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Perioperative nurses' experiences of communication in a multicultural operating theatre: A qualitative study

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ABSTRACT

Aim: To explore the lived experiences of perioperative nurses in a multicultural operating theatre in Melbourne, Australia.
Background: Multiculturalism has become the norm in the health workforce of several developed countries due mostly to immigration. Within an operating theatre setting where good communication is paramount, the presence of nurses and doctors from multiple cultures and different training backgrounds could pose a major challenge.
Method: Using a qualitative research methodology underpinned by phenomenology, we interviewed fourteen nurses from different sections of an operating theatre.
Results: From the lived experiences of the participants, difficulties in communication emerged as the major theme. Difficulties in communication affected patient care and the working atmosphere. In addition, social integration appeared to improve communication.
Conclusions: Addressing the needs of patients from culturally and linguistically diverse backgrounds in the operating theatre continues to be challenging. However, developing a sense of camaraderie and fostering good relationships between staff through regular social gatherings can improve communication and the working atmosphere.
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What is already known about the topic?

- Communication in the operating theatre is pivotal to ensure good patient outcomes.
- Measures to improve communication in mono-cultural settings such as the use of standardised protocols and computerisation are undertaken in several operating theatres.

What this paper adds

- Difficulties in communication in an operation theatre that occur due to a multicultural workforce can affect quality of patient care.
- Difficulties in communication can also affect the working atmosphere.
- Marginalisation of internationally educated nurses (IENs) in the peri-operative setting could be overcome by regular social gatherings of theatre staff.

1. Introduction

Communication is pivotal to nursing (Brereton, 1995) and more so when working as part of a team (Leonard et al., 2004). When difficulties in communication arise in high pressure technical environments such as the perioperative setting, there is a potential for adverse outcomes for patients (Nagpal et al., 2012). Moreover, when staff in the operating theatre belong to multicultural backgrounds, each with their own unique style, background and training, it is likely that breakdowns may occur during communication.

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Multiculturalism has become the norm in several developed countries (Australian Bureau of Statistics, 2011; Culley, 1996; Esses and Gardner, 1996; Reisch, 2008). Whether it is due to immigration or to colonisation, the clash of cultures can cause difficulties. Issues around race and ethnicity are multiplied in the presence of low socio-economic status. The experience of immigration can cause struggle, frustration and conflict for individuals and their families as they work to gain acceptance within their new culture. This is also true in the health sector both for patients as well as for health professionals employed in a foreign system (Magnusdottir, 2005; Papadopoulos, 2006). Although the health care system seems to accept multiculturalism in the workplace, practices continue to remain monocultural (Meleis, 1999). For instance, in their study, Omeri and Atkins (2002) highlight some of the problems faced by immigrant nurses in Australia which include, 'professional negation', 'otherness', and communication problems.

Few reports have explored the dynamics of communication in a multicultural operating theatre setting. Using a phenomenological approach, this paper describes the 'lived experiences' of perioperative nurses in a multicultural operating theatre of a metropolitan public hospital in Melbourne, Australia.

2. Background

A multi-cultural society is one which consists of people belonging to different cultures. Such a society can exist in three different ways. First, and the most commonly observed process is where individuals belonging to the minority culture adopt most of the cultural norms and behaviours of the dominant or host group (assimilation). Second, individuals from the minority and majority groups adopt some cultural norms of the other groups (cultural pluralism) and third, where there is little adaptation on either side (cultural separatism) (Cox, 1991a,b). It is important to realise that it is not easy to abandon one's own culture (Nemetz and Christensen, 1996) and therefore there needs to be strong reasons for individuals to choose to adapt to other cultures. When nurses from developing countries are unhappy with professional attributes such as their pay, working conditions, career prospects and job prestige in their own country, they migrate to developed countries such as Australia (Buchan and Sochalski, 2004). In doing so, one could argue that they would expect to have to adopt some of the cultural norms of the host country.

Perhaps a key factor that influences the development of cultural pluralism is the ability of those belonging to the host and migrant cultures to effectively communicate with each other. Most if not all visa categories under which professionals migrate to work in Australia require proof of their English language competency by passing the English-language test (Australian Government Department of Immigration and Citizenship, 2013). However, despite proving their competency in English, some nurses find it difficult to communicate without the assistance of translators (Omeri and Atkins, 2002) and this inability to communicate precludes the smooth merging of cultures.

Furthermore, when organisations make formal announcements that embrace multiculturalism, the formal announcement may not be taken seriously by staff unless those announcements are also accompanied by tangible cultural and behavioural changes within the organisation that reflect those announcements (Nemetz and Christensen, 1996). For instance, when hospitals hire professionals from culturally and linguistically diverse backgrounds but do nothing to enable them to acculturate into their new work environment, their peers are not likely to afford them much value.

The operating theatre is known to be a high pressure, technically complex and intensely hierarchical work place where effective communication is paramount (Riley et al., 2006; Seifert, 2012). Communication in the operating theatre has been extensively studied (Hu et al., 2012; Manser et al., 2013; Smallman et al., 2013; Weldon et al., 2013) .In order to achieve desired outcomes good communication must be embedded within the operating theatre culture (Davies, 2005). Elements of effective communication in the operating theatre are suggested to include listening, clarity of speech and politeness (Nestel and Kidd, 2006). This is possible when there is mutual respect for team-mates (Leighton, 1986). What has also been observed is that the longer people worked together, the better they seemed to communicate with each other (Gillespie et al., 2012).

Communicating with patients extends beyond the parameters of understanding what a patient says. It also involves the patient understanding the theatre experience. Meleis studied the health benefits to patients who received preoperative visits by theatre nurses and identified that patients who were able to articulate their concerns and engage in their own plan and postoperative care had shorter hospital stays, reduced requirements for pain relief and complied better with postoperative care (Meleis, 2007).

Effective communication in a health care team is influenced by two main domains. They are: the use of clear standardised protocols and the relationship between members of the team (Leonard et al., 2004). Incorporating standard protocols in communication is less complicated and is part of setting up workplace policies and practices. Communication within this domain can breakdown either intentionally or unintentionally (Herlehy, 2011). Unintentional or honest mistakes can occur at any time and organisations commonly put systems such as computerisation and checklists in place that can reduce the incidence of these mistakes. However, intentional breakdowns in communication occur when caregivers do not report their safety concerns. This behaviour may be due to their fear of speaking up (Herlehy, 2011) or may be used as a strategy to show dissent (Gardezi et al., 2009). In order for caregivers such as nurses to speak up, they need to feel safe and empowered in their work atmosphere. A clear power differential and hierarchy in the team is known to inhibit people from speaking up. Although creating a safe working environment was initially considered the responsibility of the team leader, more recently, training programmes such as Crew Resource Management have been adopted which lays the responsibility on all team

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