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## **Cross-cultural Socialization into a Common Profession: Exploring how Nursing Students in Taiwan and in the U.S. Narrate Professional Identity**

**Abstract.** This discussion will draw on a series of written stories and commentaries on professional values in nursing for a cross-cultural pragmatics study of US nursing students in North Carolina and Chinese nursing students in Kaohsiung, Taiwan. We explore cultural differences in salience as a pragmatics construct for a professional construct important in nursing, that of *caring*. The nursing students were not in direct contact with each other except through written stories and commentaries: The Chinese nurses first wrote their thoughts in Mandarin and then translated them into English, after which the US students read and responded to them. The nursing students from both countries assumed that they shared constructs of what constituted professional values in nursing. However, our discussion will question the degree to which they shared common ground and assigned similar salience to the construct. We conclude that the Chinese and the US student nurses erroneously assumed that they shared each other's understanding of 'caring,' underestimating the differences in work environment and cultural expectations. We also propose that they are readily capable, through communication, of recalibrating their reference frames once made aware that they differ.

**Keywords:** salience, socialization, intercultural, pragmatics, oral narrative, professional identity, personal identity, nursing.

### **1. Background**

The process of acquiring the pragmatic skills of language use in varying situations has been described for novice lawyers and medical students (Hobbs 2003). Novice nurses begin to acquire pragmatic skills for professional socialization in their early training experiences, and again through interaction and observation when they enter the workplace (Messersmith 2008). However, there is frequently a mismatch between real-world experience and training demonstrations of valued ways of speaking/critical thinking. That mismatch reveals needs based on register: The new nurse has to identify functions for patterns of speaking to and about patients, peers, and supervisors, without necessarily sharing the same interactional styles (Li 2000).

At a time when Western universities propose collaboration with Asian nursing programs in China, Korea, Taiwan, Thailand, and Japan, differences in caring theory and

caring practices within either cultural milieu may cause misattribution of inner states (Rosen 1995), conflicts in intention, and varying interpretations of the meaning of crucial constructs.

This discussion will use a series of written stories and commentaries on professional values in nursing, elicited from US nursing students in North Carolina and from Chinese nursing students in Kaohsiung, Taiwan. We explore cultural differences in salience for an important professional construct in nursing, that of *caring*. Because the nursing students were not in situations of direct contact with each other except through written stories and commentaries, and because the Chinese nurses first wrote their thoughts in Mandarin and then translated them into English, the two groups of students were in what Kecskés calls "the first phase of the communicative process". In that phase, they "articulate their own thoughts with the linguistic means that are easily available to them", an egocentric behavior "rooted in speakers' and listeners' relying more on their own knowledge than on mutual knowledge" (Kecskés & Mey 2008: 3).

Partly because the notion of *caring* is multiply layered, and partly because Chinese nursing has to some extent a Western framework, the nursing students from both countries assumed that they shared constructs of what constituted professional values in nursing. However, our discussion will question the degree to which they shared common ground and assigned similar salience to the construct.

We first review findings from studies of socialization of nurses in the U.S. and provide an overview of the development of nursing education and new emphases on professional socialization in Taiwan. Next, we look at short narratives by Chinese nurses in response to a longer narrative by an American nurse-educator, and subsequent reflections by Chinese and American student nurses on how their narratives evidenced professional values. Both sets of reflective reviews identified caring for patients as a primary value; each framed that value slightly differently, however, identifying culturally different ways both in speaking about the profession and about the development of clinical judgment, and in negotiating intercultural practices. We close with implications and suggestions keyed to our findings.

## **2. Professional Socialization of Nurses in Western or Western-oriented Countries**

Research on socialization into the professions has grown over the last two decades; in linguistics, it "focuses primarily on the linguistic socialization of learners at work or preparing for work by means of education activities and apprenticeship" (Duff 2008: 257). Other disciplines offer additional perspectives. Boyle et al. (1996) draw on contingency theory of role socialization (Feldman 1976) to identify experiences supporting job satisfaction and high commitment for nurses. Etheridge (2007) interviews new nurses to discover how they learned to "think like nurses" and to develop belief in ability and competence; see MacIntosh (2003) for further discussion of professional nursing identity.

As was done in a number of previous studies, Deppoliti (2008) emphasizes the notion that the nurse's professional identity is constructed gradually. For example, Fagerberg & Kihlgren (2001) claim that Swedish nurses settle into their professional identity in the third year after their degree, when they are able to take charge and show leadership. MacIntosh (2003) identifies phases in how beginning nurses adjust identity as they move from educational program to workplace, keyed both to their development of reflection and to the impact of mentoring. Messersmith (2008) studies the development of the role of nursing, commenting that nurses develop a sense of their role first in nursing school and then in the professional workplace, through interaction developing communicative competence. Vågan (2009) adds the importance of teacher-doctors as role models for developing a professional identity with medical students, which is similar to the impact of nursing preceptors on nurses

in clinical practice (Carlson et al. 2010): Preceptors use occupational language or institutional jargon to offer explicit, experience-based explanations that help students develop competence.

However, looking at professional identity and developing a timeline for its construction is not the only way to examine professional socialization within nursing. Holmes & Meyerhoff claim that a *community-of-practice* construct is more useful than social-identity theory in developing "a shared repertoire of joint resources for negotiating meaning" (1990: 176). This emphasis on community is applied to nursing in the discussion by Andrew et al. (2008: 247; Andrew et al. 2009), who, like other authors working with this construct, comment that situated learning facilitates collaboration based on shared values. Similarly, Reybold (2008) explains that the community of practice "represents both the local milieu and larger ethos of the profession". As we shall see, the very effort to balance both the local situation and the larger ethos can occasion cross-cultural confusion, miscomprehension, or stereotyping.

Professional socialization begins when a prospective nurse first enters a program, and it extends into joining the workforce (Melrose et al. 2013). This socialization may occur during clinicals that are designed to promote key concepts such as *caring*, or it may not occur until the novice nurse, newly graduated from a nursing program, can fully enter the workforce. In the US, nursing education began within hospital contexts. During the mid-nineteenth century, the impact of Clara Barton's work during the American Civil War and that of Florence Nightingale in the Crimea led to new approval of nursing and its need for training in the West. The first American nursing school opened at Bellevue Hospital in New York City in 1873, and two others opened that same year (Connecticut Training School at New Haven Hospital, and the Boston Training School at Massachusetts General Hospital) although a number of nurses had graduated from various hospital programs over the previous 15 years. Nightingale established the Nightingale Training School for nurses at St. Thomas' Hospital in 1860. All three of these U.S. nursing schools were based on Nightingale's principles, which include the individuation of the patient, the value of teamwork, and the combination of theory with practical application for the never-ending growth of the nurse as a specialist in care.<sup>1</sup>

### 3. Socialization Studies and Nursing Education in China and in Taiwan

Western-based nursing as an occupation for women outside the family was formally introduced into China not long after its institutionalization in the US, though it faced greater difficulties in becoming a respected vocation. A brief review of the history of nursing first in China (PRC) and then in Taiwan (ROC) highlights cultural issues that are still influential on what nurses think nursing to be.

According to Liu (1991: 319-20), medical knowledge was part of a largely Confucian outlook, though Buddhists introduced institutions of hospitals. Male doctors treated men; women were treated by 'old wives' or *san gu liu po*, who practiced different crafts associated with health and healing. Western medicine in China begins with smallpox vaccinations, first administered in 1808; the first hospital was established in 1835, and foreign missionaries began in the 1830s to establish hospitals and to train aides. Nightingale's influence sent the American nurse Elizabeth McKechnie to Shanghai in 1884, where she introduced the Nightingale system of nursing (Chan & Wong 1999). Chen (1996) adds that missionaries

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<sup>1</sup> Both text and audio for Nightingale's *Notes on Nursing* (1859) may be found at <http://goddessnike.com/library/NightingaleNotesonNursing/>.

were highly important in China during the last 20 years of the 19th century, with an emphasis throughout 1887-1914 on establishing nursing schools. However, Confucian-based attitudes about roles for women made it difficult to attract nursing students, a difficulty compounded by suspicion of foreign teachers. A similar situation existed in Taiwan: Western medicine was introduced to Taiwan by missionaries (Liu 1998). Liu adds that the first British Presbyterian doctor, James L. Maxwell, came to Taiwan in 1865 and that others followed. The earliest hospitals were established by missionaries, and missionary medical work continues to exist in Taiwan.

However, historians of medicine in China remind us that China had a medical tradition before the Western missionaries arrived. As Liu (1998) observes, Western medicine in Taiwan competes with an ancient healing system that is still a deeply rooted part of the culture, linked to profoundly valued religious and philosophical traditions, and in turn to the intense Chinese feeling of nationalism: "Having to adjust itself to Chinese culture, Western medicine has had to justify its existence by efficiency and a quick cure rate" (Liu 1998: 7).

The retention of traditional values combined with traditional practices is frequently mentioned in both anecdote and story. In Fall, 2010, anthropologist Joel Stocker asked his nursing students in Taiwan to talk about their nursing experience of death and dying, building from a guest lecture and assigned reading. He comments:

The stories were amazing, most of them about the student or someone she knows seeing a ghost in a hospital, having an out-of-body experience, going to a spirit medium (*danggi*) or going to a temple for guidance... nurses in Taiwan participate in many traditional and non-biomedical health practices, often medico-religious ones... (Stocker, 2010).

Traditional or Confucian values are maintained by many Chinese nurses. According to a survey by Pang et al. (2000: 27-28), nurses in Beijing, China "articulate two versions of caring practices within the clinical context as their ideal of service. One version is grounded in traditional caring values that require nurses to treat patients as their family members". This compassionate, familial care is called *cheng*. "The other version is grounded in emerging professional values that require nurses to realize the therapeutic value of nursing work" – that is, proficiency in bodywork skills, which Pang calls *jing* (excellence in practice). In their survey, Pang et al. asked nurses to write definitions with examples of the concept of caring: 41 were grounded in traditional values, such as treating the patient as a family member, or *cheng*; 29 were grounded in 'emerging professional values' or *jing*.

The retention of traditional values can also be seen in the study by Lee-Hsieh et al. (2005) about the development of an instrument to measure patient perceptions of caring behaviors, the results of which could be used to train student nurses. Patient-reported behaviors fell into two factors, with items in the first factor measuring sincerity, empathy, and respect, such as "Make me feel like I have a sincerely caring nurse. For example, avoid making me feel I am part of a routine or a cog in a machine" (which had the highest factor loading, .974). The second factor measured professional behavior, such as "Explain to me what my medicine is supposed to do and what side effects I might expect". When the same group of scholars, headed this time by Kuo, initiated the measurement of a student-training curriculum on caring, they identified key divergences from the Western measurement tool typically used to measure caring, "keyed to differing cultural practices in education, caring and behavior" (110). One example: the importance of 'classmate' in Chinese nursing training.

In Chinese nursing education, the entering student is assigned to a cohort; one is expected to listen to and offer help to classmates, for this is a long-term relationship within a relational network, not just a manifestation of curriculum. Kuo et al. conclude: "[W]hile caring may be universal among humans, its expression is entirely local" (2007: 112). Turale et al. (2010: 2602) come to a similar conclusion, quoting the English-language abstract of the

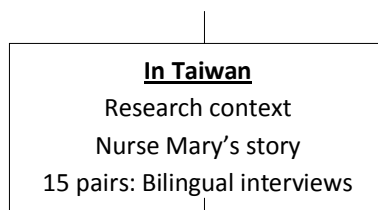
Chinese article by Liu (2006): "Modern nursing was introduced to Taiwan over a century ago. It is now a complex mix of cultural borrowings from the West, anti-imperialist experiences, colonialist influences, ethical and gender issues and Chinese culture and traditions". The problem for the researcher, then, is to identify salient cultural issues that surface in the language used to describe what a professional learns to do. The two-phase innovation we devised, a seminar and follow-up reflective writing, was intended to elicit language about professional socialization into nursing in both cultures.

#### 4. The Innovation: Phase 1

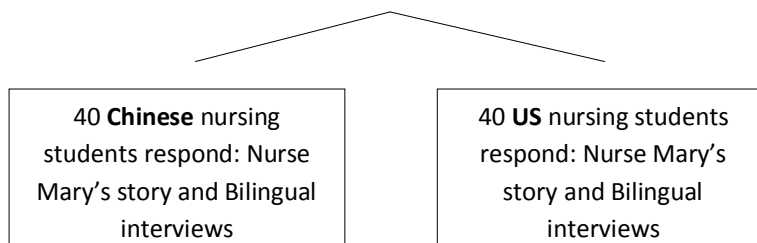
Fifty practicing nurses in Taiwan joined a day-long English-language seminar on *Developing Professionalism through Narrative Techniques* as part of their own advanced training. The objective of the seminar was to explore ways in which reflective narratives could develop empathy and professionalism and promote intercultural competency. Supported by partial oral translation into Mandarin by the Chinese host, they analyzed components in "Nurse Mary's story," a practicing American nurse educator's English narrative of her earliest experiences. Following that, they interviewed each other in Mandarin for brief recounts of important early experiences on the job and translated their interviews into English, as part of the seminar's requirements. Sharing their work was consented and voluntary. Their translations have not been changed: They are preliminary drafts not yet polished into a standard written format, but are easily understandable. Indeed, their rough-draft translations furnish a more direct glimpse into their nursing culture. The Chinese nurses' brief stories and a recap of Nurse Mary's story formed the content of Phase 2: responses by Chinese / U.S. nursing students, as displayed in Figure 1.

**Figure 1: Phases in the study**

##### Phase 1



##### Phase 2



The seminar had three sections, each comprised of a didactic presentation followed by group discussion and activities:

1. Goal, Objectives, and Definitions: Cultural Competence, Community of Practice, Narrative Analysis
2. Socialization into a Healthcare Community of Practice
3. The Nurse's Story: A Personal Story about Professional Socialization.

Section 1 presented the seminar's goal: Demonstrate how writing/reading reflective narratives can promote cultural competency by increasing the empathy and professionalism essential for caring. Brief definitions of narrative were based on Hymes (1972) and Labov (1972); the definition for community of practice referenced Eckert's website.<sup>2</sup> The group as a whole discussed frameworks for cultural competence, including whether Western training can be effective in non-Western countries. Section 2, on socialization, presented a brief literature review of Chinese and American discussions and added examples of contemporary use of narratives in medicine and nursing, such as DasGupta et al. (2006) and Swift and Dieppe (2005), who link narrative to training in cultural competence and improved understanding of patient concerns.

#### 4.1. The Nurse's Story

Nurse Mary's story, recounted by the third author, introduced Section 3. Her narrative responded to a prompt that asked her to talk informally "about things you were told on the job by other nurses, that you think helped make you be a better nurse, or indeed put you in touch with what you were supposed to be doing." To her own surprise, Mary's earliest lessons were in way finding and in the importance of tacit knowledge in the culture of a big New York City hospital:

I really just didn't even know to get to – the name of the place was Babies 11, which you would think was on the 11th floor, but it wasn't. And so that, that was my first shock on my very first day, was to find out that Babies 11 was not on the 11th floor, it was uh, a re-redone hospital, and trying to find my way around was very confusing. So my socialization to nursing began just from a direction point-of-view and learning not to trust the signs that were written, you had to ask somebody, because what was written was never checked. Because the people that lived there, they knew where Babies 11 was...

An older unlicensed nurse assistant, a twenty-year veteran of work in the hospital, mentored all the new nurses on the floor on how to organize tasks and where to find things. For Nurse Mary, learning to deal with patients came from three sources:

first, interaction with my classmates... there were maybe 8 of us that lived together in one apartment and we would come back after a day and share our problems with different patients and learning how to deal with that.

A second source was a host of experiences in the city and the hospital with ethnicities different from her own, necessitating learning in order to identify their unspoken rules and expectations:

The people in the neighborhood as well as the people in the hospital would teach me different things but not until I stepped over the boundary... what I learned from that first two years of working as a new nurse was um to ask.

A third source was her willingness to ask, to be laughed at for asking, and to seek collaborative participation from co-workers and supervisors:

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<sup>2</sup> [www.stanford.edu/~eckert/csofp.html](http://www.stanford.edu/~eckert/csofp.html); cf. Eckert & Wenger 2005

mostly I followed other people and saw how they did it and became a partner and said "If you will show me how to do this, I will help you with yours, if you'll help me with mine"

Nurse Mary returned at the end of her narrative to the importance of interaction with her classmates:

We shared at the end of the day, all kinds of things, whether it be from patients or just generally how the organization worked, liked who said what to who, how the doctors perf... uh... expected uh... a certain thing to be done, even though we didn't deal with the same group of people, we did find very much uh... similarities and started to make our own... ideas about um different groups of people.

#### **4.2. The Bilingual Stories**

Like Pang et al. (2000), we sought written responses to Nurse Mary's story and found the construct of *caring* to be a crucial component in them. Thirty of the seminar participants, who were taking a course in Advanced English for Nurses for a master's degree, talked about Nurse Mary's story and decided that a key component was being advised by a more experienced colleague. With the seminar leader (the first author), they developed several interview prompts, which are illustrated in the excerpted interviews. They interviewed each other in Mandarin and translated their interviews, as illustrated in Tables 1 and 2.

In Story 1, Claire identifies early nervousness, her concerns about the possibility of harming a patient, and the need to seek advice from her elder. Another elder teaches her skills and shows warmth, acting as both teacher and friend. In Tuan-I's response to Claire, Tuan-I shares a similar anxiety, since clinical work differs from school. She adds that her moving away from her hometown added to her concerns, but that she has a model who teaches her "how to become a good nurse" through deep study and sincere caring for patients.

#### **Table 1: Claire's interview-story**

<p><b>(1) Claire's interview of Tuan-I</b></p> <p>1.請告訴我你初次做護理工作的經驗。</p> <p>從專科畢業後我就投入職場，在醫院的小兒科病房工作，由於沒有臨床經驗，起初顯得很緊張又害怕。做事時總是不確定這樣對不對，都要請教學姊後才敢去做，擔心自己的疏忽造成病人的傷害。但是三個月後，漸漸的得心應手，工作中接觸的是可愛的小孩，也增添了工作的樂趣，因此護理工作就一直做到現在。</p> <p>2.在你的工作中，曾有其他護士告訴你你應該需要知道的事，或是無法從教科書或正規訓練得知的事，幫助你成為一個好護士？</p> <p>永遠不會忘記有位Lily學姊，她提醒我許多工作中應該注意的細節，教導我很多技巧，讓事情做得既好又快。除了做事的方法外，最重要的是她甜美、溫暖的笑容，解除了我緊張、害怕的心情，她是我的良師兼益友，過了這麼多年，我還是深深感謝她，且懷念以前共事的時光。</p>	<p>1. Please tell me about your experience when you first started working as a nurse.</p> <p>I entered my work at pediatric ward in a hospital, when I had graduated from junior college school. I felt nervous and fear at first, as a result of I never have the clinical experience. I always didn't sure this is right or not when I to act and must ask for advice with elder nurse. Worry the carelessness of myself to harm the patient. But three months later, I had done skillfully little by little. This was also to increase pleasures that can contact lovable children in the work. For this reason I have worked as a nurse up to now.</p> <p>2. Did one of the other nurses at your job help you become a better nurse by telling you things you really needed to know, things you wouldn't find out from at textbook or formal training?</p> <p>I never forget an elder nurse Lily, she reminded me to take notice of details in the work and taught me many skills to make things faster and better. Beside the way to work, it was important that her smile with sweet and warm. That releases my mood of nervous and fear. She is my good teacher and helpful friend. So many years so far, I deeply appreciated her kindness and remember the time that we work together.</p>
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Table 2 displays the turn-by-turn interview that Joanne and Joyce conducted with each other. Each faced a specific challenge to her ability to offer *caring*. Joanne worried about facing terminal patients and their families without the support of senior nurses. Joyce became nauseous at the sound of the ambulance, since it was the harbinger of severe problems and massive bleeding in the emergency room. For Joanne, a "senior colleague" showed "how to treat every patient by your own heart" with her comforting voice. Joyce met a "good older sister" who taught her skills.

**Table 2: Joanne and Joyce exchange early experiences**



**(7) Joyce's & Joanne's interviews of each**

**other**

**Joyce:** Joanne,請你告訴我你剛當護士時的經驗好嗎?

**Joanne:** 當我還是一個新手護士時,我第一個待的病房是腫瘤外科。常可以見到治療中或末期的癌症病人,我常覺得面對這些病人及家屬很難。

**Joanne:** Joyce, 你呢? 請你告訴我你剛當護士時的經驗好嗎?

**Joyce:** 當我是一個新護士,我在急診工作,我很害怕救護車的到來,他的聲音很大聲而且會帶來一些重症病患,我會很緊張和焦慮,因為病患可能有大量的出血,我會感到頭暈與噁心。

你成為一個比較好的護士一些必要知道的事?

**Joanne:** 新手護士常受到資深護士的排擠,但是有一位和藹可親的學姊告訴我說:別擔心,我想你一定很快適應就能跟他們一樣厲害。從那位學姊的照護過程中我看見如何真誠的對待每一位病人,甚至癌末的病人。他的話語常常可以撫慰病人及家屬的心,因此很多病人及家屬都很喜歡她。那是無法從教科書中學習到的。從那時起我就決定要當一位像他一樣棒的護士。

**Joanne:** Joyce, 那有其他的護士幫助你,告訴你成為一個比較好的護士一些必要知道的事?

**Joyce:** 你是一個幸運的人。我面對不熟悉的工作環境,和嚴格的醫生與護理長,我有很大的壓力,但是很幸運地,我在單位遇到了一位學姊,他教我照顧病患的技巧與知識,我會每天唸書,這樣可以改善知識,增加照顧病患的自信心

The inspiration to be a new nurse:

**Joyce:** Joanne, please tell me about your experience when you first started working as a nurse?

**Joanne:** When I was a new nurse, the first station is the oncology surgical department. Patients are almost under cancer treatment or terminal stage of cancer. I felt difficult to face these patient and family.

**Joanne:** And you? Tell me about your experience when you first started working as a nurse?

**Joyce:** When I was a new nurse. I was worked in Emergency Department. I was afraid of ambulance coming. It had the loud warning sound and the delivery severe patient to the urgent department. I felt nervous and anxious. Owing to the patients was active bleeding. My experience was very poor. I felt dizziness and nausea.

**Joyce:** Joanne, did other nurse help you to become a better nurse by telling you things you really needed to know?

**Joanne:** A new nurse was almost pushed out from senior colleagues. But, one of my senior colleagues is very kindness and affability. She took to me: Don't worry! I think you would soon as good as them when you get used to these affairs. In that time, through her way to care patient. I realized how to treat every patient by your own heart, even the terminal stage patients. Her voice could comfort patients and family's anxiety. So, a lot of patients and family liked her. It can not be learned from our textbook. From that time, I decided to become a nurse like her.

**Joanne:** Joyce, and you? Did other nurse help you to become a better nurse by telling you things you really needed to know?

**Joyce:** You are a luck girl. I faced unfamiliar environment of work. I met rigor doctor and head nurse. I had a lot of stress. Fortunately, I met good older sister in my work unit. She taught skill and knowledge to me for take care of the patient. I learned textbook ever day. It can improve my

	knowledge. Let me increase confidence to care patients
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Even allowing for a tendency to follow the storyline modeled by Nurse Mary, in which an anxious novice is helped by a kindly expert, and for the occasional use of questions derived directly from the seminar interaction ("Did someone help you to become a better nurse by telling you things you really needed to know?"), the pairs of interviews nonetheless highlight similar experiences, and their descriptions of early experiences are suggestive of several discussions of Chinese nursing history.

### 5. The Innovation: Phase Two

Two new groups, this time of novice nurses, reviewed the bilingual stories and wrote reflections identifying how those stories evidenced professional values. One group was comprised of 40 Chinese nursing students, and the other group was composed of 40 U.S. nursing students. While both sets of reflective reviews identified caring for patients as a primary value, not surprisingly, each framed that value slightly differently, identifying culturally different ways in speaking about the profession and about the development of clinical judgment.

The Chinese nurses seeking advanced degrees referred to senior nurses as seniors and as sisters in their interviews. The Chinese nursing students also consistently cited the models set by seniors, the desirability of good character, the importance of inspiration, and the need to listen to patients: "Giving your patients more opportunities to express themselves, and listening to them true-heartedly. As you guide the expressions in their minds, you will get to know their stories so that you can solve their problems more efficiently". In their responses, we can see the maintenance of traditional values such as *cheng* as well as new awareness of best technical practices, or *jing*. We would assume that, at least for now, Chinese nursing students abstract salient features of best practices, as they dovetail with and fit into a traditional perspective on caring for people as if they were one's family members.

**Table 3: Two examples of Chinese nursing student responses to bilingual stories**

<p><b>What the nurse learns:</b></p> <p>She gained many things, such as knowledge and experience, from the instructor instead of the textbooks. Also, she got inspired from all these things.</p> <p><b>What I learn from the nurse:</b></p> <p>When coming across problems, you have to ask for advice from seniors or notice how they deal with difficulties. Learn it as an outsider.</p>	<p><b>What the nurse learned:</b></p> <p>(1) The fun at work. (2) Thankfulness.</p> <p><b>What I learn about nursing:</b></p> <p>In nursing, using your heart to feel everything around you, observing keenly and sympathetically people and things in order to create the fun and passion toward nursing.</p>
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U.S. nursing students were strongly focused on finding common ground with Chinese nursing students around being nervous when entering post-graduation clinical situations. For the Chinese nursing student, an admission of anxiety in such situations no doubt reflects the

situation; however, it is also a cultural expression of humility, which is not quite required but is nonetheless expected. The U.S. students have no cultural obligation to present themselves as deferent and humble, and they are more interested in personalizing the Chinese interviews to themselves and their own emotional reactions. Table 4 displays two typical U.S. responses.

**Table 4: Two examples of U.S. nursing student responses to bilingual stories**

<p><b>What the nurse learns:</b></p> <p>Each of these Chinese nurses learned something from a senior nurse. The similarity in each of the stories was that something was learned when the situation was not turning out as planned. For example, one of the nurses learned to include the family in the patients' care after she had an experience trying to give a child a shot who was not cooperating. Another nurse learned how to prioritize her patient care...</p> <p><b>What I learn from the nurse:</b></p> <p>It is important to remember that it is okay for us to ask questions or ask for help. We are not expected to know everything when we first start working. Even some of the more experienced nurses have to ask for help.</p>	<p><b>What the nurse learns:</b></p> <p>In each one of the three interviews, the new nurses explain how they were really anxious and nervous during the first few weeks at their job. In all three of their stories, they mention a mentor who taught them crucial aspects of their job and made them better nurses.</p> <p><b>What I learn from the nurse:</b></p> <p>Once again, these stories highlight how common it is for new nurses to enter the workforce feeling inadequate and anxious. The stories encourage new nurses to acknowledge these feelings and realize that their more experienced co-workers are there to help.</p>
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## 6. Implications

This short study hopes to add to the growing conversation about cross-cultural pragmatics, particularly as associated with language expectations and language teaching, and to converse with other linguists who are focused on looking at constructs such as 'caring' from a metaphorical or idiomatic viewpoint. We construe the construct of 'caring' in this way:

1. Innate propensity (close to 'denotation' or 'literal' or 'prototypical') in the sense of instinctive altruism. An illustration: when a toddler gets his mommy on the playground to comfort another child, or when a newborn cries when hearing recordings of other babies' crying (but not her own).
2. Associated with any event that conforms to a script: individual A, knowing that individual B is suffering and would not resent the attention, feels or expresses that sympathy through words or action, in good faith that B will not come to harm through A's actions.
3. Idiomatic, as we see in advertising, such as a hospital or a boarding school advertising itself as a 'caring environment'; the script is extrapolated here, not associated with an event, though the understanding is that events conforming to that script occur all the time.

4. Metaphoric, such as a robot in a hospital or nursing home 'caring' for patients by delivering medication and transmitting video images from a doctor elsewhere; this would be the case if the agent credited with 'caring' is not capable of satisfying the condition in 1. above.

There are additional implications for the field of nursing from studying cross-cultural differences in socialization into the profession, particularly given the global migration of nurses and the need for certification of nurses coming from one country to practice in another. Accordingly, we asked Dr. Mary Kotsakalis, an American Nursing Program Director with experience in training students and new nurses from a variety of cultures, to review the American and the Chinese responses to the bilingual stories, looking for commonalities and dissimilarities that could affect training delivery. For example, Chinese nurses focus on elders and seniors and are encouraged to memorize medication errors; geographical location and initial department may well have more bearing on Chinese nurse retention than on American nurses. Dr. Kotsakalis (2010) identified salient distinctions around 'respect.' These features are shown in Table 5:

**Table 5: Review of Bilingual Stories by American Nursing Director**

Chinese – US Differences	Chinese – US Similarities
References to mentor / preceptors as elders.	Feeling of not enough clinical experience to do the job Reason for entering nursing is love of children and wish to help Learned better ways of working Encountered feelings of accepting attitude from mentor and has fond memories of same
The discussion of how the change in geographic location and different work department influenced career. Got degree and friend for good nursing life.	School experience different from what work turns out to be. Anxious, hesitant in the beginning.
Encouraged to memorize the medication error.	Nervous, difficulty adapting, stress, fear Found a mentor, learned good work techniques, assessment skills Made a medication error and felt guilt. Encouraged by mentor to pay attention to detail.
Learning English in order to emigrate and make a better life.	Unable to finish work. Nightmares about work. Nurse mentor to help learn skills.
Emphasis on respecting parent / child as own family	Involve parents in care of child for best results. Emphasis on communication, attention to detail.

Is the resistance to incorporate new models for healthcare delivery an 'inability to accept change' in models for nursing, as one colleague suggested? Or is the resistance an insistence on culturally and linguistic appropriate use of language in adjusting the model to differing cultural contexts? And what do we mean by culturally and linguistically appropriate use of language in health and medical situations? In the example we have been using, is the problem in achieving consensus keyed to the literal 'meaning' of this complex and polysemic construct, or to its idiomatic sense, or to its metaphoric sense? Is it that one culture prefers one set of meanings to another, and neither has stopped to interrogate either set? The readers of each other's commentaries in this study think they understand each other, and each is confident not only that they believe the construct, they also attribute a similar belief to the other. Once either group – in this case, the Chinese – notices metapragmatic contradictions, they then realize that they might not understand and that they might not believe all of what the other is saying. Their common ground is only partial.

Moeschler (2007: 73) claims that "context and its content (a set of implicated premises) are the core issue for explaining intercultural misunderstanding," which he sees as very different from ordinary misunderstanding. His data would seem to support his assumption that "intercultural misunderstandings are caused by the triggering of erroneous higher-level explicatures by the hearer" (75) – that is, an "erroneous evaluation of the communicator's abilities and preferences" (82). Disambiguation in our example has not taken place, because the participants reading each other's commentaries are not aware that such is needed; the implicated premises and eventually the implicated conclusions are faulty (85). The readers have each attributed to the other the notion that they shared the same beliefs and knowledge.

Identifying salience in the cultures of other people is as difficult as is finding it in one's own. Perhaps only in comparisons can we begin to tease out the different ways in which we narrate ourselves into becoming professionals and start to hear the differences as resources. In a recent comprehensive systematic review, Jayasekara and Schulz (2006) examined whether, and under what conditions, it is appropriate to introduce Western nursing curricula into developing countries.<sup>3</sup> Findings were limited because research in this area is just beginning; however, "direct applicability of a curriculum model from another country is not appropriate for different cultural context(s) without first assessing its cultural relevancy". In Taiwan, as in China, the cross-cultural model for care most often adapted – not adopted – from the West is that of Leininger (2002); another frequently adapted model for caring is that by Watson (2002). The models differ in crucial ways; both their cultural and their linguistic appropriateness are now frequently discussed by Chinese nursing researchers in Taiwan. In professional collaborations across international boundaries, ideas and practices that educators and researchers think to be common ground warrant careful study and a commitment to teasing out linguistic practices that account for pragmatic differences.

In reviewing the interviews and the subsequent commentaries, we do not see evidence to suggest that American and Chinese nurses are unable to come to an understanding of each other's notion of *caring* on account of linguistic or socialization constraints. Rather, we interpret the difference in how nurses on both continents frame their discourse on '*caring*' as a reflection of what is salient in each nurse-patient environment.

We see the notions of *cheng* 'familial compassion' and *jing* 'excellence in practice' as scalar rather than polar, and we can readily project such a scale onto the four levels of meaning of the English word *caring* above. By default, we assume that all nurses can feel compassion at the most instinctive level of altruism (level 1). How they frame '*care*' in their narratives must therefore depend on context. In each speech situation, speakers adopt a

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<sup>3</sup> While Taiwan is not a developing country, China was so classified at the time in terms of healthcare.

persona that responds to norms. In a hospital, the nurse's caretaker persona will adjust to the roles of their discourse partners: the status and expectations of doctors, superiors/ elders, and patients. Chinese patients may have expectations of their nurses that prompt them to emphasize *cheng*, whereas American patients are cast as active participants in their care – by giving informed consent, following a regimen (such as managing medication), and pushing the button to call a nurse only as a last resort since the nurse efficiently takes care of many other patients. Such a patient elicits a caretaker persona that emphasizes *jing*.

In each discourse situation from either country, whether with a doctor or with a patient, the nurse has to bring about an equilibrium of interests and demands to bring about a satisfactory outcome of care. The practiced social norms that achieve equilibrium have linguistic expressions, but they are also discoverable without them. While language may, as Boroditsky (2011) contends, "shape thought" to some degree, it does not determine or constrain thought. A personal anecdote may illustrate this. The second author learned to drive in his native Germany, where directions on the interstate system (Autobahn) are given in terms of major cities closest to the destination, e.g. "take a right on ramp 88 onto A1 towards Münster". After moving to the US, he tried to adapt to directions given by hemispheres by mounting a compass on the dashboard of his station wagon, only to find out that it is quite possible to turn East on Exit 58 in order to go North on I-85. The task of navigation is the same, but the language used to describe (give, ask for) directions can emphasize either the largest city closest to the destination, 'left' and 'right' turns relative to the direction of driving, or terms such as 'North' and 'East' relative either to the current direction of the driver or the final destination of the highway itself. None of these frames have improved or harmed his sense of direction, but he can readily adopt and talk about each framework depending on the country in which he is driving.

Postema (2008) would contend that this kind of reference-frame recalibration needs no special instruction or training, claiming that as social human beings, we have an aptitude for "salience reasoning". Linguists study pragmatics precisely because the linguistic expression must be interpreted within context. We propose that potential misunderstanding of a professional construct, caring, between nurses across two continents more probably reflects unfamiliarity with each other's work environments, including cultural expectations for nurses and patients. Greater understanding can begin when training for the nurses in any country includes a greater focus on local and foreign contexts for major professional constructs such as *caring*, or *cultural competence*, and an awareness that different practices can sustain the same construct. Finally, we can postulate that Postema (2008: 43) is correct when he assumes that "Exercising our uncanny ability to identify and appreciate the practical significance of salient options available to us, we often solve our cooperation problems".

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