Using Appreciative Inquiry on a Multicultural Nursing Unit
As a Transcultural Method for Discovering Individual Strengths and Common Values
about Caring Relationships

Lisa Kyle Miller

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Appreciative Inquiry (AI) is a relatively new but increasingly popular organizational development approach for creating positive organizational change. In this study, AI is used as the methodology to discover individual strengths and common, unifying values of caring among a diverse team of nurses caring for patients in a multicultural setting. A nursing team with a high percentage of Philippine American nurses was selected as the study population, as this group represents the majority percentage of internationally educated nurses currently practicing in the United States. Furthermore, the current nursing shortage is creating a continued demand for internationally educated nurses and there is anecdotal evidence to support the need for practical and positive strategies which promote cultural awareness and understanding. An action research study was conducted using a representative sample of thirteen nurses from one nursing unit. Key words include the following: Appreciative Inquiry, Philippine American nurses, internationally educated nurses, diversity and teamwork, nurse satisfaction linked to patient satisfaction and Culture Care.
Introduction

Experienced as a nurse and a hospital administrator for 30 years, I now work as a consultant. Two years ago, I was retained by a corporate client to assist in their celebration of National Nurses Week. The request was to develop a motivational presentation for the nurses about improving customer service. Given that it was National Nurses week, I knew I wanted to honor and celebrate the nurses versus presenting a speech about customer service. Quite by accident, I heard an interview segment on National Public Radio with the author of Letters to Sam, Daniel Gottlieb. Dr. Gottlieb, a psychologist, told a story of how two nurses in separate occasions, literally saved his life. The stories were so compelling I knew I had my answer. I would facilitate groups of storytelling among nurses. I was convinced that the inspiration and motivation for caring and compassion, what Florence Nightingale referred to as “the calling” was already evident in the personal stories each nurse has to share. From my thirty years in the field, I know that not all of us come to the profession for the same or “right” reason but we, for whatever reason, also choose to stay. During our careers there are experiences when we touch a patient or a family in a deep and meaningful way that is usually not about the technical care or clinical expertise.

Soon after hearing the interview, I had the occasion to have lunch with a consultant colleague who has a graduate degree in organizational development. She suggested that the approach I was considering was very similar to a well defined organizational development technique from Case Western Reserve referred to as Appreciative Inquiry. I briefly researched the subject and concluded that I would base my interview questions on the Appreciative Inquiry model of discovering the best in
people through a series of questions based in the past, present and future. The results were profound. Nurses from differing cultures, backgrounds, beliefs, genders, ages, disciplines all came together to share “their stories”. The sense of renewal, inspiration, connectivity and common respect for each other, and for the profession, was in a word, remarkable.

After the success of this experience, I began thinking about a problem that had been troubling me in my consulting work. I am hired to assist hospitals in improving their patient satisfaction scores by working with nurses to improve their communication and relationship abilities. Ironically, these “soft skills” are sometimes harder to teach than technical clinical skills. Adding to this complexity, is the fact that in light of the nursing shortage, many of the nurses in today’s hospitals were recruited and are foreign born and internationally trained. A majority of internationally trained nurses come from the Philippines. I have been surprised with the frequency in which I am asked by nurse executives, usually in private and behind closed doors because the issue is so culturally sensitive, to help them address communication and relationship skill problems that they believe are issues specifically associated with Philippine nurses. Several of my clients have described similar observations: formation of dominant cliques, timid or passive-aggressive forms of communication with superiors, conflict between generations of Philippine nurses (particularly in nurses trained before and after the 1980’s) and persistence of certain behaviors that often lead to patient/family misunderstandings such as speaking in their native tongue in front of patients. Nurse executives often report that communication and behavioral styles can be misperceived by patients and families as task oriented, condescending or domineering.
Without prior organizational behavior training in cultural diversity, other than my own experience as a healthcare executive, I was reluctant to take on this sensitive problem. I did not feel I had enough consultative expertise in diversity and cultural issues to adequately assist my clients. However, the positive results I experienced using the Appreciative Inquiry model were so remarkable, I felt the desire to deepen my understanding of this methodology so that I could contribute to positive solutions for an issue that remains somewhat of an “elephant in the room” in healthcare.

Statement of Problem

Judgments, assumptions and lack of cultural awareness can negatively affect both collegial teamwork and patient satisfaction. Philippine nurses represent the majority percentage of internationally trained nurses working in the United States. Clients have anecdotally reported that, in particular, they feel Philippine nurses seem to have more difficulties or lack the desire to assimilate with non Philippine nurses and professional colleagues. In addition, they have reported the communication and behavior styles of internationally trained Philippine nurses are sometimes misinterpreted by patients, families and colleagues.

Appreciative Inquiry (AI) has evolved as philosophy and a process which seeks to identify the best in individuals and organizations through a model of inquiry and discovery. Different from more typical change management techniques which focus on problem solving, this process assists organizations and individuals in finding their strengths or “positive core”. This is accomplished through a story telling methodology
which includes a series of premeditated questions for facilitating discovery of strengths (Whitney, 2003).

An AI inquiry tool is a predetermined set of questions used to facilitate the storytelling process resulting in a narrative answering of the questions from the participants. The inquiry tool includes a series of questions that contextually refer to past, present and desired future experiences.

**Purpose Statement**

The purpose of this study is to use the philosophy and techniques of AI as a method to discover individual strengths and common, unifying values of caring among a diverse team of nurses who are caring for patients in a transcultural setting. A second purpose of this study is to help this nursing team identify key characteristics of building and establishing relationships that lead to positive collegial and patient relationships. Furthermore, the purpose is to use AI as a practical and positive method to improve cultural awareness and sensitivity by identifying and focusing on existing strengths among the team members (seeing the best in people) and then enhancing those strengths through a reflective discovery and valuing storytelling process. The longer term goal for this work is to enhance communication and relationship building skills among these nurses and their colleagues so that the patient’s and their families’ experience of care is improved.
Appreciative Inquiry on a Multicultural Nursing Unit

Research Question

How does the use of Appreciative Inquiry as a practical methodology serve in identifying individual strengths and unifying values in Registered Nurses within a multicultural nursing unit? Using the theoretical perspective and methodology of AI, this study assesses the impact of using this technique as an effective method to improve cultural understanding, enhance collaboration, and improve communication and relationships skills among a diverse team of nurses which contains a high proportion of internationally educated nurses from the Philippines.
**Theoretical Rationale**

Appreciative Inquiry (AI) was conceived in 1985 by David Cooperrider from Case Western Reserve Weatherford School of Management. Cooperrider was assisted by his colleague and mentor, Dr. Suresh Srivastva, in the development of an approach to improving organizational effectiveness that differed from the preceding traditional models of problem identification and resolution.

During a management consulting assignment at the Cleveland Clinic, Cooperrider and Srivastva experimented by focusing on an analysis of factors that contributed to what was working versus what was not. The initial results were very positive. Since that time, AI has evolved as philosophy and a process which seeks to identify the best in individuals and organizations through a model of inquiry and discovery. This process assists organizations and individuals in finding their strengths or their “positive core”. This is accomplished through a story telling methodology which includes a series of premeditated questions for facilitating discovery of strengths. The questions are based contextually on the past, the present and future. A conceptual model includes the 4 D cycle surrounding the “positive core: Discovery – appreciate what was and is, Dream – what might be, Design – what should be, and Decide - what will be” (Whitney, pg 6). The AI theory posits that people and organizations have a collective wisdom and undiscovered potential waiting to be unleashed. Finally, people and organizations will readily change and grow toward a direction that is the focus of positive study and attention (Whitney, 2003).
Cooperrider defines the word Appreciative as “Ap-pre’ci-ate, v., 1. valuing; the act of recognizing the best in people or the world around us; affirming past and present strengths, successes, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems 2. To increase in value, e.g. the economy has appreciated in value. Synonyms: Valuing, Prizing, Esteeming, and Honoring.” He further defines the word Inquiry as “In-quire’ (kwir), v., 1. The act of exploration and discovery. 2. To ask questions; to be open to seeing new potentials and possibilities. Synonyms: Discovery, Search, and Systematic Exploration, Study.” (Cooperrider, 2005).

Assumptions

First, the percentage of internationally trained nurses is growing and is compounding the issues of culture clash. Second, Philippine nurses represent the majority of internationally trained nurses and therefore, this group may be a current focus of tension. Third, there are many similarities between healthcare and education as described in the examples of cultural tensions by Larson and Ovando (2004) and nursing leaders may be, like educators, ill prepared to handle the complexity of today’s diversity issues in that they do not fully appreciate the “limitations of their own logic”. Fourth, judgments and assumptions can negatively affect both teamwork and patient satisfaction. Fifth, the use of Appreciative Inquiry will be of benefit to nursing leadership in facilitating trans-cultural awareness and sensitivity, in improving teamwork, and in enhancing patient satisfaction. As Larson and Ovando state in The Color of Bureaucracy, “When our problems are multicultural, multiracial, and multieconomic; the answers are not typically within us, but between us. Hence, we need processes of inquiry that help us
to cross the many borders that have historically kept many people apart” (Larson, pg.166).

*Background and Need*

To address nursing shortages, American hospitals have heavily recruited nurses from other countries. The Philippines is the world leader in training nurses for emigration and Philippine nurses now comprise the majority of all internationally educated practicing nurses currently practicing in United States hospitals (Berg, 2004). Assimilation of these nurses into the American inpatient hospital environment is not always easy (Mills-Senn, 2005). As Zenaida Spangler reported in her landmark 1991 study of Philippine and Anglo American nurses, judgments and assumptions and a lack of cultural awareness and sensitivity can harm collegial relationships and communication, as well as, negatively affect patient satisfaction. Nursing leadership is often uncomfortable addressing such issues and are more frequently requesting consultative guidance for strategies to improve collaborative relationships and communication.
Appreciative Inquiry on a Multicultural Nursing Unit

Review of the Literature

The problem under study relates to the use of Appreciative Inquiry as a method for assisting a team of diverse nurses in discovering their best selves. By uncovering individual strengths and identifying commonalities in values, as well as, increasing cultural sensitivity and awareness, the ultimate goal of the project is to enhance the collaborative working relationships and communications among teammates and to, ultimately, improve patient satisfaction. The research strategy, therefore, includes the general topics of: Appreciative Inquiry as a theory for positive organizational change, the experience of Appreciative Inquiry in business and healthcare, the link between employee (nurse) and patient satisfaction, the growth of internationally educated nurses in the United States and cultural implications of Philippine nurses, diversity within teams and nursing models of caring.

*Appreciative Inquiry in Business and Public Service*

AI and has been implemented in a wide variety of organizations including NATO, the US Navy, the US Department of Health and Human Services, Hunter Douglass, GTE, British Airways and other major corporations (AI Commons, 2006). As a result of their work with AI, GTE won the national prize for Excellence in Practice, awarded by the American Society of Training and Development. AI has been used by organizations to improve customer service and to address multicultural issues with clients and employees. AI has also increasingly been used in public service organizations within both education and healthcare (Cooperrider, 2005; Whitney, 2003).
Appreciative Inquiry in Healthcare and Nursing

Although AI was originally conceived during a consulting project at the Cleveland Clinic, a small but growing body of literature exists regarding the use of AI in healthcare. Several of these reports are indirectly or directly devoted to the subject addressing nursing morale, team relationships, and recruitment and retention issues. In this regard, AI is utilized for identifying existing strengths and articulating a vision for the future within nursing divisions of specific organizations such as Lovelace Health Systems, University of Kentucky, and Children’s Hospital of Philadelphia. Two of the organizations, University of Kentucky and Children’s Hospital of Philadelphia have received special certification from the American Nurses Credentialing Center as a Magnet Hospital™ (Havens, 2006). Lovelace Health Systems in Albuquerque, New Mexico used AI as a process for visioning the future of their Nursing Division. The work resulted in their “Passion for Nursing” campaign which resulted in increased nursing satisfaction, recruitment and retention. Their nursing turnover rate was reduced by 13%, the nursing positions vacancy rate was reduced by 30%, nurse satisfaction survey results improved by 16% and patient satisfaction results for nursing measures rose by 20 percentile points (Wood, 2004).

A recent report (October, 2006) by Havens, Wood, and Leeman describes initial lessons learned working with nursing leaders in a six hospital project using AI in combination with other more traditional improvement strategies such as learning collaboratives and benchmarking. The purpose of the project was to improve communication and collaboration across disciplines, increase nurse involvement in
decision making and enhance cultural awareness and sensitivity. The article describes the process and structure for their AI implementation process and how they are employing the principles of AI to guide all of their improvement initiatives. The article describes anecdotal evidence of initial positive results in their efforts to improve communication, involvement in decision making and increase cultural awareness (Havens, 2006).

*Internationally Educated Nurses from the Philippines in the United States*

In order to address cyclical periods of severe nursing shortages over the past 30 years in the United States, periodic extensive recruitment of internationally educated nurses has taken place (Berg, 2004). A 2004 national sample of nurses conducted by the United States Department of Health and Human Services Bureau of Health Professionals, Health Resources and Services Administration (HRSA) estimated in their preliminary report that of the 2.9 plus million registered nurses in the United States workforce, 3.5% percent (100, 791) received their basic nursing education outside of the United States. According to this sample, the Philippines represented the majority country of origin of these internationally educated nurses. The breakdown of practicing internationally educated nurses according to country of training from the 2004 sample was as follows: Philippines (50.2%), Canada (20.2%), India (8.4%) Nigeria (2.3%), Ireland (1.5%), India (1.3%), Hong Kong (1.2%), Israel (1.0%), South Korea (1.0%), and 47 other countries (12%) (U.S. Department of health and Human Services, 2004).

Many predict the number of internationally educated nurses coming to the United States will rise in the coming years due to, in part, the current shortfall of available nurses versus the projected need. In one report, the number of internationally educated registered nurse candidates taking the National Council Licensure Examination for
Registered Nurses (NCLEX-RN®) increased by 50% from 2001 to 2002 (Crawford, 2004).

Statistical information on internationally educated nurses varies due to limitations in the national systematic collection of data (Xu, 2005). However, in two separate recent sampling procedures, the Philippines surfaced as the top exporter of nurses, as has been the case now for several decades (Crawford, 2004; Xu, 2005). The exact percentage of nurses from the Philippines representing the proportion of all international educated nurses currently practicing in the United States varies in the literature from a reported 80% in the mid eighties to more recent reports of 40% (Berg, 2004 & Xu, 2005). However, it is well understood that nurses from the Philippines continue to represent the majority of internationally educated nurses currently practicing in the United States.

Job dissatisfaction and attrition of Philippine nurses is frequently related to cultural misunderstandings among non Philippine teammates (Kinderman, 2006). Kinderman interviewed Philippine nurses who reported feelings of disrespect due to assumptions made by teammates that the education and training level of the Philippine nurses was inferior to that of American nurses. The article points out that although the Bachelor of Science in nursing program is patterned after the United States programs, Philippine nurses are not typically trained in the skills of heart/lung assessment, catheter insertion and intravenous line insertions. These skills common to United States nurses are in the Philippines, reserved for Philippine medical students. Other contradictions to normative United States training include questioning of the physicians orders, as well as, taking an active role in being accountable for decisions and providing extensive personal care to impoverished patients, due to a “cash and carry” practice of medicine. In
addition, nurse to patient ratios are lower in the Philippines making the pace and quantity of the work assignment a more difficult adjustment (Kinderman, 2006). Another article published by the Health Forum describes strategies for “avoiding a culture clash” as the number of foreign-born nurses has increased from 9 percent in the mid 1990’s to over 12% currently. This article suggests relying on veteran Philippine nurses to serve as mentors. Berg, et al, in a convenience sampling of 300 plus Philippine nurses found that job satisfaction of Philippine nurses was directly related to age; older nurses who had been in the United States longer were more satisfied. The study also confirmed that a majority of the Philippine nurses were trained in the Philippines and that the majority were educated with baccalaureate degree (Berg, 2004).

Choy (2004) describes in the history of the migration of Philippine nurses to the United States and the cultural implications of the colonization. For decades the Philippines have been the number one source of internationally educated nurses with this trend continuing into the twenty first century. The author postulates that the former colonization relationship between the United States and the Philippines, prior to their independence in 1946, created the circumstances which directly led to, what she describes as a massive drain of medical talent to the United States.

The first wave of nurses came in 1948 as part of a foreign exchange program which was designed by the United States government to “combat Soviet Propaganda during the Cold War by exposing foreigners to United States democracy.” Following WWII, a cycle of nursing shortages, converted the exchange program into a recruiting effort for United States hospitals. In 1965 the United States immigrations laws were relaxed, allowing for immigrants from the Philippines and Asian Countries to obtain
tourist visas without pre-employment arranged. Entrepreneurs in the Philippines set up multiple nursing schools, an “Americanized hospital training system, to meet the recruiting demands from the United States (Choy, 2001). Ms. Choy posits that the culture of American imperialism exists today in the reception of so many Philippine nurses into the United States workforce.

The Philippine Cultural World View as Compared to the United States

The Southeast Asian island nation of the Republic of the Philippines has a diversely rich culture which is the result of the history of indigenous peoples, coupled with a long series of political invasions, dominance, and colonial rule. Multiple ethnic and political influences have contributed to the complex culture including, Malaysia, Spain, America, Japan; all of whom left an indelible imprint on the Republic and the culture. The national language is Pilipino which is based on Tagalog, however, it is the native language for only 1/6th of the peoples of the Philippines. Although a relatively poor country the literacy rate is ninety percent. English is the language used in all formal educational instruction. It is common for business to be conducted going back and forth between Tagalog and English (Spangler, 2001; Wikipedia, 2007).

Culture has been defined by Bates and Plog as “the system of shared beliefs, values, customs, behaviors and artifacts that the members of a society use to cope with their world and with one another, and that are transmitted from generation to generation through learning” (pg.7). Nurse anthropologist, Madeleine Leininger, defines culture as “the learned, shared, and transmitted values, beliefs, norms and lifeways of a particular
culture that guides thinking, decision, and actions in patterned ways and often intergenerationally” (pg.13).

Frequent descriptions of the culture of the Philippine people derived from the literature review and from interviews include: close family ties, the importance of and obligation to the nuclear and the extended family (Ka-patiran), respect for elders and authority (Pag-galang), a desire for harmony or getting along (Pakikisama), compassion (Damayan), hospitality and food sharing, obligation through esteem and honor (Amor proprio), shame as a motivation behind behaviors (Hiya), moral debt of gratitude (Utang na Loob), conforming to social norms, creation of alliances with neighbors and helping when one is in need (Bayanihan), strong group social interaction, “one of us” (hindi ibang tao) versus “not one of us” (ibang tao) (Cantos, 1996; Pasco, 2004; Zangler, 1991).

Using anthropologist, Edward Hall’s classification of cultures based on communication, the Philippines is considered a high context culture, whereas the United States is a low context culture. High context cultures embody the following communication characteristics: the meaning of a message is contained in the context or setting, group assumes they share common meaning, prefer indirect or covert message, rely heavily on nonverbal codes, time open and flexible, commitment high, strong interpersonal bonds, distinct in-groups and out-groups. In contrast, a low context culture communication is characterized by: meaning is embedded in the words, more direct, details verbalized, reactions on the surface, flexible in-groups and out-groups, fragile interpersonal bonds, commitment low, time highly organized (Northouse, 2004).

The culture of the Philippines can further be compared to that of the United States by using anthropologist’s Geert Hofstedt’s Five Values Dimensions of Classifying
Cultures. Value One, Power Distance, refers to the socially determined equilibrium between subordinates and those in authority. Superiors are considered a special class who deserve privileges but also have the obligation to take care of less fortunate subordinates. There is a coercive and referent power base. The Philippines is considered a high power distance culture. A low power distance culture emphasizes interdependence, relies on reward, legitimate and expert power. The United States is a moderately low power distance culture. Value Two, Individualism-Collectivism, refers to the culture’s emphasis on the needs of the individual and immediate family, as in the United States, versus group identity as is valued in the Philippines. Value Three, Masculinity-Femininity, refers to the social patterns of a culture described as either masculine equaling assertive, decisive, competitive, ambitious, dominant versus feminine equaling serving, caring, intuition, interdependent, concern for the small and weak. The United States ranks higher in masculinity than the Philippines. Value Four, Uncertainty Avoidance, refers to the extent to which people feel comfortable with unstructured, unpredictable situations and the lengths they will go to avoiding ambiguity by following strict rules or believing in absolute truths. Both the United States and the Philippines rank fairly low in this value which means both cultures tend to value risk taking and are easier going than cultures that rank high. Value Five, Long term/Short term orientation, references cultures which are oriented toward a value for the past and present versus those with more future orientation. A long term oriented culture expects great sacrifice and shame can be a motivator. A short term oriented culture has an emphasis on spending versus savings and expects quick results. The Philippines is more long term oriented than the United States. (Northouse, 2004)
Managing Diverse Work Teams

According to Anderson and Collins (2004) race, class, and gender remain relevant considerations for today’s society and our institutions. They posit that race, class and gender are interconnected, serve as “structures of group opportunity, power and privilege” and form a “matrix of domination” (pg.5). They further state that “These realities exist even in an age when the dominant modes of thinking claim that they no longer matter” (pg.7). Therefore, in most of our organizations the white, male, middle class, Judeo-Christian perspective is taken for granted as normal. This perspective directly affects the ideas of what we believe to be just and right. In institutions in the United States, these assumptions and embedded patterns are taken for granted as the normative viewpoint, daily affecting the policies and operating procedures within our institutions (Anderson 2004; Larson, 2001). Speaking specifically about healthcare institutions, nurse researcher Debra Curren posits, “Given that the majority of healthcare institutions are led by predominantly Caucasian administrators, one can predict that cultural blindness, ethnocentric views, and cultural bias need to be addressed by management, human resources departments, and employees” (in Leininger, 2006; pg.162). Pre conceived assumptions and judgments can prevent us from seeing the true potential in ourselves and others and from discovering the positive center of a group, team or organization.

Current research on diversity within workgroup teams suggests that diversity can either lead to more effective teams or it can be a source of conflict. Leininger has described cultural pain as a “hurtful, offensive experience often identified in the workplace due to a lack of awareness about specific cultures” (2006, pg.161). Thompson and Gooler found
in their literature review of diversity and work teams, that diverse groups preformed better if members receive information and become knowledgeable about attitudes and beliefs of the other team members (1996).

Furthermore, the role of leadership within these diverse environments has been shown to affect the productivity and harmony of the team and there are negative implications for the weak or missing manager (Thompson & Gooler, 1996). Nurse Managers have an impact on the commitment and productivity of their work teams (Mckneese-Smith). They can actively coach and guide diverse teams to higher levels of job satisfaction which in turn leads to higher patient (customer) satisfaction (Heskett, 1994).

Nurse theorist and anthropologist, Madeleine Leininger (1991) has predicted that as societies and healthcare become more diverse, nursing administrators and nurse managers will necessitate the understanding and enlightenment of transcultural knowledge and skills. Business as usual will no longer be sufficient. Managers thinking and actions will require a change from a unicultural perspective to one that incorporates multicultural viewpoints and methods. Nurse researcher Ann Hubbert posits, “Promoting personal cultural awareness is an essential task for nurse administrators and managers. It is a wise strategy to offer healthcare members the opportunity to identify the cultures and or subcultures (e.g., ethnicities, gender age, marital status, political views, urban, rural, single parent, etc.) with which they strongly identify. Then healthcare teams will be able to discuss and share ways for understanding different client and staff cultures” (in Leininger, 2006, pg. 353).
Patient Satisfaction Linked to Employee Satisfaction

Larson describes a study by Press Ganey and Associates, a national patient satisfaction survey company, linking the positive correlation between employee satisfaction to patient satisfaction and notes this has been well recognized for many years by researchers in the industry. Furthermore, Press Ganey report that respect for differences and culture also is linked to both employee and patient satisfaction. (Larson, 2004; Press, 2002).

Patient Satisfaction Linked to Relationship with Caregiver

In the Picker Institute movie, Through the Patient’s Eyes, the narrator points out that although patients cannot readily evaluate their technical care, they can and do evaluate the way in which care is delivered. Press Ganey national patient satisfaction research shows the most important variables in positively affecting the perception of the patient and family experience often have to do more with so called “soft” skills versus technical care. For example, addressing the emotional needs associated with being in a hospital, being treated with respect and dignity, being treated as an individual not as an illness, and being included in decisions regarding their treatment are all issues which are highly correlated to positive satisfaction results. Most clinicians think they are already excellent at relationships but good patients and families report otherwise. Many clinicians focus primarily on their technical duties and forget or avoid developing the human relationship. This lack of connection often leaves the patient feeling vulnerable, disrespected and dehumanized. (The Picker Institute, 2003; Press Ganey, 2003)

Furthermore, as Irwin Press points out in his research (2002), patient satisfaction is a product of what both participants (the care recipient and the care-giver) bring to the
encounter. He describes, similarly to Leininger in her classic nursing theory of Culture Care Diversity and Universality (1991) that patient’s and their families’ perceptions of care are viewed from the filters of culture, values, experiences, hopes and expectations.

**Social Intelligence, Caring Relationships, Caring, Culture Care Theory**

Recent studies in the emerging field of social neurosciences demonstrate the desire for and the benefit of basic human connection. Social scientists research on interpersonal relationships demonstrates that humans are literally “wired to connect” (Goleman; 2006, pg. 4). Physiologist and social scientist Daniel Goleman, in his book *Social Intelligence*, reports on a new class of neuron, the spindle cell that is more abundant in the human brain than any other species and accounts for the unique human ability to make snap decisions, or what Malcolm Gladwell refers to as rapid cognition or a “blink” (2005). Gladwell notes that these rapid cognitions or snap judgments can, if we are not careful, contribute to stereotyping (2005).

Goleman also describes “mirror cells” which are brain cells that allow a human being to instantaneously sense and mirror the movement and feelings that another person is about to make. Again, this underscores the important of putting judgments and assumptions under check to avoid projecting and then receiving a negative reaction in return. Communication and customer service expert, Ron Willingham, has referred to this phenomenon as psychological reciprocity (1992). Goleman points out that mirror cells also enable human beings to feel empathy and respond compassionately. He notes that that social neuroscience is now proving what we have instinctually known; positive and caring relationships have an effect not just on our mental status but on our entire functioning body by delivering the flow of either nourishing or toxic (hormonal)
substances. What transpires between two people when they connect has the potential for either healing or hurting. This has important implications for day to day collegial relationships, as well as, clinical ramifications for the relationship between the care giver and care recipient. Goleman further notes the ease and rapidity with which our brains intertwine and “emotions spread like a virus” (pg. 12).

Goleman also discusses the human capacity for empathy and compassion. He states, “Empathy plays a pivotal role in caregiving, which after all centers on responding to the needs of others versus self” (pg. 215). He references the work of social scientist Mario Mikulincer’s 2005 findings that the degree to which an individual has a strong sense of security is directly linked to that individual’s capacity for compassion. Goleman notes, “Feeling cared for frees us to care for others and when we don’t feel cared for, we can’t care nearly so well” (pg.214).

To the non medical person, a “caring” relationship established between the caregiver and the care recipient may seem entirely essential and routinely understood by healthcare providers, most especially nursing. However, several decades of a focus on cost cutting and business efficiencies within healthcare organizations and an emphasis on high technology skills within nursing education curriculum have, until recently, diminished the importance of these so called “soft skills” at the bedside. The tide is turning within the last decade as there has been a tremendous increase in the priority organizations give to their patient satisfaction results, due in part to the transparent nature of the data. State and national hospital comparison data is now readily available to the public. Initially organizations focused more on customer service tactics and strategies comparable to other industries. Only more recently has the importance of establishing
the basic human connection between the care giver and the care recipient re-emerge as a critical skill. Patient satisfaction consulting firms such as Sage Consulting (First Touch), The Studor Group, Integrity Services, and Creative Health Care Management emphasize social, communication, and relationship skills in their organizational change efforts and focus on the essential role of the caring relationship between the care provider and the patient (2007). Nursing theorist and anthropologist Madeleine Leininger defines care as the essence of nursing and recently stated “nurses are learning that care is more than doing or performing physical action tasks. Care has cultural and symbolic meanings such as care as protection, care as respect, and care as presence”. (2006, pg. 12)

While several Nursing Theories of Care have been described from the 1950’s through the 1980’s to current e.g. Leininger, Watson, Swanson and others (Koloroutis, 2006) knowledge of these theories until recently has remained primarily within the domain of nursing education and is apparently, not widely understood or integrated into the everyday practice of the working nurse manager or staff nurse. An in depth discussion of the various Care Theories is beyond the scope of this paper. However, a brief explanation of Madeleine Leininger’s Culture Care Diversity and Universality Theory and her Sunrise Enabler model is warranted. As previously stated Leininger is an anthropologist and a nurse theorist and the founder of transcultural nursing in the 1950’s. She asserts that caring is the “essence of nursing” and “is the central and unifying domain for the body of knowledge and practices in nursing” (Leininger 2006, pg. 3). She states that “there can be no curing without caring” (2006 pg.18). Furthermore, she maintains that human caring is a universal phenomenon, but the expressions, processes, and patterns vary among cultures. She synthesized the two constructs of care and culture into
what she calls Culture Care; which has now become a significant theory in nursing. To promote nursing research on improving care to patients/clients of specific cultures she developed an original and specific qualitative form of research called Ethnonursing. To aid in this research method she also developed the Sunrise Enabler/Model which observes that human beings cannot be viewed as separate from their cultural background and social structures and that “care is predicted to be embedded in culture” (Cohen, 1991; Leininger, 2006, pg.3). The model depicts the various factors predicted to have an influence on culture care expressions, patterns and practices. She further maintains that once transcultural information is known and acknowledged, there are three theoretically care decision and action modes that can take place: culture care reservation/maintenance, culture care accommodation/negotiation, and culture care repatterning/restructuring (pg. 25).

Using Leininger’s ethnonursing methodology Leininger and other transcultural nursing researchers have identified both universal and diversity themes. Hubbert summarizes the twelve universal care constructs as reported from an analysis by Leininger (ordered by priority): respect for or about; concern for or about; attention to, helping, assisting, and facilitative acts; active listening; giving presence, (being physically present); understanding cultural beliefs, values, lifeways; being connected to or showing relatedness: protection of or for; touching; providing comfort measures: and showing filial love (in Leininger, 2006 pg. 354).

Nurse researcher, Zenaida Spangler used the Leininger ethnonursing methodology in the first ever research study of transcultural care givers (Leininger, 1991, 2006). She compared a group of Philippine and Anglo-American hospital nurses and
their care practices. She identified four diversity themes and two universal themes. Diversity theme one was that Anglo American nurse’s care “is characterized by promotion of autonomous care based on informed decision making and control of situations” (in Leininger, 1991; pg. 131). Consistent with the American value for individualism, Anglo American nurses stressed value for: patient education, patient independence and self care, patient compliance with healthcare regime and having control of changing medical situations and conditions, to “be on top of things” (pg.133). Diversity theme two was that “Philippine nurse’s care is characterized by ‘obligation to care’ based on the care values of physical comfort, respect and patience” (pg. 133). Consistent with the Philippine value for obligation to serve and respect, Philippine nurses emphasized conscience, duty and commitment. They highly valued attention to physical comfort as a method to establish an empathetic, sensitive connection. Diversity theme three was that “Cultural differences between Anglo-American and Philippine nurses generated nurse-to-nurse conflicts.” Issues that generated conflict were associated with the areas of language, communication differences, interaction and relational behavior differences and lifestyle differences (pg. 135). Diversity theme four was “Philippine nurses worked to achieve care congruence with Anglo-American nurses through cultural care preservation, accommodation, and repatterning” (pg. 137). Philippine nurses preserved their cultural values related to caregiving practices of comfort and maintaining relationships but accommodated by learning American technology, policies and procedures. Over time, they repatterned some of their values such as deference to authority. Spangler also identified two universal themes or themes common to both Philippine nurses as well as the Anglo nurses. The two themes were: a nursing shortage
led to frustrations over a heavy workload leading to an inability to provide ideal nursing care and institutional cultural norms and standards heavily influenced caregiving practices (Spangler, 1991).

**Summary of Major Themes**

Extensive recruitment of internationally educated nurses has been employed as one of many strategies to reduce a cyclical pattern of nursing shortages. A growing portion of the United States nursing workforce is internationally educated with nurses from the Philippines representing the largest majority. Job dissatisfaction and attrition of Philippine nurses is frequently related to cultural misunderstandings. Sharing of knowledge about transcultural differences and similarities among diverse members of a team enhances the cohesiveness of the team and strengthens collegial relationships. Managers have an important impact on establishing and environment for such cohesiveness and in turn, the productivity of diverse teams. Employee satisfaction is a predictor of patient satisfaction. The care giver/patient relationship has the biggest impact on overall patient satisfaction results. The emerging field of neurosocial sciences shows that people are hard wired to connect or to form relationships and emotional caring can affect the biology of healing. The human capacity for empathy and compassion is enhanced by an individual’s sense of security. Feeling cared for allows one to care more freely for others. Universal transcultural concepts of caring include being respected, being culturally understood, being listened to, being present for, assisting, helping, touching, being connected and showing relatedness. These concepts have implications for both the care recipient and for the care giver from colleagues and supervisors.
Compared to other methods of organizational change which are problem identification and resolution focused, AI is focused on identifying existing strengths (seeing the best in people). Furthermore, the AI process focuses on enhancing those strengths through a reflective discovery and valuing story telling method. There is an emerging body of literature suggesting the use of AI for organizational change has had positive results in business, military, education, service organizations. Some recent data exists on the use of AI in the healthcare setting and at the nursing care delivery level. AI has been successfully used by organizations to improve customer service and to address multicultural issues with clients and employees.

*How Present Study Extends Knowledge on the Topic*

There is much in the literature describing the increasingly diverse healthcare workforce and suggesting the need for increased cultural awareness and collaboration. Only recently, however, has information been reported to guide nursing leadership and staff in implementing strategies to accomplish this goal. In particular, given the high percentage of international trained nurses from the Philippines actively practicing in the United States, there is only one study which addresses the culture and caring practices of this group. This study will extend the current limited research on the topic of Philippine nurses practicing in the United States. It will present new research on Appreciative Inquiry as a practical, positive, and respectful method in which to work with a diverse multicultural nursing team in discovering individual as well as collective values, strengths, diversities and commonalities.
Appreciative Inquiry has been emerging as an organizational development theory for twenty years. Although, there is sufficient literature suggesting success in business, there is a limited historical body of scholarly literature on use of this technique in healthcare. There are reports of growing excitement for its use within healthcare but most studies of actual implementation are reported only recently. Most of the reports are related to nursing with only a few involving other disciplines such as medical schools, a cancer clinic, and a long term care facility. The majority of the nursing articles are descriptive of efforts to affect positive change in enhancing nursing image, communication, and collaboration as a way of addressing recruitment and retention strategies. There is one study of a hospital with measurable improvements in patient and nurse satisfaction. A large scale study of a six hospital system reported as recently as October 2006 has as objectives the improvement of cultural awareness and patient satisfaction. However, the report is currently limited to a discussion of planning and implementation of the AI process. Measures of success are anecdotal and preliminary.

While consideration of cultural implications of patients is well known to practicing nurse leaders and nurses, the cultural implications of the care givers are not widely understood or addressed. Furthermore, the body of information regarding Philippine nurses, the majority of internationally educated nurses, is sparse. Only one 1991 comparison study of Philippine and Anglo American nurses exists. Recent literature is emerging regarding the role of the nurse administrator in the increasingly
multicultural healthcare setting. To date, this literature appears to be not commonly well known.

*Implications for Future Research*

Although research is emerging, there is a need for additional qualitative and quantitative research on the long term impact of Appreciative Inquiry in Healthcare organizational change. Furthermore, as the numbers of internationally educated nurses working in American hospitals increases, continued research on the impact of transcultural issues is warranted.

*Overall Significance of the Literature*

There is ample evidence in the literature to suggest that Appreciative Inquiry is an effective organizational development technique to build and enhance collaborative relationships among cultural diverse teams. The growing body of AI work in healthcare also suggests this model is effective in enhancing nurse patient relationships. Although sparse, the literature on culturally sensitive issues specifically related to international trained Philippine nurses, suggests that cultural misunderstandings do exist and contribute to nurse and patient dissatisfaction. Current literature suggests a direct link between employee satisfaction and patient satisfaction. Recent studies in the field of social sciences demonstrate the desire for and benefit of intimacy of human relationships between the receiver of care and the caregiver. Theories of nursing care suggest that care is the essence of nursing and that care includes both technical and relationship skills and knowledge. There is ample evidence in the literature that the healthcare environment is
Appreciative Inquiry on a Multicultural Nursing Unit 34

and will increasingly be diverse. Transcultural nursing research provides ample evidence for the important implication of cultural diversities and universalities on care giver to care recipient relationships, as well as relationships among care givers. Only one comparison study exists of Philippine and Anglo American nurses cultural caring values but demonstrated diversities which led to cultural conflict affecting team and patient relationships. Literature on diverse teams suggests that the more knowledgeable team members are about cultural differences and similarities, the less conflict occurs and the more productive a team can be. The literature also suggests that managers and leaders have a significant impact on the cohesiveness and productivity of diverse teams.
Setting, Site and Sample

The setting and site for this 2007 study was a 200 bed inner city campus of a multi-hospital system which is located within a large urban area. This particular campus primarily serves a low income Latino and African American patient population. The nursing unit under study was a general medical surgical floor with a group of 25 core Registered Nurses and was selected by the former Director of Nursing, in part due to low patient satisfaction scores. This nursing team was also selected because it comprised a large proportion of internationally educated nurses, of whom the majority (>95%), were from the Philippines. During the study several internal and external organizational circumstances occurred: due to low patient census two unit staffs combined into this unit, the Director of Nursing resigned and was replaced by an interim Director (who also agreed with the former Director’s selection for the study site), the hospital underwent an unannounced accreditation survey by the Joint Commission Accreditation of Healthcare Organizations, as well as a California Nurses Association strike and work stoppage, and the news media reported conflicts between the city officials and the hospital ownership organization regarding the future of the local entity.

A convenience sample included thirteen out of forty-five registered nurses, 28 % of the unit’s registered nursing core staff. Participants were from the day and evening shifts. The sample was highly representative of the cultural composition of the study unit. All participants were recruited and subsequently volunteered to be interviewed as part of this research project.
Access and Permissions

Access and permissions were obtained from the appropriate executives including the Chief Nursing Officer of the Medical Center, the Director of Nursing at the local site, the replacement Interim Director of Nursing and the unit Nurse Manager. Individual participants were afforded the opportunity to willingly take part in the study and were provided with information about the study prior to the interview. An informed consent, approved by The Dominican University of California’s Institutional Review Board, was provided to and collected from each of the willing participants. Appropriate measures were provided and taken to assure and protect the participant’s confidentiality including but not limited to disidentifying participants in this paper.

Design and Data Gathering Strategies

An action research study using a convenience sampling of 12 nurses was conducted. The participants voluntarily took part in an AI inquiry process conducted by this researcher. Although group and individual interviews were originally planned as part of the study, a group interview did not take place due to the external constraints placed on the unit and organization during the study time period. All interviews occurred individually, in a private setting and at the convenience of the interviewee. Demographic characteristics of each participant were obtained as part of the private interview. Information on the non participants was obtained from interviews with the Nurses Manager. A semi-structured AI inquiry tool was used (Appendix A) and included predetermined questions used to facilitate the story telling process. The story telling resulted in narrative answering of the questions from the participants. Notes from these interviews and the inquiry process were taken and transcribed by this researcher.
Data Analysis Approach

A qualitative method of analysis was utilized. The participant demographic information is presented in descriptive statistics. Notes from the interviews were transcribed into a narrative for qualitative analysis. A full follow-up intervention survey was unable to be completed due to a nursing strike and therefore, was limited to a three verbal questions asked of each nurse immediately following the interview questions.

Ethical Standards

This study adheres to Ethical Standards in human Subjects Research of the American Psychological Association (Publication Manual of the American Psychological Association, 2007). Additionally, the project was reviewed and approved by the Dominican University of California Institutional Review Board, number 6004.
Results/Findings

The term “Philippine” will be respectfully used throughout the remainder of this paper as a universal descriptor representing both female and male participants from the Philippines.

I met with each of the thirteen volunteer registered nurse participants in a private room located on the nursing unit from approximately forty-five minutes to one hour each. After introducing myself, I thanked each participant for agreeing to take part in the study. I explained that I was a master’s degree candidate at the Dominican University and that I was interested in the organization development method of Appreciative Inquiry. I briefly explained what the philosophy of the method was about; “appreciative”, meaning to value and “inquiry” to discover the best in themselves and the world around them. I told them that I would be using this method as an interview style to discover/uncover individual strengths and look at common values of caring and establishing relationships within a diverse setting. I explained that I am interested in interviewing representatives from all cultures and background on this unit but I am also focusing on nurses from a Philippine background, as they comprise a large proportion of internationally educated nurses in this country. I told them that I thought they would find the interview to be a pleasant and non-threatening experience and that it would take approximately thirty to forty-five minutes, depending on the length of their responses. I also told them that if they needed leave at any point they could and that they were not obligated to answer any question that they felt uncomfortable answering.

I then began with the following demographic questions:
1. Where were you born and raised? Do you mind if I ask you how old you are?

2. What is the story of why you chose to become a nurse?

3. Where did you do your training?

4. How many years have you been a nurse?

5. Tell me the story of how you came to this hospital.

6. How long have you worked here?

All the participants readily answered all of the questions. The individual results are summarized in the table below. The age of the participants ranged from 24 to 58 years old with an average age of 38. Five of the participants were in their fifties, one was 43, three in the thirties, and three in their twenties. Nine participants described themselves as Philippine, two as Middle Eastern, and two as Caucasian. Two of the nurses born in the Philippines were raised in the United States, although one of those returned to the Philippines for her nursing education. One of the Middle Eastern nurses was born and raised in the United States by first generation Middle Eastern emigrants. Seven out of the nine Philippine nurses were BSN educated and two with associate degrees in nursing. Of the two Philippine nurses with associate degrees in nursing, one was also an MD and the other had a BS in finance. Two nurses were diploma graduates, one Middle Eastern trained and one American trained. One nurse with an unrelated bachelor’s degree received her Masters in Nursing from a bridge program. Nine out of the thirteen stated that they did not choose nursing as their first choice in a career. Most of the Philippine nurses further stated that they became nurses due to parental decision or strong direction but had chosen to stay as they had grown to love the profession. The
number of years as a registered nurse ranged from less than one year to thirty-six years. Five nurses had greater than 25 years of experience, two had ten years or greater of experience, two had five years or greater and three had one year or less of experience as a registered nurse. Four out of the thirteen were referred to the hospital by friends or family, three through an Internet ad, one from attending a job fair, one from a Philippine recruiter, one was sponsored by the Site hospital, one attended the hospital’s nursing school, one through a local newspaper ad and one was a traveling nurse who stayed. The range of years worked at the current institution was from over thirty years to one month, four of whom had worked there for over twenty-five years, two under seven years and six had worked at the institutions one year or less.

<table>
<thead>
<tr>
<th>#</th>
<th>Born/Raised/Ethnicity</th>
<th>Age</th>
<th>M/F</th>
<th>Nsg 1st Choice</th>
<th>Highest Level of Education</th>
<th>Yrs as Nurse</th>
<th>How Came to this Hospital</th>
<th>Years Worked at Site</th>
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<tbody>
<tr>
<td>1</td>
<td>Philippines/Asian</td>
<td>35</td>
<td>M</td>
<td>No</td>
<td>BSN</td>
<td>10</td>
<td>Internet</td>
<td>&lt;1 yr</td>
</tr>
<tr>
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<td>43</td>
<td>F</td>
<td>No</td>
<td>BSN</td>
<td>11</td>
<td>Job Fair</td>
<td>1 yr</td>
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<tr>
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<td>57</td>
<td>F</td>
<td>Yes</td>
<td>BSN</td>
<td>36</td>
<td>Friends</td>
<td>&gt;30 yr</td>
</tr>
<tr>
<td>4</td>
<td>Jordan/Middle Eastern</td>
<td>53</td>
<td>F</td>
<td>No</td>
<td>Diploma</td>
<td>30</td>
<td>Friend</td>
<td>26 yr</td>
</tr>
<tr>
<td>5</td>
<td>Philippines/Asian</td>
<td>53</td>
<td>M</td>
<td>No</td>
<td>MD + Associate Degree in Nursing</td>
<td>5</td>
<td>Family</td>
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<tr>
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<td>50</td>
<td>F</td>
<td>No</td>
<td>Diploma</td>
<td>26</td>
<td>Local Ad</td>
<td>10 yr</td>
</tr>
<tr>
<td>7</td>
<td>Philippines/Asian</td>
<td>26</td>
<td>F</td>
<td>No</td>
<td>BSN</td>
<td>&lt;1 year</td>
<td>Traveler</td>
<td>&lt;1 yr</td>
</tr>
<tr>
<td>8</td>
<td>Philippines/raised United States/Asian</td>
<td>27</td>
<td>M</td>
<td>No</td>
<td>BS Bus. Adm. + Associate Degree Nursing</td>
<td>&lt;1 year</td>
<td>Vacation/Internet</td>
<td>&lt;1 yr</td>
</tr>
<tr>
<td>9</td>
<td>United States/Caucasian</td>
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<td>F</td>
<td>No</td>
<td>Diploma</td>
<td>30</td>
<td>Attended the Nsg School</td>
<td>30 yr</td>
</tr>
<tr>
<td>10</td>
<td>Philippines/raised Hong Kong &amp; United States/Asian</td>
<td>24</td>
<td>F</td>
<td>Yes</td>
<td>BSN</td>
<td>&lt;1 year</td>
<td>Family member</td>
<td>&lt;1 yr</td>
</tr>
<tr>
<td>11</td>
<td>United States/ Middle Eastern</td>
<td>34</td>
<td>F</td>
<td>No</td>
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<td>Internet</td>
<td>&lt;1 yr</td>
</tr>
<tr>
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<td>F</td>
<td>Yes</td>
<td>BSN</td>
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<td>&gt;30 yr</td>
</tr>
<tr>
<td>13</td>
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<td>F</td>
<td>No</td>
<td>BSN</td>
<td>7</td>
<td>U.S. Hospital Sponsored</td>
<td>7 yr</td>
</tr>
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</table>
Following the completion of the above demographic questions, I then proceeded with informing the participants that I was starting the Appreciative Inquiry portion of the interview. I reminded them that this Appreciative Inquiry process would have taken place in a group setting, however due to the current situational issues; we would be proceeding with these individual interviews as an adaptation. I took notes throughout the session which I transcribed shortly thereafter. I had some difficulty in understanding one of the interview subjects due to a heavy accent. Although arrangements had been made with the Charge Nurse to cover their patient assignments, several of the participants were restless at first, warning me that they did not have much time to spend. As we moved through the process, they became increasingly relaxed and became unaware of the passing time. They appeared pleased that someone was taking the time to hear their story and were very eager to share their experiences and opinions. Most of the interviews lasted over the predicted thirty minutes and stretched to forty-five minutes to an hour. Several of the stories brought forth a strong emotional response with a few participants becoming teary.

Appreciative Inquiry Part One:
Honoring Similarities and Differences, Values of Self and Culture

I began Part One of the with the following Appreciative Inquiry introductory, provocative statement. “We know in our hearts and minds that life can be more meaningful when we establish great relationships with people. So let’s begin with talking a little bit about valuing and honoring ourselves and then about valuing similarities and differences with colleagues we work with. With out being humble or feeling that you are
When asked what they most valued about themselves, almost all of the participants answered the question primarily in the context of the work setting. Several of the Philippine nurses described themselves in direct relation to their patient caring practices. For example, “I treat my patients like family”, “I am empathetic to the patient’s needs,” “I find gratification in helping others”. Values of patience, honesty, integrity, trustworthiness, hard work and being a team player were also described. Two of the second generation Philippine nurses valued their sense of humor and their ability to get along in a diverse environment. Several of the older nurses from all of the cultures specifically mentioned that, as they have aged, they value about themselves the ability to “speak up”. Although only one nurse directly mentioned valuing higher education during the values question, the Philippine nurses referenced their BSN status with pride. The non Philippine nurses, trained in diploma programs, when questioned about returning to school responded with lack of interest and with comments such as “What for, I am too old.” The only master’s prepared nurse interviewed was second generation Middle Eastern descent. When asked about what they value about their culture, all eight of the Philippines mentioned strong family relationships. Several also mentioned how a in the Philippine culture a relative always stays with the patient. This theme resurfaced several times throughout the rest of the interview. Also mentioned were the cultural values of modesty, patience and a desire for harmony. A male participant said, “Philippines . . . we have this obsession with maintaining harmony, to a fault. Sometimes I think we even lie to hide our feelings.” The Philippine nurses also frequently spoke of a responsibility to
watch out for each other “We take care of each other . . . we are brothers/sisters, best friends.” Almost all of the Philippine nurses at some point during the inquiry session spoke of a strong obligation of respect toward their elders and those in authority. Both of the Middle Eastern nurses mentioned they valued the strong commitment to family and the discipline of their “strict” Christian religion. Hard work and organization were values prized by the two Anglo nurses. One of the Anglo nurses, also identified her culture as Latin/Jewish, valued her close family relationships.

I then asked the question, “How do you bring the best of those values, yours and those of your culture, to your daily professional life.” The responses to this question were quite individual and varied. A younger first generation Philippine male nurse replied “Since we are dealing with a very diverse population of patients it is important to be patient because you can encounter rude people from all walks of life”. An older, seasoned Philippine nurse responded, “You can bring the best out in people by acknowledging them and valuing them. You respect that person and tell them we need you to build our team so all of our work will be easier”. An older, seasoned Middle Eastern nurse replied with firmness, “I bring these values. God creates you to have a brain and use your brain wisely.” A younger nurse born in the Philippines and raised in the United States stated, “At work, dealing with a patient I do not consider their social class or standing. I encourage patients to verbalize their feelings and I try to be good listener.” I asked her what are the key things she does to contribute to being a good listener and she replied, “I sit down, give them eye contact and give them caring touch.”

I then moved into the Appreciate Inquiry set of questions aimed at finding out about their opinions and experiences working with people from diverse cultural
backgrounds. I began with a general question reflecting on both past and present, “Could you please tell me what you have learned, either growing up in your family or from your own life experiences that makes it easy for you to get to know and work with people from cultural backgrounds different from your own?” Again the answers were varied but several of the younger nurses or nurses who were raised in the United States credited being routinely exposed to diversity in the large metropolitan cities in which they grew up and did their schooling. A young, second generation male Philippine nurse stated, “I get along very well with all different kinds of people. I got accustomed to that growing up in a big city. I think exposure is the key. I had a lot of exposure to lots of kinds of people. I don’t have a judgmental attitude. I might ask a question of someone that might seem intrusive but to me, I am just trying to get to know them personally.” The older nurses from all the representative cultures credited their natural curiosity to learn about others. However, the first generation Philippine nurses appeared to be more comfortable with a less directive questioning approach as demonstrated by the following statements, “With people from another culture, I am very cautious at first. I think of how to approach this person. When we are eating, I will find out something about them and start a rapport. I will think to myself, ‘What’s the best way to get to know her?’ I don’t want to invade on someone’s privacy. I ask general questions and build trust. I volunteer myself like that I have children, etc.” Two older nurses, one Philippine and one Middle Eastern, answered simply about colleagues from different cultures, “We are all the same underneath.” Two other nurses mentioned humor as a method to ease into relationships.

I then asked the participants to think back to a specific time and describe an experience when they made a point of getting to know a colleague from another culture. I
asked them how they made that connection and if it changed how they originally saw that person. In general, the participants did not answer the question directly with a specific example and of a specific individual. Only two responded with a story about a particular individual and both examples ended in a slightly negative experience. Some of the general responses from the first generation Philippine nurses included, “Many of the nurses were African American and not very friendly to me. I made a big effort to try to fit in”, “When I come here I have culture shock, the way of living . . . very fast paced and have to wake up early. I try to be friendly, to treat them with respect”. Another non-Philippine nurse said, “I have a friend she is American. She is very nice but she worries too much about going by the book. Americans worry too much about this. For example, the patient wants to do something, he can walk, talk, do everything but because he is on bed rest he does nothing. I watched the patient, I review the chart. I’m busy; I can’t always call the doctor. In my culture we use our brains and don’t always have to go just by the book.”

Moving onto another Appreciative Inquiry reflecting on a past experience, I began with the question, “Think back over your adult life and think of a person for whom you had a great deal of respect but didn’t always agree with. How did you communicate the disagreement and how did you maintain respect for each other?” Again, very few specific experiences describing specific individuals were discussed although two mentioned disagreements with doctors as a category versus a specific person. Most of the responses were general and described behaviors that participants see themselves demonstrating. In general, the behaviors described by the Philippine nurses, including the second generation Philippines, reflected more non-confrontational terms versus the non
Philippines who described comfort with more directive behaviors. For example, a second generation Philippine nurse responded, “I appreciate what the colleague is saying and I try to explain in a non offending way what I am thinking. I acknowledge what they are saying. There is a difference in nurses trained here in the United States and those trained in the Philippines, like my sister. Those trained here have more theoretical knowledge and those trained in the Philippines are better at skills like I.V.’s. I tend to be left behind a little there but I am proud of my theoretical knowledge as it gives me a better understanding of what is going on with the patients.” Another said, “If I disagree, I would examine myself then I would tell the doctor if the patient really needed it. Then I would go to my supervisor.” An Anglo nurse recounted the following experience, “I had a friend at work. He blew up. I let him have his say. I like to get things out. I didn’t let it interfere with our relationship. We got back on track.” A non Philippine internationally trained nurse said, “I try to convince and explain. I will not get into an argument or bad temperament if I know it’s a limited mind.”

Appreciative Inquiry Part Two: Enhancing Relationships with Our Patients and Their Families

Transitioning to Part Two of the Appreciative Inquiry process, which dealt more specifically with the subject of enhancing relationships with patients and their families, I began with by stating, “Now, let’s talk a little bit about enhancing relationships with patients and families. Again, we know that life and work has more meaning we establish great relationships with people. So, without being humble or feeling like you are bragging, could you please tell me about a time when you were very proud of a great
relationship, a human connection that you made with a patient or a family member? How did you make that connection and how did it make you feel?”

With the exception of one nurse, who spoke only in generalities, all of the participants readily responded to this prompt with very detailed stories describing their experience and feelings about making a particularly close human connection with a patient or family member. The stories were told in great detail and with obvious passion. Several became teary during the telling. Throughout all of the stories of these nurses seeing themselves at their best, a pattern of common values and characteristics was described including: empathy, patience, lack of or putting aside judgments and assumptions, respect for the patient as an individual, listening, taking time, caring touch and cultural sensitivity.

A first generation seasoned Philippine nurse told the following story. “There is this patient, he is African American. He is always very angry and sometimes very mean. He is an above the knee bilateral amputee. I can understand; he has lost so much. It’s his way of saying ‘I am a human being. I am here and I matter.’ He’s very aggressive and demanding . . . ‘I want this right away’. I think he’s trying to say, ‘I am a human being and you have to acknowledge that I am here’. I always put myself in his shoes that I don’t want people to bush me off and treat me as if I’m not there; that I don’t exist. If your ego, your pride, your self esteem is very low, you feel sorry for your self and become aggressive. I put these thoughts in my head and I give him allowances as long as he doesn’t cross the line. Sometimes I have to say I’m sorry and put boundaries because he can be manipulative. He will throw all the utensils on the floor. I will tell him it’s not acceptable. Recently, I went in and sat down with him and just talked to him. He was
very touched and later he apologized to me. He had something in him . . . he became very apologetic of his behavior and said to me ‘I was disrespectful. I will try and be less imposing on you. I will be more patient.’ He had tears in his eyes. It made me feel very good that I could make such a connection with him.”

A young Philippine born/United States raised, nurse told a story about a connection he made with a patient and a family member. “I had a patient with end-stage AIDS. He was really demented. He had a nice family; a wife and kids. Because he was so demented, he was yelling and cursing at his wife and kids. All the visitors to this patient, were really suffering, especially his thirteen year old daughter. She was so hurt and was crying because of all the things he was yelling. But one day when I was caring for him, he was pretty clear for a few moments and he said to me – ‘Look out there at my daughter, isn’t she beautiful? And she is so smart.’ Later I took his daughter aside and explained how the disease had affected her father’s mental status but I also told her what he had just said to me. She just started crying, happy crying and hugged me and thanked me so much for telling her this. It made me feel really grateful that I was able to make a difference for her that may affect the way she feels her whole life.”

Three additional examples from first generation Philippine nurses included, “Two weeks ago I had an older patient who had birthday on the day that I was caring for her. I asked her, ‘Can I have permission to hug you?’ She said yes and I hugged her. It touched her very much. I further asked her what was her wish for her birthday. She said that she wished for ice chips and a room with a window. I worked very hard with the charge nurse to make this happen. We transferred her and she was so happy. It made me feel good.” And another nurse’s story was as follows, “When I make my rounds I talk to
the patients and ask them questions about themselves. For example, I had a patient and I talked to her and found out that she was very fond of gardening. ‘Do you like roses?’ I asked her. She said that she did and we shared all the names of the types of roses that we both liked. The next day I gave her some roses. She was so pleased. Her relatives wrote a letter to the Big Bosses to tell them about how pleased they were with her care and mentioned me. I felt happy they were so pleased.” A final example, “There was this young patient. She had been very ill and was technically very difficult to care for. She had a bad infection and required an amputation. She was not satisfied at all with how she was being cared. She had lots of friends who were nurses who started visiting, inspecting and checking up on the nurses here. Most of the nurses were responding to this negatively. I had her as a patient six months into her illness. I asked one of her friends, ‘What do you know that I don’t know, how to help me help her?’ She told me that she was able to calm her with alternative medicine. So one day, I asked the patient to tell me about a picture of an Indian Guru she had. We talked about these things. I seemed to be the first one who asked her about these things. I saw a person striving to be respected for who she was. She thought she was being blamed for her own illness. I asked another patient who was a bilateral amputee to come and visit her and he did. I showed interest and jumped in. Although our patients can be very demanding here sometimes, it is gratifying and I receive great satisfaction from the personal relationships that I develop.”

A second generation of Middle Eastern nurse told a story about a special connection she made with a patient who was Samoan. “There was a patient at the Clinic who was pregnant and a newly diagnosed diabetic. She was labeled by the other nurses as non compliant. One of the medical assistants was Samoan and he told me he thought
she did not understand things. So I had him come with me to translate for her. I went
over again all the diabetes education and instruction. Lots of things came out. I asked her
if she was depressed. She said yes. So I asked her if she had ever thought of hurting
herself and she said yes. I called psych and she was treated for depression. I saw her
further along in her pregnancy and I would always take time for her and get her
translation if she needed it. She brought her baby to show me after she delivered. She
was so proud and happy and she hugged me. It was so touching.”

As previously mentioned, only one of the thirteen nurses, a non Philippine did not
respond to the prompt with a story describing an individual connection with a patient or a
family. The response was, “In general, I make relationships with every patient. During
my rounds and when I give medications . . . if they have the same mind. It depends on
the patients. Not all the patients I talk to I like. For example Mr. ----- I know he is a
patient but I disrespect him. I will be responsible for him and I will be calm in my mind
but I disrespect him.”

The next Affirmative Inquiry question was, “Could you describe for me a time
when you felt you did a great job caring for and getting to know a patient from a culture
other than your own?” Most of the nurses pointed out that the stories they had just
recounted were with patients and families who were not from their cultures. A few added
additional comments or told a story. For example, “I think the story I just told illustrated
how I connect with patients from other cultures, but the other day I went to do a blood
draw on a patient. He had been on the unit for three hours and everyone spoke English to
him. He was not an English speaker; he was a Spanish speaker. They also had told me
he was Mexican. He was not. He was from El Salvador. That is wrong and hurtful to
make those assumptions.” Another offered a general comment, “I am at my best when I am with someone of a different culture. I have a curiosity for other people and cultures. I read a lot. I enjoy knowing. I tap into that curiosity. I convince myself, ‘Wouldn’t you like to know what is making the person the way they are?’

I then asked a summarizing and reinforcing question for this section of the inquiry, “What do you think it is about you that makes it possible for you to establish great relationships with people, especially those you serve? The following statements represent the answers from each of the twelve respondents: “I offer myself to the patient.”; “We work as a team, like family.”; “I feel so good, thank God that everything went smoothly for the patient.”; “I am empathetic to the patient’s needs.”; “I am curious, I show interest and jump in.”; “I am approachable and I spend time with them.”; “I really try to give one hundred percent, I try to slow down, listen and give them respect.”; “I am respectful, I try to be kind and considerate, to put myself in their shoes.” “I include everyone and interact so they feel welcome.” “I know what it’s like to be a patient, I hold those experiences with me and I want to be different.”; “I try to put myself in their shoes because they are sick and we should be understanding. I have been a patient and I know what a kind touch and caring mean.”

The final series of questions were positioned in accordance with the Appreciative Inquiry method so that each respondent would end the session energized to envision a more valued future. “We are coming to the end of the interview process but I would like to close with having some fun and asking you to hope and dream a bit. If you could have three wishes to enhance all the relationship you encounter here at work, what would those wishes be? I will ask you in five categories: patients, families, colleagues, supervisors,
and physicians. Let’s start with patients and if you can’t think of three wishes, just start with one.”

The Philippine nurses wishes for the patients were described in altruistic, empathetic and in two responses, slightly self effacing terms, such as, “I wish I could speak better English for the patients” and “I wish I will have more energy to give to my patients.”. The two Anglo nurses expressed the desires for the patients to be more respectful of the nurses and to have better listening skills. To enhance relationships with the families, eleven out of 12 participants wished the families would be more involved. Two of the nurses mentioned that they wished their colleagues would be more patient, friendlier and inclusive with the families.

Regarding wishes for colleagues, in general the Philippine nurses felt good about their relationships with their team members, however, the younger Philippine nurses and all but one of the non Philippine nurses expressed a desire for more inclusiveness among the group. Three nurses wished for respectful communication among colleagues, as well as being more respectful of each nurse’s individualistic styles. A younger second generation Philippine nurse commented, “I wish for communication with respect. Realize that everyone has their own style and don’t step on their toes. Make kinder suggestions, especially the older Philippine nurses.” Five respondents, both Philippine and not, mentioned that they wished there would be a concerted effort to speak English, as opposed to Tagalog, especially during end of shift report. The end of shift report surfaced as a subject for improvement several times by both Philippine and non Philippine nurses alike. They described their current process with words such as “unorganized, hectic, loud, and unprofessional”. One nurse, alluding to the uncertain
status of the hospital, mentioned a wish that the nurses would not have to be fearful for their jobs. A strong universal theme was a desire by the nurses to understand and be understood without judgment and assumptions as evidenced by such comments as “I wish they could know the real person underneath”, “I wish they knew my heart” I wish they could see beneath the brown skin,” “I wish the older nurses treated me with more respect and recognize everyone’s style is different”, “I wish I could speak better English so I could express myself and be better understood by others”, “I wish I had a friend I could trust”. A minor theme emerged from the non Philippine nurses in a desire for greater alliances or belonging within the larger group.

In speaking of wishes for their supervisors there was no difference between the Philippine and non Philippine nurse’s responses. Most of the nurses wanted the relationship to remain respectful with a common pattern of wishes mentioned by several of the respondents: “calm and respectful communication”, “more available and more hands on”, and “really listening to what we need, following up and fixing little things”.

A distinct pattern appeared among all the respondents regarding wishes for enhanced relationships with the physicians. Most desired that the relationships remain as they currently are which was described most commonly as collaborative. One physician’s name was specifically mentioned five times as an example of what they wished all the physicians would be like. Words they used to describe his behaviors were “approachable, collegial, mutual respect, inclusive, stand out, collaborative, available, and gives good explanations.”

The session was closed with the thanking the participants for their time and telling them that it had been a pleasure to interview them. I reiterated that due to the Joint
Commission survey and the nursing strike that the procedures for the study had changed
and that we would not be coming together right away for group reflection and workshop,
as had been planned but that I would gather the collective themes and would attempt to
convene them together at some point for story sharing, discussion and next steps. They
all expressed interest in reconvening, with the exception of one nurse who was
transferring to another hospital and one nurse who stated that she would be retiring at the
end of the month.

Finally, I asked each participant to evaluate the Appreciative Inquiry process by
the following questions: “Did you feel honored and valued through the inquiry process?”
“Did you feel that the questions were respectful and non-threatening?”, “Did you enjoy
the process?” “Would you be willing to participate in a follow-up group activity to
discuss the collective meaning from the interviews?” All of the participants responded
“yes” to all four of the questions and those who would be remaining on the unit were
enthusiastic about reconvening and sharing as a group.

Conclusions/Implications

In the middle of another cyclical nursing shortage, numbers of internationally
trained nurses immigrating to and practicing in the United States are increasing. While
numbers from India, Africa and Europe are on the rise, the Philippines remain the number
one exporter of internationally educated nurses. The current nursing shortage and the
increasing diversity of the general population of the United States, increases the
likelihood that nursing teams will continue to grow in diversity and include growing
numbers of internationally educated nurses. While consideration of cultural implications
of patients is well known to practicing nurse leaders and nurses, the cultural implications of the care givers has not been widely studied and is not generally understood or addressed.

Current research on diversity within workgroup teams, suggest that diversity can lead to more effective teams or it can be a source of conflict. The role of leadership within these diverse environments has been shown to have an effect on the productivity and harmony of the team. Transcultural implications of patients are well recognized in the nursing literature, theory and in practice, however, research regarding the cultural implications of the caregiver is sparse and seemingly not well known to practicing nursing administrators, managers or staff. Currently, Philippine nurses comprise the majority of internationally educated nurses and while issues of cultural conflict appear occasionally in trade journals, only one research study has discussed the implications of the Philippine nurse cultural considerations. There are anecdotal reports of culture clash existing between cultures of nurses, as well as, patient/family complaints of misinterpretations and miscommunications. Common perceptions and some misperceptions about this cultural group exist within some nursing leadership groups and these leaders admit to not being prepared to handle conflict associated with diversity issues.

Appreciative Inquiry represents an effective and practical method in which a diverse group of nurses can, through a simple and non-threatening process of narrative story telling, see themselves and others at their best, identify their own individual strengths and discover among their diverse colleagues universal values for establishing and maintaining caring relationships with patients, families and colleagues. AI is an
organizational development method that is adaptable and relatively simple to conduct. Due to a variety of internal and external organizational challenges a planned group Appreciative Inquiry process was modified. One on one interviews with a collective meaning making process served as a valuable AI adaptation.

The convenience sample studied included thirteen registered nurses from one inpatient medical surgical unit whose multicultural work team included a high percentage of international educated nurses from the Philippines. Although the sample was small, it was highly representative of the current distribution of the larger work group including a range of additional variables such as age, gender and years of nursing experience. It is my belief that a larger sample, although desirable, would have yielded similar results.

The interviews were beneficial in identifying similarities and differences in individual and cultural values and caring practices among a diverse nursing team. The individual participants stated they gained benefits and insights from the interviews, although I believe small group facilitation would have had a more robust effect in discovery of differences, similarities and collaborative meaning making of the stories within the context of a diverse team.

Several themes, both diverse and common, emerged among the group. Common themes of cultural and caring values that emerged among the Philippine nurses were compassion, humility, patience, strong family ties and are consistent with Spangler’s 1991 study results. Also consistent with Spangler’s results, were the themes among the Anglo nurses (also seen in the Middle Eastern nurses) of promoting patient independence and value for patient education. Common values shared among the Philippine and Middle Eastern nurses were close family ties, discipline, respect for elders and authority
and an obligation to care for patients. Anglo and Middle Eastern nurses were expressed values of order and organization, being able to speak up, being skilled at technical and clinical care, patient independence and patient education. Two of the older more experienced Philippine nurses also mentioned placing a high value on technical experience and patient independence in care, a finding consistent with Leininger’s (1991, 2006) predictions for cultural adaptation of caring practices.

Consistent with Leininger’s culture care constructs and universal themes, all cultures placed a high value on and a desire for respect in communication, even though the definition of respect may have varied. In general the Philippine nurses preferred a less direct, confrontational form of communication especially during disagreement. They described less directive methods of persuasion such as being “playful”, using humor, coaxing, story telling and giving examples. Preserving ones professional dignity or avoiding being shamed in front of colleagues and patients was described as an important value by several of the Philippine nurses. This value was also referenced indirectly by two of the more senior nurses, one Anglo and one Philippine, as in “not eating the young”, being supportive and encouraging of the less experienced nurses. The Philippine nurses also placed value on hospitality, harmony and getting along within the team.

A strong universal theme was a desire by the nurses to understand and be understood without judgment and assumptions as evidenced by such comments as “I wish they could know the real person underneath”, “I wish they knew my heart” I wish they could see beneath the brown skin,” “I wish the older nurses treated me with more respect and recognize everyone’s style is different”, “I wish I could speak better English so I could express myself and be better understood by others”, “I wish I had a friend I could
trust”. A minor but important theme emerged from the non Philippine nurses in a desire for greater alliances or belonging within the larger group.

Finally, although the majority of the nurses did not select nursing as their first choice profession, all commented that they had grown to love and value the profession as a way to maintain financial independence and as a way to make a difference and have meaningful work.

The principles and methods of AI are easily understood and could be taught to existing members of a diverse work team. AI serves as an excellent method to identify and address sensitive issues in a non threatening way. Although the study design required modifications due to multiple external and internal circumstances, beneficial information was exchanged and will be eventually shared with the broader work group. In addition, ideas emerged from the interviews which highlight opportunities to enhance understanding of each other, team cohesiveness, leadership behaviors, staff nurse job satisfaction, team productivity and patient satisfaction.

Although some information about cultural implications of internationally educated nurses exists, it is seemingly unknown to many practicing nurse administrators and managers. Lack of cultural awareness may unknowingly promote stereotypical thinking and may limit the perspective of leadership in today’s healthcare institutions. Just as countries have a predominant culture, so does an organization. An organization’s culture is affected by the attitudes and beliefs of its leadership. Executive nurse leader’s attitudes, beliefs and values have an effect on nurse managers, and, in turn, these managers have an important impact on the commitment and productivity of their work teams. With transcultural knowledge, nurse managers can actively coach, mentor and
guide diverse teams to higher levels of job satisfaction, which can, in turn, lead to higher patient and customer satisfaction.

An understanding of the differences and similarities of cultural values and caring practices among a diverse team of nurses is essential to the building of a cohesive team. Certain behaviors are associated with establishing a “caring” human connection and are universal to most cultures. Tapping into and reinforcing these empathetic, healing behaviors and actions, can enhance the human connection and improve relationships among patients, families and colleagues alike in the highly diverse, challenging but rewarding environment of this inner city hospital.

Finally, from my studies, readings and through my applied research, I have come to believe that to truly understand people’s behavior, one must understand their culture. Appreciative Inquiry is a practical and respectful method for doing so.
References


Appendix A

Demographic Interview:
Nurse’s background:

1. Where were you born and raised?
2. What is the story of why you chose to become a nurse?
3. What is your age?
4. Where did you do your training?
5. How many years now have you been in the profession of nursing?
6. Tell me the story of how you came to this hospital?
7. How long have you worked here?

Using Appreciative Inquiry to Discover Individual Strengths and Common Values of Caring Among Members of a Multicultural Nursing Unit

Appreciative Inquiry Guide

Thank you so much for agreeing to participate in this project. As you know, I am a Masters candidate at Dominican University. I am interested in an organizational development method called Appreciative Inquiry; “appreciative”, meaning to value and “inquiry” to discover. I will be using this method as an interview style to discover/uncover individual strengths and look at common values of caring and establishing relationships within a diverse setting. I am interested in interviewing representatives from all cultures and background on this unit but I am also focusing on
nurses from a Philippine background, as they comprise a large proportion of internationally educated nurses in this country. I think you will find this interview will be fun and non-threatening. It will take about 30 minutes. Are you ready?

I have few quick demographic questions to ask you first before we start the Appreciative Inquiry part of this process. If there are any questions that you feel uncomfortable answering, you can just feel free to pass. Okay, let’s get started.

1. Where were you born and raised? Do you mind if I ask you how old you are?
2. What is the story of why you chose to become a nurse?
3. Where did you do your training?
4. How many years have you been a nurse?
5. Tell me the story of how you came to this hospital?
6. How long have you worked here?

Appreciative Interview Part One and Two:

Now we are moving into the Appreciative Inquiry portion of this interview. There are two parts but they both deal with establishing great relationships. We know in our hearts that life has more meaning when we establish great relationships with people. So let’s begin with talking a little bit about valuing and honoring similarities and differences among the colleagues we work with.
1. Without feeling you are bragging, without being humble please describe for me what you value the most about yourself and then about your culture. Let’s start with your self.

2. How about your culture?

3. How have you brought the best of these values (yours and your culture) to your daily professional life?

4. Could you please tell me what have you learned, either growing up in your family or from your own life experiences that makes it easy for you to get to know and work with people from cultural backgrounds different from your own?

5. Can you tell me about a time when you made it a point to get to know a colleague from a culture other than your own? How did you make the connection? Did it change how you originally saw that person?

6. Think back over your adult life and think of a person for whom you had a great deal of respect but didn’t always agree with. How did you communicate the disagreement and how did you maintain respect for each other.

Now let’s talk a little bit about Enhancing Relationships with Patients and Families:

7. Again, without being humble or feeling like you are bragging, could you please tell me about a time when your were very proud of a great relationship, a human connection, that you made with a patient and or a family member

8. Could you describe for me a time when you felt you did a great job caring for and getting to know a patient from a culture other than your own?
9. What do you think it is about you that makes it possible for you to establish
great relationships with people --- especially those you serve?

We are coming to the end of the interview but I would like to close with having
some fun and asking you to hope and dream a bit. If you could have three wishes to
enhance all the relationships you encounter here at work, what would those wishes be? I
will ask you in five categories: patients, families, colleagues, supervisors, and physicians.
Let’s start with patients (if you can’t think of three wishes, just start with one).

Patients:
Families:
Colleagues:
Supervisors:
Physicians:

Thank you so much. It has been a sincere pleasure to talk with you. I very much admire
the work you do here at xxxx hospital.

Follow-up Workshop Outline: (deferred)

• The power of initiating a real human interpersonal connection

• Understanding the concept and power of psychological reciprocity and the
dangers of judgments and assumptions
• Developing deep listening skills

• Communicating with body language and tone of voice

• The role of caring touch in a therapeutic, healing environment

• The role of culturally sensitive caring

• Establishing and maintaining trust and loyalty
Appendix B

Consent to Be a Research Subject

Purpose and Background:

Lisa K. Miller, R.N., a graduate student in the School of Education at Dominican University of California, is conducting a research study designed. The researcher is interested in using an Appreciate Inquiry process to enhance relationship and communication skills in a multicultural setting with patients, their families and each other.

I am being asked to participate because I am a nurse on a unit with a high percentage of foreign born or trained nurses and our unit delivers care to a highly diverse population of patients.

Procedures:

If I agree to be a participant in this study, the following will happen:

1. I will participate in four parts of this project.

   Part 1 includes a one on one interview process, which will include a few demographic questions about my country of birth and nursing training and then a series of questions about my thoughts and opinions on valuing similarities and differences among nurses in a multicultural setting.

   Part 2 includes a paired (or small group) interview about establishing great relationships with patients and families concluding with a collating process of the groups’ collective wisdom.

   Part 3 includes an interactive workshop on enhancing communication and relationship skills based, in part, on the collation of collective wisdom process (as above).

   Part 4 includes a questionnaire about my opinions of the Appreciative Inquiry and workshop process.

2. I understand that I will not be anonymous to the researcher and to the other participants in the workshop, but that my confidentiality has been assured in the final report.

3. I will be allowed to view the final version of this project. Such results may not be available for six months.

4. I will be allowed to read the “participants’ bill of rights” document before giving consent.
5. I understand that data will be reported in summary form, and all personally identifying information will be deleted. After the thesis is accepted I understand that all data will be destroyed.

Risks and/or Discomforts:
1. I understand that my participation involves no physical risk.
2. I may elect to stop the interview at any time and may refuse to participate in any part of the project before or after the study is started without experiencing any adverse effects.

Benefits:
There may or may not be direct benefits to me from participating in this study. The anticipated benefit of this study is a better understanding of communication and relationship building skills.

Questions:
I have talked to Lisa Miller, R.N. about this study and have had my questions answered. If I have further questions about the study, I may call Lisa Miller or the research supervisor Dr. Madalienne Peters, School of Education, Dominican University of California, (415) 485-3285.

If I have any questions or comments about participation in this study, I should talk first, with the researcher and the research supervisor. If for some reason I do not wish to do this, I may contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with the protection of volunteers in research projects. I may reach the IRBPHS Office by calling (415) 257-0168 and leaving a voicemail message, by FAX at (415) 458-3755 or by writing to the IRBPHS, Office of the Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901.

Consent: I have been given a copy of this consent form, signed and dated, to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study or withdraw my participation at any time without fear of adverse consequences.

My signature below indicates that I agree to participate in this study.

SUBJECT’S SIGNATURE DATE
______________________________________  __________

SIGNATURE OF RESEARCHER DATE
______________________________________  __________