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Beyond the Anger and Lack of Communication: Strategies for Managing Intercultural Conflicts Between Italian Nurses and Patients. A Phenomenological-Hermeneutic Study

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Abstract
The aim of the paper is to explore cultural conflicts between nurses and clients with different cultural backgrounds, in order to identify the main factors that facilitate or hinder the effective management of those conflicts. Phenomenological-hermeneutic method was used to study sixteen semi-structured interviews at nurses. Intercultural conflicts are perceived as rare and underestimated, sometimes like a "conspiracy of silence". A combination of personal and organizational factors related to both parties involved emerges as a cause of failure of conflict management. Vice versa, mutual openness to the other, transparent and accountable use of linguistic and cultural mediation, a good ability to manage prejudices and emotions and desire to find a common solution are considered the right way for effective management of cultural conflicts. The first cause of conflict is the lack of elaboration of cultural differences. Intercultural competence can help nurse in processing these situations. This paper encourage the surfacing and the professional management of intercultural conflict situations.

1. Background

A cultural conflict is referred to assistance procedures deemed unnecessary and/or worrying and/or dangerous by one or the other protagonist, as they fail in meeting the other's cultural expectations, as well as her/his beliefs, values or lifestyles [1, p. 65].

We can be broadly grouped the possible causes of intercultural conflict in nursing practice into three interconnected and overlapped categories [2, 3]. *Linguistic incomprehension* is the most important cause of intercultural conflicts [4, 5], and can

lead to a wrong nursing diagnosis, to inappropriate care for the patient or to waste resources [6, 7]. Lack of communication can lead to cultural conflicts when, for example, it prevents the patient from expressing his/her ideas, his/her concerns about a certain nursing procedure [8]. Instead, for nurses, lack of communication is often emotionally important and can result into a sense of frustration, discomfort [9], desire to escape from the clinical situation [10], and to the extreme decision of abandoning the profession [11]. These linguistic difficulties cannot always be solved with the help of a professional translator, whom usefulness is controversial. Some authors consider it necessary [4, 7]; some others consider it limiting because it leads to an "information crunch" [10, 12, 13] or because it is seen as decreasing the health professional "sense of responsibility" [3, 14].

A second cause of intercultural conflict stems from *misunderstandings of the meanings* about some gestures, words or rites [4, 14, 15]. Different meanings can indeed be given to non-verbal communication that occurs in the clinical setting, such as therapeutic touch or facial expressions [9, 15], although facial expressions may, in their essence, be equally misleading and deceptive [6, 8, 16]. Even some standard caring procedures (i.e. body care, alimentation or wound care) or compliance with the hospital rules may convey misunderstandings [3, 16, 17].

The third main cause of intercultural conflicts is related to principles and moral values of patients and healthcare professional. Literature identifies usual conflict situations in the refusal to transplantation or blood transfusion, the requests for genital mutilation or even different practices' assessments such as the voluntary termination of pregnancy, or finally tell the truth to cancer patients [18-21]. More specifically, for certain cultures such as the Arab culture, nurses complain that they cannot communicate to women patients directly, but only through the paterfamilias who acts as an intermediary between the patient and the healthcare professional [12, 16].

In accordance with Cross et al. [22, p. IV], we define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations".

Recently the need of cultural competence in healthcare has been reaffirmed thanks to the Amsterdam Declaration for the creation of migrant-friendly hospitals signed in 2001, whose need has been strengthen also by some of the major US medical associations' declarations [23].

Chiarenza [24] highlights some points that characterize it the concept of "cultural competence" (Table 1). Consequently, to build an effective relationship with the patient it is necessary that the healthcare professionals develop skills that can bridge cultural differences. Dogan et al. [10] argue that in order to treat a foreign patient as well as possible, four characteristics are necessary: compassion, empathy, sincerity and openness to different cultural values. Besides, according to Purnell and Paulanka [25], the concept of cultural competence develops and changes over the time with the experience of a nurse.

Table 1. *Cultural and Interpersonal Competences in Healthcare [24].*

1	Recognize and respect the beliefs, values, conceptions of health, preferences and needs of the patient
2	Establish a relationship of trust
3	Look for a common ground
4	Be aware of one's own prejudices/assumptions
5	Be aware of disparities and barriers in services
6	Use the services of intercultural mediation effectively

The Ethics Code of the Italian nurse indicates that the management of any possible conflict between the nurse and the patient should be guided by dialogue and prudence [26]. Recently, an increasing interest has been registered in developing cultural competence in nurses, since migration has become a phenomenon on huge scale also in Italy [27].

This study aimed to explore situations of conflict between Italian nurses and patients belonging to a different cultural background, as reported by professionals, in order to identify the elements that facilitate or hinder the effective management of it. The leading research questions were the following: "How is represented by Italian nurses the conflict with patients and family members who have a different cultural background from that of the healthcare professional? What are the key factors that have determined the effective or ineffective management of the conflict, in nurses' opinion?"

2. Materials and Method

The methodological approach considered most appropriate to this study about nurses' representations of cultural conflict was phenomenological-hermeneutic one [28], based on multiple cases' study [29, 30].

The study took place at San Raffaele Hospital in Milan, a town in Northern Italy. San Raffaele hospital is one of the biggest one in the city: it has 1.300 beds and about 1.000 nurses are employed. Among them, approximately 80% are Italian, 15% come from European Communitarian Countries and only 5% from non-Communitarian Countries. About 8.000 foreigner patients, who live or working Italy, are cured at San Raffaele Hospital each year.

2.1. Sample

We purposely looked for nurses who had experienced intercultural conflicts at San Raffaele Hospital. All Head Nurses were asked to indicate registered nurses who had experienced intercultural conflict situations (snowballing sampling) [30]. Inclusion criteria were: to be a registered nurse or a third years nursing student, having experienced an intercultural conflict and being fluent in the Italian language. First, 19 nurses or students were recruited. Then, a purposive sample of 16 participants was selected. As data saturation was reached, no other informants were approached.

2.2. Data Collection

Data were collected through a semi-structured interview. An interview grid was created (Table 2), in order to explore the representation of cultural conflict with the selected nurses. Two researchers, who had been specially trained and supervised for this purpose, conducted the interviews, recorded on audio files, in 2012. The interviews took place in quiet rooms in the wards and no incentives were provided.

Table 2. *Trace of the Semi-Structured Interview.*

1	In your opinion, what are the most frequent situations of cultural conflict with patients (or family members of patients) in your ward?
2	Can you tell me, from your point of view, one of these episodes?
3	What are the main topics that have triggered the conflict? What have been, in your opinion, the causes?
4	How would you describe the kind of relationship that has been set up with the patient during the conflict?
5	What have been the key factors that determined the positive or negative solution of the conflict?
6	What did you feel on an emotional level during this experience?
7	What have been your reflections on what happened?
8	Have there been situations of conflict or potential conflict of culture that you believe were handled positively by the operators?
9	Do you have other considerations / additions you want to report on this issue?

2.3. Ethical Aspects

San Raffaele Hospital Ethics Committee approved the study. Data that enabled in any way the clients' identification were not collected. Interviewed nurses were guaranteed of anonymity and confidentiality, and they gave their written declaration of consent for the research.

2.4. Data Analysis

An Interpretative Phenomenological Analysis (IPA) was conducted on the texts of the interviews aimed at exploring the main themes related to the nurses' experience of cultural conflict [28].

The interviews were typed and inductively analysed by five researchers. First, each interview had been read several times to grasp its global sense. Meaning units (labels) were then individuated by the researchers, reporting quotes from the nurses; afterward. The resulting list of labels was re-applied to the interviews, verifying if the labels covered all the meanings emerging from the participants' interviews. A few labels were added and a final list of meaning units for analysing the interviews was defined. Then the researchers assembled groups of labels into categories. Finally, the main topics emerging from the interviews were identified, grouping categories into themes [31].

All of the data analysis steps were performed at first individually and were then discussed collegially by all of the researchers, until an agreement was found. Interpretative phenomenological analysis seeks to discover participants' meanings, but proponents accept that through a process of interpretative activity the researcher uses personal experience and professional or academic concepts to make sense of the participant's personal world [29].

In order to improve trustiness, at the end of the interviews analysis, the emerged themes were submitted to all the nurses interviewed for *member checking* [29, 30, 32].

3. Findings

Sixteen interviews were conducted (Table 3): 14 women and 2 men; 14 had Italian nationality, one was Polish and one was Spanish. Among the respondents, three were nursing students. The average age of nurses was 38 years (range 21-56), and their average professional experience was 19 years (range 5-35).

Table 3. *Characteristics of the Sample of Nurses Surveyed.*

Interview code	Sex	age	Origin	Years of professional experience	Ward	Interview Lenght
1.DHOE	F	38	Italy	18	DH Paediatric Haematology	31'5"
2.DHOE	F	40	Italy	20	DH Pediatric Hematology	14'25"
3.DHOE	F	47	Italy	26	DH Pediatric Hematology	8'35"
4.CCH	F	48	Poland	20	Cardiosurgery	17'21"
5.STUD	F	21	Italy	/	Neurosurgery	15'37"
6.STUD	F	29	Italy	/	General Surgery	16'1"
7.STUD	F	21	Italy	/	Orthopedics	17'56"
8.CARDIO	F	26	Italy	5	Cardiology	7'59"
9. CHGEN	F	31	Spain	10	General Surgery	12'36"
10.DHEM	F	44	Italy	23	DH Haematology	17'28"
11.ARITMO	F	46	Italy	28	Arrhythmology	23'
12.ARITMO	F	46	Italy	28	Arrhythmology	23'
13.ARITMO	F	39	Italy	18	Arrhythmology	15'49"
14.PS	M	56	Italy	35	Emergency	22'54"
15.UTIC	F	29	Italy	6	Cardiac ICU	14'38"
16.UTIC	M	43	Italy	19	Cardiac ICU	24'13"

The themes emerged from the analysis of the data collected are presented in following diagram (Figure 1).

Figure 1. *Map of Findings.*

3.1. Nurses Perceived Conflict as a Professional Failure

The vast majority of nurse's surveyed perceived intercultural conflict intended as a real clash between different positions as rare. On the other hand, misunderstandings and tensions between nurses and clients with different backgrounds are, instead, common, in particular when it comes to language barrier/ linguistic difficulties, life habits, education of hospitalized children and nutrition. One interviewee working in Coronary ICU says: "There are few conflictual situations, but there are always minor issues…"

Language is especially a problem in itself and a source of misunderstandings, but at the same time, a barrier that hinders the understanding of all possible elements of conflict, aggravating or delaying the conflict elaboration process.

With some Arabic patient, the conflict arises from the non-recognition of the female nurse's professional authority. A student told us: "[That patient] with women just did not talk [...]. In fact, we had some problems because he had been hospitalized for a head injury [...], and he was ordered that he could not get up, but he teared everything in order to go to the bathroom. [...] I tried to tell him to stop, that it was for his own good, but he was pissed off bad with me". For some nurses the conflict with patient is a kind of professional defeat and tend to underestimate it or hide it further. As a polish nurse says, "You definitely cannot afford to react as you would react at home". Both in the presence of intercultural conflict or simple misunderstanding, ineffective communication between nurses and patients results in clinical negative consequences for patients and causes drawbacks or distress to the staff, but above all, it has consequences on the quality of nursing care that is compromised and impoverished, sometimes putting at risk the patient' safety. One student reported witnessing the attempted escape of a 27 years old Moroccan patient hospitalized for hip fracture. After a series of misunderstandings with the staff in the ward, "he was convinced that there was someone who wanted to kill him".

3.2. Causes of Failure

A combination of different factors related to both parties involved emerges as a cause of failure in preventing conflict, and searching for a shared solution, closing the dialogue between nurse and patient. *Organizational factors* concern the lack of time available to understand the care needs of patient or the inability in work and organization's patterns to find a meeting point between the parties. On the nurses' side, *personal factors* like low knowledge of cultures and social contexts of origin of the patients, as these determine the patient or family members' intensity of demands, influence relationship with foreigner patients. In addition, nurses recognize that prejudices against patients or against their ethnic origin, facilitates neither interaction nor the management of a possible conflict situation.

On the patients' /family side, respondents reported that when families have a high sense of cultural belonging, their position is stiff and, as a result, dialogue is hindered. Similarly, when patients show aggressive or pretentious attitudes conflict management is stalled and the risk of misunderstanding with the staff increases. One student says:

“The relationship with [the] patient had to be very controlled: it was necessary t to be extremely careful when treating him in order to avoid over-reactions. He has had difficult relations both with healthcare operators and ’his room’s neighbor as well as with his wife”. Respondents as a cause or a contributing cause of an ineffective conflict management often pointed out an inappropriate use of cultural linguistic mediation service. A significant proportion of respondents say they do not "fully trust" the quality of the translation carried out by the family. In some cases, as a nurse said, “both the patients and their families are taking advantage of the linguistic challenges, to do what they want" hiding some things, for example in cases of violence and/ or family abuse, or, omitting to report some aspect that they consider less important.

Some nurses affirm that a linguistic misunderstanding can be at the origin of a certain concealment or underestimation of the conflict, because it prevents the parties to understand each other’s positions that can potentially clash.

In all these cases, conflict management is ineffective because, as an interviewee says: "When both relatives and nurses remain in their own beliefs and mutual listening is lacking, conflict can be contained, but not solved”. It is no more important to find a common solution and the conflict ends up with one party giving way the other whom proposed or imposed solution.

Cases of real closure to dialogue are rare, but sometimes the patient or the family members are forced to adapt to the hospital rules or to the nurse’s care indications, even if they do not agree with them. In these cases, the conflict appears to be resolved; however, the failure in sharing decision making to both parties influence the relationship between professionals and patients and family members parties leaves some consequences.

For some nurses, the decision to stand by their beliefs and, hence, to close the dialogue with the patient, reduces the value of nursing assistance, and puts its results at risk, often increasing their costs (diagnostic investigations/analysis / additional and unnecessary therapies). This has negative consequences on the patient’ experience, because, in some cases, he feels neglected, persecuted or discriminated against, accusing the staff of racism: "The patient has an aggressive behavior and he thinks he is discriminated against [...] as a foreigner".

3.3. Outcomes of an Effective Conflict Management

The majority of nurses believe that it is necessary to find a common linguistic code between nurses and clients as this facilitates conflict management. Some report the use of non-verbal communication as an effective strategy. In this case, it seems essential to have an attitude based on: mutual willingness, openness, understanding and dialogue.

The majority of them believe that the management of conflict is entirely in the hands of the nurses, and that it lays on their listening and mediation skills. As a nurse said: "We have not changed our mind, but in the end, we found an agreement between the hospital rules and patient’s habits". For some experienced nurses, however, it is clear that an effective conflict management necessarily requires a reciprocal openness towards the other, a correct use of language translation tools and a greater awareness of one’s own prejudices. “You have to be in a listening mood; of course, it is easier when the other person would like to listen to you too and my requests and the other person’s requests are equally important. I feel welcomed by the other person and able to welcome what he wants to communicate and this facilitates collaboration”.

Even in the presence of aggressive behavior by family members, relatives or caregivers, nurses strive to avoid conflict, and seek shared compromises that let it be resolved. The acceptance of such behavior causes distress in nurses, especially if inexperienced. Faced with a conflict or misunderstanding, the goal, as explained by a foreign nurse, is to seek a compromise that is valid for both the nurse and the patient. This kind of agreement is more difficult to achieve in emergencies or when patient needs a therapeutic education with impact in changing the daily habits of the patients.

A set of elements that many respondents pose as essential for successful conflict management is related to the nurses ‘emotional balance, a sense of responsibility and clear ethical principles.

An expert nurse told: “The aggressiveness of this patient was inexplicable [...]; I did not react because I have a calm character […] because the principles of the profession, because you know that you are dealing with a sick person, a frailty person”.

Similarly, in times of great conflict, the same ability to control their emotions and a certain degree of confidence in the health workforce is also required to patient \ family. In an interview, a nurse remember something about a conflict experience with the Afghan mother of a child who was hospitalized for a gene therapy for a rare form of blood disease: “During this long hospitalization, the child’s mother gave birth to a baby girl and, a few days later, she brought the baby to the ward so that the nurses could meet her. The nurses realized that the little girl was wearing Kohl, according to the family’s tradition, and that this make up had caused a severe eye-infection. At first, the mother showed irritation at the nurses’ worrisome reaction, but then, thanks to the trust they had built up over time with each other, she understood and accepted their indications”.

Some nurses reported that the acceptance of shared solutions is facilitated when the patient and family members do not belong to constraining social contexts and are themselves available to dialogue. Many of the nurses interviewed indicate to need a greater knowledge of the background and motivations that support the patients and their families’ problems.

For the nurses interviewed the shared resolution of an intercultural conflict is rewarding because of the patients/ foreign family‘s gratitude /and for being able to manage the conflict to a successful conclusion, while maintaining high

results of nursing care and enhances nurse' role. Moreover, according to an interviewee, the positive resolution of the conflict puts everyone in a state of serenity, gives confidence to the team and creates a shared memory on which to rely upon in future experiences.

4. Discussion

According to the results of this study, some interviewed have a negative perception of the expression "cultural conflict" and do not accept the idea of establishing a tense relationship with clients. It appeared that, the emergence of conflict with the clients was not a conceivable option among the choices of care. Furthermore, it seems that it has been experienced as a failure of providing care rather than simply and realistically being seen as "a perceived or real tension between values, expectations, processes or outcomes between two or more parties" [33].

The phenomenon of conflict is probably underestimated because it establishes a relational dynamic that depletes the content of communication. Nurses and clients, for different reasons, tend to reduce the confrontation to limit the occasions of conflict. In this way, a situation characterized by an apparent lack of conflict could disguise a superficial caring relationship and a "silent conflict". This phenomenon has already been described by Leininger & McFarland, who defined these situations, as a "conspiracy of silence" [1, p. 61]. As for the causes of conflict, also our data have confirmed many of the indications already found in literature, including the prejudicial outlook that some clients have towards female healthcare professionals [16].

Among respondents, this negative view of women, and therefore the view of the professional female nurse's loss of authority, has been one of the most contributing factors reported to trigger the emergence of conflict. Nurses feel themselves as discriminated and this causes frustration and anger. Even literature reports that discrimination linked to gender can be a source conflict between nurses and clients in particular because of the healthcare professional' struggle to communicate directly with the patient [16, 35].

All effective and ineffective attitudes and strategies put in place by nurses when managing conflict are related to the concept of cultural competence and its interpersonal categories [24, see Table 1]. Yet, the very notion of "cultural competence" has never been mentioned in the interviews, nor it emerges in the nurses' an awareness and perception of their level of cultural competence related to the difficulty of the case management, as stated by other studies [10, 34, 35, 37].

According to literature [1, 24, 38] prejudices are present and difficult to control, both for nurses, patients and family members. Their presence is much more negative for a shared unconscious conflict as much as bearer is unaware.

Strategies, organizational practices and tools that facilitate the successful conflict resolution in the field of intercultural care emerge from the interviewers. Firs table, a cultural and linguistic translation services that must somehow be provided by the hospital and effectiveness of non-verbal channel/communication indicated by respondents is supported by many studies [8] but it can also generate misunderstandings [14, 15]. Several respondents reported the involvement of an inter-professional group and of the nursing coordinator could be an effective strategy. It is therefore possible to confirm that, in spite of the difficulties and misunderstandings, nurses use a multi-method solution to set up their relationship with the patient.

The respect of beliefs, values, as well as the understanding and acceptance of patients' welfare requests, pose the whole relationship between nurses and clients on a level of mutual confidence and openness. Reciprocity has been indicated by a minority of respondents, while the use of dialogue as a tool for stimulating dialogue and mediation is a cross-cutting theme in the interviews, confirming literature's indications [3, 10, 14, 39].

The attempt to find a common solution to the conflict is most often triggered by nurses rather than by clients. A key determinant for both, however, is the ability to manage their emotions. Many of the respondents recognize this as an essential pre-condition for the conflict's containment and resolution. As stated by literature [2, 14, 40], it is not only a matter of maintaining an emotional balance in situations of high tension, but also the competence in listening to emotions.

The conflict resolution is therefore positive when the agreement makes sense for both parties; although it can obviously has different meaning and interpretation [41]. In this sense, an effective resolution is appreciable by the parties, because reaching common health goal. On the contrary, the management and resolution of a conflict is perceived as negative, or ineffective, when one part is forced to surrender the other's decisions, without, however, having worked them out, understood them or accepted them. We could say that the first real cause of intercultural conflict is not related to differences about language, culture or values – but in the failure of their processing and elaboration. Consequently, conflict can be understood as a physiological reaction, and its emergence is a necessary step for both protagonists. Without this emergence and without some elaboration of the tensions and difficulties, it is therefore necessary to wonder about the validity or strength of compromise [3, 40]. The very purpose of intercultural nursing relationship seems to have changed over the years. In the works of Leininger, one of the objectives of transcultural nursing was explicitly to restrain cultural conflicts [42, p. 13]. Now, the directions of research would seem to confirm the European cultural competence's indications [23, 24] to direct the assistance objectives not towards the containment of conflicts, but rather towards their resolution – through a constructive dialogue, developed with a targeted negotiation and with the identification of common solutions.

5. Limits

Despite reaching data saturation, we wish to restate that the data collected do non-represent the Italian situation.

Moreover, only one side of the conflict has been studied. Patients involved in conflict situations could have pointed out other kinds of suggestions and a different lived experience compared to what professionals lived on their own.

6. Conclusions

In Italian context, our study show that intercultural conflict in nursing is underestimated and negatively conceived. This could have unclear consequences: in fact, it leads the nurse or the patient to seek the conflict reduction or silencing rather than facing its management, aimed at finding shared welfare goals.

Further studies are necessary to investigate how the levels of clinical and cultural competence or cultural background of nurses influences the conflict.

With a focus on the methods and strategies for managing intercultural conflict through its emergence, its containment and its pursuit of shared solutions especially in the Italian context, that has a short history of intercultural service and Migrant friendly hospital.

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