patients seems to differ. Nurses in Western countries may encounter English-speaking and non-English-speaking patients. Non-English-speaking patients might come from non-Western countries such as Pakistan, Bangladesh, Saudi Arabia, China, Japan, etc. Similarly, nurses in Indonesia may speak to patients in Bahasa Indonesia or in local languages. Indonesian nurses might share a local language with a patient and might also speak different local languages than the patient.

As Indonesia has thousands of local languages, Indonesian nurses have a greater possibility to encounter more varied languages than Western nurses, who might only encounter three or four languages apart from English. For instance, nurses in the United Kingdom might care for a range of British and non-British patients in their daily practice, but generally the majority of their patients are British. In Indonesia, one nurse’s daily work might include caring for a range of patients, many of whom speak different local languages and different dialects that have different rules of formal speech. For instance, on Java Island, there are four major ethnic groups: Javanese, Sundanese, Betawi and Madurese. Each ethnic group has several local languages with several different dialects and each also has its own distinct culture, traditions and values.

There are three major dialects within the Javanese ethnicity, including the nine dialects of western Java, the four dialects of central Java, and the six dialects of eastern Java, which include the Suroboyoan, Malang, Tengger, and Osing dialects (Aljauhari, 2015). The Sunda and Betawi ethnicities also have several distinct dialects. Different dialects usually use different terms and different intonation that might result in misperception or misunderstandings. People from central Java have a refined dialect and accent compared to people from eastern Java. If
nurses do not comprehend the distinctions between the dialects of central Java and eastern Java, misperceptions might arise. A patient from eastern Java might be perceived as impolite by a central Javanese nurse when asking for help from the nurse as the eastern Javanese dialects are coarser than central Javanese dialects. Hence, nurses on Java Island may care for patients who might speak one out of nine dialects of western Java, the four dialects of central Java, or the six dialects of eastern Java; in addition, they may encounter patients from other tribes who are living on Java Island, such as people from the Betawi, Sunda, Bali, Batak, Padang, or other ethnicities.

Overall, the diversity of local languages spoken by indigenous people in Indonesia can explain why language barriers encountered by Indonesian nurses seem more complex than the language hindrances faced by nurses in Western countries. The language complexity includes the manifold local languages, the wide range of dialects of each local language, the different levels of address in each local language, and the different cultural values embedded in each local language. Hence, this study indicates that language barriers have influenced and shadowed nursing staff in caring for patients from diverse backgrounds in Indonesia. A nurse must face the complexities of communication problems before performing nursing work, as communication is an essential element in beginning a nurse-patient relationship.

Perceptions of illnesses and health treatments
Nurse participants in the present study also reported encountering another cultural barrier in caring for their very diverse patients. Members of certain ethnic groups have a limited understanding of medical and healthcare needs. This is a preconception of mine that I needed to review during the process of learning and working through the circle of horizons. This study indicates that in caring for very diverse patients, nurse participants needed to confront some patients’ and families’ opinions that were based on incorrect information about
disease and health treatment. Poor health literacy was shown by nurse participants to be an issue among several particular ethnic groups; as outlined in Chapter Four, for example, someone may be perceived as healthy as long as he or she can eat food, even in the presence of symptoms of disease. As another example, some people consider injection therapy as the only powerful health treatment; in addition, social stigmatisation of people with HIV/AIDS or leprosy remains problematic.

Nurse participants in this study acknowledged that, given the fact that nurses in Indonesia encounter a wide range of beliefs and cultures, they need to understand some of the incorrect views regarding health and treatment that are held by members of certain community groups. This understanding is important to the building of nurse-patient relationships. Through an understanding of a society’s views about health, disease and treatment, a nurse can avoid or minimise the personal judgments that might lead to the development of an implicit bias towards people living in rural areas or in the countryside. This is important as a nurse’s bias might affect that nurse’s attitude towards patients; the erroneous views might be not held only by those from rural areas, but also by people in urban areas or cities who have a limited understanding of health care.

As underlined by Stepanikova and Simpson (2011), implicit bias has a negative impact on individual behaviour towards others as an individual’s generosity may disappear in the presence of implicit bias. The issue of unconscious bias is outlined in the next section. Therefore, nurses should be aware of the various perceptions of health, illness and treatment that exist in society in order to avoid bias in caring for diverse patients.

Nurses also need to identify the cause of the emergence of erroneous perceptions in order to be able to take appropriate action in speaking with
people who bring incorrect opinions to the health care setting. Tate and colleagues (2003) suggested that assessment and evaluation of the perceptions and levels of knowledge of local people are notable for improving healthcare programmes. In accordance with the present results, a previous study demonstrated that inadequate health knowledge inherited from the older generation contributed to the formation of individual perceptions about health, illness and treatment (Anania, 2014). These erroneous perceptions could also influence people’s ways of seeking help to overcome their illnesses. Based on the interview analyses in the present study, it is clear that individual values, beliefs and insufficient information about health and illness can lead to misconceptions about disease and health treatment.

This present study demonstrates that the limited understanding of health, illness and injection therapy common among members of certain local groups is particularly prevalent among those who have low levels of formal education and those who live in the countryside or in rural areas. Poor health literacy is related to indigenous knowledge that is passed on from generation to generation; this is still in existence and is strongly upheld by the societies in question (Demartoto, 2013). Little is known about the cause of erroneous perceptions about health and illness. In this study, no data emerged to explain why an individual would be considered healthy despite the appearance of symptoms of illness. Family views about diseases and family members’ lack of knowledge seem to significantly influence the perceptions of patients.

Concepts regarding the conditions of health and illness are considered to be another factor that causes misperceptions; moreover, these concepts can be taken on and followed by other members of a family. As revealed by one participant in this study, the mother of a toddler did not take her child to the primary health centre, the nearest health care facility in her region, to obtain health treatment. The reason for this was that her child, though feverish, was
still willing to eat. The mother believed that as long as an individual is willing to eat, he or she is not ill. Rather, he or she is healthy. Individuals are perceived as ill only when they are reluctant to eat. This perception and behaviour might well be adopted by her ill child when the child grows up and has his or her own family. This poor health literacy view will then be passed on from generation to generation.

According to nurse participants in the present study, some people are very obedient when family members from the older generation make suggestions. Parents and the older generation tend to advise family members to follow their suggestions. They are also more prone to believe in non-medical therapies; they may be more in favour of seeking help from a shaman or traditional healer rather than from healthcare staff. This phenomenon is discussed further in the next section. Therefore, health education programmes are required to break the chain of misperceptions regarding health and illness that are still present in some Indonesian communities.

The majority of patients and families who lack knowledge about health and illness have little formal education and live in the countryside, in rural areas, in the mountains or even in remote areas. It is difficult for them to get health information from the mass media such as news and television. They may only obtain health information and education from health care staff at their local primary health centres, whereas some of them live far from the location of the nearest primary health centre. Lack of health information in a community gives rise to the emergence of limited understanding about health and illness in society. This result is in accordance with La Cruz and colleagues’ (2016) findings, which showed a close association between illness perception and knowledge.

La Cruz et al. (2016) found significant distinctions in illness perception and illness knowledge about obsessive–compulsive disorder (OCD) among White British,
Black African, Black Caribbean, and Indian parents in South East London, UK. Parents with better knowledge about OCD perceived that parents who were suffering from OCD would negatively affect their children’s lives, and they were entirely convinced of the effectiveness of treatment. In contrast, those with less knowledge about OCD perceived that parents with symptoms of OCD would not have a negative impact on their children’s future lives, and they were also uncertain as to whether treatment would be effective (La Cruz et al., 2016). This demonstrates that lack of health knowledge has a significant impact on people’s perceptions of health and illness and that it also affects people’s help-seeking attitudes.

Some people have also poor health literacy regarding the uses of injections. According to nurse participants in this study, some Madurese people perceive injection therapy as the best medication. They may ask for injection therapy in situations in which it is not indicated. This finding is in accord with an earlier, similar study conducted by Mulyadi and Hannan (2015) that discovered the unique behaviour of Madurese patients. The Madurese assume that health service is good, complete and perfect if they obtain medication by injection. Injections as referred to by Madurese patients include injections into buttocks or intramuscular injection into the dorsogluteal muscles of the buttocks. They also consider injection therapy to be the core of health services. If they do not receive an injection, they assume that they have not been provided with any health services, they are disappointed and they consider the health services to be unprofessional (Mulyadi & Hannan, 2015).

The findings of the present study also indicate that perceptions about injections as the most powerful healthcare intervention are passed down in families from the older generation. Participants in this study reported that this limited understanding about the injection of medication has been in existence for a long time. Nurse participants often encountered cases in which patients had incorrect
perceptions about injections. Most Madurese patients in primary health centres ask for injections, whether they are elderly patients or other adult patients. In accordance with this result, a previous study undertaken in Indonesia by Mulyadi and Hannan (2015) demonstrated that Madurese patients follow their parents’ views and behaviours. As they saw their parents ask for injections when their parents were ill, they likewise try to obtain injections when they are ill. As they feel better after receiving an injection of medication, they also assume that injections constitute the best medical therapy.

Little is known about the causes or origins of these perceptions about injections. Nurse participants opined that this behaviour resulted from patients’ sugesti (‘positive assumptions’). Patients may have a positive assumption about injections. This perception might be caused by a ‘positive illusion’, an assumption which may be associated with psychological adaptation among individuals (Wiseman & Watt, 2004). Nevertheless, this phenomenon could present a dilemma in patient care. On one hand, it could be beneficial for patient care because it implies patient trust in health services rather than in non-medical care such as that offered by shamans or other traditional healers. However, on the other hand, misunderstandings regarding injections can result in a barrier as health staff must decide how to proceed in the present of this misperception. When patients insist on receiving an injection though this form of medication is not required, nurses sometimes give an injection of vitamins to provide a placebo effect. Whilst none of participants in this present study admitted to engaging in this practice, they acknowledged that, anecdotally, it did occur.

Poor understanding about health, illness and treatment persists even among members of the younger generations in Indonesia. Nurses in Indonesia must confront not only lack of health knowledge but also a strong family culture. Family culture influences the adoption of incorrect opinions that have been upheld for generations in family and society and thus shape incorrect
perceptions about health, illness and treatment. Hence, it is not easy and is indeed quite challenging for nurses in caring for patients, as nurses must confront this cultural barrier that is significantly affected by patient levels of knowledge as well as by the role of family. This barrier has shadowed nurses’ work in caring for patients who have incorrect perceptions about health, illness and treatment. While nurses provide care for patients, nurses must also overcome this barrier by disseminating accurate health information to patients, families and societies that still uphold incorrect perceptions.

Through the identification of mistaken perceptions about health, illness and treatment, nurses can determine appropriate methods for approaching and overcoming this barrier. Health information and education programmes can be provided to correct wrong ideas in society. Health education programmes should consider aspects of the culture of a society, including values, beliefs and the knowledge level of the indigenous people. As each region and ethnic group may have different perspectives and views about health, illness and medical treatments, Indonesian nurses should recognise that there are diverse perceptions and opinions in society. Thus, a community health promotion programme can amend and correct the wrong perceptions that exist in the community.

As suggested by Tate and colleagues (2003), public perceptions and local knowledge should be included in the evaluations of multi-sectoral community-based health promotion programmes to enhance the health of society. Policy makers and all health care staff should also be aware of socio-cultural factors when building strategies to improve health knowledge and to encourage help-seeking attitudes in the community (La Cruz et al., 2016). However, it is more difficult to access communities in rural areas, especially those that are situated far from cities.
A limited understanding in the population as revealed by nurse participants in this study related to the social stigmatisation of people with HIV/AIDS or leprosy. As revealed by nurse participants in this study, the stigma related to HIV/AIDS and leprosy has affected patients’ help-seeking attitudes. Most patients with HIV/AIDS or leprosy hide their illness from their families and communities as they do not want to be rejected. Many people living with HIV (PLHIV) have revealed a feeling of being stigmatised and socially rejected by others. They suffer terribly from a lack of financial support, food, housing, and respect from others (Gausset et al., 2012).

The stigma of HIV/AIDS is usually expressed through verbal insults, gossiping and keeping a distance from PLHIV. Stigma often results from the propagation of improper information about disease; examples include misconceptions about HIV contagion and misperceptions about the causes of leprosy (Kaehler, 2015; Jacobi, 2013; Liamputtong, 2013). HIV/AIDS-related stigma can consist of negative self-stigma, enacted stigma and public attitude stigma. Self-stigma is a negative self-image in which an individual living with HIV/AIDS feels inferior, ashamed and guilty. Enacted stigma occurs when PLHIV have experienced rejection or discrimination in the past due to their HIV status. Public attitude stigma is related to subjective concerns with public attitudes in which PLHIV fear that they would be stigmatised if they were to reveal their HIV-positive status (Heggeness et al., 2017; Jacobi, 2013; Liamputtong, 2013). Similarly, there is stigma associated with leprosy; the stigma is frequently related to the deformities suffered by people affected by leprosy (Nagaraja, 2011).

The effects of stigma and discrimination can cause isolation, low self-esteem, depression, self-harm, poor academic achievement, poor physical and mental health, and delays in seeking medical help; they may also discourage treatment adherence (Liamputtong, 2013; Gausset et al., 2012; Machine et al., 2011). Leprosy-related stigma also leads to serious consequences such as psycho-social
dysfunction, isolation, rejection and participation restriction (Marahatta and Adhikari, 2015). Furthermore, Kaehler et al. (2015) found that community members refused to buy food from those with leprosy and believed that a person affected by leprosy would encounter difficulty in finding work. Stigma reduction strategies are therefore considered essential. Along with intensive therapy to decrease the prevalence of leprosy, dissemination of information about the causes and the treatment of leprosy can enhance public awareness concerning leprosy and counteract the stigma related to leprosy (Kaehler, et al., 2015; Nagaraja, 2011). Stigma associated with HIV/AIDS is also recognised as a serious hindrance for health care providers to support PLHIV to access medical treatment and to effectively control the spread of HIV/AIDS (Jacobi, et al., 2013).

According to the interview analysis in the present study, there were three aspects considered to be the causes of stigma surrounding HIV/AIDS and leprosy; these continue to exist in Indonesia, particularly in the countryside, where people rarely have the opportunity to obtain health information and where local cultural values remain strong. Social stigmatisation of people with HIV/AIDS or leprosy results not only from lack of knowledge about HIV/AIDS or leprosy. It is also influenced by certain cultural beliefs according to which HIV/AIDS and leprosy are ‘curse diseases’ or a punishment from God.

In addition, social perception holds these diseases to be very contagious and very deadly. Though modernisation has enabled more people to obtain information regarding HIV/AIDS and leprosy, including information about the causes of HIV/AIDS and leprosy and how to live with patients suffering from HIV/AIDS or leprosy, cultural beliefs and social perceptions formed in the community have affected people’s perceptions and attitudes toward patients with HIV/AIDS or leprosy. People suffering from HIV/AIDS or leprosy are often avoided, excommunicated and excluded from social activities as other people are worried about becoming infected or about transmission of the disease. The
stigma often leads patients with HIV/AIDS or leprosy to live outside society in order to hide their disease as they are worried about being rejected by society. People with leprosy usually stay at home all day and lack the confidence to engage in social activities, particularly when they have visible deformities.

Though some healthy people might accept people with HIV/AIDS, sufferers still often hide their illness due to social stigma, and this in turn has a significant impact on their help-seeking behaviours. Patients with HIV/AIDS usually go to hospital when their symptoms are at their worst. As a result, the barriers encountered by nurses in caring for patient with HIV/AIDS or leprosy involve many aspects including the patient him- or herself, family, people in the community, as well as cultural values and the stigma surrounding HIV/AIDS and leprosy that have resulted in incorrect views about patients with HIV/AIDS or leprosy. Nurses must overcome all of these aspects of the barriers to care in order to eradicate the barriers and ensure the provision of best care for patients with stigma-related diseases.

Therefore, nurses, particularly community nursing staff, should provide and disseminate health information about what HIV/AIDS and leprosy are, what the causes are and what treatments are available, how to prevent transmission and how to live with people who suffer from HIV/AIDS or leprosy. Through provision of proper health information about HIV/AIDS and leprosy, Indonesian nurses can correct wrong opinions in society about people with HIV/AIDS or leprosy; this would facilitate nurses’ care of patients with HIV/AIDS or leprosy. Overall, in caring for patients who suffer from certain diseases such as HIV/AIDS or leprosy in communities with culturally diverse populations, nurses in Indonesia encounter barriers beyond patients’ behaviours in seeking health care; nurses also need to overcome the stigma surrounding HIV/AIDS and leprosy that continues to exist in the community. Nurses need to overcome barriers stemming both from patients and from social stigma. Clearly, this is made more
difficult because of the shadow barriers of diverse cultures and the more tangible problem of language.

Traditional beliefs

Another cultural barrier revealed by nurse participants in the present study is related to traditional beliefs in the community. As outlined in Chapter Four, nurse participants reported several traditional beliefs in the community that impede patient care. Some nurse participants experienced caring for patients who had superstitious beliefs, wore amulets, believed in traditional healing practices such as the use of herbal remedies, or went to shamans. Nurse participants in hospitals and communities often face several superstitious beliefs held by patients and families. These may include a prohibition of cutting fingernails and washing or cutting hair during illness as well as a belief in bad or inauspicious days and good days.

According to participants of this study, some patients refuse to cut their fingernails or wash their hair when they are ill, though these activities help to maintain patients’ personal hygiene. According to their beliefs, these activities would have a negative impact on patient health. Some patients are also reluctant to leave the hospital and return home on the day when one of his or her parents died although the physician has released the patient; the patient and family may believe that this will bring bad luck to the patient. People who believe in fortune have a propensity for superstition, and thus superstition is often linked to a belief in luck (Chen & Young, 2018). According to Wiseman and Watt (2004), certain behaviours or beliefs that are assumed to be related to bad fortune and to be potentially harmful to individuals are categorised as negative superstitions.

Supernatural beliefs are related not only to negative superstitions; certain behaviours are also believed to be associated with positive superstitions which
can bring good luck to individuals (Wiseman & Watt, 2004). For instance, carrying lucky charms, amulets or other talismans may be believed to give good fortune to individuals. Positive superstitions also appear in this study. Nurse participants in this study sometimes found amulets or fetishes among patients’ belongings. Sometimes patients wear amulets as bracelets or necklaces. Nurse participants revealed that some patients trust fetishes or amulets as a source of power which can provide protection against misfortune and calamity.

An amulet, charm or fetish is an object that is often put on the body, in the wallet or in the house as a protective material that can prevent the user from jeopardy and bad luck (Wessing, 2010); thus, it is considered to bring good luck to the user (Wiseman & Watt, 2004). It is evident that positive superstitious belief can enhance an individual’s psychological adaptive abilities, including optimism and self-efficacy (Wiseman & Watt, 2004). Though this study did not specifically investigate superstitious beliefs in Indonesia, it is interesting to discuss this phenomenon which is encountered and perceived by nurses as a barrier to caring for patients. According to nurse participants in this study, sometimes nurses must persuade patients and even involve family members to persuade patients to remove all amulets from their bodies when patients require diagnostic examinations such as Roentgen X-rays, ultrasonography, or other diagnostic procedures.

Superstition refers to a belief emerging from anxiety or worry resulting from uncertain forces that cause individuals to wish to eradicate bad luck in order to experience good fortune (Ang et al., 2014). Ross (2011) predicted that traditional cultural beliefs and practices probably comprise a hint of ‘electromagnetic field’ interaction in the atmosphere (Ross, 2011, p.284). Though Ross’s finding was not supported by sufficient evidence, the study provided a number of anthropologically testable scientific ideas regarding electromagnetic fields and cultural traditional beliefs such as sacred places, fertility rituals, and the like.
Superstitions are also viewed as irrational beliefs that yield from mistaken conceptions of causality (Chen & Young, 2018).

There have been many studies about superstitions. An internet-based study about superstitious beliefs undertaken by Wiseman and Watt (2004) through British National Science Week indicated significant interactions between psychological beliefs in negative and positive superstitions and individual differences such as gender, self-perceived neuroticism and life satisfaction. Wiseman and Watt’s work contradicts the use of the Paranormal Belief scale, which only measures negative superstitions. Wiseman and Watt (2004) suggested that a measurement of superstitious beliefs should consider both positive and negative superstitions. This means that supernatural beliefs should be seen not only from a negative perspective but also from the positive side.

Consistent with Wiseman and Watt’s findings (2004), the current study found that nurse participants reported some negative and positive superstitious beliefs still current in society and strongly believed by some patients. These included a reluctance to cut fingernails and hair during illness and the wearing of objects as amulets.

There is also evidence that superstitious beliefs are frequently used in trade and commerce to predict the propensity of individuals to choose a product (Ang et al., 2014). Ang and colleagues found a significant relationship between three aspects of superstition, including valence, accessibility and relevance, with choice and latency. Individuals have a tendency to make faster choices when exposed to negative, accessible and relevant superstitions (Ang et al., 2014). Negative superstitions tend to be more likely than positive superstitions to cause individuals to choose an auspicious product. Though Ang and colleagues’ study is more closely associated with marketing and economics than with nursing, there are similarities between the attitudes expressed by nurse participants in the present study and those described by Ang and colleagues (2014). It is likely that
a connection exists between individual exposure to superstitions and the decision to follow superstitious beliefs.

As indicated in the present study, nurse participants revealed that some patients hold superstitious beliefs as this has been a cultural tradition in their communities. Some Madurese and Javanese people still hold these superstitious beliefs. Patients learn local beliefs from their families, particularly from the older generation, and pass them from generation to generation. Patients generally follow their cultural traditions and family beliefs and values. According to nurse participants in the present study, some people are very obedient when members of the older generation make a suggestion. Parents and the older generation tend to advise family members to follow their suggestions. This can take place with both adult patients and younger patients. Though the patient may be of the millennial generation and may have an understanding of health knowledge and technology, the patient is often unable to avoid parents’ or elders’ doctrine of beliefs and the family and cultural values of society.

Such patients may not themselves hold the superstitious beliefs, but considering the characteristic of Indonesia as a collectivist population and the major role that parents generally have in family life, patients might follow their parents’ instructions. For instance, a twenty-year-old male patient agreed to be helped by a nurse to cut his fingernails and wash his hair to make him feel clean and fresh, but this plan failed as his family did not allow him to cut his fingernails and wash his hair due to their superstitious beliefs. The traditional beliefs that still exist and are strongly believed by society also led the patient to be afraid not to comply with those beliefs.

These superstitious beliefs often become a barrier to caring for patients. Some nurses know that superstitious beliefs still persist in their communities as they live in the culture and may also share the patients’ culture. Nurses face a
dilemma in working with patients and families who still uphold local beliefs that might run contrary to health care treatment. On one hand, nurses are familiar with the local beliefs, and on the other hand, nurses understand that the local beliefs sometimes hinder patient care. Nurses live in the culture, but they understand that the superstitious beliefs sometimes contradict health care therapy and they also want to behave in a professional manner. Nurses must overcome this cultural barrier in performing their nursing activities. This situation is not only encountered by nurses who share the ethnicity of a patient, as described above, but is also experienced by nurses of ethnicities that differ from that of the patient. Discrepancies in cultural beliefs between nurses and patients can affect nurses’ attitudes towards diversity, as outlined in the next section.

Tension can emerge due to the abovementioned barrier. Educational level and analytical thinking might contribute to this tension. Thinking analytically may diminish the level of an individual’s supernatural beliefs as he or she is more likely to scrutinise ‘irrational ideas’ and not trust in them (Pennycook et al., 2012). According to Pennycook and colleagues (2012), higher levels of formal education, cognitive ability and analytical thinking often support one another. Individuals with higher levels of formal education thus tend to have greater analytical thinking abilities; they also have a propensity to ignore and disbelieve superstitions. The findings of this study demonstrate that patients who believe in superstitions are generally those who lack knowledge and those who have had lower levels of formal education. Therefore, this study is in line with the findings of Pennycook and colleagues (2012); patients might have lesser analytical thinking abilities than nurses, so that it is more likely that a patient would hold superstitious beliefs.

Though nurses in this study did not convey their personal perspectives regarding superstitions, based on the interview analyses, nurses appeared to be unhappy
when patients followed and applied their superstitious beliefs, given that these beliefs are often contrary to a patient’s medical therapy. Nurses tend to respect and understand patients’ superstitious beliefs, although nurses feel that those beliefs often influence their ability to perform their nursing work and thus can impact patient care.

The finding of this study is contrary to a previous study, which suggested that late adolescents become less superstitious as adulthood is assumed to be related to the maturation of cognitive ability (Sagone & Caroli, 2014). Though the relationship between age and superstition was not confirmed in the current study, superstitious patients are generally adults. However, the families of paediatric patients are sometimes superstitious, and this may in turn have an impact on the child’s care. Nurse participants in this study did not reveal the ages of their patients who believed in superstitions. The nurses depicted the ways in which patients’ superstitious beliefs impact them in their efforts to provide the best patient care.

This barrier might be also encountered by nurses around the world. Though superstitious beliefs and practices may seem unacceptable or nonsensical in modern countries, some people might nevertheless still hold superstitious beliefs (Cheng & Young, 2018). Some successful figures, such as Al Shugart, CEO of Seagate, and Matthew Szulik, CEO of Red Hat, believe in positive superstitions and carry objects such as talismans or magical amulets (Cheng & Young, 2018). Superstitious and supernatural beliefs can be discovered in diverse cultures and countries. Superstitions do not exist only in developing countries and among countryside populations such as those in Indonesia, but also in developed countries such as the United Kingdom and other Western countries.

Overall, though, such superstitious beliefs have a significant impact on patient care and affect nurses’ attitudes towards patients’ traditional beliefs; this might,
in turn, also influence nurses’ strategies in caring for patients with diverse superstitious beliefs. Nurse participants in this study saw superstitious beliefs as a barrier to caring for patients as nurses must overcome them in order to provide the best care for their patients.

Nurse participants in this study also conveyed that some patients and families preferred shamans (dhukun) to doctors or nurses as they were prone to believe more deeply in non-medical therapy. Patients and families are more in favour of seeking help from shamans or traditional healers than from healthcare staff. Some patients and families perceive hospitals or primary health centres as a second choice after traditional healers.

The data from the nurse participants in the present study indicate that some people ask for help from individuals who they believe can cure their ill loved ones. People usually ask healers to pray for patients or give objects to patients such as water that has been prayed over or paper on which a prayer has been written. The paper may be placed on the patient’s body or mixed with water to wipe onto the patient’s body. These healers are often called tabib or kiyai. Though these healers may seem similar to shamans, people consider that they are different from shamans. These healers are considered more religious because they pray to God. By contrast, shamans often use mythical objects to heal, which is considered to go against religious beliefs. However, this does not mean that individuals who visit shamans are not religious people or that they have no religion. They do have a religion, but they still trust the shaman. Recently, shamans have become less popular compared to religious healers, tabib or kiyai. Sometimes people also ask religious leaders to pray for patients, inviting religious leaders to visit the hospital and pray for a patient’s health.

Nurse participants view this phenomenon as a barrier to caring for patients as patients often decide to go to the only hospital when their illnesses worsen and
best care and medical treatments are more difficult to achieve. Further, a barrier also emerges when patients and families want to combine medical treatment and traditional treatment from healers; for instance, prayed-upon water from a healer may be given to a patient who is receiving haemodialysis in which case the patient’s intake of water must be restricted.

Nurses must overcome this barrier by approaching the patient and family and asking them to follow the medical instructions they have been given. As long as the amalgamation of medical treatment and traditional healing therapy would not negatively influence the patient’s condition, nurses facilitate this amalgamation. For instance, prayed-upon water is only wiped onto the patient’s body. This practice has been inherited from generation to generation. As patients and families know that their parents went to shamans or traditional healers and that the treatment was effective, patients imitate this behaviour. Parents or members of the older generation tend to advise their family members to follow their suggestions. This help-seeking attitude is inherited from generation to generation.

There are some reasons for which people often prefer to see traditional healers rather than going to health professionals. The traditional healers’ explanations are generally more understandable for local people; for example, a traditional healer might say that a patient’s fever is being caused by a spirit. By contrast, health care providers in the hospital or at the PHC may use some terms that the patient does not understand. Patients and their families are usually afraid when a doctor or nurse states that the patient has a serious or dangerous disease and must be hospitalised, which is costly. Therefore, people generally prefer to adhere to the traditional healers’ treatments, which are seen as divine acts or gifts from God; in these cases, in addition, the patient may pay according to what they can afford. However, people usually go to the hospital or seek health care professionals when the patient contracts a severe illness; they are often too
late (Wessing, 2010; Rustamadji, 2000), which only further demonstrates the limits of Western medicine in their minds.

The use of traditional healing practices is quite often connected to populations with lower and middle incomes and low levels of formal education (Suswardany et al., 2015). Consulting with a traditional healer before or after a medical diagnosis, however, may result in a greater risk of treatment delay and missing treatment sessions (Iskandarsyah et al., 2014). Therefore, nurses and other health care providers need to be aware of their patients’ understandings of disease and medical treatment, as well as their beliefs in traditional healers. Health professionals should provide clear and proper information about their patients’ illnesses and the required treatments in order to reduce misunderstandings and negative conceptualisations of the illnesses (Iskandarsyah et al., 2014).

Herbal remedies are also frequently used to replace modern medication. Herbal remedies as part of traditional healing are used widely throughout many Indonesian communities. According to Rustamadji (2000), with Indonesia’s vast number of available medicinal herbs and plants, the use of traditional remedies is adopted by many populations, and herbal treatments are used considerably more than modern medicine. Further, Rustamadji (2000) suggested that caregivers should offer an appropriate combination of modern medicine and traditional medicine in providing health care support.

7.1.3 Spiritual issues
This study also indicates that several spiritual issues emerge in the health care setting and influence caring activities. This study demonstrates that differences in religious ideas among followers of the same religion can affect individuals’ relationships. As described by participant 15, discrepancies in spiritual ideas between a Muslim nurse and a Muslim patient’s family once resulted in a
problematic situation for patient care. The patient’s family refused a medical treatment that was assumed to be against the patient’s religious beliefs. However, participant 15 revealed that the treatment was eventually able to be performed as the patient was aware of the Muslim rule according to which a medical treatment considered as the best way to care and cure does not go against religious rules. The nurse believes that the treatment does not against the religion; the family members or carer refuse the treatment because they perceive the treatment is not allowed based on religion rules; and the patient accept the treatment because patient understand this treatment does not against religion’s rules.

This phenomenon depicts the fact that possible difficulties in caring for patients can emerge due to differences in religious perspective. This study indicates that even though nurse and patient, and family may share the same religious identity, it is possible for them to have different religious ideas. As a result, problems might arise among nurses, families and patients, influencing health care decision-making for the patient. The finding of the present study is in line with the study of Linnard-Palmer and Kools (2004), who argued that religious values may lead patients to consent to or to refuse certain medical treatments. This phenomenon should be seen not only from a spiritual viewpoint, but also from an ethical perspective. Linnard-Palmer and Kools (2004) related this situation to the ethical principle of nonmaleficence, or inflicting no harm.

Antommaria and colleagues (2013) suggested declining families’ refusals of medical treatment for patients though such refusals might be based on patients’ religious ideas. Antommaria and colleagues (2013) considered this to be particularly important for paediatric patients who must rely on their parents’ decisions to protect them from severe conditions or death. Though the findings of the present study are more concerned with participants’ experiences with adult patients, the study of Antommaria and colleagues (2013) remains relevant.
The situation the researchers described might be problematic for nurses. Some patients and families may insist on adhering to their religious values, but at the same time, nurses as health professionals must consider the ethical consequences of their decisions and activities (Linnard-Palmer and Kools, 2004). Nurses should provide patients and families with information about the potential impact of refusal of treatment and the attendant possibility that doing so might endanger patient care.

The present study also demonstrates nurses’ attitudes towards people from different religious backgrounds. One of the Christian nurses who participated in this preferred not to discuss personal religious identity with Muslim patients to avoid potential conflict in nurse-patient relationships. This nurse perceived that those who engage in religious fanaticism might not be friendly to others from different religions. This finding indicates that nurses’ personal views about other religious beliefs significantly influence nurses’ perceptions and attitudes toward people from other religious groups.

According to my analysis, this nurse is probably unusual in this approach, because Muslim and Christian patients in Indonesia are commonly treated by nurses from different religious backgrounds. It is common in Indonesia for Muslim patients to be treated in a Christian hospital or for Christian patients to be hospitalised in a Muslim hospital, because there are no differences in the health services provided in the two types of hospitals. This Christian nurse’s perception might be influenced by religious tensions that might occur in other regions, but they affect the nurse’s perception of and attitude towards followers of other religions.

However, in the interview process, the nurse did not report having had experience with any religious conflicts. The nurse only expressed the wish to avoid conflict with patients from different religious groups. As this study does
not involve patients’ perceptions of and attitudes toward nurses’ religious identities, further study is necessary to investigate whether and in what ways nurses’ and patients’ religious beliefs influence nurse-patient relationships and how people with quite profound religious beliefs behave with others from different religions.

To summarise, it is well known that workload is a problem for nurses around the world, but I have identified that the cultural and spiritual heterogeneity of Indonesia add a layer to this problem because nurses are trying not only to do their jobs but also to find their way with very diverse patients. This both shadows and adds a layer to the nurses’ work. Some previous research has pointed out the existence of this barrier. However, previous researchers have not made mention of the fact that people’s spiritual, linguistic and cultural backgrounds impose an additional difficulty on nurses who are exhausted due to their workloads.

Other studies have identified the workload barrier, but these studies may have taken place in locations in which nurses only encounter patients from one or two different backgrounds. In Indonesia, there are many differences in cultural, spiritual and linguistic background. This study, then, can help nurses begin to think about how to overcome the barriers they experience. Through this study of Indonesian nurses, we can apply the results to other areas with heterogeneous populations.

This study not only demonstrates that nurses have much to do in their jobs; it shows that caring for patients from different cultural and spiritual backgrounds adds to nurses’ workloads. This makes the current study distinct from other studies. In this study, nursing work is shown to be shadowed and complicated by another layer formed by cultural and spiritual barriers. The nursing workloads that appear in this study are thus specific to Indonesia. The shadow barriers add
to the layers of nursing work. As a result, the point of contact remains somewhat unclear. Before nurses can begin their work, they must move through the shadow barriers. Indonesian nurses must manage the culturally and spiritually diverse backgrounds of their patients before they can begin to do their jobs. This cultural and spiritual diversity adds to nursing workloads and becomes a thick barrier that adds layer upon layer of work.

For example, if one female white British nurse has six patients and only one of them has a background that is different from her own, for example in the case of an older Muslim gentleman, the workload is probably manageable. The nurse might only need one interpreter for one patient. However, when six patients have six different cultural, spiritual or linguistic backgrounds and the nurse herself is from a seventh background, she cannot begin to do her nursing work until she has moved through six different language barriers. This creates an enormous additional workload. Nurses must move through these differences before they can begin their work. Nurses cannot do their work until they develop a relationship with the patient, and a nurse cannot develop a relationship with a patient who seems culturally very different from the nurse.

Some research papers have identified several barriers to caring for patients in a multicultural population, such as language problems, family matters and religious beliefs, as outlined in the literature review in Chapter Two; however, none has raised the issues of culture, spirituality or language as additional barriers to nursing workloads, nor has there been mention of the need for nurses to overcome these issues before they can begin their work. The abovementioned papers provide discussions of how barriers influence nursing care, but they do not acknowledge that cultural, spiritual or language issues can add to nurses’ workloads.
No previous researcher has discussed these issues; barriers, in fact, manifest not only physically but also relate to culture, spirituality and language. No paper has identified that these things do affect nursing care, and that is what makes this study distinct from previous studies. Therefore, this study offers a significant contribution to nursing science as it can raise nurses’ awareness of this issue and thus help them to provide the best possible care for patients from diverse backgrounds in heterogeneous populations.

7.2 Nurses’ attitudes towards patients’ cultural and religiously diversity

Nurse participants’ attitudes toward differences and similarities are varied. Describing and stereotyping, cultural ties, trying to be fair and respecting difference are four types of participant responses to diversity that emerged in this phenomenological study. This section outlines each of these types of participant attitudes towards patient diversity.

7.2.1 Describing and stereotyping

The findings of the present study indicate that in caring for patients from a wide range of ethnic groups, nurse participants frequently unconsciously portrayed patients and families using cultural stereotyping. Stereotypical views about patients from certain ethnicities were expressed not only by nurse participants with a different cultural identity than the patients, but also by nurse participants from the same ethnic groups they were describing. Participants in the present study believed that they were simply describing common cultural characteristics of patients.

This study indicates that nurse participants appeared to be unaware that their own stereotypical perceptions can result in the development of racial attitudes (Pauker et al., 2010) and ethnocentrism (Almutairi et al., 2015). A Javanese nurse might not be conscious that he or she appraises Madurese patients more negatively than patients who share his or her own cultural identity. According to
Pauker and colleagues (2010), racial attitudes emerge when two different groups are compared with one another and one group is perceived more positively and the other more negatively. People might also have ethnocentric perceptions (Almutairi et al., 2015), perceiving their own culture to be better than those of other groups.

This study also demonstrates that it is difficult to eradicate stereotypical perception as sometimes patients and families behave in a stereotypical manner and justify their behaviours based on the stereotypes attributed to them. According to an experimental study conducted by Rydell et al. (2010), negative stereotypes may significantly impact the learning and performance of an individual. Rydell and colleagues’ study revealed that negative stereotypes of women in mathematics could decrease their level of mathematical knowledge and thus induce substandard performance. Similar findings also arose in the present study. Participant 8 described family visitors as acting in a way that reflected the stereotypical behaviours attributed to them. Madurese families who visit patients in hospital have been labelled as visitors who come in large groups with many people. This stereotype influences them in their interactions with healthcare staff.

The stereotypes of certain ethnic groups, which are deeply embedded in Indonesian communities, have affected nurse participants’ assumptions about their patients as well as the ways in which they treat others from those ethnic groups. The cultural or racial stereotypes that people attach to others may be constructed from childhood. According to Pauker et al. (2010), stereotype content can be construed from cultural knowledge in a child’s social environment, such as explicit information provided in books, in the news or on television, explicit and implicit conversations with relatives, teachers, neighbourhood friends or schoolmates.
In addition, as pointed out by Lee and Thien (2014), the media as a means of mass communication plays a significant role in establishing racial stereotyping. The authors’ survey in Singapore, a country whose multicultural society is similar to Indonesia’s, demonstrated that people who gain more race-specific information from the media indicate having more positive perceptions of their own race and less positive racial perceptions about others (Lee & Thien, 2014). For instance, in Indonesian society, male Madurese are considered to be sensitive and vindictive men who are easily offended and who often fight using a sickle called a *carok* (Wiyata, 2002; De Jonge, 1995). The Madurese are well known as a loyal and amicable people who also have a strong connection of kinship and ethnicity (De Jonge & Nooteboom, 2006). However, there are also negative stereotypes attributed to the Madurese such as those of being troublemakers, poorly educated, and poorly paid workers (Nooteboom, 2015). These stereotypes have been widespread throughout Indonesia from generation to generation and do impact peoples’ attitudes towards others.

Pauker et al. (2010) stated that the racial separation of pupils in schools or stratification related to professional occupation would also lead to racial stereotyping in communities. There is in fact no racial separation or segmentation in Indonesia. The government treats all pupils in school equally regardless of race. There is likewise no evidence of stratification according to professional occupation in Indonesia. In the case of the Madurese, they migrate (*merantau*) intensively to other cities or islands due to a lack of economic resources in their unfertile mainland (Sukimi, 2009). They generally work as *sate* (grilled beef) sellers, unskilled workers, construction labourers, and sellers of second-hand goods (Nooteboom, 2015). When they succeed as migrants, the Madurese generally ask relatives to join them and make their livings as migrants as well. The conventional image of the Madurese, developed over a long period, significantly affects public views of the Madurese.
7.2.2 Cultural and ethnic ties

The findings of this qualitative study describe the fact that a sense of cultural ties enables nurse participants to build nurse-patient relationships. This is similar to findings from the economics and the sociology literature, both of which highlight ‘cultural taste’ as having the potential to improve social connections and relationships (Prashantham et al., 2015; Foley & Kerr, 2011; Lizardo, 2006).

The present study demonstrated that cultural ties could strengthen social connections. Interpersonal relations were shown to be based not only on personal identity as linked to ethnicity, as expressed by participants 13 and 18, but also to build upon cultural sense, as revealed by participant 1. These phenomena are consistent with a model created by Lizardo (2006) indicating that ‘cultural taste’ can form social networks (p.778). Lizardo’s work was inspired by Bourdieu’s and DiMaggio’s original observations of a significant association between cultural taste and social relationships. Culture has a pivotal role in shaping and altering networking connections (Lizardo, 2006).

Prashantham et al. (2015) posited that ethnically based relationships could accelerate collaborative connections within the ethnic network through communication, trust, and ideas shared among people (Prashantham et al., 2015; Foley & Kerr, 2011). The important basis of this concept for the health care context is that cultural ties can facilitate the establishment and improvement of the interpersonal relationships between health care staff and patients. While the abovementioned studies are related to economics and sociology, they support the present study in stating that cultural ties can enhance human relationships.

Multicultural living enables people to experience cultural ties. In a heterogeneous population such as Indonesia’s, the movement of people from one city to another city or from one island to another island affords them the opportunity to meet others from a wide range of ethnic backgrounds who may
or may not share an ethnicity. According to Martin and Shao (2016), there are two kinds of multiculturalism that develop in individuals: innate multiculturalism and achieved multiculturalism. An innately multicultural person is defined as an individual who has had experience in mixed cultures since childhood. Achieved multicultural individuals did not experience early immersion into multiple cultures and thus obtain multicultural experience in other ways (Martin & Shao, 2016). Innately multicultural and achieved multicultural individuals might have different responses to diversity. However, living in several areas with various behaviours and customs could enrich individuals’ life experiences as well as strengthen cultural bonds, as found in the current study.

7.2.3 Trying to be fair

While participants might not provide equitable care to patients who are not from their groups due to their cultural ties, findings within this study emphasise nurses’ dedication to providing fair nursing care. This qualitative inquiry posits that fair does not mean equal. Nurse participants in the present study were aware of the importance of providing appropriate nursing care for each patient with his or her individual background as different patients and those of different ethnicities might require different approaches to meeting their healthcare needs.

This study indicates that nurses consider that understanding a patient’s characteristics is important. To reach such an understanding, nurse participants in this study perceived that nurses should be familiar with their patients’ cultural identities. For instance, taking care of Madurese and Javanese patients might require different approaches. Such increased consideration on the part of healthcare staff may prevent patients feeling unsafe being cared for in a hospital in which healthcare staff label them according to their cultural or religious identities.
As found in a previous study conducted by Peguero (2009), generalisations based on racial and cultural identity could evoke a feeling of insecurity in an individual’s environment. Therefore, inquiring into demographic data, and asking with which ethnicity or social group a patient is affiliated, may be asking patients to reveal sensitive information. Clark et al. (2015) suggested placing a demographics question at the end of an investigation to avoid negative stereotypes. By contrast, a panel on the United States Department of Health and Human Services (DHHS), regarding the collection of racial and ethnic data (2000), suggested that ‘high-quality data on race and ethnicity are necessary to identify and eliminate disparities in health and health care’ (p.3). Worrisome disparities regarding the accessing and utilisation of health care services have been found to be linked with racial and ethnic groups as well as with economic and social strata in the United States.

In the case of healthcare services in Indonesia, demographic data, including ethnicity and religious identity, is part of the initial admissions assessment in hospitals and primary health centres. Demographic data are considered important as different religious or ethnic groups may have different preferences regarding health care services. Patients from different ethnic backgrounds may also speak different local languages. The participants in the present study found that some patients prefer to use their local languages in nurse-patient communications. The participants felt that it was easier to approach patients when they speak using a local language rather than the national language of Indonesia. DHHS (2000) highlighted that ‘mismatches between the language spoken by health care providers and by patients can be a limiting factor in health care interactions and health information exchange’ (p.3).

Language is considered as a major obstacle for communicating with others who have different cultures and local languages, as outlined in Chapter Four. While demographic data on the ethnicity and religious identities of patients might be
considered necessary to diminish disparities in health care utilisation, collecting such data may lead to prejudice among nurses and influence the way nurses care for the patients. It can result in unconscious bias in caring for patients. Implicit bias has a negative impact on patient care (Johnson et al., 2016). Implicit bias unconsciously influences individuals’ perceptions and behaviour (Johnson et al., 2016). The present study suggests that nurses and other health staff learn to recognise and diminish implicit bias in caring for diverse patients.

7.2.4 Respecting differences

The present study demonstrates that participants respected the differences found among their diverse patients. Nurse participants respected patients’ spiritual beliefs, despite the problematic circumstances they might encounter concerning patients’ beliefs.

Multicultural societies in developed nations such as the United Kingdom, the United States and Australia exhibit differences with Indonesian society. Multicultural living in developed countries is generally induced by globalisation, refugee mobility, natural disasters or the impact of wars (Crisp & Turner, 2011). The socially and culturally diverse society of Indonesia is more affected by the nature of Indonesia as a very multicultural country having six official religions, more than 700 ethnicities and more than one thousand local languages on 17,000 islands. Further, transmigration or population migration on the islands due to geographic mobility, marriage or job seeking leads Indonesian inhabitants to encounter social and cultural diversity in the community.

Crisp and Turner (2011) highlighted several advantages of a heterogeneous environment. Living in a multicultural society may not only encourage people to develop greater tolerance for others but also to improve self-efficacy, dignity, creativity, and problem-solving methods. A multicultural community can encourage people to believe that everyone deserves equal rights and
opportunities. Thus, the experience of cultural and social diversity can contribute to the psychological well-being of individuals, social groups, and society (Crisp & Turner, 2011). Leung and Chiu (2010) posited that the valuable benefits of multicultural experiences include cognitive complexity and the stimulation of cognitive flexibility. Individuals living in heterogeneous societies have a greater chance to establish the capability to acknowledge, appreciate and incorporate standpoints from other cultures. They may also be more flexible in adapting intellectual sources from other cultures (Leung & Chiu, 2010).

As outlined in the previous paragraphs, multicultural living can enhance an individual’s awareness of diversity. Respect for cultural diversity can be generated from an individual awareness of heterogeneity. As stated by Martin and Shao (2016), people may or may not experience early immersion in multicultural experiences. Roaten and Schmidt (2009) argues that multicultural awareness can be stimulated from school age through experiential activities that help students confront and overcome bias, stereotyping, and exclusionary behaviour. Such learning activities can encourage students to gain awareness, discover beliefs and attain knowledge and skills about their own cultures and the cultures of others (Roaten & Schmidt, 2009). This can also be applied to nursing education. Nursing students can learn about cultural diversity either in class or in healthcare settings. Nursing students’ awareness of cultural diversity is relatively easy to develop given that nursing students are at an educational level at which classroom learning can be enriched by real working experience. This awareness is central to increasing nurses’ competence in respecting diversity.

### 7.3 Strategies in addressing differences

The third theme of this phenomenological study portrays nurse participants’ strategies in confronting diversity; these consist of communication strategies, cultural approaches and spiritual support.
7.3.1 Communication strategies

The interview analysis captured seven communication techniques that arose from participants’ narratives. These are clear explanations, rectifying mistaken opinions, suggesting without coercing, non-verbal communication, using the services of a translator or interpreter, involving community leaders, and making jokes or utilising irony. Providing clear information and rectifying mistaken opinions are both important to minimising misunderstandings between nurses and patients or family members. Nurses’ explanations should be understandable for patients and families, particularly for members of certain ethnic groups who predominantly speak their local language in daily communication.

This study also reveals that nurse participants have experienced arduous situations while working with patients who possess misperceptions about health, illness and health treatments. Nurses must give clear and yet subtle explanations to rectify patients’ mistaken perceptions. This qualitative study also reveals that suggesting without coercing is required when facing patients and family who have strong personal beliefs. According to nurse participants, a ‘try it and let’s see’ strategy proved to be effective in influencing or convincing patients to adhere to the prescribed health treatments.

Non-verbal communication and involving family, colleagues and other health staff as translators or interpreters are also considered as useful techniques to overcome language barriers. These findings are consistent with a previous study conducted by Cioffi (2003) that proposed the use a multiplicity of communication strategies when caring for patients from diverse backgrounds, such as body language and involving a translator or interpreter.

The results of this study augment notions about communication strategies that nurses can use, including involving community leaders and using jokes or irony to communicate with patients and family. In a society in which community
leaders are respected as influential figures, it is easier to disseminate health information more widely when health staff involve influential people from the community. It is evident in this study that humour, as well as using local cultural approaches such as local slang and local language, is beneficial in nursing care. This finding clearly reflects theorising about the benefit of humour in interpersonal relationships (Kuiper and Martin, 1993; Beck, 1997).

Culturally based communication is sometimes employed to manage nurse-patient relationships. Participants in the present study acknowledged the significance of understanding patients’ local languages, particularly when communicating with elderly, rural patients or patients who prefer to speak their mother tongue. However, local communication styles must also be taken into consideration as people from different ethnicities may have different communication styles. The elements of these styles may include verbal and non-verbal communication, maintenance of personal space, eye contact and touch in interpersonal communication. Spiritual approaches constitute another strategy applied in caring for patients from diverse background. Nurse participants in this phenomenological study provided spiritual support and encouraged patients to believe in God while offering professional medical treatment.

Communication is a dynamic, ‘reciprocal process’ of dispatching and receiving information which involves a combination of verbal and non-verbal communication skills (McCabe, 2004, p.41) where ‘information, thoughts and feelings’ are exchanged among the speakers (Kourkouta & Papathanasiou, 2014, p.65). Interpersonal communication can influence relationships between health care professionals and patients (Cypress, 2011). Thus, good communication is essential for effective nurse–patient relationships in health practices (O’Hagan et al., 2014). The participants’ narratives in this study demonstrate that the intention to provide clear explanations serves only to provide health information and education and to obtain consent prior to carrying out treatment. It is only
one of the seven communication strategies that emerged in this study, which are mostly used simply to carry out ordinary nursing tasks such as daily health assessments, paperwork, and practical nursing work. However, a therapeutic relationship is perceived by patients as including caring and supportive behaviours (Mottram, 2009). Therefore, nurses as health professionals should demonstrate caring engagement in their communications with patients and families.

7.3.2 Cultural approach and spiritual support

This study indicates the effectiveness of cultural approach in patient care, through speaking the patient’s mother tongue and understanding the value and cultural tradition of patient. Hunter and colleagues (2009) posited that culturally competent patient-centered care is of great importance. This cultural competence can minimise and eliminate health disparities among minorities in healthcare as the needs of diverse populations are met through culturally competent services (Castillo and Guo, 2011). Patient-centered care must consider an individual’s cultural traditions, values, lifestyle, family situation, and preferences, including cultural language preferences (Hunter et al., 2009).

Participants’ quotations in this study show that culturally based communication can bridge nurse-patient interactions that might be otherwise be hindered by language problems. However, nurses should not focus solely on learning patients’ local language; other factors of communication, including verbal and non-verbal communication, personal space, eye contact and touch in interpersonal communication should also be considered.

When caring for patients without attending to their cultural traits, in terms of communication style, patients may become offended and, as a result, they may not comply with treatment recommendations or may even be reluctant to return for care (Hunter et al., 2009). As people from different ethnicities may have different communication styles, nurses should also understand local
communication styles. Cultural competence cannot be gained instantly; rather, it is a long-term process of learning that takes place while caring for patients from a variety of cultural backgrounds every day (Samnick, 2011; National Association of Social Workers, 2001). Nurses can thus obtain and enrich their cultural knowledge, including local languages and communication styles, in a healthcare atmosphere whilst caring for their diverse patients.

This study also demonstrates spiritual support provided by nurses in caring for diverse patients can enhance nurse-patient relationship in heterogeneous population. Though participants in this study appear to involve their spiritual ideas in their caring activities, this spiritual support has effectively improved patient outcomes. Participants convey some patients sometimes follow and agree with nurses and other health staff’s suggestion through spiritual support. Individuals’ religious belief do influence cognition, work ethic and moral judgment (Cohen and Varnum, 2016). Nurses’ cognitive capabilities that are affected by their religious capacities do enhance nurses’ capability in addressing barriers or problem in caring for diverse patient and in building social interaction with patients and colleagues.

7.4 Summary
This chapter provides a comprehensive discussion of the results in this study. Three major themes have been discussed, elaborated and linked to other similar studies. Discussion has also involved theories or concepts associated with themes that support or contradict to findings of this study. The findings of this study reveal a number of issues in caring for patients with highly heterogeneous backgrounds.

Heavy nursing workloads present a global problem and a potential barrier to the provision of high quality therapeutic nursing care. What this research demonstrates is that in Indonesia, whose specific circumstances include its
multicultural and religiously diverse population, nurses experience an exacerbation of these difficult conditions because they first need to move through what I have termed ‘shadow barriers’ before they can even begin to face the nursing work that nurses in other nations perform.

Regarding cultural issues, barriers related to cultural issues such as superstitious beliefs, might also be experienced by nurses in other countries, either in developing countries or developed modern countries. It is hoped therefore that, this study raises the awareness of nurses around the world about the potential for patients to engage in their own cultural traditional beliefs. Certain cultural traditional beliefs might be inappropriate in the context of a patient’s medical care. Conflict might arise between patients and health staff due to patients’ beliefs and the fact that they contradict the prescribed medical treatment. Cultural beliefs might also vary between Asian countries and Western countries. Barriers might also emerge differently in the course of patient care.
CHAPTER EIGHT
CONCLUSION

8.1 Why nurses seem uncaring

A therapeutic relationship contributes significantly to a patient’s healing process and recovery, even in short-stay conditions such as in a surgery room and outpatient unit or in the most difficult and dangerous situations (Brooks, 2015; Mottram, 2009). Brooks’ essay (2015) underscored that nurses had a vital role as therapeutic agents in the deserts of the Middle East and North Africa during the Second World War. The therapeutic nursing provided by nurses at that time was central to ‘support healing and well-being of combatants, even in a location where survival is difficult’ (Brooks, 2015, p.2526). According to Mottram’s grounded theory study, the therapeutic connection can be established in health care even when the care only lasts a short period. Nurses need to recognise that routine nurse-patient therapeutic interactions can be of great significance to patients (Mottram, 2009).

It was suggested by Shattell and colleagues (2007) that the nurse-patient therapeutic relationship can be potentially be enhanced by understanding the patient as a whole person, not only as a service user. Thus, nurse participants in this study needed to be aware of several components of the therapeutic skills which are essential to building therapeutic connections and thus overcoming family barriers: respect for the person, awareness of the patient’s needs, good listening skills, empathy, seeing the client as a unique individual, being honest, and using touch and appropriate self-disclosure (Mottram, 2009; Shattell et al., 2007; Welch, 2005).

Caring is part of the therapeutic relationship. From the patient’s viewpoint, the therapeutic relationship can be seen through an attitude of being ‘caring,
supportive, non-judgmental and to offer a perception of safety from threatening events’ (Mottram, 2009, p.2830). Based on the research findings in the present study, nurse participants emphasised the completion of nursing tasks rather than showing a caring attitude in providing nursing care. Nurse participants treated patients’ families as if they were not part of the patient, whereas patients and families cannot be separated because prior to entering the hospital, the patient lived with the family. Caring for the family should be considered as part of caring for the patient. McKiernan and McCarthy (2010) found that nurses who are able to provide care for the family are perceived as being able to give optimal care to the patient. Caring for the family can be embodied through good communication between nurses and families.

The reasons why nurse participants in the present study seemed to behave with uncaring attitudes to families, and how nurses interpret caring in nursing practice, has been taken into consideration. It was identified that nurses in the current study defined caring in different ways. Some nurses interpreted caring as performing nursing interventions, which is closer to engaging in medical activity, and occasionally nurses implied that caring includes psychological support, empathy, and caring about or loving the patient. However, generally nurses in the present study simply focused on how the patients’ complaints were addressed or healing the patients by performing nursing or medical activities. It appears that the nurse participants were very task-oriented and/or stressed at work.

Though some nurses were able to explain the definition of caring in a theoretical sense, analysis of the in-depth interviews showed that nurses consistently described their experiences in caring for patients from the perspective of completing nursing tasks. Clearly, nurse participants expressed the inconvenience they experienced in certain situations related to family presence as the nurses wanted to carry out and to finish their nursing or medical jobs.
According to Kuhse (1997), the term ‘caring’ in nursing practice has been perceived in different ways. While many empirical studies on caring have been undertaken by nurses and researchers around the world, the concept of caring in nursing remains ambiguous (Brilowski & Wendler, 2004). Caring has been defined differently as either a technical proficiency or the nurse’s involvement in patient care as a whole.

Issues related to the job of nursing in the current study need to be taken into consideration. One of the causes of the seemingly uncaring approach of nurses is the excessive extent of nurses’ duties. The participants emphasised task achievement, admitting that they could not provide the best care for patients as they had many jobs to complete. Indonesian society’s perception of medical and nursing interventions should be considered in the present study as well. Although the present study did not explore patients’ perceptions of caring, it was identified that generally, once a patient is hospitalised, his or her expectation of receiving medical treatment outweighs the importance of nursing treatment.

In Indonesia, injections are thought, particularly by people in rural communities, to be the most powerful of health treatments. The perception of society as health service customers also has an impact on nurses’ perceptions. Nurses may merely focus on medical treatments as the patients want to be treated using a medical approach. This might therefore be one of the reasons for which nurses seem to behave in an uncaring way to family and to simply focus on performing their nursing tasks.

The problems with family as described in this study are a prime example of the difficulties that Indonesian nurses encounter in that they are caught between their Western health care education and Indonesian cultural philosophy. The nurse exists in that space between cultural upbringing and professional education. Something that may also be challenging for nurses in Western
countries who are caring for patients with a very strong community base or who have strong family backgrounds. This difficulty in Indonesia may help people from across the globe to understand the difficulties that nurses from different cultural backgrounds may have in their adopted countries. Therefore, I consider that further research should be undertaken to investigate how nurses balance nursing education with their cultural heritage.

This study concludes that nurses want to be caring but they also do not want to be caring. They want to be looking after the patient compassionately but their concentration is frequently on physical tasks. They want to be able to treat all patients the same, but in fact the shadow barriers prevent them from doing so. Once nurses have a heterogeneous group of patients often with very different expectations from the nurses’ expectations, nurses will experience clashes of culture and spirituality with their patients, and also clashes within the nurses’ culture and spirituality. This challenges nurses as individuals, when they are required to rationalise their own culture, patient culture and other cultures at the initial point of contact. This study has elaborated how nurses manage these clashes of culture: professional, patients, tribal, cultural, religious in a microcosm. The Indonesian hospital is a microcosm of clash. If we can work out how nurses can manage that microcosm of clash in somewhere so heterogeneous, this might be help us to understand how nurses across the world can manage patients who are not like them. For my postdoctoral study, I wish to explore the patients’ perspective.

8.2 Study limitations and strengths
8.2.1 Limitations of study
There are limitations to the present study related to generalisability. Sampling for this qualitative investigation was performed in both hospital and community settings in East Java Province. Although East Java is one of the largest provinces of Indonesia, with 319 public and private hospitals and 960 primary health
centres, including 504 inpatient PHCs and 456 non-inpatient primary health centres (Ministry of Health of Indonesia, 2014), it cannot be assumed that the life stories and narratives included in this study are representative of the experiences of other nurses in the country. The findings of this study may not represent the experiences of nurses from other regions or provinces as each region has its own majority and minority ethnicities, local languages, predominant religions, traditional beliefs and customs.

Another limitation of this study is that it relied solely on nurses' narratives rather than on observed nurse-patient interactions and on patients' views. It might have been useful to interview patients to gain their perspectives on caring relationships. Furthermore, in order to obtain comprehensive information, interactions between nurse and patient can be captured through direct observations.

To ensure the validity of the translations provided in a study, professional translators should be involved in the translation of all Indonesian transcripts. However, due to financial issues and time constraints, only two of Indonesian transcripts in this study were translated by external professional translators. Discussions of doubtful or unclear words and phrases were regularly held with the supervisors throughout the analysis process. The process of external checking by supervisors is essential to ensure that meaning and interpretation are appropriate (Creswell, 2007).

8.2.2 Strengths of study

The major strength of this qualitative study is that it addresses a gap in the knowledge related to caring for patients from diverse backgrounds in a heterogeneous population. This study may serve as a valuable phenomenological study to uncover nurses’ experiences of caring for culturally, religiously, and linguistically diverse patients. Most of the studies examined as part of the
literature review were conducted in multicultural populations in the sense of immigrant and minority groups. No similar studies of caring for patients from multiple indigenous populations, in which the ‘culture of clash’ is examined have been found.

Another strong point of this study is the data collection method chosen for this phenomenological inquiry. This study was conducted using individual, face-to-face interviews that generated rich data about caring in a heterogeneous population. Despite the fact that the participants were meeting me for the first time at their interviews, they shared their experiences freely over long periods of time. The interviews generally took approximately 90 minutes. The longest interview was 128 minutes. During face-to-face interviews, researchers can capture participants’ nonverbal signs and facial expressions. As underscored by Berg and Lune (2012), interviews are considered as a means of entry to capture the perceptions of respondents and to apprehend how participants give certain meanings to the phenomena or situations under investigation.

8.3 Implications and recommendations

8.3.1 Policy and practice

Data revealed in this study serve as a valuable description of what nurses’ experience when caring for diverse patients and how nurses try to overcome the various difficulties and barriers in order to perform caring activities. The findings of this study could be a valuable source for managers of hospitals and primary health centres to identify the barriers encountered by nursing staff in the provision of care. Nurse managers could use these data in both positive and negative ways. It is possible that the data could be used to performance manage nurses. However, it is hoped that the benefit of competent and caring nursing care will be realized and that data are used to evaluate and identify programmes or strategies which can support and enhance nursing staff’s caring skills.
The findings of this study can be used as a useful input for health policy makers to enhance the welfare of nurses. By focusing on the complexity of nursing work and the barriers to maintaining and managing the therapeutic encounter, health policy makers could utilise the findings of this study to evaluate the work of nurses with diverse patient populations and thus, could generate health policies that have a positive impact on both patient care and also the welfare of nurses.

8.3.2 Nurse education
This study provides a description of Indonesian nurses’ understanding of concept of caring in heterogeneous population and how they manage the caring aspects of nursing work as they care for such a diverse patient population. Richardson et al’s (2016) work on teaching caring and therapeutic nursing in the UK could act as a platform to further this current study. Results from this current study could therefore act as a foundation to develop nursing curricula that involves the caring concept in nursing education and practice. Nursing students should learn concept of caring before they practice in hospital or primary health centre.

8.3.3 Future research
Data in this present study provide evidence of the experiences of nurses in their daily work, which unveil the complexities of nursing tasks. The findings of this study could be a helpful resource to undertake similar nursing research to investigate nurses’ caring activities in other heterogeneous populations. This study also provides valuable data which could be beneficial for the development of nursing science, particularly regarding the concept of caring in nursing. Further ethnographic research could also be undertaken of nurses’ daily caring to explore the similarities and otherwise of their belief in how they practice and the realities of the performance of their nursing work. Secondly the study findings encourage further research that investigates the patients’ perspective on the nurse-patient relationship and the manner in which nurses engage in a caring or non-caring manner in heterogeneous populations.
8.4 Summary

This chapter provides the conclusion of the study. Caring has been defined in various ways by nurse participants, whether as carrying out nursing –medical interventions or as psychological support. The complexity of nursing tasks has been considered as main barrier in caring for patients from very diverse cultural background. The limitation and strengths of this study have been presented. Study implications and recommendations have been provided.

This study demonstrates a wide range of barriers which influence and shadow nurse participants in caring for patients from diverse backgrounds. Nursing workload is classified as the actual barrier. Cultural and spiritual issues are the shadow barriers. These barriers cannot be ignored in the understanding of nurses’ daily practices as they continue to affect nurses’ views towards and engagement with their patients.

Nursing workload is an actual barrier in this study. While nursing workload has long been a concern among all nurses around the world, the results of this study might further indicate that the cultural, language and spiritual backgrounds of patients can add to nursing workloads as barriers to caring for diverse patients. The findings of this study draw our attention to the importance of considering not only the adequacy of the number of nursing staff, but also patients’ linguistic, spiritual and cultural identities: nurses must make their way through these shadow barriers before they are able to do their work.

Finally, the study highlights the limitations of nurses’ understanding about their caring and compassionate engagement with patients alongside practical nursing tasks. It is possible that the nurses in this study simply did not know how to express their caring practices with the ease that they described their clinical skills. It is hoped that future studies which include observation and patient views, will capture these elements and to improve caring in the future.


Appendices
Appendix 1. Protocol of approved ethical application

Application form for ethical approval of a research project by a University Research Ethics Committee

The University Research Ethics Committees meet on a weekly basis between September and July each year. All applications must be submitted to your School/Institute Signatory by the end of June or it will not be considered until September. Please see here for the calendar of UREC meetings. The normal expectation is that your application will be reviewed in the third week after submission by the School/Institute Signatory. Please note that the School/Institute signatory process aims to take an average of 10 working days.

Guidance on completing the form
This form should be completed by the Principal Investigator(s). For student research, the Supervisor must provide guidance to the student on the application and sign off the form.
Guidance can be found by clicking on the links provided with some sections. Additionally, guidance can be found here.
The form must be completed succinctly and in plain, jargon-free English so that committee members, who may not be familiar with your academic discipline, are able to understand it.
Applicants are asked to forward all supporting papers in one document, preferably in a PDF format. Experience indicates that it is easy for separate documents to get misplaced as they are transferred from one office to another during the review process.

Submitting the form
Your form must be submitted to the UREC via your assigned School/Institute Signatory. Please see here for a list of current Signatories:

Checklist of documentation to include
Please DO NOT include CVs

☐ □ V Participant Information Sheet
☐ □ V Consent form
☐ □ Letters to gatekeepers (i.e. those from whom permission is required such as employer or data custodian) if applicable
☐ □ Questionnaire (if using)
☐ □ V Interview schedule
☐ □ Any advertisements/flyers/posters to be used
☐ □ Research Protocol (if applicable)*

*Please note: a research protocol is NOT a substitute for information provided on the UREC form. The committee will only read it when the UREC form refers to specific sections which explain, illustrate or expand on the information contained in the form. PLEASE DO NOT ATTACH GRANT PROPOSALS
Insurance Questions

Please answer the following questions. If in doubt, err on the side of caution and answer yes. If you answer yes to any of the questions below then your application, Participant Information Sheet and Consent form will be forwarded to the Insurance Office by the Research Governance, Ethics and Integrity team.

For additional guidance for completing the Insurance Questions, please see here.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
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</thead>
<tbody>
<tr>
<td>Is any part of the research, or use of the protocol, to be carried out outside the UK (including internet-based research that could include respondents from abroad)?</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>If yes</strong>, does the research also involve medical content?</td>
<td>No</td>
</tr>
<tr>
<td>Does the research involve “first into man” use of a medicinal product?</td>
<td>No</td>
</tr>
<tr>
<td>Do the research subjects deliberately include:</td>
<td></td>
</tr>
<tr>
<td>pregnant women?</td>
<td>No</td>
</tr>
<tr>
<td>children aged five or under?</td>
<td>No</td>
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<tr>
<td>adults who lack the capacity to give informed consent?</td>
<td>No</td>
</tr>
<tr>
<td>Does the research include medical intervention involving:</td>
<td></td>
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<tr>
<td>investigating a medical device?</td>
<td>No</td>
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<tr>
<td>contraception?</td>
<td>No</td>
</tr>
<tr>
<td>Is the research to be carried out by other organisations where the University is required by contract to provide insurance cover for the research if it proceeds?**</td>
<td>No</td>
</tr>
</tbody>
</table>

Signed Anisah Ardiana

Date: 24 June 2015

**If you are unclear of the responsibilities please provide any contract conditions/agreements for review.

Insurance Office approval (not required if all answers above are ‘No’)

Signed: ___________________________ Date: ___________________________
SECTION A – Administrative information

** Do you also need to obtain NHS R&D approval?
No

** If yes, have you already contacted your University sponsor regarding NHS R&D approval?
☐ Yes  ☐ No

1. **Title of the research:**
Indonesian nurses’ experiences of caring: A phenomenological study in a multicultural and multireligion country.

2. **Investigator(s)** *(nb. In the case of postgraduate student applications the supervisor is always the joint investigator):*

<table>
<thead>
<tr>
<th>Title</th>
<th>Student</th>
<th>Supervisor/Staff</th>
</tr>
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<tbody>
<tr>
<td>Surname</td>
<td>Ardiana</td>
<td>Brooks</td>
</tr>
<tr>
<td>First name</td>
<td>Anisah</td>
<td>Jane</td>
</tr>
<tr>
<td>Post</td>
<td>Postgraduate (PhD in Nursing)</td>
<td>Lecturer</td>
</tr>
<tr>
<td>Qualifications</td>
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<td>Doctor of Nursing</td>
</tr>
<tr>
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<td>School of Nursing, Midwifery and Social Work</td>
<td>School of Nursing, Midwifery and Social Work</td>
</tr>
<tr>
<td>Contact Address</td>
<td>1 Rita Avenue, Manchester M14 4HF</td>
<td></td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:anisah.ardiana@postgrad.manchester.ac.uk">anisah.ardiana@postgrad.manchester.ac.uk</a></td>
<td><a href="mailto:jane.brooks@manchester.ac.uk">jane.brooks@manchester.ac.uk</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>07448888411</td>
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3. **School contact (if applicable):** The School/Institute Signatory will receive a copy of the outcome of the ethical review. *If the School wishes anyone else to receive a copy, the relevant details should be entered here.*

   Name:
   Post:
   Email address:

4. **Is this study, or any part of this study a student project?**
   Yes, this is for the PhD project

5. **Please provide the names and email addresses of any academic staff or students involved, other than those named at 2 above:**
   Dr. Cliff Richardson, email: clifford.richardson@manchester.ac.uk

SECTION B – Details of Project

6. **When will the data collection take place?** *(If your research will be conducted outside the UK borders, please specify the duration for each country)*
   Start date: 20 September 2015
7. What is the principal research question?
The study aims to address the question of how Indonesian nurses experience caring in a multicultural-multi religion country. There are 4 objectives of the study:
1. to find out what Indonesian nurses consider caring to be
2. to explore Indonesian nurses’ experiences of caring for patients from all backgrounds.
3. to investigate nurses’ views about barriers that may emerge in caring for patients from all backgrounds.
4. to identify how Indonesian nurses to resolve the barriers in caring for patients from all backgrounds.

8. What is the academic justification for the research? (Must be in language comprehensible to a lay person)
Caring has been recognised as being the essence of nursing and the pivotal element of nursing practice (Leininger, 1988) whereby the aim is to promote human dignity (Watson, 1988). This promotion of caring in the nurse-patient relationship protects patients against ‘being reduced to the moral status of objects’ (Gadow, 1985, p. 34). Caring has several levels beyond mere concern for patients; it can be a deeply relational, spiritual, and meaningful as one engages in the lives of others (Ray, 2010). Caring, therefore, requires a personal, social, moral, and spiritual involvement of the nurse and a commitment to one’s self and other human beings (Watson, 2012).

Wikberg & Eriksson (2008) noted caring might differ across cultures and be unique to each patient depending on the culture and context. The absence of cultural, religious, and faith understandings can contribute to the unfair treatment of those who are from minority ethnic groups (Samanta, 2012). Furthermore, Cortis & Kendrick (2003) suggest that cultural awareness is of significant importance to nurses in establishing the nurse-patient relationship. This cultural and religious awareness is particularly critical in a country with a community as religiously and culturally diverse such as Indonesia.

Indonesia is the largest archipelago in the world consisting of 17,504 islands and 1128 tribes (Statistic of Indonesia, 2013). Indonesia has the national motto Bhinneka Tunggal Ika which means 'Unity in Diversity' or, 'We are of many kinds, but we are one'. The ethos of Indonesia, is that all members of the population are respected and tolerated and that the diversity of their country’s inhabitants enriches the dynamism of life (Baidhawy, 2007). However, in the past two decades, Indonesia has experienced many conflicts among religions triggered by dissatisfaction of minorities and provoked by certain social organizations in Indonesia. Nurses as members of the community might share many of the attitudes and ideologies of the communities in which they live. Indonesian nurses might encounter challenging work every day with culturally and religiously diverse
patients. So, the question arose whether the Indonesian nurses are capable of caring for patients from all backgrounds, if not, what are the challenges and what are the barriers? This may call into question the accepted stance that nurses are able to care equally with patients of all backgrounds, why should they be any different to other people?

9. Give a brief summary of the design and methodology of the planned research. It should be clear exactly what will happen to the research participant, how many times and in what order. Describe any involvement of research participants, participant groups or communities in the design of the research. (This section must be completed in language comprehensible to the lay person and should be no longer than half a page. A research protocol is NOT a substitute for information provided on the UREC form. The committee will only read it when the UREC form refers to specific sections which explain, illustrate or expand on the information contained in the form. PLEASE DO NOT ATTACH GRANT PROPOSALS)

The study will investigate the experience of caring. This study will enquire how the nurses understand the personal challenges in caring for patients from all backgrounds, how that is different, or not, from caring for their own. Qualitative approach will be employed in this study as the investigator needs a detailed perspective of the nurses’ lived experiences, in which this detail can only be gathered by talking directly with the people (Creswell, 2007).

The individual face-to-face interview will be used in this study as in phenomenological studies, the interview is the major data collection method used (Munhall, 2001). An interview is a means of entry in qualitative inquiries to capture the perceptions of respondents and to apprehend how participants give certain meanings to phenomena or situation (Berg & Lune, 2012).

The research participants will be involved three times in the study. Firstly, the participants will be invited in a face-to-face interview at the time & place will be based on the participants’ preference. It is likely that the interviews will be conducted at the end of a nurse’s work time in her/his workplace. However, If the participants prefer to be in a publicly accessible private space or in their own home, the researcher will consider a lone worker policy. Secondly, the participants will be asked to check the interview transcript to clarify or rectify the answer if needed (Chan, Fung & Chien, 2013). The transcription will be sent to the participants. Thirdly, the participants will be offered to involve in final validation, as this study employs Colaizzi’s seven steps of analysis in which the participant is involved in final validation. This step will be done by via phone calls in which the approval for validation will be obtained from the participants during interviewing. The result will be discussed whether it reflects the essence of their experience. The participants’ final validation involves taking the overall findings back to the participants for verification (Creswell, 2007) to enhance the credibility of the study.
10. **How has the scientific quality of the research been assessed?** *(Tick all that apply)*

- Internal review (e.g. involving colleagues, academic supervisor)
- Review within a multi-centre research group
- Independent external review
- Review within a commercial company
- None external to the investigator
- Other, e.g. in relation to methodological guidelines *(give details below)*

The study had been reviewed by Dr. Jane Brooks and Dr. Cliff Richardson as they are the academic supervisors of the student. The study will also be reviewed by Professor Ann Cares and Dr. Carol Bedwell as they are the assessors in the transfer report review of this study.

11.1 **Does the research involve the administration of any physically invasive procedures, physical testing or psychological intervention (apart from the administration of standard psychological tests)?**

No

If No, proceed to 11.2  If Yes, please ensure you complete Section F

11.2 **Does the research involve human blood or tissue samples? If you are unsure, please see here for guidance relating to HTA.**

No

If No, proceed to 11.3

11.3 **Does the research involve interviewing participants or focus groups?**

Yes

If No, proceed to 11.4

If Yes, please describe briefly how they will be conducted

Data will be generated by an individual interview at the place they work or other place based on the participants’ preference in order to ascertain convenient situation, comfortable conversation and to avoid any distraction. It is likely that each interview will take 1-1.5 hours. The interviews will be arranged at a time based on nurses’ preference. The interviews might be conducted at the end of a nurse’s work time. All interviews will be audio recorded. Semi-structured interviews with using open-ended questions will be employed to gather the data. The interview in this study will begin with an open-ended question “share your experience of caring for patients from all background within the past six months”.

11.4 **Does the research involve the administration of questionnaires?**

No

If No, proceed to 11.5

If Yes, please describe the process of delivery and collection

11.5 **Is statistical sampling relevant to this research?**
No, this study will employ a qualitative approach which does not require statistical consideration.

**If No, proceed to 11.6**

**If Yes, please answer the following questions:**

11.5.1 Has the protocol submitted with this application been the subject of review by a statistician independent of the research team? Select one of the following:
- [ ] Yes – copy of review enclosed
- [x] Yes
details of review available from the following individual or organisation (give contact details)
- [ ] No – justify below

11.5.2 If relevant, specify the statistical experimental design and why it was chosen.

11.6 If you are not using statistical sampling how was the number of participants decided upon?

This study will recruit a maximum of 30 nurses as samples, which are 15 from hospitals and 15 from the community. It is decided upon the length of individual interview, the process of transcribing and the process of translation as this study will employ two languages (English and Bahasa Indonesia). Each interview will take 60-90 minutes. The transcription of each interview will take 10 hours. Then it will take approximately 300 hours of the total transcription of Bahasa Indonesia. The process of translation of the transcription will take around 300 hours. It is, therefore, a maximum of 30 participants is sufficient for this study conducted by such a novice researcher.

11.7 Describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The study will involve stages of transcribing, coding and categorizing. The investigator will undertake the transcription herself to allow her to become sensitive and aware of the important issues in the data. Coding refers to labels, names or tags given to the section of data. Coding process aims to develop categories, themes, or major constructs.

As the study will be undertaken in a non-english speaking country, the process of translation and transliteration is undertaken in the data analysis. This study will employ a professional bilingual translator to assist the investigator in converting or replacing or completing the transcripts from Bahasa Indonesia into English. In the process of translation of the transcripts, the study will adopt five stages (Weeks, Swerissen, & Belfrage, 2007) involve: determination of relevance; forward translation (Bahasa Indonesia to English); backward translation (English to Bahasa Indonesia); evaluation of the translated meaning in both languages;
revisiting the whole process to get similar interpretations. In the proposed study, each transcript of the interviews conducted in Bahasa Indonesia will be translated into English. This process might be time consuming (Regmi, Naidoo, & Pilkington, 2010). However, this aims to maintain the accuracy and to ensure data is trustworthy. Regarding the utilise of a professional bilingual translator in the process of translation of the transcription, the researcher will employ a staff of the language centre of University of Jember (in Indonesia). The confidentiality will be maintained through a confidentiality agreement between the researcher and the translator for commitment to maintain the confidentiality of the transcription.

Colaizzi’s (1978) seven-step method will be utilised in data analysis. The seven steps are: reading all transcripts to acquire a feeling of them; reviewing each transcript and extracting significant statements; formulating meanings for each significant statement; organizing the formulated meanings into cluster of themes; integrating results into exhaustive description of the phenomena under study; formulating exhaustive description into statement of identification of its fundamental structure; return to participant for validation of findings (Polit & Beck, 2012; McCance & Mcilfatrick, 2008).

**Step one**, each transcript will be read several times to get a sense of the whole content. **Step two**, significant statements from each transcript that related to the phenomena under examination will be extracted. The significant statements will be put on the table of lists of significant statements. **Step three**, the meaning of each significant statement will be determined. The formulated meaning will be listed with the themes in the table (each theme will be followed by a numerical list of significant statements, including numerical of transcript, page and line of each significant statement). The whole formulated meaning with the significant statements will be checked by supervisors to ensure the process is correct and the meaning is relevant (Parse, 2001). **Step four**, the formulated meaning will be sorted into cluster of themes (category). The themes cluster then will refered back to the original written description to validate them. The possibility of contradictory themes emerged will be reevaluated. **Step five**, the significant statements, the formulated meaning and the cluster of theme will be integrated into a narrative exhaustive description. **Step six**, the fundamental structure of the concept will be described based on formulated exhaustive description. This process will also be checked by the supervisor. **Step seven**, final validation will be conducted by return to the participants with the result of analysis. It will done by via phone calls in which the approval for validation will be obtained from the participants when they perform the interview. The research findings and the result will be discussed in order to evaluate whether it reflects the essence of their experience.

12.1 What do you consider to be the main ethical issues which may arise with the proposed study?
Ethical considerations in this study will involve informed consent, anonymity and confidentiality. Regarding ethical issues in phenomenological inquiry, informed consent is an important part in the research interview (Jackson, Daly & Davidson, 2008). Informed consent refers to consent received from the participant who has received information about the research (Fontana & Frey, 2008).

Since qualitative research encompasses small sample size and rich description, it can be difficult to maintain anonymity (Holloway & Wheeler, 2002). The participant may be concerned that they can be identified. However, this study will ensure that anonymity and confidentiality are kept by using participant numbers when data are reported or published in journal papers.

Regarding the time of the interview, it may be problematic as the interviews might be conducted at the end of a nurse’s work time. Whereas, collecting high-quality qualitative data requires deep concentration and energy (Polit & Beck, 2012). The participants may be exhausted at the end of the working day.

12.2 What steps will be taken to address the issues raised in question 12.1?
The interested participants will be given at least 48 hours after they accept the Participant Information Sheet (PIS) to give a time for them to determine whether they would like to participate in the study or not. Once they agree to take part, they will be asked to sign the consent form enclosed with PIS. The researcher will explain that there is no coercion to participate, if they decide to participate, they can withdraw anytime they want without any consequence for them.

As the study will use small numbers of participants, they may be concerned that they can be identified. The participants will be informed that the anonymity will be maintained. The researcher will give code numbers to disguise the real names and identities of all participants. In addition, they will also be ensured that the head nurse will not be involved in the interview process. The consent form will be kept by the participants themselves.

The investigator will follow the nurse’s preference of the time and place for the individual interview. It is expected that the participants will feel relax and talk freely during the interview process.

12.3 What qualifications/experience do the researchers have relevant to the conducting of this research? (For details about requirements for specific types of research click here)
The researcher has undertaken M.Res units and training course relevant to the research. M.Res units include: units of Research design, qualitative research method. The training courses: an introduction to analysing qualitative interview data, an introduction to collecting qualitative interview data, research ethics application: university.
The researcher is a nurse with considerable experience in clinical nursing work as well as academia for 9 years. The researcher’s role is to teach nursing students in nursing college and supervise the students in the clinical settings. The researcher had been invited by nurse manager in some public hospitals in Jember (East Java Province) to be a facilitator in some discussion about nursing management in the hospitals. However, the nurses in these public hospitals will not be involved in the study to avoid imbalance power distribution between the researcher and the participants.

13. Has this or a similar application been previously considered by a Research Ethics Committee in the UK, the European Union or the European Economic Area?
   No
   If Yes give details of each application considered, including:
   Name of Research Ethics Committee or regulatory authority:
   Decision and date taken:
   Research ethics committee reference number:

SECTION C – Details of participants

14. How many participants will be recruited? (If there is more than one group, state how many participants will be recruited in each group. For international studies, say how many participants will be recruited in each country and in total. Please ensure you clearly state the total number of participants)
   A maximum of 30 nurses will be recruited as participants. It is anticipated that this will include 15 nurses from hospitals, and 15 nurses from the primary health centres.

15. Age range of participants:
   The participants will all be over 25 years of age as they will all have been registered nurses for at least 5 years (adult).

16. What are the principal inclusion criteria for participants? (Please justify)
   The inclusion criteria in the current study involve nurse who:
   1. Has at least five years of working experiences. A five or more years of working experience is linked to individual proficiency (Cioffi, 2005).
   2. Nurses from any area of care. The study would achieve a maximum variation through the involvement of nurses from diverse settings. Maximum variation sampling is undertaken purposefully by including subjects with diverse backgrounds. This will ensure that the study involves nurses with a relevant diversity of views and perspectives (Polit & Beck, 2004).
   3. Had cared for patient from all backgrounds within the previous six months. In accordance with the human memory limitation, Foddy (1993) noted people generally memorize satisfactory salient events up to one
year, and for unexpected salient events not more than one month. Thus, the researcher considers the past six month events are adequately memorised by nurses.

4. Able to provide informed consent

17. **What are the principal exclusion criteria for participants? (Please justify)**

The exclusion criteria in the study include:

1. Nurse apprentices
2. Nursing students
3. Nursing assistants

Nurse apprentice and nursing student are considered as nurses who have less working experience in caring for culturally and religiously diverse patients. Nursing assistants (in Indonesia) do not have a nursing education background. They graduated from senior high school. Hence, these groups will not be included in the study.

18.1 **Will the participants be from any of the following groups? (Tick all that apply)**

- Adult healthy volunteers (i.e. not under medical care for a condition which is directly relevant to the application)
- Children under 16
- Adults with learning difficulties
- Adults who have a terminal illness
- Adults with mental illness (particularly if detained under mental health legislation)
- Adults with dementia
- Adults in care homes
- Adults or children in emergency situations
- Prisoners
- Young offenders
- Those who could be considered to have a particularly dependent relationship with the researcher, e.g. students taught or examined by the researcher.
- Other vulnerable groups

**Please note:** If an adult participant is not able to give informed consent (eg through mental capacity or is unconscious) or if a prisoner or young offender is involved in health related research ethical review should be undertaken by an appropriate NHS Research Ethics Committee.

18.2 **If you will be using participants other than healthy volunteers please justify their inclusion:**
19. How will the potential participants be identified, approached and recruited? (Where research participants will be recruited via advertisement, please append a copy to this application)
Research approval from Ethical Committees of the University will be used to obtain approval from Indonesian Indonesian Nursing Ethics Committees. Letter of research permission from Indonesian Nursing Ethics Committees and the letter of approval from Ethical Committees of the University will be used to make initial contact with the directors of nursing or other relevant authority in the public hospitals and the primary health centres where the study will be conducted. This process is necessary to acquire the research approval from the settings. Once the head of nursing has given agreement, then ward nurse managers will be approached and given details of the project. The information of the potential participants will be received from ward nurse managers, however the ward nurse manager role to give the access to the nurses. When those nurse managers agree to give access to their nurses, all interested participants will then be invited in team meeting to discuss the project and hand out the Participation Information Sheets (PIS). The PIS has a contact number and anyone interested will be able to contact the researcher for more information. This will normally be more than 24 hours after contact has been made in order to give them time to consider.

20. Will individual research participants receive reimbursement of expenses or any other incentives or benefits for taking part in this research?
Yes
(If yes, indicate how much and on what basis this has been decided)
All participants will be given the equivalent of 10 GBP to compensate them for any costs associated with taking part. These costs are most likely to be travelling to and from the interview as it is unlikely that all interviews can be conducted around clinical shifts.

21. What is the expected total duration of participation in the study for each participant? For ethnographic research focussing on one or more groups rather than individual participants, indicate the approximate period of time over which research will focus on particular groups
The total duration of participation of each participant will be up to 2.5 hours, which are 1-1.5 hours of interviewing, 30 minutes to read and check his or her own interview transcript, and 30 minutes for final validation. It, thus, the participant will be aware of a significant period of time expected to participate during the research process.

22. What is the potential benefit to research participants?
The potential benefit might not be felt immediately by the participants. However, as this study will be the first research which explore the nurses’ experience in caring for patients from all backgrounds, it is expected that the nurses as participants will be aware and understanding of their own feeling towards the meaning of their lived experience. Furthermore, the study may help the policy
makers to construct a caring assessment tool based on the Indonesian nurses’ own traits as a multicultural & multi religion society. The hospitals as well as the primary health centres will be able to optimize the supporting factors and overcome the inhibiting factors in caring for patients, so that caring behavior can be implemented optimally by nurses. However, the participants will be informed that there is no guarantee that the information in the study will be utilised by the policy makers.

23. Will any benefit or assistance, which the participant would normally have access to, be withheld as part of the research?
No

SECTION D – Consent
24.1 Will informed consent be obtained from the research participants?
Yes
If Yes, give details of how consent will be obtained. Give details of your experience in taking consent and of any particular steps to provide information to participants before the study takes place eg information sheet, videos, interactive material. If participants are recruited from any of the potentially vulnerable groups listed in Question 19.1, give details of extra steps taken to assure their protection. Describe any arrangements to be made for obtaining consent from a legal representative. If consent is not to be obtained, please explain why not.

All interested participants will be invited to a nurses meeting where the purpose of the research will be described by the researcher. Participant information sheets, the personal contact sheet and consent form will be given and questions will be answered. It will be also explained that the study will only need a maximum of 5 participants for each hospital or community. The participants will be given a minimum of 48 hours to decide whether they want to take part in the study or not. If they agree to take part, they can contact the researcher to inform their agreement of participation. The participants will then be asked to sign the consent form enclosed with PIS. Then, the time and the place for the interview will be arranged based on the participants’ preference. The consent forms will be signed by both the participant and the researcher. One consent form will be kept by the participants, and one will be kept by the researcher. Through this process, the confidentiality is maintained.

24.2 Will a signed record of consent be obtained?
Yes
If not, please explain why not. Please append any consent forms to this application.

25. How long will the participant have to decide whether to take part in the research? (If less than 24 hours please justify)
The participants will have at least 48 hours to determine whether they want to participate or not in the study. They have an opportunity to ask the researcher
about the study. The researcher provides contact details in the participant information sheets.

26. What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters etc.)

As the study will be conducted in Indonesia (a non-English speaking country), the process of study will be undertaken using the national language of Indonesia (Bahasa Indonesia). The interviews will be performed using Bahasa Indonesia. Regarding the participant information sheets and the consent form, the researcher will provide two versions of language, one in English and one in Bahasa Indonesia. The study will employ a professional bilingual translator to assist the author in converting or replacing or completing the forms from English into Bahasa Indonesia. The participants will keep the Bahasa Indonesia version. The English version will be kept by the researcher in a locked office.

SECTION E – RISKS AND SAFEGUARDS

27. Activities to be undertaken (This should be in the form of a brief list, such as answering a questionnaire, being interviewed)

The activities in the study will involve interviewing

28. Where will the research/data collection take place?

The research will be undertaken in East Java Province of Indonesia in two settings, which are the hospital and the primary health centre.

29.1 What are the potential adverse effects, risks or hazards for research participants, including potential for pain, discomfort, distress, inconvenience or changes to lifestyle for research participants? Are they any greater than those that would arise from normal social interaction?

The author’s position as a nurse educator and PhD student might affect the interviewer-interviewee relationship. The participants might consider about the researcher’s evaluation of them. In a multicultural and multireligion country such as Indonesia, possible tensions may arise during the provision of nursing care for diverse patients. It may also affect nurses’ feeling in caring for these patients. The interview may lead to the participants divulging sensitive information. Discussing experiences of caring for someone from different backgrounds (culture or religion) may cause temporary discomfort such as emotional risk. The participants might feel anxiety, upset, or embarrassed associated with responding to the interview question. In addition, poor practice or racially discriminating behaviour is possible disclosed during the interview.

29.2 Could individual or group interviews/questionnaires raise any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that
criminal or other disclosures requiring action could take place during the study (e.g. in the application of screening tests for drugs)?

Yes

*If yes, provide your distress policy/give details of procedures in place to deal with these issues:*

The investigator will be careful in exploring the participants’ experiences. The interview situation will be established based on egalitarian relationship to allow the participants sharing of deeply personal thoughts and feelings (Collins, Shattell, & Thomas, 2005) without any feeling of difference. The investigator will try to show the neutral attitude and convince the participants that there are no correct answers to the questions in the interview.

The main researcher will also explain to the participants that if they raise unethical or discriminatory practices, it will be informed to the nurse manager and nursing ethical committee of the Indonesian National Nurse Association. The researcher will send a statement of poor practice of nurses to the relevant authorities. It is considered important to report such statements of poor practice as the nurse manager and nursing ethics committee of the Indonesian National Nurse Association may need to take an action regarding the nurse’s racially discriminating behaviour.

29.3 What precautions have been taken to minimise or mitigate the risks identified above?

The researcher will report any information about the research progress to the University (via the supervisors). The main researcher will also report any disclosure of poor practice or racially discriminating behaviour during the interview to the relevant manager or regulator authority.

30.1 What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience to the researchers themselves? *(If any)*

The potential risk to the researcher in the study is related to the safety in travelling and conducting the interviews as the researcher will work alone and the data will be generated from several different cities in East Java Province, Indonesia.

30.2 What precautions have been taken to minimise or mitigate the risks identified above? *(If the research means working alone in a location which is not public, semi-public or otherwise risk-free, please describe your lone worker policy or append a copy)*

The study will require travel to obtain the data from three different cities and the researcher will apply lone worker policy (see appendix 7).

31. □ √ I confirm that any adverse event requiring a radical change of method or design, or even abandonment of the research, will be reported to the Committee.
SECTION F – MEDICAL INTERVENTION
This section need only be completed by applicants whose project involves any form of medical or other therapeutic intervention or any physically invasive procedures, physical testing or psychological intervention (apart from the administration of standard psychological tests) (i.e. you answered ‘Yes’ to question 12.1)

32. Drugs and other substances to be administered (if applicable)
Indicate status, eg full product licence, CTC, CTX. Attach: evidence of status of any unlicensed product; and Martindales Pharmacopoeia details for licensed products

| DRUG | STATUS | DOSAGE/FREQUENCY/ROUTE |

33. Procedures to be undertaken
Details of any invasive procedures, and any samples or measurements to be taken. and/or any psychological tests etc. What is the experience of those administering the procedures?

34. Will any procedures which are normally undertaken be withheld?

35.1 Will the research participants’ General Practitioner be informed that they are taking part in the study?
☐ Yes ☐ No
If No, explain why not

35.2 If you answered yes to question 35.1, will permission be sought from the research participants to inform their GP before this is done?
☐ Yes ☐ No
If No, explain why not

36. What are the criteria for electively stopping research prematurely?

SECTION G – Data protection and confidentiality
37.1. Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Tick all that apply)

☐ Storage of personal data on any of the following:
  ☐ V Storage of personal data on manual files
  ☐ V Storage of personal data on laptops or other personal computers
  ☐ V Storage of personal data on University computers
  ☐ V Storage of personal data on NHS computers
  ☐ V Storage of personal data on private company computers
  ☐ V Use of audio/visual recording devices
  ☐ V Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
  ☐ V Electronic transfer by magnetic or optical media, e-mail or computer networks
  ☐ Examining of medical records by those outside the NHS, or within the NHS by those who would not normally have access
  ☐ Sharing of data with other organisations
  ☐ Export of data outside the European Union
  ☐ V Publication of direct quotations from respondents
  ☐ V Publication of data that might allow identification of individuals
37.2 Please provide details of how you plan to store and protect the study data as stated in 37.1 above.

Data such as papers and digital audio recorded materials will be stored in a locked cabinet in the researcher's office room at the School of Nursing University of Jember and the University of Manchester. Data in soft copies will be stored in the researcher's personal encrypted laptop equipped with a password. The data can be also stored in the University computer which can be only accessed with password (in the protected server from The University of Manchester). Sending data through emails between the researcher and the supervisors will not be avoided due to the long distance. Therefore, the data will be sent through The University of Manchester link as the servers is secured. Signed consent forms, the master list of subject’s names and code numbers will be stored in a locked cabinet in the researcher's office room.

38. What measures have been put in place to ensure confidentiality of personal data? Give details of what encryption or other anonymisation procedures will be used and at what stage? Note: the University requires all personal data stored electronically to be held on wholly managed University servers or to be encrypted.

The researchers will maintain the confidentiality of participants by giving no name for any participant in any written reports as a part of the study. The researcher will give numbers to disguise the real names and identities of all participants. Any information that could identify the participants will be removed. Regarding the utilise of a professional translator in the process of translation of the transcription, the confidentiality will be maintained through a confidentiality agreement between the researcher and the translator for commitment to maintain the confidentiality of the transcription.

39. Where will the analysis of the data from the study take place and by whom will it be undertaken?

The data analysis will be conducted in two places, which are in the investigator’s office in Indonesia and the University of Manchester. The data will be analysed by the chief investigator herself. However, documentation of data, method, and result will be audited by supervisors. The supervisors as peer debriefers will help the researcher to keep the researcher honest, to check the method, meaning and interpretation (Creswell, 2007).

40.1 Who will control and act as the custodian for the data? Note: for a student project this must be a supervisor or a permanent member of staff

The researcher will keep and secure all data during the PhD. It will need to pass to Dr Jane Brooks and Dr Cliff Richardson as the supervisors and the University staff members on completion of PhD.
40.2 Who will have access to the data and where are they based?
The researcher and the supervisors, in the investigator’s office in Indonesia and the University of Manchester.

40.3 Will the data be stored for use in future studies? If yes, has this been addressed in the consent process?
Yes, it has been informed in the consent process.

41. For how long will the data from the study be stored?
The digital audio recorder materials will be stored up to 1 year after the PhD project ends as the researcher might need to go back to analyse. Other data will be stored up to 5 years after the PhD project completion as the researcher need to return to the data for dissemination and future study purposes regarding nurses’ caring experience in other provinces in Indonesia.
*Note: The University requires non-medical data to be held for a minimum of 5 years and medical data to be held for a minimum of 10 years after the completion of the research. Some funding bodies require storage for longer periods.*

42. What arrangements are in place to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?
The researcher will provide contact details, including the office address (at Indonesia and Manchester), email address and phone number.

43. What arrangements are in place for monitoring the conduct of the research by parties other than the researcher?
The researcher will frequently contact the supervisors during data collection. Frequent monitoring via the University of Manchester eProg will take place during data collection. The investigator will also have regular contacts with Indonesian Nursing Ethic committee who is responsible for the administrative supervision of the research conduction in the country.
*Will a data monitoring committee be convened?*
Not relevant

SECTION H – Conflict of Interest

44.1 Will individual researchers receive any personal payment over and above normal salary and reimbursement of expenses for undertaking this research?
Yes
*If Yes, indicate how much and on what basis this has been decided:*
The researcher will receive expenses from the research funding (The Ministry of Education of Indonesia).
Amount: equivalent of 1800 GBP during data collection (four months). It is decided based on the living allowance when collect the data in the country.
44.2 Does the principal researcher or any other investigator/collaborator have any direct personal involvement (e.g. financial, share-holding, personal relationship etc.) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?
No
If Yes, give details:

45. Will the host organisation or the researcher’s department(s) or institution(s) receive any payment of benefits in excess of the costs of undertaking the research?
No
If Yes, give details:

SECTION I - Reporting Arrangements
46. How is it intended the results of the study will be reported and disseminated? (Tick as appropriate)

☐ v Peer reviewed academic journals
☐ v Book or contribution to a book
☐ v Other published outlets e.g. ESRC or Cochrane Review,
☐ v Thesis/dissertation
☐ v Conference presentation
☐ v Internal report
☐ v Other e.g. deposition in University Library

47. How will the results of research be made available to research participants and communities from which they are drawn?

☐ v Presentation to participants or relevant community group
☐ v Written feedback to research participants
☐ Other e.g. videos, interactive website

48.1 Will dissemination allow identification of individual participants?
No
If No, proceed to 49
If Yes, indicate how these individuals’ consent will be obtained:

48.2 Will dissemination involve publication of extended direct quotations from identified participants and/or distribution of audiovisual media in which identified participants play leading roles?
No
If No, proceed to 49
If Yes, indicate how the participants’ possible Intellectual Property or Performance Rights in these outputs will be negotiated. Where relevant, attach a model of the release form that will be used.

48.3 Are special arrangements needed to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants on grounds
such as libel, breach of confidence and infringement of Intellectual Property or Performance Rights?

SECTION J – Funding

49. Has external funding for the research been secured?

Yes

If Yes, give details of funding organisation(s) and amount secured and duration:

**Organisation:** Indonesian government scholarship e.g. Directorate of Higher Education, Ministry of Education, Republic of Indonesia.

**UK contact:** Indonesian Embassy 38 Grosvenor Square London W1K 2HW

Phone: 020 7499 7661/ 020 7499 766

Website: www.indonesianembassy.org.uk

Amount (£): 1800

Duration: 4 Months

SECTION K – Confirmation of Application

Note: Student applications must also be signed by their supervisor

Signature(s) of applicant(s):

Anisah Ardiana

SIGNATURE (Name in italics is sufficient) DATE

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Anisah Ardiana, Postgraduate (PhD in Nursing)

NAME AND POST OF APPLICANT (PLEASE PRINT)

Signature of supervisor (if applicable):

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SIGNATURE (Electronic signature is required) DATE

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Dr. Jane Brooks, Lecturer

NAME AND POST OF SUPERVISOR (PLEASE PRINT)
Appendix 2. Letter of Ethical approval

Ref: ethics/15344

Dr Jane Brooks
School of Nursing, Midwifery and Social Work
University Place 6.336

26th August 2015

Dear Dr Brooks

Study title: ‘Indonesian Nurses’ Experiences of Caring: A Phenomenological Study in a Multicultural and Multireligion Country’

Research Ethics Committee 6

I write to thank you and Miss Ardiana for coming to meet the Committee on 18th August 2015. I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

This approval is effective for a period of five years. If the project continues beyond that period an application for amendment must be submitted for review. Likewise, any proposed changes to the way the research is conducted must be approved via the amendment process (see below). Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. Amendments
2. Breaches and adverse events
3. Notification of Progress/End of the Study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a feedback sheet [https://survey.manchester.ac.uk/pssweb/index.php/535286/lang-en]

We hope the research goes well.

Yours sincerely,

Ms. Genevieve Pridham
Secretary to University Research Ethics Committee 2 and 6
Appendix 3. Participant information sheet (English version)

Participant Information Sheet

Indonesian nurses’ experiences of caring: A phenomenological study in a multicultural and multireligion country

You are being invited to take part in a study exploring the experiences of nurse in caring for patients with different culture and religion background.

What is the purpose of the study?
The study aims to investigate Indonesian nurses’ experience of caring in a multicultural-multi religion country. There are 4 objectives in this study:
1. to find out what Indonesian nurses consider caring to be
2. to explore Indonesian nurses’ experiences in caring for patients who have similar or different culture or religion.
3. to explore nurses’ views about barriers that may emerge in caring for patients who have similar or different ethnic or religion
4. to identify how Indonesian nurses to resolve the barriers in caring for patients who have similar or different cultures or religion

Why have I been chosen?
We are giving this letter to all nurses in this hospital/ primary health centre according to nurse manager’s information. If you have the experiences of caring for patients who have similar or different cultural or religion background with you, we would be interested in hearing from you. Even if your experiences happened a long time ago (within the past 6 month), as long as you still remember the experiences, your views and input into the project would still be very valuable.

Do I have to take part?
It is up to you to decide whether or not to take part. Even if you consent to take part, you are still free to withdraw at any time, without giving a reason. A decision to withdraw, or a decision not to take part, will not affect your career in the future.

What will happen to me if I take part?
If you agree to get involved, you will be invited to take part in individual interview. It might take 1 – 1.5 hours for interview.

What do I have to do?
Anyone interested in taking part in the research should complete contact form enclosed with this letter. You will be given 24 hours to decide whether will participate or not in this study. Then, the researcher will come back to ask your confirmation in joining the study. If you agree to participate in the study, you will
accept two written consent forms and will be asked to respond to the questions in the consent form and then to sign the forms.

**What are the possible disadvantages and risks of taking part?**
If you take part and feel uncomfortable with a particular question asked in an interview, you do not have to answer. Similarly, if you take part and wish to stop the interview at any point, simply tell the researcher and they will stop. The researcher will not be upset if you do not answer a question or choose to stop the interview early.

**What are the possible benefits of taking part?**
At the end of the study, we will have an overview about the experiences of nurse in caring for culturally and religiously diverse patients. We hope the study will help the health policy makers to construct a caring assessment tool based on the Indonesian nurses’ own traits as a multicultural & multi religion society. The hospitals as well as the primary health centres will be able to optimize the supporting factors and overcome the inhibiting factors in caring for patients, so that caring behavior can be implemented optimally by nurses. However, we cannot guarantee that health policy makers will use the information from the study.

**How long will the study last?**
The study will last for about 6 months, although your involvement will only be taking part in 1-2 interviews, each lasting for between 1 – 1.5 hour for. You will also be involved in transcription checking and final validation as verification process.

**What if something goes wrong?**
We do not anticipate that taking part in the study will cause you problems. If, however, you are unhappy with any aspect of the way that you are treated, you should inform your nurse manager or the researcher (Anisah Ardiana). Any complaint you make will be taken very seriously. If an issue arises that you do not want to raise with the research, you can inform the researcher directly or by text message (mobile number: 0+447448888411).

It is possible that the questions asked may raise issues or concerns for you. If this happens, you could ask the researcher to pass these on to the relevant person (the researcher will not tell your nurse manager about anything you have said unless you ask them to do so or unless they believe that either you or others are concern about the issues). Or you could discuss the issues or concerns with a friend or relative.

**Will my taking part in this study be kept confidential?**
All information collected about you during the research will be kept strictly confidential. Any information about you will be stored in a locked cabinet at the researcher’s office at School of Nursing University of Jember or at the University
of Manchester or on a password protected computer. We will not name anyone in reports we write as part of the study. We will give people taking part a number and remove any information that could identify them.

**What will happen to the results of the research study?**
We will write articles for nursing, medical and midwifery journals and give presentations at health-related conferences, so that others can learn from our study. We will be careful to ensure that it is not possible to identify you individually in any reports, papers or presentations. If you take part, we will send you a summary of the results when we have completed the research. The data will be stored for use in the future studies.

**Who is organising and funding the research?**
The study is funded by the Ministry of Education Republic Indonesia. The lead researcher, Anisah Ardiana, is responsible for the day-to-day conduct of the study. She can be contacted at the address above, or by email anisah.ardiana@postgrad.manchester.ac.uk or by telephone on +447448888411. Other researchers included in the project are Dr. Jane Brooks and Dr. Cliff Richardson.

**Who has reviewed the study?**
This study has been reviewed by the Research Ethics Committee of The University of Manchester.

Please feel free to discuss this information with others (e.g. your family, your colleague or your manager) before deciding whether or not to take part. You can also contact the research team directly (details above), if something is unclear. If you would like to take part, please complete the enclosed contact form and return it to the lead researcher in the prepaid envelope provided. If you agree to take part in an interview, we will contact you to arrange a time, venue and date that is best for you. The interview can take place in your work place in a nurse room.

**Thank you for taking the time to read this information.**
Appendix 4. Participant information sheet (Bahasa Indonesia version)

Lembar Informasi Partisipan

Pengalaman Perawat Indonesia: Studi Fenomenologi tentang Caring di negara Multikultural-Multiagama

Anda diundang untuk berpartisipasi dalam penelitian ini yang bertujuan mengeksplorasi pengalaman Anda dalam merawat pasien dari berbagai latar belakang budaya dan agama yang berbeda-beda. Penelitian ini merupakan bagian dari studi PhD yang dilakukan oleh peneliti. Sebelum Anda memutuskan berpartisipasi dalam penelitian ini, penting bagi Anda untuk memahami mengapa penelitian ini dilakukan dan apa yang akan dilakukan dalam penelitian ini. Luangkan waktu untuk membaca informasi berikut dengan seksama.

Siapa yang akan melakukan penelitian ini?
Penelitian ini akan dilakukan oleh Anisah Ardiana sebagai mahasiswa PhD serta peneliti utama di bawah pengawasan Dr Jane Brooks dan Dr. Cliff Richardson di the School of Nursing, Midwifery, and Social Work, The University of Manchester, Inggris.

Apa tujuan dari penelitian ini?
Penelitian ini bertujuan untuk mengidentifikasi pengalaman perawat Indonesia dalam merawat pasien di negara multikultural multi agama. Adapun 4 tujuan khusus dalam penelitian ini meliputi:
1. untuk mengetahui bagaimana perawat Indonesia mendefinisikan makna caring (merawat pasien).
2. untuk mengeksplorasi pengalaman perawat Indonesia dalam merawat pasien dari berbagai budaya dan agama, dimana pasien mungkin memiliki budaya atau agama yang sama atau berbeda dengan dirinya.
3. untuk mengeksplorasi pandangan perawat tentang hambatan yang mungkin muncul dalam merawat pasien yang memiliki agama atau budaya yang sama atau berbeda dengan dirinya.
4. untuk mengidentifikasi bagaimana perawat Indonesia mengatasi hambatan-hambatan tersebut.

Mengapa saya dipilih?
Kami memberikan surat ini ke semua perawat di Rumah Sakit/ Puskesmas ini berdasarkan persetujuan Manajer/ Pimpinan Rumah Sakit/ Puskesmas. Jika Anda memiliki pengalaman merawat pasien dari berbagai budaya dan agama, dimana pasien mungkin memiliki budaya atau agama yang sama atau berbeda dengan Anda, maka kami tertarik untuk mendengarkan pengalaman Anda tersebut.
Bahkan jika pengalaman Anda tersebut terjadi beberapa waktu yang lalu (dalam 6 bulan terakhir), selama Anda masih ingat dengan pengalaman tersebut, maka hal tersebut akan sangat berharga untuk penelitian ini.

**Apa yang akan terjadi pada saya jika saya berpartisipasi dalam penelitian ini?**
Jika Anda setuju untuk ikut serta dalam penelitian ini, Anda akan diundang untuk berpartisipasi dalam dua kegiatan yaitu wawancara selama sekitar 1-1,5 jam dan cek transkripsi Anda (hasil wawancara Anda) selama sekitar 30 menit. Dalam kegiatan wawancara tersebut, peneliti akan memberikan beberapa pertanyaan yang berhubungan dengan pengalaman Anda dalam merawat pasien dari berbagai latar belakang budaya dan agama. Proses wawancara akan direkam oleh peneliti sendiri. Anda juga akan membaca dan memeriksa transkripsi Anda (transkrip hasil wawancara) untuk memastikan bahwa peneliti tidak salah mentranskrip data wawancara Anda. Transkripsi akan dikirim kepada Anda melalui email atau pos sekitar 7 hari setelah kegiatan wawancara.

**Apakah saya harus berpartisipasi dalam penelitian ini?**
Anda bebas untuk memutuskan apakah akan berpartisipasi atau tidak berpartisipasi dalam penelitian ini. Keputusan untuk tidak berpartisipasi dalam penelitian ini, tidak akan mempengaruhi karir Anda di masa depan. Anda tidak diharuskan untuk berpartisipasi, tetapi jika Anda memutuskan untuk berpartisipasi, Anda hanya dapat menarik kembali data Anda maksimal 7 hari setelah kegiatan wawancara dilakukan. Anda diperbolehkan mundur dari penelitian ini tanpa memberikan alasan apapun.

**Apa yang harus saya lakukan jika saya ingin berpartisipasi dalam penelitian ini?**
Apakah kerugian dan risiko yang mungkin terjadi jika saya berpartisipasi dalam penelitian ini?

Apakah manfaat yang mungkin diperoleh jika saya berpartisipasi?

Berapa lama studi akan berlangsung?
Penelitian ini akan berlangsung selama sekitar 6 bulan, namun total waktu yang dibutuhkan dari anda secara keseluruhan hanya 2 jam. Pertama, Anda hanya akan mengambil bagian dalam satu wawancara, untuk antara 1 - 1,5 jam. Kedua, Anda akan diminta untuk memeriksa transkripsi Anda (transkrip wawancara) yang akan berlangsung hingga 30 menit.

Bagaimana jika terjadi sesuatu yang tidak diinginkan?
Peneliti yakin bahwa berpartisipasi dalam penelitian ini tidak akan menimbulkan masalah pada Anda. Namun, jika Anda merasa tidak puas dengan perlakuan peneliti kepada Anda, maka Anda harus memberitahu peneliti (Anisah Ardiana) melalui telepon: +44 (0) 161 306 7614 atau +62 (0) 323450 atau menulis email ke anisah.ardiana@postgrad.manchester.ac.uk. Setiap keluhan atau pertanyaan yang Anda buat akan ditangani dengan sangat serius.
Jika peneliti tidak dapat memuaskan pertanyaan atau keluhan Anda, maka Anda dapat menghubungi supervisor (pembimbing) peneliti melalui telepon atau email. Pembimbing I: Dr Jane Brooks, telepon: +44 (0) 161 306 7636, email: jane.brooks@manchester.ac.uk. Pembimbing II: Dr Cliff Richardson, telepon: +44 (0) 161 3067639, email: clifford. richardson@manchester.ac.uk. Jika Anda ingin mengajukan keluhan resmi tentang pelaksanaan penelitian, Anda dapat menghubungi Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, dengan mengirim email: research.complaints@manchester.ac.uk atau dengan menelepon 0161 275 275 2674 atau 8093.

Akankah kerahasiaan saya berpartisipasi dalam penelitian ini terjamin?
Peneliti akan menjamin kerahasiaan partisipan dengan memberikan nomor untuk menyamarkan nama asli dan identitas dari semua partisipan. Setiap informasi yang dapat mengungkap identitas peserta akan dihapus. Semua data seperti lembar consent, daftar master nama partisipan, nomor kode, transkrip wawancara, terjemahan transkripsi, dan rekaman wawancara akan disimpan dalam lemari terkunci di kantor peneliti di Prodi Ilmu Keperawatan Universitas Jember dan University of Manchester. Data berupa soft copy akan disimpan di laptop pribadi peneliti dilengkapi dengan password. Data dapat juga disimpan dalam komputer University of Manchester yang dapat diakses hanya dengan password (di server dilindungi dari The University of Manchester). Semua data dapat diakses hanya oleh peneliti dan supervisor dengan izin dari peneliti. Mengirim data melalui email antara peneliti dan supervisor tidak dapat dihindari karena jarak yang jauh. Oleh karena itu, data akan dikirim melalui The University of Manchester Link karena servernya terjamin.

Bahan rekaman wawancara akan disimpan sampai 1 tahun setelah studi PhD berakhir karena peneliti mungkin masih memerlukan data tersebut untuk proses analisis. Data lainnya akan disimpan hingga 5 tahun setelah studi PhD karena peneliti memerlukan data tersebut untuk diseminasi dan mungkin juga diperlukan untuk penelitian di masa mendatang berkaitan penganalaman caring perawat di berbagai provinsi di Indonesia. Ini akan membantu peneliti dan/ atau pembuat kebijakan untuk mengembangkan alat ukur caring berdasarkan ciri-ciri perawat Indonesia sendiri.

Apa yang akan terjadi dengan hasil penelitian ini?
Peneliti akan menuliskan artikel hasil penelitian ini pada jurnal keperawatan, medis dan kebidanan dan memberikan presentasi di konferensi yang berhubungan dengan kesehatan, sehingga orang lain dapat belajar dari penelitian ini. Peneliti akan memastikan bahwa identitas Anda tetap akan terjamin kerahasiaanunya, baik dalam setiap laporan, makalah ataupun presentasi. Jika Anda berpartisipasi dalam penelitian ini, peneliti akan mengirimkan ringkasan hasil penelitian ketika peneliti telah menyelesaikan penelitian.
Siapa yang melaksanakan dan mendanai penelitian ini?
Peneliti utama yaitu Anisah Ardiana, yang dapat dihubungi di alamat di atas, atau melalui email anisah.ardiana@postgrad.manchester.ac.uk. Peneliti lain yang termasuk dalam penelitian ini adalah Dr. Jane Brooks, email Jane.brooks@manchester.ac.uk dan Dr. Cliff Richardson, email: clifford.richardson@manchester.ac.uk. Penelitian ini didanai oleh Kementerian Riset Teknologi dan Pendidikan Tinggi (Kemristekdikti) Republik Indonesia.

Siapakah yang telah mengkaji atau mereview penelitian ini?
Penelitian ini telah direview oleh Komite Etik The University of Manchester.

Kontak untuk informasi lebih lanjut
Jika Anda memerlukan informasi lebih lanjut Anda dapat menghubungi peneliti utama (Anisah Ardiana) di the School of Nursing, Midwifery and Social Work, The University of Manchester, University Place, Oxford Road, Manchester M13 9PL phone: +44 (0)161 306 7614 atau Prodi Ilmu Keperawatan, Universitas Jember, Kampus Tegalboto Jember, telepon: +62 (0) 323450 atau email ke anisah.ardiana@postgrad.manchester.ac.uk. Rincian kontak supervisor: Dr Jane Brooks, Ruang 6.336 Jean McFarlane Building, University of Manchester, M13 9PL, telepon: +44 (0) 161 306 7636, email: jane.brooks@manchester.ac.uk dan Dr Cliff Richardson, Ruang 6.325 Jean McFarlane Building, University of Manchester, M13 9PL, telepon: +44 (0) 161 3067639, email clifford. richardson@manchester.ac.uk.


Penelitian ini telah disetujui oleh Komite Etik Penelitian the University of Manchester [Nomer Referensi: 15344]
Appendix 5. Consent form (English version)

CONSENT FORM FOR INVOLVEMENT IN THE STUDY

(To be kept in a locked cupboard by the research team)

Indonesian nurses’ experiences of caring: A phenomenological study in a multicultural and multireligion country

Please put your initials next to the statements below and then sign the bottom of the form where it says ‘name of participant’.

PLEASE RESPOND TO ALL OF THESE QUESTIONS

Please initial box

<table>
<thead>
<tr>
<th>Statement</th>
<th>Please initial box</th>
</tr>
</thead>
<tbody>
<tr>
<td>I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask a member of the research team any questions I may have about the study.</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected.</td>
<td>☐</td>
</tr>
<tr>
<td>I am aware that the interview will be tape recorded (no one else, apart from the researchers, will have access to the tapes), which will be stored in a secure location and destroyed by the researchers once the study has been written up. The data may be used also for the future studies.</td>
<td>☐</td>
</tr>
<tr>
<td>I agree to the use of my direct quotes in any reports or publications, if they are used in such a way that I will not be identified.</td>
<td>☐</td>
</tr>
<tr>
<td>I agree to participate in this study</td>
<td>☐</td>
</tr>
</tbody>
</table>

_________________________  ___________________  ___________________
Name of Participant        Signature           Date

_________________________  ___________________  ___________________
Lead Researcher            Signature           Date
You will have a copy of this form to keep. A further copy will be stored in the researcher's site file.

**Lead Researcher:** Anisah Ardiana, School of Nursing, Midwifery and Social Work, University of Manchester, University Place, Oxford Road, Manchester, M13 9PL, phone: +447448888411
### Appendix 6. Consent form (Bahasa Indonesia version)

**LEMBAR PERSETUJUAN PARTISIPASI**

Pengalaman Perawat Indonesia: Studi Fenomenologi tentang Caring di negara Multikultural-Multiagama

Jika Anda setuju untuk berpartisipasi dalam penelitian, mohon berikan tanda setelah anda membaca setiap pernyataan berikut dan bubuhkan tanda tangan Anda pada baris yang telah disediakan.

<table>
<thead>
<tr>
<th>Pernyataan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Saya menyatakan bahwa saya telah membaca Lembar Informasi Partisipan dan memiliki kesempatan untuk berfikir, bertanya kepada peneliti dan telah memperoleh jawaban yang memuaskan terkait beberapa pertanyaan yang perlu saya klarifikasi tentang penelitian ini.</td>
<td></td>
</tr>
<tr>
<td>Saya memahami bahwa keikutsertaan saya dalam penelitian ini bersifat sukarela dan tanpa merugikan diri sendiri</td>
<td></td>
</tr>
<tr>
<td>Saya menyadari bahwa wawancara akan direkam (tidak ada orang lain, selain dari para peneliti, yang akan memiliki akses ke hasil rekaman), yang akan disimpan di lokasi yang aman dan dihancurkan oleh para peneliti setelah penelitian diselesaikan karena peneliti mungkin perlu mengakses data untuk keperluan diseminasi ataupun untuk penelitian di masa mendatang.</td>
<td></td>
</tr>
<tr>
<td>Saya menyetujui penggunaan kutipan langsung saya dalam setiap laporan atau publikasi dan anonimitas saya tetap terjamin.</td>
<td></td>
</tr>
<tr>
<td>Saya setuju untuk berpartisipasi dalam penelitian ini</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nama partisipan</th>
<th>Tanda tangan</th>
<th>Tanggal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Peneliti utama</th>
<th>Tanda tangan</th>
<th>Tanggal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Appendix 7. Letter of accuracy of the translation of PIS

CERTIFICATION OF TRANSLATION ACCURACY

I, Meiga Rahmunita, a qualified translator at GET Global English Training, Indonesia, have thoroughly checked and proofread the Bahasa Indonesia translation of the Participant Information Sheet (PIS) that Miss Anisah Ardiana presented to me. After some minor corrections, I hereby certify that to the best of my knowledge and belief, the current Bahasa Indonesia version of the PIS is an accurate and complete translation of the original PIS document.

This is to certify that this document is translated from Indonesian to English.

Jember, February 30, 2010

Meiga Rahmunita, M.Pd.

Translated by Global English Training
Member of GEPKI Reg. No. 211/ER/2005
Accredited by: Domi Pendidikan Jember, East Java, Indonesia No. 56/2004/ER.216/2005
Appendix 8. Interview schedule

Indonesian nurses’ experiences of caring: A phenomenological study in a multicultural and multireligion country

Interview length: 60-90 minutes

<table>
<thead>
<tr>
<th>Introduction</th>
</tr>
</thead>
</table>
| Thank you for being willing to take part in an interview in this project. Can I first of all assure you that you, if you wish so, will remain completely anonymous and no records of the interview will be kept with your name on them.

Also I would like to ask you for permission to audio record this interview. The main reason behind this recording is to have the set of accurate data – your responses and opinions. Also it will facilitate the analysis of the date we have to conduct during the course of the project.

If you don’t have any further question I would like briefly to introduce you to the subject of this interview.

As we know that as a nurse we meet very diverse patients. We face vary of characteristic of patients. We are expected to provide a good and fair nursing care to all patients. However, we may encounter experiences in caring for patients from all backgrounds that probably need a different approach.

More precisely, this research is concerned with your perceptions and experiences in caring for these patients and some factors that might influence your caring.

<table>
<thead>
<tr>
<th>Aims</th>
<th>Question</th>
<th>Probe</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine how Indonesian nurses define caring</td>
<td>Q1: how do you define caring in associated with your profession?</td>
<td></td>
</tr>
<tr>
<td>To explore the experiences of Indonesian nurses of caring for patients from all background (with a variety)</td>
<td>Q2: share your experience of caring for patients from all backgrounds within the past six months</td>
<td>What was the experience When did the experience happen How often did the experience happen</td>
</tr>
<tr>
<td></td>
<td>Q3: How did you nurse your patients from all backgrounds?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Q4: did you provide a different approach of caring when nurse people from all backgrounds?</td>
<td>Can you explain that to me?</td>
<td></td>
</tr>
<tr>
<td>Q5: what were the challenges in working out your duties?</td>
<td>Can you please tell me more about these challenges</td>
<td></td>
</tr>
<tr>
<td>Q6: how patients respond to you when they have diverse culture and religious background?</td>
<td>How did this affect your working experiences?</td>
<td></td>
</tr>
<tr>
<td>Q7: did you encounter any barriers in caring for patients from all background within the past six months?</td>
<td>Can you explain that to me?</td>
<td></td>
</tr>
<tr>
<td>Q8: how often do the barriers emerge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9: are there any differences of barriers among patients?</td>
<td>Can you please tell me more about these differences</td>
<td></td>
</tr>
<tr>
<td>Q10: how do the barriers influence or inhibit nurses caring for patient?</td>
<td>Can you explain that to me?</td>
<td></td>
</tr>
<tr>
<td>Q11: is there any facilitators who may help you when caring for patients in these circumstances?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q12: how did you deal with the barriers?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q13: what factors might enable or disable nurses to resolve the barriers?</td>
<td>Can you please tell me more about the factors</td>
<td></td>
</tr>
</tbody>
</table>

**Closure**

I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know regarding your experiences?

Do you have any other comments about what we have discussed, or about the research as a whole?

As mentioned in PIS that the transcript of the interview will be sent to you and you can check whether your answer
need to be rectified or not and the researcher will not misinterpret the data.

You also are invited in final validation to ensure whether the result of analysis reflects the essence of your experience. Do you want to participate in final validation?

We will send you a summary of the research findings after the completion of my PhD.
Appendix 9. Confidentiality Agreement

Confidentiality Agreement

Translator

I, ______________________________ a translator, agree to maintain full confidentiality in regards to all interview transcriptions received from Anisah Ardiana related to her research study on the researcher study titled Indonesian nurses’ experiences of caring: A phenomenological study in a multicultural and multireligion country. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the translation and transliteration of interview transcriptions.
2. To not make copies of any transcription, unless specifically requested to do so by the researcher, (Anisah Ardiana).
3. To store all study-related transcriptions in a safe, secure location as long as they are in my possession.
4. To return all transcriptions to Anisah Ardiana in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Translator’s name (printed) ______________________________

Translator’s signature ______________________________

Date ______________________________
Appendix 10. Data extraction

Table 5. Data extraction of first literature review

<table>
<thead>
<tr>
<th>No</th>
<th>Author(s), Year, Country</th>
<th>Aim(s)</th>
<th>Sample characteristics and size</th>
<th>Methodology (data collection method)</th>
<th>Summary of findings (themes emerged)</th>
<th>Comments</th>
<th>Hawker’s score, range 10-40 (10 very poor; 40 good)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Jones (2008), USA</td>
<td>To investigate emergency nurses’ experiences in caring for Mexican-American patients</td>
<td>5 nurses who had cared for immigrants in the previous 2 weeks in emergency department (ED), with at least 1 year of working experience in ED</td>
<td>Phenomenological study, individual interview</td>
<td>Language barrier, Continuity of care, Limited cultural knowledge</td>
<td>The study did not involve participants in final validation, which might affect the credibility of findings; however, the study employed peer debriefing.</td>
<td>30</td>
</tr>
<tr>
<td>2.</td>
<td>Hoye and Severinsson (2008), Norway</td>
<td>To explore the perceptions of intensive care nurses’ interactions with families of patients from multicultural backgrounds</td>
<td>16 intensive care nurses who had cared for multicultural patients in the previous 3 months, with 2 years of working experience</td>
<td>Phenomenological study, Multistage focus group interview</td>
<td>Cultural diversity, Workplace stressor</td>
<td>The possible dominance of one head nurse involved in multistage focus group might have affected others’ expressions of own views.</td>
<td>30</td>
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<tr>
<td></td>
<td>Authors</td>
<td>Country</td>
<td>Aim</td>
<td>Participants and Context</td>
<td>Methodological Approach</td>
<td>Main Findings</td>
<td>Notes</td>
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<td>3.</td>
<td>McKinley and Blackford (2001), Australia</td>
<td></td>
<td>To explore cultural issues for nurses in caring for families from non-English-speaking backgrounds (NESB)</td>
<td>6 PICU (paediatric intensive care unit) nurses who had cared for NESB patients within the past 12 months, with 2 years of working experience</td>
<td>Participatory method with focus group interview</td>
<td>Structural boundaries, Controlling communication, Cultural practices in death of a child</td>
<td>As first author was also working in the PICU, the subjectivity of the author as a participant might lead the discussion in focus groups.</td>
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<tr>
<td>4.</td>
<td>Cioffi (2005), Australia</td>
<td></td>
<td>To describe nurses’ experiences of caring for culturally diverse patients</td>
<td>10 RNs who had at least 5 years of working experience with culturally diverse patients on general wards</td>
<td>Phenomenological study, individual interview</td>
<td>Acquiring cultural knowledge, Committing to culturally diverse patients, Engaging with culturally diverse patients</td>
<td>The study involved 5 of the participants in final validation, contributing to the rigour of the study</td>
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<tr>
<td>5.</td>
<td>Cioffi (2003), Australia</td>
<td></td>
<td>To describe nurses’ experiences of communication with culturally and linguistically diverse (CLD) patients in acute care settings</td>
<td>23 nurses who had at least 5 years of experience working with culturally and linguistically diverse patients</td>
<td>Phenomenological study, individual interview</td>
<td>Accessing and working with interpreters, Accessing and working with bilingual health workers, Using other strategies for communicating, Attitudes in communication</td>
<td>The study involved 9 participants in final validation, contributing to the rigour of the study</td>
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<tr>
<td>6.</td>
<td>Tuohy et al. (2008), Ireland</td>
<td></td>
<td>To explore nurses’ experiences in caring for patients of</td>
<td>7 nurses who had cared for patients of</td>
<td>Phenomenological study, Dealing with cultural issues in practice</td>
<td>Data variation not demonstrated.</td>
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<tr>
<td></td>
<td>Research Question</td>
<td>Methodology</td>
<td>Findings and Limitations</td>
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<td>7.</td>
<td>McCarthy et al. (2013), Ireland</td>
<td>To explore nurses’ experiences of communicating with people from diverse cultures</td>
<td>7 nurses who cared for people from different cultures within the previous 6 months</td>
<td>Individual semi-structured interview and one focus group interview</td>
<td>Accessing and using interpreters</td>
<td>Planning and taking action</td>
<td>The rigour of analysis was not demonstrated.</td>
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<tr>
<td>8.</td>
<td>Ekblad, Marttila, and Emilsson (2000), Sweden</td>
<td>To obtain reflections on issues among hospice staff after a 3-day seminar in multicultural end-of-life care</td>
<td>19 hospice staff worked at the hospice for 8 years and attended a 3-day seminar/training in multicultural end-of-life care</td>
<td>Qualitative, focus group interview conducted about one half-year after the seminar</td>
<td>Limited conversation (language barrier) Ways of talking (interpreter)</td>
<td>Data was elicited from one region in Ireland – data variation not demonstrated. The participants were not involved in final validation.</td>
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<td>9.</td>
<td>Lim, Downie, and Nathan (2004), Australia</td>
<td>To explore undergraduate nursing students’ perceptions of self-efficacy in caring for patients from culturally diverse backgrounds</td>
<td>109 first-year undergraduate nursing students 90 fourth-year undergraduate nursing students</td>
<td>Quantitative, cross-sectional questionnaire using the transcultural self-efficacy tool (TSET)</td>
<td>The fourth-year students’ perception was higher than the first-year students’ Score on the affective subscale was the highest</td>
<td>The lecturer being involved in supervising the completion of questionnaires might affect the findings.</td>
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<tr>
<td></td>
<td>Authors</td>
<td>Country</td>
<td>Objectives</td>
<td>Participants</td>
<td>Methodology</td>
<td>Findings</td>
<td>Adequate Sample Size and Maximum Variation Sampling was Demonstrated</td>
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<td>10</td>
<td>Ayaz, Bilgili, and Akin (2010), Turkey</td>
<td>To determine the cultural diversity that students experience when providing care for patients</td>
<td>622 senior undergraduate nursing students</td>
<td>Survey quantitative, questionnaire adopted from Transcultural Assessment Model of Giger &amp; Davidhizar</td>
<td>Differences in dialect and pronunciation Differences of language Individual traditions and customs Religious beliefs and sects</td>
<td>The study employed students from 3 universities; however, the findings cannot be generalized to the entire country.</td>
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<td>11</td>
<td>Cortis (2004), UK</td>
<td>To investigate nurses’ experiences of caring for Pakistani patients</td>
<td>30 nurses who had cared for Pakistani patients in the previous 3 months</td>
<td>Grounded theory, semi-structured interview</td>
<td>Understanding of culture and spirituality Knowledge of the Pakistani community Nursing challenges and deficits Possible explanatory factors</td>
<td>Adequate sample size and maximum variation sampling was demonstrated. The rigour of study was demonstrated.</td>
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<tr>
<td>12</td>
<td>Nielsen and Birkeland (2009), Denmark</td>
<td>To explore nurses’ experiences of caring for patients from ethnic minorities</td>
<td>Four nurses (indigenous Danish) with 5 years of working experience</td>
<td>Phenomenological study, interview and observation</td>
<td>Difficulties in communication Ethnic pain Ethnic food culture and community</td>
<td>The study involved small sample size and did not describe the characteristics of the ethnicities. Final validation was not demonstrated.</td>
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<tr>
<td>13</td>
<td>Vydelingum (2006), UK</td>
<td>To describe nurses’ experiences of caring for patients from South Asian minorities in general hospitals</td>
<td>Forty-three nurses from six medical wards</td>
<td>Qualitative (grounded theory), Focus group interview and field notes</td>
<td>Changes in services False consciousness of equity Limited cultural knowledge Victim blaming Valuing of the relatives Denial of racism</td>
<td>Adequate sample size and maximum variation sampling were demonstrated. There was no group member</td>
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<td></td>
<td>Study</td>
<td>Country</td>
<td>Objectives</td>
<td>Methodology</td>
<td>Themes</td>
<td>Rigour and reliability</td>
<td>Peer Debriefing</td>
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<td>14.</td>
<td>Debesay et al. (2014), Norway</td>
<td>Norway</td>
<td>To explore community nurses’ experiences of caring for patients from ethnic minorities</td>
<td>Phenomenological, semi-structured interview</td>
<td>Intimate care work and religious practice Conflicting beliefs about activity and rehabilitation Different ways of coping with dying Need for cultural competence training</td>
<td>The rigour of the study was achieved through participant checks and reflexivity.</td>
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<td>15.</td>
<td>Festini et al. (2009), Italy</td>
<td>Italy</td>
<td>To estimate the frequency of problems perceived by nurses in caring for immigrants</td>
<td>Quantitative, questionnaire developed by the authors with focus group discussions</td>
<td>Language barriers Different nutritional and personal hygiene customs Religious and spiritual practices</td>
<td>The validity and reliability of the developed questionnaire was not reported.</td>
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<tr>
<td>16.</td>
<td>Jirwe, Gerrish, and Emami (2010), Sweden</td>
<td>Sweden</td>
<td>To explore nursing students’ experiences of communication in cross-cultural care</td>
<td>Qualitative (framework analysis), semi-structured interviews</td>
<td>Conceptualizing cross-cultural care Problems in communication Communication strategies Factors influencing communication</td>
<td>The study emphasised challenges in cross-cultural care. Peer debriefing was performed to enhance credibility of analysis. Dependability was demonstrated.</td>
<td></td>
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<tr>
<td>No.</td>
<td>Author(s) and Year of Publication</td>
<td>Country</td>
<td>Research Purpose</td>
<td>Sample Size</td>
<td>Data Collection Method</td>
<td>Data Analysis</td>
<td>Findings and Methodological Notes</td>
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<td>17.</td>
<td>Berlin, Hylander, and Tornkvist (2008), Sweden</td>
<td>To theoretically explain the PCH nurses’ core problem of interaction with children and parents of foreign origin</td>
<td>15 PCHC (primary child health care) nurses</td>
<td>Qualitative (grounded theory), face-to-face interviews</td>
<td>PCHC nurses experience anxiety about missing children exposed to a disease due to home environment. Elucidating active (more home visits) and passive (wait and see) strategies.</td>
<td>The study employed participant checks for rigour.</td>
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<td>18.</td>
<td>Englund and Rydstrom (2015), Sweden</td>
<td>To explore nurses’ experiences of caring for non-Western immigrant patients</td>
<td>13 nurses who have more than 5 years of working experience in caring for children with asthma from immigrant families</td>
<td>Qualitative (grounded theory), interviews</td>
<td>Gender and professional issues. Impact on professional relationship. Communication challenges. Unfamiliar disease and treatment perception. Time issues.</td>
<td>The two authors participated in the entire process of the study.</td>
<td>40</td>
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</tbody>
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