A Defining Moment: Malaysian Nurses' Perspectives of Transnational Higher Education

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Abstract

Transnational Higher Education (TNHE) post-registration top-up nursing degree programmes are relatively new in Malaysia and their impact in clinical settings is unknown. This research interprets Malaysian nurses' experiences of such programmes and their perspectives of the extent TNHE theoretical knowledge has been applied in clinical settings.

The contextual framework was established by drawing on a range of relevant dominant discourses, i.e. TNHE, nurse education, continuous professional development, theory-practice link in nursing, and culture and its influences, including coping with and adjusting to new ways of learning. Hermeneutic phenomenology and the ethnographic principle of cultural interpretation were used to explore the views of eighteen Malaysian nurses from two UK and one Australian TNHE universities (determined by convenience and snowball sampling methods) to enable data saturation. Semi-structured interviews were conducted to enable the nurses' voices to define, describe and evaluate their TNHE experiences that were focused on personal and professional development, implementation and reaction of others towards change. In addition to the interviews, three threads of my own personal, professional and researcher experiences were reflected upon, to provide the contextual lens to shape the research process and situate the work firmly in the practice context.

Data was analysed using thematic analysis. Four pre-determined key areas drawn from the literature were investigated and eight new sub-themes emerged. Findings indicated nurses' improved self-confidence, knowledge, questioning skills and professionalism. The extent to which TNHE theory was applied in clinical practice was unable to be determined due to conflicting perceptions, contradicting views and restricted number of nurse-led examples.

The main contribution this thesis offers to practice is what the voices of nurses tell about their experiences in TNHE programmes and in applying the taught theory in clinical settings. This study indicates enhanced application of theoretical knowledge in practice for improved quality and culturally competent patient care is unlikely to occur under current TNHE arrangements. Nurses' motives for enrolling were mainly to obtain the high status western degree and the extrinsic benefits of a financial incentive and promotion. However, drawing on their resilience, nurses developed self and professional perspective transformation. The research provides new insights to inform continuous professional education policy for nurses, employers and the Malaysian Nursing Board, and can assist TNHE provider institutions to improve their programme delivery.

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1.0   CHAPTER 1   SETTING THE RESEARCH SCENE

1.1   Introduction

Internationally, the current and pertinent trend in nurse education is the shift from diploma to degree level to ensure a well-educated nursing workforce for delivery of quality patient care. For trained nurses to upgrade or convert their existing diploma qualifications to a degree level, post-registration top-up degree programmes are offered either full-time or part-time. Limited part-time provision of these degrees in Malaysia led the Malaysian Nursing Board (MNB) to accept UK and Australian Transnational Higher Education (TNHE) programmes. As provision of TNHE programmes continue to grow and more trained nurses pursue these degrees, it is essential to highlight the gaps in the literature regarding these programmes and the extent to which theory taught in them has been applied in clinical settings.

In this thesis, the unique voices of Malaysian nurses will depict to the reader a sense of who they are, as they illuminate and give meaning and significance to the reality of their TNHE experiences. With the emphasis on internationalisation, it is pertinent to identify whether TNHE programmes pedagogy delivered in Malaysia stimulates knowledge transfer to inform practices in clinical settings where strong cultural factors continue to affect society.

Globalisation is defined by Knight and de Wit (1997: 6) as the "*flow of technology, economy, knowledge, people, values, ideas ... across borders*". This has led both economically developed and developing countries to reconsider how they fit into and relate to the precedence, history, geography, traditions and culture of the wider world. Although the globalisation-internationalisation nexus is seen as different, in reality they overlap and are interlinked in many ways. One way in which countries respond to the impact of globalisation is by internationalisation of Higher Education (HE), "*… the process of integrating an international, intercultural or global dimension into the purpose, functions or delivery of post-secondary education*" (Knight, 2003: 21). In the context of HE, internationalisation involves diverse types and methods of education delivery.

To reflect internationalisation, some American, British and Australian university schools of nursing have attempted to capitalise on their positive reputation, the prestige of nurse education, their pioneering professional practice and development, and HE for working adults (lifelong learning). Their aim, according to Ziguras (2008 cited in Dunn & Wallace, 2008) is to increase their influence, profile, market expansion and income generating contracts through collaborative links with Malaysia. Some of these initiatives are to deliver TNHE post-registration nursing top-up degree programmes. United Nations Educational, Scientific and Cultural Organization's (UNESCO's) /Council of Europe's (2000: 2) Code of Good Practice in the Provision of Transnational Education define TNHE as "*all types of higher education study programmes or set of courses of study, or educational services … in which the learners are located in a country different from the one where the awarding institution is based*".

In recent years, Malaysian government policy called for upgrading nursing qualification and improving the quality of health care services (Samy, 2006; Newell & Burnard, 2006). It resulted in the Malaysian Ministry of Health (MoH) offering a monthly graduate allowance of RM$400 as an incentive for qualified nurses to upgrade their diploma to degree level in a move to emphasise university education as an influencing factor in human capital development. In tandem with this policy call, in 2008, Continuous Professional Education (CPE) as a criterion for annual re-license was enforced by the Malaysian Nursing Board (MNB).

However, it was recognised there were a) a lack of part-time courses to upgrade hospital-based diploma trained nurses to degree level, and b) insufficient personal and professional development opportunities. In addition, the potential for nurses to obtain a high status western degree with reduced costs (Jantan, Chan, Shanon & Sibly, 2005; Morshidi, 2006; Hassan, 2006) also led the MNB, private Higher Education Institutions (HEIs) and private hospitals to embrace TNHE post-registration top-up nursing degree programmes from developed western countries. Their institutional choice is often based on the Times Higher Education Supplement and QS World University Rankings report. These leagues or global rankings reflect internationalism and provide a snapshot review of the positioning, prestige and quality of education provided by a HEI.

Malaysia expects internationalisation and TNHE programmes to provide western expertise and innovation as a benchmark against international standards (Ismail, 2006). The aim is to improve provision of patient care, enhance the status of the profession and meet the National Vision Policy (Vision 2020) as outlined in Appendix A. In brief, Vision 2020 was an idea adopted by a previous Prime Minister, Tun Dr Mahathir Mohamed in 1990. It illustrates Malaysia's commitment to be a fully developed country (Mohamed, 1991).

In this chapter, the aim of this study is outlined, followed by a brief profile of the pre-registration nurse education in UK, Australia and Malaysia and the TNHE top-up degree programmes. The researcher's rationale for undertaking this study and the research question is identified. Then, the structure of the thesis with a brief summary of each of the six chapters is set out. Finally, a brief overview of the purpose and content of this chapter is provided.

1.2   Aim of the study

This research aimed to explore Malaysian nurses' perspectives of the extent to which TNHE theoretical knowledge taught in post-registration top-up nursing degree programmes' is applied in clinical settings. The study involves Malaysian TNHE nurses' from two UK and one Australian university, thus, in this thesis, TNHE provider countries, or the word 'western' is only used to signify Britain (UK) and Australia. As nursing is a practice-based profession, it is essential for the nursing knowledge taught in the TNHE classroom to be grasped, translated and applied in a meaningful way within the national context (Leininger,1978; Chiu, 2006). Recognition and consideration of this relationship is vital as it is the nurses' knowledge that will make a difference to or enhance the care of patients in their multicultural, multiracial and multilingual Malaysian health care system.

1.3   Pre-registration nurse education

The move to HE for nursing is supported by the International Council of Nurses (ICN). The ICN stress "*university preparation is essential if nursing is to receive the public trust as a profession and, accordingly, be granted the accountability and rewards of professionals*" (ICN, 2008: 12). Each school of nursing initiates and develops their own undergraduate programmes for student nurses that reflect their

preferred approaches to curriculum development and implementation. Thus, they vary between providers / universities within and between countries.

However, all pre-registration nursing programmes have an integration of theoretical and practical knowledge. The theoretical or viable knowledge is acquired in academic settings to enable understanding of what is being done and why (Glaserfeld, 1990). On the other hand, practical or process knowledge is learnt in clinical settings (Phillips, Schostak & Tyler, 2000). In nursing both the theoretical and practical knowledge are developed in parallel to enable application of the knowledge in an integrated and meaningful way in the provision of patient care. This highlights the importance of theoretical knowledge being context-based to allow the nurse to process knowledge in their relevant practice (Leininger, 1978; Chiu, 2006).

In Malaysia, student nurses in diploma and degree pre-registration nursing programmes are required to complete a three year diploma programme or three or four year degree programme of study. On completion of their study, all nurses in either diploma or degree programmes are required to take the national Lembaga Jururawat Malaysia [translated as Malaysian Nursing Board] examination. On passing this examination, which is only assessed at Diploma level as stipulated by the Malaysian Nursing Board, both diploma and degree nurses register with the Malaysian Nursing Board for their annual practicing certificate at diploma level and are known as Registered Nurses or junior nurses.

In comparison, in the UK both diploma and degree student nurses are required to fulfil theoretical, clinical and professional criteria as laid down by their professional body, the Nursing and Midwifery Council (NMC) (2010). These are interpreted by each individual HEI providing pre-registration nurse education. In order to register with the NMC and attain the title Registered Nurse, a nurses' specialisation rather than academic level (diploma or degree) is recorded. This is similar in Australia. But, in Australia their diploma pre-registration nurse education programme was quickly replaced after two years of implementation by degree pre-registration programmes. Student nurses are only assessed by their HEIs and attain the title Registered Nurses on registration with the state nursing boards which has now been

replaced by the Australian Health Professionals Regulation Agency (AHPRA). AHPRA oversees the national Australian Nursing and Midwifery Council (ANMC).

1.4   TNHE post-registration top-up degree programmes

The shift from diploma to degree qualified nurses has been driven and influenced by socio-economic factors, ongoing developments in healthcare and professional nursing issues. These worldwide trends are linked to developing a well-educated nursing workforce to ensure quality provision of patient care. In addition, the nursing profession stresses the importance of continuing education for trained nurses. The development of evidence based critical reasoning, advanced knowledge and clinical skills improve professional status of nurses and meet the demands and complexities of modern healthcare (Davey & Robinson, 2002; Dugdall & Watson, 2009).

At national and professional level, diploma registered nurses affected by the pre-registration education change are given the option to meet the new standards through post-registration top-up degrees. These are bridging programmes that do not change nurses' registration to practice as a nurse but allow trained nurses to upgrade their diploma qualifications (240 credits) to a degree level (360 credits). This is achieved through successful completion of a number of modules or credits, usually 15 or 30, allocated to each module.

Previous research (IDP, 2000; Biggs, 2003; Miliszewska, Horwood & Mc Gill, 2003; Miliszewska, 2006; Dunn & Wallace, 2006, 2008; Helms, 2008) suggest that UK and Australian TNHE providers are likely to take modules off the shelf from existing programmes that mirror their curriculum and assessments. Customisation is only made to meet the necessary regulatory frameworks of host countries as their concern is to maintain quality standards, academic norms and assessment strategies etc. similar to home students. Banks & Mc Burnie (1999) and Ohmori (2004) stress it is to ensure integrity and identical value of the certificates. Based on an insight from one UK university school of nursing in this study, the modules selected for the different top-up degree awards are part of existing programmes in the UK. It is likely the modules were taken off the shelf with some adaptation made to the Module Syllabus in an attempt to meet the MNB and Malaysian Qualifications Agency (MQA) requirements.

The conceptual and theoretical materials taught in TNHE programmes meet the needs of the MNB and employers. Malaysian nurses who complete the TNHE degree programme attain the academic award. It does not warrant registration to practice in the UK by the UK Nursing and Midwifery Council or in Australia by the Australian Nursing and Midwifery Council. This is because the programme a) content is 100% theory, b) does not bestow a registration upon those who successfully complete. In theory non nurses such as medical assistants could (and some have) apply to do the programme, c) lacks a practice component, d) does not require clinical assessment. As a consequence of these factors that do not meet the UK and Australian professional body standards, there is no automatic right of registration to practice.

1.5   Rationale for study

This study was initially motivated by the request from a UK university for expressions of interest to teach in TNHE post-registration top-up nursing degree programmes to be delivered in Malaysia. I identified two flying faculty academic staff selected to teach in these programmes, to be part of a small scale study I undertook in the first year of my Education Doctorate (EdD). The research explored lecturers' knowledge and understanding of the influence cultural values have on nurses' preference to learning. During the focus group interview, they made statements that appeared to be from their own cultural group orientation (Appendix B). It appeared these two UK academics made several assumptions as their limited awareness or knowledge of the significance of entrenched cultural values and beliefs of nurses, the educational and health care system in Malaysia became evident. The question that arose was how would they negotiate these cultural differences, and would they be successful?

From the findings, it appeared the two academics assumed Malaysian nurses in TNHE programmes would possess the necessary language and subject knowledge to immediately understand the what, why and how of the taught theory within the short one or two week teaching time frame (Arunasalam, 2009). Evidence that lecture audiences struggle to maintain concentration levels for lengthy periods of time is also well known. Mac Manaway (1970) for example, reported that for the vast majority (84%) of his students, lecture concentration was limited to 20–30 minutes. In 2000, Bligh also stressed the importance of remembering the 20 minute rule for

concentration. Yet, these two academics did not consider the impact this intense and accelerated pace of teaching would have on nurses.

There was also no recognition of the differences in western and Malaysian teaching and learning methods. The western teaching and learning approach is learner-centred. Critical thinking, analysis and reflective practice are pertinent to this approach that is also supported by evidence in the form of resources such as evidence based journals. Western assessments require nurses to seek information from a variety of sources, to debate and justify using academic writing conventions (Hyland, Trahar, Anderson & Dickens, 2008; Kingston & Forland, 2008; Montgomery, 2010). These are all aligned to meet the UK nurse education standards (NMC post-registration education and practice, 2011). In contrast, the approaches to study that arise out of the Malaysian nurses' cultural, social, political, economic and educational backgrounds was didactic teaching that focused on learning by memorisation to demonstrate mastery of the knowledge gained from the teacher and textbook (Biggs, 2003; Ahmad, Shah & Aziz, 2005; Jedin & Saad, 2006). The aim was to elicit correct answers to pass examinations. But, these nurses were expected to easily bridge from their totally different and existing valid learning and assessment mode into a new educational UK and Australian paradigm rather than an internationalised curriculum and assessment strategies (c.f. Healey, 2008).

As a certain knowledge level is required for effective performance in the care of patients, UK, Australian and Malaysian nurses in both clinical and educational settings, have for many years, stressed that it is important for the nursing knowledge taught to be related and relevant to the practice in clinical settings (Rolfe, 1996; Corlett, 2000; Chiu, 2006; Croxon & Maginnis, 2007). Some studies have even acknowledged that theoretical knowledge is directly related to the ability to perform in the clinical context (Eraut, 2004; Muthu, 2006; Banning, 2008; Mantzoukas & Jasper, 2008). Aiken et al (2003), Birks (2005), Chiu (2005), Whyte (2009) and Moore (2010) studies showed improved patient outcomes when nurses have a higher level of education. Adaptation to the institutionally modified practice standards of the real world was essential rather than the ideals that had been taught in schools of nursing (Cahill, 1996; Gray, 1999; Cadman, 2000; Duchscher, 2001; Hamilton, 2005).

The two academics appeared to perceive that the TNHE theoretical knowledge based on the western notions of nursing articulated by their professional bodies was relevant, appropriate and adequate. However, differences are highlighted by a study commissioned by the Royal College of Nursing in 2003 into the experiences of internationally recruited nurses in the UK (Allan & Larsen, 2003). 11 focus group discussions were done with 67 internationally recruited nurses (average 3.8 years working experience in UK) in three sites from 18 different countries in Africa, South Asia, Australia, North America and various European countries. Findings indicated British nursing showed advanced practice and technology, autonomous working and working within protocols. Less positive outcomes showed a focus on documenting rather than giving care, and less advanced scope of practice.

Also, despite the standards in nursing practice worldwide being governed by the World Health Organisation (WHO), nursing in different countries hold their own intrinsic values and beliefs. Western countries have a clear expectation that professional guidelines are implemented regardless of cultural and religious practices (NMC, 2008; ANMAC, 2009). Thus, the UK theoretical knowledge and professional standards, prepares nurses to function primarily in the egalitarian approach to nursing culture and professionalism in the UK health care system (McCaugherty, 1991; Reed & Procter, 1993; Gijbels, O'Connell, Dalton-O'Connor & O'Donovan, 2010). In contrast, Malaysian nurses are expected to not only integrate their clinical practice in line with the WHO's and MNB's (2002) professional standards, but within their work ethics, provision of care must also be carried out alongside the cultural traditions derived from the diverse ethnic groups and societal attitudes (Chee & Barraclough, 2007; Hishamshah, Rashid, Mustaffa, Haroon & Badaruddin, 2011). The data in chapter 5 will clarify and address this point further.

Equally important, is the appreciation of the culturally different contexts in which that care is delivered to ensure a positive TNHE theory-Malaysian practice relationship. However, the academic ideal of nursing taught in TNHE programmes would seem to be focused on preparing nurses to function within the western health care system. There appears to be little recognition that this may clash with the clinical practice in Malaysian nursing. In reality, the fundamental key points of care are not shared worldwide, rather they are determined culturally and linguistically by individual

countries. In Malaysian clinical practice, nurses do not carry out or perform basic roles and responsibilities like providing personal hygiene in the same way nurses are expected to in western countries. This is because there is a disconnection between the western framework of culturally derived values and beliefs and the heavily culturally influenced contexts expected of nurses and found in Malaysian clinical practice (Chiu, 2005; Birks, Chapman & Francis, 2009).

In conclusion, the Malaysian nurses' culture, subject knowledge, education and clinical practice background was not taken into account. These two UK academics' lack of awareness and insight into the different cultural rules of Malaysian nursing students' education, approaches and clinical practice reflected what is often perpetuated in the literature. It is this which is at the heart of the theory-practice divide - the use of formal knowledge instead of developing the knowledge base from clinical experience based on the realities and needs of practice (Reed & Procter, 1993; Ferguson & Jinks, 1994; Maben, Latter & Macleod Clark, 2006).

Given the findings from my earlier small-scale study, it was evident my research focused on the blending of western and eastern cultures (multiculturalism) and the TNHE teaching and learning environment (intercultural). It appeared to me that assumptions were being made by some UK TNHE academics, on the basis of their particular academic and practice models. Although these two academics did not share the same culture, education and health care system as the Malaysian nurses, they seemed to think the western degree theory which is pedagogically designed to meet the needs of UK nursing students would be able to cross intercultural divides. Personally, I also knew from previous experience as an international student that although what is taught and the way it is taught may be the same, what is meant may be construed differently due to dissimilar language histories. Differences in academic translation may have implications in the TNHE teaching and intercultural classroom environment and application of learning in practice.

Further, TNHE post-registration top-up degree programmes with modules that are delivered within one or two weeks continue to grow as they are believed to promote education provision that is relevant to the needs of healthcare practitioners (Wilkie &

Burns, 2003). These programmes are still relatively new and the benefits to nurses, employers, patients and the overall impact on clinical practice in UK and Australia remains unclear as no research shows a profession-wide improvement (Glass, 1998; Hardwick & Jordan, 2002; Pelletier, 2003; Griscti & Jacono, 2006; Gijbels et al., 2010). However, these findings conflict with three studies undertaken in Malaysia (Chiu, 2005; Birks, 2005; Chong, Sellick, Francis & Abdullah, 2011) which reported application of knowledge in practice that resulted in improved patient care delivery. Additionally, TNHE programmes with a variety of knowledge acquisition methods are also evaluated using a range of tools by the western providers. In Malaysia, where the culture promotes consensus rather than critique (Abdullah & Pedersen, 2003; Abdullah & Koh, 2009) it is conceivable that the cultural bias inherent within these evaluation tools may not reflect the real picture, or have failed to capture the efficacy, or offer direction of nurses' learning, academics' performance and programme outcomes. Also, these tools only evaluate whether nurses have received the knowledge imparted rather than provide an insight of the application or impact in clinical practice. Nor do these tools allow nurses to depict issues from cultural dislocation (Pyvis & Chapman, 2005). This study aims to explore this.

The findings of the small scale study and my interest and concerns regarding these two UK academics teaching approaches and viewpoints alerted me to the fact that it warranted further investigation. This led to my unravelling and rewinding specific childhood and adult memories and personal attunement to both Malaysian and UK nuances. Based on the extensive cultural variations in Malaysian society, this prior knowledge and experience highlighted to me the significance of culturally sensitive entrenched language, traditions and customs in daily life, education and health care. Recognition of these was pertinent as they may influence nurses' expectations in the intercultural teaching environment and create difficulties. My findings of Malaysian nurses views in chapter 5 will clarify this point.

The questions that emerged as I synthesised this avenue of exploration were influential in shaping my personal interest. The ultimate research question has its origins in my theory-practice professional interest and connects strongly to the nature of my Malaysian identity and life experiences as an international student nurse. I was also aware that my assumptions and experiences may accentuate the

negative, whilst other people may focus on more positive intercultural experiences. However, the need to raise consciousness of differences (Abdullah & Pedersen, 2003) is essential in this instance due to the potential that it may influence application of learning in practice. This is because nurses will need to make personal, professional and cultural shifts in themselves to apply the TNHE theoretical knowledge in clinical practice. Also, they will need to ensure provision of care is consistent with the expectations of each patient ethnic group as both Leininger (2002) and Campinha-bacote (2003) stress that cultural values, beliefs and practices are embedded within an individual's social structure. This indicates the need for nurses to be aware and sensitive to provide culturally appropriate care (Giger & Davihizer, 2004).

The research focus was changed from an institutional perspective, to the Malaysian nurses' views. Interview extracts which were articulated through the unique voices of nurses will be used to speak for themselves as I interpret their TNHE experiences.

In line with the changed nature of enquiry, I also recognised the strand I intended to research i.e. the extent TNHE post-registration nursing degree theoretical knowledge has been applied in clinical practice appeared to be "*hidden from public view*" (Seale, 2004: 72). Due to limited research undertaken in the area, I have drawn on a range of related material in order to consider the key issues pertinent to my study.

My thesis aims to capture meaning and add value to understanding of nurses' views and experiences of TNHE, and the extent theory taught has permeated into their clinical settings. Addressing issues arising from these will be beneficial for other Malaysian nurses, TNHE providers, academics, MoH, MNB, employers who sponsor these programmes and the HE sector.

1.6   Research question

The research question was to identify *to what extent have Malaysian nurses applied theoretical knowledge taught in TNHE post-registration top-up nursing degree programmes' in clinical settings?*

To answer the research question, four key areas of the nurses' perspective were considered pertinent, essential and meaningful to provide breadth and add depth to

the question of impact of TNHE theoretical knowledge in clinical practice. These key areas were: personal development, professional transformation, implementation and acceptance of nurse-led changes. Personal development and professional transformation were considered main motivators for these nurses to pursue further study as it improves professional socialisation (Chaboyer & Retsas, 1996; Pelletier, Donoghue, Duffield, Adams & Brown, 1998; Chiu, 2005).

Acceptance of nurse-led changes was also included as an important aspect due to a previous UK study by Hardwick & Jordan (2002), and an Australian study by Glass (1998) that revealed hostility and tension with colleagues who did not have degrees impeded application of knowledge in practice settings. It was also vital because Sturdy & Gabriel (2000) argue that Malaysians resist western practices due to former colonial status and Juhary's (2007) belief of the keenness to construct a unifying national identity. In addition to the four pre-determined key aspects, during analysis of the data, other relevant and interesting themes in relation to the research aim also emerged. Figure 1 below articulates the relationship between Malaysian nurses' perspectives of TNHE theoretical knowledge, Malaysian clinical practice and the extent of their application of TNHE theory into their clinical practice in Malaysia (theory-practice link). This is derived from my personal and researcher interest in these relationships which are being analysed within the context of my own experiences as a Malaysian, UK trained nurse and academic working in a UK HEI.

Figure 1: Overview of research aim
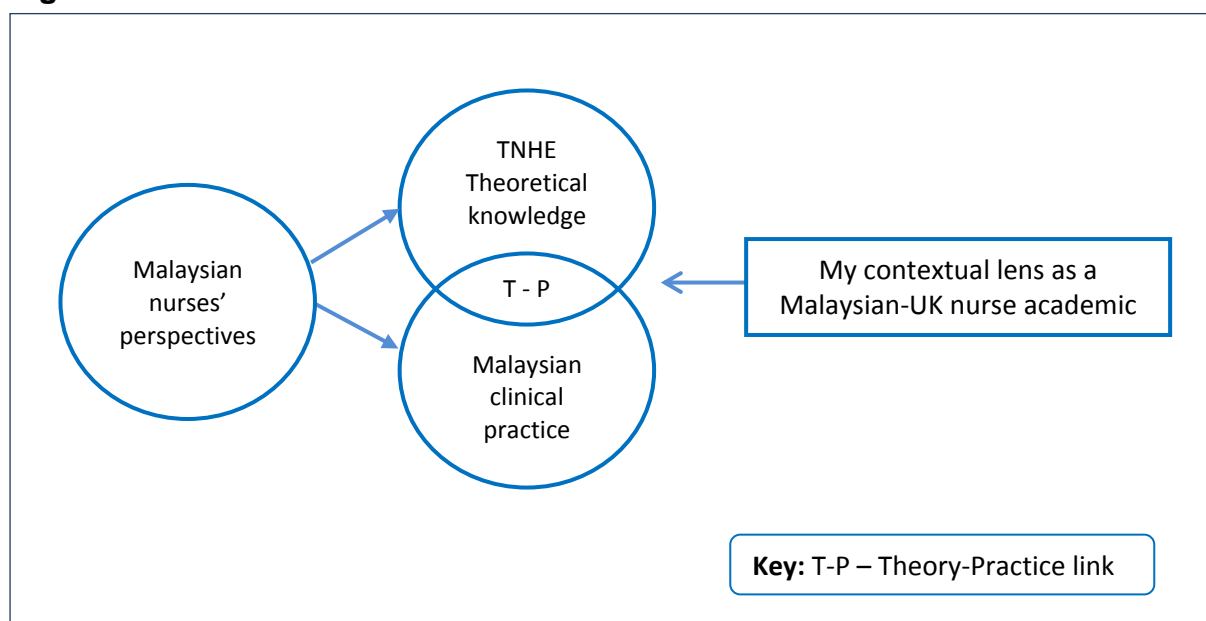
1.7 Structure of the thesis

In Chapter 2, I will discuss and critique the contextual framework, involving both the descriptive and theoretical aspects of TNHE, nurse education, post-registration nursing degree programmes, motivations, the theory-practice link and professional attitudes and tensions. This will enable me to identify the relationships between nurse education and training programmes within and between three countries – Britain (UK), Australia and Malaysia. This is followed by cultural influences on intercultural teaching, learning and practice, culture and learning shock, coping, adjustment and adaptation to new ways of learning and change. It is intended to provide an in-depth understanding of the context in which either application or non-application of western theoretical knowledge in Malaysian clinical practice occurs.

The research design, methodology and research process is the focus of Chapter 3. I outline the interpretive paradigm and the hermeneutic phenomenological research design that looks at lived experiences focusing on everyday issues and that which is unknown. The design was also informed by the ethnographic principle of cultural interpretation. Semi structured interviews were used to collect qualitative data with demographic data obtained via a survey questionnaire. Given the nature of this study, I detailed and justified the research process that included trials and errors. Ethical considerations in all aspects of this research are outlined and discussed throughout the thesis. Data was analysed using thematic analysis. The demographic survey questionnaire revealed a snapshot of collective details, and complemented the qualitative methodology of semi-structured interviews and personal and analytical notes in a meaningful and constructive way. The following three chapters are structured and presented in this specific way to provide insight and transparency for the readers of the text of my influence in the research process and outcome. Also, it provides the reasoning and meanings to the nurses' perspectives of the extent TNHE theoretical knowledge is applied in Malaysian clinical practice.

The reflexive account that locates my own presence in Chapter 4 makes clear my pre-conceptions, views and bias and how my roles and stances influenced the research journey in Chapter 3. It is intentionally outlined prior to the presentation of the findings, analysis and interpretation as the interpretive paradigm acknowledges the researcher's interpretation is central to the process. It is also to make explicit

how it contextualises my own subjectivity, shapes, interprets and authorises me to speak to provide knowledge, reasoning and contextually situated meaning to participants' voices in Chapter 5. In addition, it gives clarity and ensures the descriptions and claims I make are valid in the conclusions I formulate in Chapter 6.

Chapter 4 is autobiographical as it traces my personal journey through multiple roles as a Malaysian, former international student nurse, UK trained nurse, academic and practitioner-researcher. My personal, professional and researcher reflections identify and reveal my social and cultural identity and experiences to make explicit my frames of reference. My reflections of the researcher-participant relationship are discussed through my varied stances as both an insider and outsider in the research field. My shared knowledge, experiences and understanding within both Malaysian and UK communities enabled cultural interpretation of the normative rules, values, belief within education, communities and health care systems for readers. I also chronicle how my thinking changed and influenced the research process. A significant feature of this chapter is the inclusion of extracts from reflexive, reflective, interview, personal and analytical notes that reveal my engagement. These provide both a personal and professional context for the presentation of the interview findings, analysis and interpretation, which is the basis of Chapter 5.

The unfolding of Malaysian nurses' perspectives in relation to the research question is presented, analysed, interpreted and defined in Chapter 5. For the research data to be generalisable the description includes information about participants, in-context data which is detailed and presented under the heading demographic characteristics. I stay true to my participants by using their words or translations, some with slight discrepancies, due to the differences in language structure. The interpretivist stance adopted allowed descriptions and reflections of what Pike (1967) calls as the emic (insider's view of their reality) and the etic (outsider's understanding of the phenomena). The contextualising in Chapter 2 also enhanced my insight of the views that emerged through nurses' unique voices. This will enable the reader to grasp the nurses' own definitions, described thoughts, feelings and meanings that illuminate their perspectives. Nurses' suggestions for improvement of TNHE programmes directed to MoH, MNB, TNHE providers and academics are also incorporated in this chapter.

Finally, Chapter 6 concludes with the basis of my thesis in relation to unfolding Malaysian nurses' perspectives through their own voices of their TNHE experiences, and the extent to which TNHE theoretical knowledge has been applied in Malaysian clinical settings. Based on nurses' experiences and evaluations, I make some recommendations to improve TNHE programmes. Then, I reflect on my methodological approach. The possibilities and directions for future research that became evident from my research within the arena of TNHE post registration nurse education are suggested in anticipation of informing countries with international students, TNHE providers and academics, MoH, MNB, employers sponsoring these programmes and HE. Finally, I articulate the key contributions of my thesis to knowledge and professional nursing practice.

1.8   Overview of chapter

Here in Chapter 1, I use the first person active voice to communicate my self-awareness in the research, develop and gain ownership of my own voice as a credible, authoritative and authentic researcher based on the cultural, political and social origins of my own perspectives. Figure 1 above articulates the relationship between Malaysian nurses' perspectives of TNHE theoretical knowledge, Malaysian clinical practice and the extent of their application of TNHE theory into their clinical practice in Malaysia. The focus is on the theory – practice relationship which is at the heart of this thesis and is a useful heuristic tool for conceptualising the aim of this research. I provided a brief outline of the TNHE top-up nursing degree programmes and discussed how the modules provided by one university were taken off the shelf and adapted only to meet the MNB and MQA requirements. I also highlighted that these UK assessment strategies and standards, equal to home students, may have been maintained to ensure quality assurance.

I engaged critically through the viewpoints and assumptions of TNHE academics in the small scale study and utilised the literary, academic, research and personal influences to underpin and make explicit my rationalisation for this study to both myself and the reader. Finally, an insight into my thesis was provided with an outline of the overall structure and chapter organisation. This research aims to explore Malaysian nurses' perspectives of the extent theoretical knowledge taught in TNHE

post-registration nursing top-up degree programmes is applied by them in clinical practice. The next chapter will explore the contextual framework of the study.

2.0   CHAPTER 2   EXPLORING THE CONTEXTUAL FRAMEWORK

2.1   Introduction

This chapter presents findings from the literature to provide the context against which to interpret Malaysian nurses' perspectives on the extent to which they have applied TNHE post-registration nursing theoretical knowledge in clinical settings. The dominant constructs or discourses that were selected from the literature to guide the interpretation were internationalisation (specifically focusing on TNHE) and standards of quality control. The literature search has been directed towards identifying the relationships between pre and post registration programmes within and between three countries – the UK (England only), Australia and Malaysia. Each country's progress in establishing the level of entry for registration, continuous professional development, TNHE top-up degree programmes, motivations of nurses to study and the theory-practice link have been outlined for comparative purposes.

Cultural influences on intercultural teaching, learning and clinical practice, culture and learning shock, adjustment and adaptation to new ways of learning and change are then explored. To situate the findings of this literature review, the internationalisation agendas of the UK, Australia and Malaysia will be initially identified and explored.

2.2   The internationalisation agenda

Socio-economic factors have led to reduced government funding per student, vast growth in student numbers and the blurring of the university-polytechnic divide (Sugimoto, 2006; Cardoso, Portela & Alexandre, 2007; Leask, 2008). It also changed the focus of many HEIs including the UK and Australia towards economic and political market expansion, global recognition and raising international profile. For example, some HEIs directed their efforts into shaping their international profiles through management support and service functions in their international offices (Kehm & Teichler, 2007; Race, 2013).

Not surprisingly, it is argued in the literature, this has narrowed the construct of HE internationalisation as it has undermined the integration of global, international and intercultural dimensions (Haigh, 2002; Cambridge & Thompson, 2004). In this latter

understanding of what internationalisation should mean for HE, global is meant to refer to cross-cultural graduates with skills to work in a diverse world; international pertains to TNHE programmes, distance learning, mobility of academics and students with an international component in programme content; and intercultural refers to perspectives and issues of a diverse society (c.f. Knight, 2004).

Mc Nicholl, Clohessy and Luff (2006) stress offshore programmes enhance social justice by providing opportunity to students in developing countries to access a qualification not otherwise available to them. However, many like Bone (2008) believe the shift of focus of internationalisation by some western HEIs, has led to attempts to capitalise their positive reputation, prestige of nurse education, pioneering professional practice and development, and HE for working adults (lifelong learning). Mainly, their aim was to increase their influence, profile, market expansion and income generating contracts through collaborative links (Ziguras in Dunn & Wallace, 2008) which has resulted in short-term mass recruitment of students at the risk of neglecting core areas of teaching, research and learning, and the tarnishing of academic reputations of some UK and Australian HEIs. This is confirmed by The *Sydney Morning Herald,* May 10, 2005 that reported academic reputations, finances and student resources of Australian universities have been affected by overseas programmes. Nevertheless, Gerard Sutton (vice president of Australia's Vice-Chancellors Committee) disputed these allegations and emphasised they "*overwhelmingly produce positive returns*" (ibid).

The tension between these two understandings of what HE internationalisation can or should be is pertinent to Malaysia. Aligned precariously with it is the government's focus on national transformation and re-structuring its own HE system (Moja & Cloete, 2001) while controlling public expenditure. In 2009, Gill reported that Datuk Seri Najib Tun Razak, then deputy and current prime minister in Malaysia believed the presence of foreign campuses such as those from the UK and Australia, would expand the private HE sector and inspire it to improve its own potential, strength and calibre of students. It is because the government and society consider qualifications from an English-speaking country as prestigious: a way of advancement for a knowledge-based society and providing benchmarking for international standards (Middlehurst & Woodfield, 2004; Morshidi, 2006). An influx of

foreign programmes also increases their ability to attract the target number of 100,000 international students to become an international HE hub. Clearly, the aspirations align themselves with the broader definition of HE internationalisation and demonstrate the acceptance of TNHE programmes operated and located in Malaysia.

Questions raised were whether TNHE programmes integrate the global, international and intercultural dimensions of the internationalisation agenda, and the extent to which quality control measures consider these aspects when approving TNHE programmes. These will be discussed next.

2.3   Transnational Higher Education (TNHE) and quality control

'TNHE', 'offshore', 'cross-border', 'trans-border' and 'borderless' have been used to describe real or virtual movement of providers, institutions, academics, students, curricula, projects, programmes, knowledge, materials and values (cultural, institutional, educational, procedural and perceptual) from one country to another (Knight, 2002). The term TNHE, first used by the Global Alliance for Transnational Education in 1999, is the term most widely accepted and used within policy frameworks and regulations across both national and regional jurisdictional borders. In 2002, Knight argued there were conceptual differences between these terms, but both institutions, and scholars like Garret (2004) from the UK, Sugimoto (2006) from Australia and Huang (2006) from Japan continue to use this term.

Currently, TNHE is often misunderstood with no common understanding, definition or approach. It appears to have many relationships with different types of providers, rationales, perspectives, strategies, discourses, programmes, mechanisms, delivery and awards. All are components of an international education system, simply with a different emphasis as a response to globalisation.

TNHE has a close relationship with the Bologna Declaration, its follow-up process and intended goals, and a joint guideline by (UNESCO) and the Organisation for Economic Co-operation and Development (OECD) that stress the programmes provided must consider access and relevance to the national context (Knight, 2004; Morshidi, 2005; Mc Burnie & Ziguras, 2007; Dunn & Wallace, 2008).

No legal framework is available for TNHE collaborative partnerships, educational structures, quality and standards of study programmes and qualifications awarded. In Malaysia, policies related to the nation's overall development framework led the Malaysian government in the late 1990's, to put strategies in place for regulation of TNHE provision offered, often (but not always) in association with overseas awarding bodies (Banks & Mc Burnie, 1999; Ohmori, 2004; Morshidi, 2006).

Malaysians attach a high value to education and on-going effort is invested towards further development of the individual in a holistic and integrated manner, so as to produce individuals who are intellectually, spiritually, emotionally and physically balanced and harmonious, with a firm belief in God (Ministry of Education Malaysia, 1993). It has been acknowledged this effort is designed to produce Malaysian citizens who are knowledgeable and responsible with high moral standards and who are capable of achieving a high level of personal well-being to contribute to the harmony and betterment of the nation at large.

Malaysia appears to assume TNHE provision brings with it international quality standards and expertise (Middlehurst & Woodfield, 2004; Morshidi, 2006) to re-invent itself by shaping its HE to promote national development goals (Mok, 2008). The difficulty, as the literature above suggests, is that western internationalisation prioritises economic and market expansion while raising international profiles which Bone (2009) believes may override the need or ability to provide excellence in exported teaching and learning. Bone's concern appears to have some foundation as in practice there are negative accounts of TNHE programmes, with criticisms that it is purely for commercial exchange. This is because TNHE universities market their existing degrees with limited consideration towards the four fundamental gaps that Knight (2004) states need to be bridged i.e. language, culture, geography and history. Only superficial changes are made to internationalise the curricula, with limited local references to social, cultural, traditional and local practices (Leask, 2003; McTaggart, 2003; Das, 2004; Tikly, 2004; Wang, 2008). The values, beliefs, teaching styles and assessments are suitable to the western context (Jones, 2007) which Pincas (2001) and Knight (2004) argue as being disrespectful to the students and a blatant commercialisation of an existing educational programme. Altbach (2000: 5) summarises these criticisms as follows:

> "*It does not really contribute to the internationalisation of higher education worldwide. Knowledge products are being sold across borders, but there is little mutual exchange of ideas, long-term scientific collaboration, exchange of students or faculty, and the like*".

The impact of cultural differences on learning outcomes was explored by Miliszewska et al (2004) whose findings indicated the curriculum must be adapted to local needs. This is also supported by Dunn and Wallace in 2008. Further, Biggs (1999) stresses the importance of considering students' prior learning in curricular development and teaching practices. The emphasis should be on balance between integrating social, cultural, educational needs to ensure what is taught has relevance to the students and the same quality assurance of western educational programmes (Cortazzi & Jin, 1997; Zhang et al, 1999; Das, 2004; Wang, 2008). The aims of the western educational programmes should be to broaden students' frames of reference, facilitate them to internalise the practices of the new culture of learning and/or mediate between and mobilise the two learning cultural resources. This in effect means to create new forms of learning to enable them to embrace these practices within their prior learning. This has brought its own set of difficulties.

Many UK and Australian universities began their TNHE collaborations with distance education programmes designed for their local students (Ziguras, 2007). It appears only limited consideration has been given to the UNESCO and OECD (2005:14) *Guidelines for Quality Provision in Cross-Border Higher Education* that state awarding institutions should:

> "*Ensure that the programmes they deliver across borders and in their home country are of comparable quality and that they also take into account the cultural and linguistic sensitivities of the receiving country. It is desirable that a commitment to this effect should be made public.*"

This refrain that TNHE provision is mainly a commercial exchange rather than an integration of international social, cultural and educational endeavour questions their appropriateness. Also questionable is their quality, applicability and effectiveness to meet the human resource needs of Malaysia's national economy, as outlined in

Vision 2020, the national plans and the industrial master plans. It also highlights that as acquiring cultural values is tacit, and even problematic as it involves intellectual humility and cognitive endeavour, TNHE providers prefer to reflect their individual HEIs' directions and particular trends in their own internationalisation strategies (Perkins, 1999; Denman, 2002).

There is a general belief that TNHE programmes are protected by national regulations and a variety of standards and codes of practice, it thought critical that the curricula of TNHE programmes are similar to those delivered in the home country, with suitable revisions made to suit the student group and the local context (Ballard, 1996; Banks & Mc Burnie, 1999; Bennett et al., 2010). This notion appears clear and straight forward. In reality, it is challenging to conform to different regulatory frameworks of collaborating countries, partly, because of the difficulty of ascertaining the degree of similarity or difference between programmes. This is due to the educational, language and cultural variations where the TNHE programmes are delivered. In short, there is no one-size-fits-all model of quality assurance. This may be contributing to evidence that some TNHE providers avoid aspects of the national accreditation restrictions of the countries receiving these programmes (Stella, 2006; Bennett et al., 2010). This is discussed further in this thesis. It has led to the potential mismatch between programme contents and host country's social norms and regulations (Schapper & Mayson, 2004; Smith, 2009). This in turn does not enhance the global, international and intercultural student experience nor does it demonstrate TNHE programmes are credible or that their credentials are internationally recognised. What seems apparent is that TNHE providers' opportunistic programme developments are income generating in the short-term but may not be sustainable long-term as their quality assurance systems are ad hoc and reactive in manner.

The next section will identify and discuss similarities and differences in the pre and post registration nursing programmes in the three countries involved in my research.

2.4 UK, Australian and Malaysian pre and post-registration nurse education

Professional nursing bodies in UK, Australia and Malaysia (NMC, ANMC, MNB), shape the pre-registration nurse education, standards and registration and post

registration professional development requirements, annual re-licensure and regulatory mechanisms.

2.4.1 UK pre-registration nurse training and education

In the UK, three year nurse training in the pre 1990s was the responsibility of schools of nursing associated with hospitals. Theoretical knowledge was taught in parallel with nursing skills learnt through hands on experience in general, psychiatric, child, learning disability and midwifery practice settings. On qualifying, in addition to registration, hospital based schools of nursing provided nurses with a certificate by United Kingdom Central Council (UKCC) (1986). Often registered nurses ventured to also obtain certificates in other specialities.

The transfer of nurse education from the traditional school of nursing into HE settings in the UK began in 1989 in line with other countries like America and Australia to ensure UK nurses would not be left behind (UKCC, 2001). Around the same time polytechnics were amalgamating with or become fully fledged universities e.g. The London Polytechnic became the University of Westminster and Huddersfield Polytechnic became University of Huddersfield.

Student nurses were offered three year diploma or degree, or four year degree nursing programmes by universities in their chosen branch specialty of Adult, Child, Mental Health and Learning Disabilities. The move into university education meant that the apprenticeship style of nurse training was abandoned in favour of students having a university based education and no longer being regarded as part of the workforce in practice settings (UKCC, 2001). The curricula differed between HEIs, but, the content covered met the registration requirements of the professional body (previously the UKCC) and in 2002, the NMC. There was no national examination and student nurses were assessed by their individual HEIs. On completion they attained an academic award from the university and registration as a Registered Nurse in their field speciality with the previous UKCC (1986) and in 2004 the NMC.

A three year university-based diploma programme became the chosen route to registration as a nurse because financially, the non-means-tested bursary and maintenance grant was more lucrative. In comparison, students in degree

programmes were only entitled to their means-tested bursary and student loan. In addition, degree programmes had a higher entry criteria and assessment level. This changed in 2008, as the NMC stipulated all new nurses qualifying in England must have the minimum award of a degree as of 2013. Both diploma and degree nurses take on similar roles as trained nurses in practice.

2.4.2 Australian pre-registration nurse training and education

Until the 1980s, Australian nurses were trained for three years in hospital nursing schools and were paid employees of the parent hospital (Dooley, 1990). On completion, a certificate was awarded in addition to registration in their specific field (Australian Nursing Council (ANC), 1994). Many registered nurses went on to hold general, psychiatric, midwifery or other certificates, known as a double (DC) or triple (TC) certificate to signify this attainment.

The transfer of nurse education to HEIs occurred at varying rates in each state and territory with diplomas for entry level nurse education. In late 1980s, only a select few Australian HEIs started offering three-year undergraduate degree programmes in nursing for registration as a Registered Nurse (RN) throughout Australia and RN Division 1 (Div.1) in Victoria to practise in general, medical, surgical, psychiatric and developmental disability nursing (Lynette, 1990).

The rapid introduction of pre-registration degree programmes (after two years) led to existing diploma nurses being given the option to upgrade their qualification to a degree level. There was no national licensing examination. Each state or territory had its own statutory authority that accredited individual university programmes against the requirements of that authority. These statutory authorities and nurses' registration boards were supported by state and territory governments but operated independently through state legislation (Stein-Parbury, 2000).

In 1992, to regulate nursing standards and processes nationally, the ANC represented by each of the eight state and territory nurse regulatory authorities was established. All registered nurses working in Australia are now required to demonstrate the ANMC's national competency standards. The standards provide a framework for assessing competency and are used to assess nurses' eligibility for

annual renewal of their licence to practice and for involvement in professional conduct matters. Mainly, these standards are used by HEIs to develop curricula to assess student and new graduate nurses' performance (Australian Qualifications Framework Advisory Board, 2002). The Australian Nursing and Midwifery Accreditation Council (ANMAC) previously known as Australian Nursing and Midwifery Council (ANMC) is now the sole accreditation authority for the nursing and midwifery professions under the National Registration and Accreditation Scheme (NRAS). The Nursing and Midwifery Board of Australia (NMBA) regulates professional registration, codes, standards, and competency (ANMAC, 2009).

2.4.3 Malaysian pre-registration nurse training

In Malaysia, the nurse education originally was modelled on that of the UK, and has developed along similar lines and continues to be influenced by the trends and literature from the UK. However, it has evolved to suit the traditional and cultural rules of the country, whereby only certain elements remain to maintain the standards the government expects. In line with other developed countries, to improve the quality of nursing practice in provision of patient care, the traditional certificate awarded on completion of basic three year hospital-based training was replaced with diploma courses in the early 1990's (Shamsudin, 2006).

Despite the transfer of traditional apprenticeship hospital based nurse training to diploma courses, these courses have remained as hospital based nurse training. Four year degree level pre-registration nursing courses are available only at selected universities. Because of the cost and limited number of places in these degree courses and due to labour force requirements, the majority of student nurses from public and private colleges of nursing still enter the profession and qualify for entry to practice or registration at diploma level. On completion of their pre-registration diploma courses and to consolidate their training in a clinical environment, nurses are encouraged to undertake six months or a year post-basic education to gain in-depth knowledge and clinical experience in specialised areas.

To enable nurses with diplomas to upgrade their qualifications, public universities provide full-time top-up degrees with only one university providing a part-time option. The full-time programmes are funded by the government with the nurses then either

having a contract or being bonded to the government for double the time taken to complete the degree. The part-time programme is self-funded by nurses themselves as employers are reluctant to sponsor a local part-time programme. Both the local full-time and part-time programmes have a clinical practice component and honours title incorporated in their programmes.

In comparing the nurse training and education programmes in UK, Australia and Malaysia, there are a few distinct differences and similarities. In UK, there is no national examination for student nurses, instead student nurses must pass both their theoretical and practice learning outcomes set by their individual HEIs. These HEIs will send transcripts of their results to NMC for student nurses to be registered.

In the UK, all nurses register under a given part of the NMC register relevant to their original field (e.g. Part 1 - Adult, Part 2 – Child, Part 3 – Mental Health and Part 4 – Learning Disability) whether they are in diploma or degree programmes (UKCC, 2001; NMC, 2004). Similarly, in Australia where the diploma pre-registration nurse education programme was replaced by degree programmes, there is no national licensing examination. Instead the statutory authority in each state accredited individual university programmes against the specific requirements of that authority and the title Division 1 Registered Nurses was attained on registration (Nursing and Midwifery Board Australia, 1981; ANC, 1994). Now, registration with the individual state nursing boards has been replaced by registration via AHPRA which oversees the national Australian Nursing and Midwifery Board and other Health Care Professions. Once a student has successfully met the course requirements and is eligible for registration, they will be required to lodge an application for registration. In October 2012, the Nursing and Midwifery Board announced student nurses about to graduate as nurses are being urged to go online four to six weeks before completing their programme of study to enable a smooth transition from study to work. In comparison, student nurses in both Diploma and Degree pre-registration training programmes in Malaysia are required to take the national Lembaga Jururawat Malaysia or Malaysian Nursing Board's 100 multiple choice questions examination which is assessed at Diploma level on completion of their three or four year programme of study.

The view in the three countries in my study was that nurses with diplomas were not expected to meet the new degree standard but they had the option to top-up or upgrade their qualifications. There was also no financial incentive or an automatic salary increase but it became apparent the degree increased one's chances of promotion (Adams, 2003). When academic qualifications increased, some nurses were motivated to study as part of their personal and professional development to fulfil their moral and legal responsibility to update their knowledge, skills, status and for professional survival (Stanley, 2003). As national needs in Australia and the UK became a degree-level entry, there was potential for diploma nurses to lose out in the job or promotion market due to competition. In Malaysia, it has become a bureaucratic target to meet the human resource needs of the national economy, as outlined in Vision 2020 (Jantan et al., 2005; Morshidi, 2006; Newell & Burnard, 2006). Recognising that only two percent of the nursing workforce had degrees, the Ministry of Health offered a financial incentive of a graduate allowance of RM$400 monthly to encourage a rise of between 10 to 15 percent of diploma nurses to degree level.

In all three countries, these top-up degrees were often delivered in the evening either by block course, or once a week, or at weekends and either as face-to-face teaching or distance learning or a mixture of face-to-face and distance mode according to the registered nurses' personal and employment constraints. Nurses were funded or supported by their practice settings financially for the degree course through their salaries and time release, or else self-funding nurses were allowed some flexibility for working patterns. One such professional development programme focused on in this study is described below in section 2.6.

The pre-registration nurse training and education for the three countries involved in relation to the context of my study have been discussed. A variance was identified between the programmes. Next, the continuous professional development that nurses in these countries have to undertake will be outlined.

2.5   Post-registration nursing requirements

Professional development is the process of promoting leadership to enhance the positive advancement of the nursing profession because of the service provided to

communities (Nicholls, 2000). Nursing professional bodies worldwide stipulate continuous professional development to maintain credentials, standards and competencies to avoid obsolete practices in the delivery of patient care. But, each country uses a different term and have different requirements for their professional development as evidenced below.

2.5.1 UK post-registration Continuous Professional Development

The UK, NMC, expects all trained nurses to assume responsibility throughout their professional lives for their continuing professional development. Nurses are required to undertake a minimum of 35 hours of post registration education and practice (PREP) every three years for annual registration. PREP utilises a critical model to ensure continuous theoretical learning that enables nurses to constantly modify their knowledge base to relate to and support the practice of nursing in practice settings and the changing health care environment (NMC, 2011). Opportunities to gain additional clinical skills after qualification are also available. The national standards, HEIs and NMC collaboratively identify ways of fostering partnerships that ensure the education of trained nurses draws from and feeds into standards of proficiency for safe and effective practice.

2.5.2 Australian post-registration Continuing Nursing Education

The ANMC works with the state and territorial nursing regulation authorities to govern the practice of nursing and to facilitate a national approach. Recently, the Royal College of Nursing Australia (RCNA) in an attempt to upgrade qualifications, enhance lifelong learning and specialisation in the area of clinical interest, has also extended its Continuing Nursing Education (CNE) program to all in the nursing profession. All registered nurses working in Australia are required by the state and territory Nursing and Midwifery Regulatory Authorities to demonstrate the Australian Nursing and Midwifery Accreditation Council's (2009), 20 hours of either self-directed, institutional or active learning a year for annual renewal of their licence to practice. No restrictions are stipulated on the type of CNE activities. But, nurses must demonstrate review of their practice, meet required learning needs and ensure the relevance of the activity and its likelihood to enhance their area of practice.

2.5.3 Malaysian post-registration Continuous Professional Education

In 1998, the MNB stipulated in the Nurses' Code of Conduct, the voluntary requirement of 10 contact hours in CPE activities annually, but many nurses did not voluntarily update their professional knowledge regularly (Chiarella, 2002). In 2008, the MNB implemented guidelines and legislation for mandatory Malaysian Continuous Professional Education (MCPE) in an attempt to improve skills, education and implementation of evidence based practice in line with globalisation. Nurses must complete 35 hours of CPE annually to renew their license of practice based on a Credit Points System where different activities are awarded varying points. The highest point of 50 is awarded annually for a degree, masters or PhD study until completion of the programme of study.

In all three countries, nursing practice is defined and governed by law, and entrance to the profession is regulated at the national or state level by professional bodies, but they vary as elements of knowing are socially/culturally and physically situated. Thus, the recommendation of Burton (2009), Burton and Kirshbaum (2012) and Race (2011; 2013) that cultural diversity should be recognised and used to shape education policy is pertinent. Despite the differences between the pre-nurse educational programmes within the three countries in my research, it is clear that all involve the study of nursing theory and clinical skills for application of learning in practice. Professional development requirements for nurses in these countries vary but all emphasise the need for continuous advancement of their knowledge base and skills to support their clinical practice and for annual registration.

2.6 TNHE post-registration nursing degree programmes

Increasing emphasis on education and significant changes in healthcare worldwide led to qualification escalation to ensure equal respect was accorded to nurses as other professionals (Glasper & O'Connor, 1996; ICN, 2008; MNB, 2008; ANMAC, 2010; NMC, 2011). The MNB, private colleges linked to private hospitals, private HEIs and public universities collaborate with UK and Australian HEIs to accept these programmes. Both the UK and Australia market the post-registration top-up degree programmes separately, as their method of delivery is different from those provided for degree student nurses (NMC, 2011; ANMAC, 2010). The varied specifics of HEIs in UK and Australia with their different curricula and mode of delivery appeared to

not affect where these diploma nurses chose to study. But, the TNHE university chosen was either selected by their employer or was their preference in self-funding. It was based on the cost, type of modules or degree they wished to acquire.

2.6.1 Description of TNHE top-up degree programmes in Malaysia

TNHE post-registration top-up degrees are bridging programmes that do not change nurses' registration to practice as a nurse (NMC, 2011; ANMAC, 2010; MNB, 2007). These programmes allow the Diploma or level two of 240 credits to be increased to a level three with 360 credits required for a degree. This is achieved through a number of modules or credits, usually 15 or 30, allocated to each module. Thus, supporting the continuous development and lifelong learning that professional nursing bodies stipulate to maintain registration for quality patient care.

Some private hospitals promote TNHE post-registration nursing degree programmes as part of their in-service training or as four stand-alone modules as a nursing degree is to become the basic qualification (MoHE, 2003; MNB, 2008). These in-service programmes do not require the Malaysian Quality Agency (MQA) approval. MQA approval is only sought when these programmes are marketed as a Degree programme (MQA, 2009). In relation to my study, some participants were in programmes provided by their employers that did not require MQA approval. Others, who funded their own study, participated in programmes with a TNHE university that had accreditation approvals. These nurses used their savings or took out loans to fund their TNHE studies. In contrast, nurses in government hospitals who are generally provided post-registration nursing degree programmes in public universities, are fully government sponsored and tend to study full-time, unless they choose to study part-time. Private hospital nurses also have the option to study full-time in public universities, but have to self-fund. Most opt to study part-time (all of my interviewees) because they choose or their employer is providing the TNHE programme. It reflects the actual difference of Malaysian Continuous Professional Education for post-registration top-up nursing degree between government and private hospitals (MNB, 2008).

To undertake the TNHE pathway or any stand alone modules, nurses must have prior registration with the MNB, a Diploma in Nursing or the ability to provide

alternative evidence (MoHE, 2007-2010). The Module Syllabus provides learning outcomes and a guide to the core knowledge and professional values essential and implicit to the module and assessment to provide students with essential knowledge and understanding.

Nurses in top-up degree programmes were only required to complete the theoretical components that include research, management and professional contents related to advancing practice and sometimes specific to a clinical specialty, essentially, similar to undergraduate programmes. There was no need to undertake any practicum (NMC, 2011; ANMAC, 2010).

However, nurses tend to relate their western assessments to their western clinical settings. In Malaysia, where these programmes are provided full-time by certain public universities and part-time by only one university, all nurses have theoretical knowledge taught in the classroom and experiential learning in practice settings (MNB, 2008; MoHE, 2007-2010). In addition, they undertake and complete a research project for the honours title. Both Chiu (2005) and Birks (2006) stress that with a limitation to the flexible off-campus or part-time study, many health care employers and trained nurses have opted for TNHE programmes for the diploma to degree conversion. The MNB (2007) and MQA (2009) attempt to indigenise the international curricula in line with its national objectives when the programmes are offered nationally. However, this is not seen when it is provided as a professional development programme for nurses by their individual employers.

In my final chapter evaluating the TNHE post-registration nursing degree programmes, I will re-consider the issues raised. These are important considerations for the Ministry of Health, Ministry of Higher Education and Malaysian Nursing Board because their investment in TNHE programmes is specifically aimed to attain a graduate workforce to enable changed mind-sets and create a knowledgeable nursing cohort to enhance standards of patient care. The incentive behind increased demands for these TNHE professional development courses in UK, Australia and Malaysia are discussed next.

Questions raised were whether UK and Australian TNHE post-registration degree programmes had integrated global, international and intercultural dimensions in their TNHE theoretical knowledge. As these programmes have only recently been offered in Malaysia for their anticipated international quality standards and expertise, it is essential to explore the extent TNHE theory improved the knowledge of Malaysian nurses who had engaged in them and by association, patient care.

2.6.2 Motivation to undertake top-up degree programmes

Studies in the UK, Australia and Malaysia of mature nursing students studying in post-registration top-up degree programmes have been considered from a multifaceted and inter-related range of perspectives (Boore, 1996; Dowswell, Hewison & Hinds, 1998; Pelletier et al., 1998; Delaney & Piscopo, 2004; Chiu, 2005; Birks, 2006). Consistent with UK findings, Boore's (1996) study revealed 80% of nurses were motivated by the course relationship to practice and the potential to improve their competence whilst only 20% were inspired by the opportunity for promotions. In contrast, Dowswell et al's (1998) study indicated nurses, midwives and health visitors felt personal (intrinsic) motivation including the desire for academic stimulation and life-long learning. Professional (extrinsic) motivation involved career progression, work environment pressures and professional group, and the need to support junior colleagues and student nurses.

Another UK study by Hardwick and Jordan (2002) showed nurses were driven by their professional development needs of research, using computers and inter-disciplinary team-working. Supporting Australian studies, Chaboyer and Retsas (1996) evaluated a tertiary critical care course where nurses believed the course increased their opportunity for promotion.

Pelletier et al.'s (1998) Australian study indicated motivating factors were job satisfaction or personal (42%), increased professional status (22%) and promotion (17%). A survey of 101 practising nurses in Australia (Delaney & Piscopo, 2004) showed personal and professional growth as reasons to obtain a degree. A raised level of professionalism was identified but was outweighed by personal satisfaction, improved knowledge and self-image, feelings of achievement and success.

In contrast, in Malaysia, a study by Chiu (2005), a Malaysian living in Australia, used semi-structured interviews and focus groups from an Australian TNHE post-registration nursing degree programme. This programme included a practice component that enabled nurses to spend four weeks in an Australian clinical setting. It revealed nurses' aspirations were for personal and professional growth and a short residential block experience at the host university campus. The degree was recognised as key to gain knowledge and achieve professional advancement, improve practice and gain higher qualifications and professional status. Mainly, the professional development arising from international experience was reported to contribute to a deeper understanding of nursing issues, as the Australian-taught theory was directly relevant to the international experience.

Another study by Birks (2006), with solely westerners used semi-structured interviews of a UK TNHE post-registration nursing degree programme. The programme had only a theoretical component. It showed nurses were motivated to enhance their knowledge, improve personally and professionally and implement learning in practice. A recent study by Chong et al (2011) with both local and westerners being part of the research team reviewed the motive for nurses to attend local post-registration degree programmes. Their quantitative self-explanatory structured questionnaire showed nurses' motives were to give quality care to patients and update knowledge to achieve professional status.

There were differences between the three studies. As an insider and outsider to Malaysia, Chiu (2005) found the interview and focus group data highlighted that nurses' aspirations were mainly for personal and professional growth. In contrast, Birks (2005) outsider influenced interview findings showed implementation of learning in practice was the nurses' main motivation for undertaking the programme. The positive theory-practice link findings showed no indication of resistance in clinical practice to western ways. On the other hand, the quantitative self-explanatory structured questionnaire used by Chong et al (2011) of a local programme with a practice component showed nurses' motives were to give quality care to patients and improve skills in practice.

The relationship between data collection methods and insider outsider stance or positionality of the researcher will be considered in Chapters 3 and 4.The next section will discuss the importance of taught theory in clinical practice.

2.6.3 The theory-practice link and the gap in nursing knowledge

Schwab (2004: 107) defined theory as a structure of information that is linked with models, meta-theory, principles, concepts and methods which should enable students to learn about work, for work, and through work to justify their actions and to ensure what they are doing is in context. Louis Pasteur said in 1854, *"without theory, practice is but routine born of habit"*. The standards derived from the World Health Organisation enable nurses to carry out their role, assess patient needs, plan interventions, apply relevant theories and principles within the boundaries of their practice and evaluate outcomes of patient care.

Workplace knowledge, in the situated perspective, thus exists socially and "*is not something that we can claim as individuals . . . this competence is experienced and manifested by members through their own engagement in practice*" (Wenger, 1998: 137). Wenger's belief adds a key point to Schwab's definition; that the knowing from theory must engage with social communities, as an individual's knowledge, thoughts, actions and insight are influenced by their culture and the national context. Wenger's (1998) view is supported by Kramsch (1999). Kramsch highlights the importance to recognise this as individuals have difficulty relinquishing previously constructed cultural perceptions, beliefs and behaviours when attempting to adapt to a new culture: in this case TNHE, a proposed community of practice. Wenger and Kramsch raise the question that is pertinent to my research: Does the TNHE taught theory include aspects relevant, related and acceptable to the Malaysian perspective, practice and provision of patient care in clinical settings. This is further expounded by Biggs (2003) that to achieve functioning knowledge (for professional activities in practice settings), it is vital to have declarative (relevant knowledge base), procedural (skills necessary to apply) and conditional knowledge (awareness to relate to appropriate circumstances).

Nursing being a practice-based profession requires both theoretical and practical knowledge. Theoretical knowledge is the knowledge all nurses acquire to understand

what they are doing and why, whilst practical knowledge is learnt in the clinical area. Both theoretical and practical knowledge must be developed alongside each other to enable application of the knowledge in an integrated and meaningful way in patient care. Glaserfeld (1990) describes the theoretical knowledge presented in academic settings as viable knowledge. Phillips et al (2000) describe the practical knowledge observed in clinical practice as process knowledge. Thus, Eraut (2004) asserts the theoretical knowledge should be context- based to enable the nurse to process knowledge in clinical practice. Chiu (2006) agrees and stresses that integration of the theoretical and practical knowledge is a pre-requisite in clinical situations as it is directly related to the ability of the individual nurse to assess, plan, implement and evaluate care in practice. Nurses with limited theoretical and practical knowledge will be unable to learn from clinical experience whilst nurses with theoretical knowledge but lacking the opportunity for practical knowledge may find it difficult to apply academic concepts in practical settings. Glaserfeld (1990) believes updating theoretical knowledge should be followed with practical knowledge gained in clinical settings to assist the nurse to attach meaning to activities and apply the learning to her/his practice.

Integration of the theoretical and practical knowledge is a pre-requisite in clinical situations, as limited theoretical knowledge may raise difficulties for gaining practical knowledge whilst advanced knowledge without the opportunity for experiential learning could result in an inability to apply the academic concepts or attach meaning to activities in clinical practice.

There has always been an implicit assumption by nurses in educational and practice settings that a certain degree of theoretical knowledge is required. This is supported by Eraut (2004). Theoretical knowledge should be directly related to the ability to apply and practice competently to provide relevant, safe and quality patient care, as professional expertise is only acquired through work-based practices. Some researchers (Jordan, 2000) have concluded CPE has no impact. Others acknowledge theoretical knowledge taught is directly related to the ability to perform in the clinical context, as experienced nurses' use different sources of knowledge to guide their practice (Clark & Holmes, 2007; Scott et al, 2008; Mantzoukas & Jasper, 2008). Whyte et al (2009) argue that having a high level of knowledge did not

always translate into practical competence and the assumption that knowledge level can be equated with effective performance is highly inaccurate in nursing.

Some question why students register in western programmes if they want to be taught in the same way as they would be in their countries whilst others ask how to contextualise theory within an unknown culture and education system?

However, Birks et al (2009) assert that attempting for 'uniformity of practices' with uncritical imitation and adoption is neither practical nor desirable. This view is further highlighted by Abdullah (2006) that Malaysians who adopted and practised western values instead of integrating western ways of knowing within Malaysian values were considered culturally ruthless, over-trained and brainwashed. Schuerholz-Lehr (2007) state there is a need to recognise and demonstrate sensitivity by making adjustments in line with cultural issues to enable the ability to apply the knowledge gained to practice.

Also, Girot's (2000) study showed that both graduate status and experience develop and influence decision making skills in practice, whilst Whyte et al's (2000) research indicated increased levels of confidence and improved integration of academic and clinical skills. Certain researchers show a dichotomy between the degree of theoretical knowledge and the ability of participants to embrace learning in their clinical settings (Hardwick & Jordan, 2002; Gopee, 2003; Stanley 2003; Tennant & Field's, 2004). Generally, the post-registration top-up degree programmes in the UK and Australia indicated no impact on a profession-wide improvement in practice. The findings conflict with the three studies undertaken in Malaysia (Chiu, 2005; Birks, 2006; Chong et al., 2011), as the perceived positive effect of the knowledge gained was application of knowledge in practice and enhancement of nurses' professional practice that resulted in improved patient care delivery. With regards to the TNHE programmes, the key factors are to identify whether the western theoretical knowledge taught has been grasped, is relevant to the wide range of settings nurses work in, and is applied in a meaningful way within patient care in clinical settings. In short, as Burton (2009) points out, nurse education from an international perspective needs to continue to develop standards related to evidence that is transferable across the international context.

Next, the factors that may impede theoretical knowledge being embraced in clinical practice will be discussed.

2.6.4 Professional attitudes and tension

In Malaysia, nursing's move to upgrade diploma nurses to degrees was to meet the demands of changing health care worldwide. But, it has led to challenges within the nursing profession and work environment as some are anti-university education, others are anti-western top-up degrees and many are against degrees that develop only western academic knowledge instead of enhancing local hands on caring skills (Gould et al., 2007; Cooley, 2008).

Nurses in western countries with or without a degree often receive mixed messages as they are given the same positions and responsibilities (Rather, 1993). This has been supported by Taylor's (2001) research that compared the careers and competencies of nurses from three-year degree and three-year diploma courses, six, eighteen and thirty six months after registration. There was little difference in the role orientation and socialisation of graduates. However, in Malaysia, often the chances of promotion for these nurses are increased.

Nursing colleagues in Malaysia who did not have a degree or have contempt for education or are disinterested in furthering their studies tend to inhibit changes suggested or implemented by those who have degrees. This is because they fear they will be forced to study (Blackie, 2001), have concerns for their own future (Owen et al., 1998) and resulting change (Esmond & Sandwich, 2004). Also, there could be professional jealousy, or they may perceive their colleagues as threatening when they have completed degree programmes (Nolan et al., 2000; Spencer, 2006).

These attitudes result in reactions that range from indifference to being defensive, resistance and hostility and quoting they are the real nurses as they provide hands on care in comparison to degree qualified nurses who are considered academic nurses. Succinctly, there is a perception that studying and caring are dichotomous (Glass, 1998; Hardwick & Jordan, 2002; Lowe, 2003) which is disputed by Jinks' (1994) and Girot's (2000) research that show the provision of patient care by nurses with degrees is the same or of better quality. The unsupportive and antagonistic

behaviours cause tensions and leave those who study angry and frustrated and this impact on their motivation and keenness to apply taught theory in practice post-course, findings echoed in studies by Hughes (1990) and Owen et al (1998). It has been posited that for behavioural change in practice settings, there must be support from managers and colleagues (Fraser & Titherington, 1991; Owen et al., 1998).

2.7   Cultural impacts on TNHE teaching, learning and practice

2.7.1   What is culture?

Hofstede (1984: 51) defined culture as the "*collective programming of the mind which distinguishes the members of one category of people from another*". In terms of his work on understanding cultures, Hofstede (1984) explained that members of a community were regulated by behavioural patterns (influenced by upbringing and socialisation in a society) towards a situation based on beliefs (conscious or unconscious thought), norms (socially accepted rules) and values (willingness to conform to rules) learnt throughout their lives. Like Hall (1976), Hofstede concluded that culture is a pattern of thought, emotions and behaviour that is learnt, not innate, inter-connected or shared within a group. It differentiates each group, in terms of their relationships with the environment, people and God, such that it becomes a way of life.

The literature reveals development around his perspective and framework. It has been used extensively by Malaysian scholars (Abdullah, 1992; 1996; Lim, 1998; Merriam & Mohamad, 2000) and foreign researchers studying Malaysia (Kennedy, 2002; Fontaine & Richardson, 2003; 2005).

If Hofstede was right then this study of 'TNHE programming' is also part of what Hofstede refers to as collective – where the collective is comprised of the relevant stakeholders – Malaysian Ministry of Health, MNB, TNHE providers and academics and Malaysian nurses – to form the 'collective'. Already, it is clear that this collective is not clearly defined category of people nor is it a mind-set. The difficulty of Hofstede's thinking and his reductionism are further compounded by post worldwide web developments accompanied by unprecedented global movements of people, information and education. Thus, the interplay between cultures represented in a TNHE classroom is what defines that culture at that moment in unique ways.

This makes sense as Hall (1976) believed we pick up certain beliefs and behaviours through our daily existence, and not specifically because our parents or other people have explicitly told us to do them. Hence, Tuohy (1999) points out that culture itself is not static nor a single entity, rather, multiple factors that changes as the world changes and evolves through different environments and interactions. He adds there is a continual borrowing and integration of cultural aspects between and amongst cultures. Neither is any culture more superior or better equipped than others (Hall, 1976). Hence, it is pointless to compare cultures since cultures are rarely formed in relation to another (Fiske, 1984). This is true. It is only when such cultures do come together, as happened in the TNHE classroom that comparison arises to understand how culture is being negotiated through underlying cultural relationships, particularly in terms of culturally understood power relationships.

Thus, it is here that Kramsch's (1999: 10) definition of culture is selected as the most viable for this research into clinical outcomes of the encounter with TNHE for Malaysian nurses. He defines culture as "*membership in a discourse community*". In this study, that discourse community occurs in the TNHE classroom and is the major focus of the investigation. If this is so, then these Malaysian nurses enrolling in TNHE programmes with different cultural backgrounds than the dominant UK or Australian culture may have different expectations of what nursing is.

This is because the above theorists' predictions are that this will have an impact on individual behaviours – in this case in clinical practice after the TNHE encounter. Kramsch for example believes when a person moves into a new community such as that found in the TNHE 'collective' or 'category' (Hofstede, 1984) they might find it difficult to give up their previously constructed perceptions of self or digress from or relinquish certain entrenched cultural perceptions, beliefs and behaviour to adapt to the new culture: TNHE – proposed community of practice. When Kramsch talks about perception of self, we can take into account for this study, self-perception amongst nurses which arise from the socio-economic backgrounds is just one amongst many other aspects contributing to the self-perceptions constructed. It is in this sense that this study attends to Kramsch's view that a person may intentionally not want to break through cultural constraints to integrate new values into his or her ingrained and learnt cultural programming (Hofstede, 1984). This study whilst

recognising the complexity of multiple factors contributing to the construction of individual identities focuses on learner identities as mediated specifically by national cultural affiliations.

Therefore, the following discussion is offered in terms of the impact of national identity on individual and collective identities of Malaysian nurses as learners and practitioners. To compare and understand cultures requires understanding interpersonal relationships that are significant to the individuals in the cultures under study. This varies between different national cultures. Also, it can be argued as behaviour differs in different cultures, people do not react towards a situation, rather toward its perceived meaning which is influenced by their national ingrained and learnt cultural values. Kramsch's view is supported by the wide variety of generic and nursing-specific research on the experiences of international students in western universities (Hussin 1999; Dunn 2000; Shakya & Horsfall, 2000; Ryan & Hellmundt, 2003).

Among the difficulties faced were language, accent of themselves and academics, western colloquialism, new terminology or jargon, different pedagogical cultures and learning styles. Students' beliefs of the high status of western academics also affected their classroom behaviour. In practice, language difficulties affected communication and understanding of instruction. There were challenges to assimilate and accept western ways of care giving and to reconcile cultural values and beliefs related to nursing in a different context. In addition, making sense of their learning and adjusting to different expectations of what nursing is within the HE and health care system had impacted on integration of taught theory in clinical practice (Matters, Winter & Nowson, 2004). Beyond that there are difficulties with Kramsch's definition of culture as the same elements of reductionism arise.

2.7.2 Intercultural versus multicultural

Interculturalism is explained by Wright, Singh and Race (2012) as how multiple cultures come together around a common purpose to promote belonging, including the pedagogy of citizenship education as policy, pedagogy and everyday practice demands. In contrast, Olson and Kraeger (2001: 116) define multiculturalism as "*when we encounter people of different culture, we discover differences in*

perspectives, behaviours, and communication styles". Succinctly, "*interculturalism is dialogical and unifying whilst multiculturalism is fragmenting*" (Carr, 2012 in Wright et.al., 2012: 278). As both are useful, it is pertinent to integrate both within domestic and international education (Race, 2011).

At this point, I return to Hofstede's five notions (1991) of power distance, uncertainty avoidance, individualism-collectivism, masculinity-femininity and long term orientation versus short term orientation. These are useful notions that would help anticipate important issues in the analysis of Malaysian nurse/ learner culture in relation to the western content and delivery of the TNHE programmes.

2.7.3 Power distance

Power distance is described by Hofstede (1991) as acceptance or non-acceptance of power inequality in society. Malaysia is a hierarchical society, where having power is considered an exclusive right (c.f. Hashim & Abas, 2000). Orders given by leaders, those perceived to have authority, elders and status are in general accepted without explicit questioning. Ahmad et al (2005) and Jedin and Saad (2006) agree individualism and freedom are considered disrespectful as they tend to challenge authoritative views.

Abdullah and Pedersen (2003), Wong (2004) and Mc Burnie and Ziguras (2007), identify the teaching and learning as that of transference with the teacher providing the knowledge which is enhanced by textbooks and the students absorbing this knowledge. This didactic and hierarchical teaching method with passive learners who are trained in rote, memorisation and an exam-oriented mode of learning remained the educational model (Putnam & Borko, 2000; Juhary, 2007).

Overall, some Malaysian scholars still deny the passive, silent, rote learners' labels that characterise the students as surface learners, whilst others acknowledge these learning behaviours, but some stress the western approaches to learning are preferred (Maesin, 2006; Jedin & Saad, 2006). The Western model is considered more critical, where the teacher is thought to facilitate on how to access all knowledge and how to evaluate or critique it.

Although there is no "*general agreement between academics across disciplines in regards to what they believe critical thinking is*" (Egege & Kutieleh, 2004: 79), the assumption is that critical thinking is desirable, beneficial, attainable and universally valued as it is seen as the "*epitome of good thinking*" (ibid). Importantly, this is based on the 'I' (self-esteem, assertiveness and achievement) orientation of the West (Cohen & Gunz, 2002) and so there is tension with Durkin's (2004) assessment of Malaysian culture as non-individualistic and harmony seeking.

Although the Malaysia Plan, with a Vision for 2020 aims for a learner-centred approach to replace the traditional didactic approach, the movement away from the traditional mode is hampered by culturally entrenched rules (c.f. Ahmad et al., 2005). Whilst Hofstede (1980) maintained there was a culture and tradition of obedience to authority in Malaysia, twenty years later, Durkin (2004) posits instead the importance of Malaysians' valuing social harmony. I refer to section 2.3, where it was identified that one of the aims of education in Malaysia was to contribute to the harmony and betterment of the family, society and country. I also point out that the power distance has an impact on the educational styles. Interestingly, the Malaysian national education philosophy was influenced by western educational philosophies instead of indigenous concepts, but the present colonial-influenced educational system is considered Eastern by the Western world (Birks, 2009; MoHE, 2010).

Asian students are challenged when they face the western academic style that Is considered of a high status as it emphasises self-directed learning, problem solving, analytical skills and critical enquiry (Ballard & Clanchy, 1991; Furnham, 1997). If western critical thinking skills are a pre-requisite, how they were to be taught is relevant to this study, in particular as Samuelowicz (1987: 124) stated "*the intellectual skills of comparing, evaluating different points of view, arguing and presenting one's point of view are not developed*". This is because the critical thinking model would need to be used by nurses to internalise and contextualise the evidence base for their clinical settings.

2.7.4 Uncertainty avoidance

This is the extent to which members of a culture "*feel threatened by uncertain or unknown situations*". They may feel uncomfortable and ambiguous, but attempt to

navigate around it, by recognising with different others of how much they share in common (Hofstede, 1991: 113). The diverse ethnic groups Bumiputeras' (a term used for Malays and indigenous groups), Chinese, Indians, Eurasians, Tamils, Babas, Portugese and Dutch in Malaysia each have their own language, religious traditions and customs that have been learned and passed down from one generation to another.

Abdullah and Pedersen (2003) use the term multicultural parallelism to describe this situation. Extensive variation in Malaysian society with regards to behaviour patterns of each ethnic group and their preference to retain their own identity, religion, custom, social practices and tradition is evident. As a range of ethnic groups are represented in the TNHE programmes, this study will only focus on the set of shared patterns as they influence beliefs, norms and values. These are particular sensitivity to shame, maintenance of face (self-esteem), defensiveness of one's own face or that of elders or people in authority or power, respect for people with higher status and westerners. Showing confidence overtly or displaying assertive behaviour is likely to be frowned upon and confrontation is avoided (Hashim & Abas, 2000; Ahmad et al., 2005; Jedin & Saad, 2006).

These writers go on to claim that in interpersonal relationships, tolerance is valued amongst and between ethnic groups. This naive final claim is in itself face saving for the national culture. It is considered polite not to express potentially negative views, therefore feelings are selectively articulated. Puteh (1998) points out that being outspoken and being articulate are not distinguished from each other in Malaysian culture. The indication here is that speaking individually or privately is likely to be favoured over speaking publicly to avoid the risk of humiliating oneself or hurting others feelings. Shared patterns due to intrinsic cultural traditions in Malaysians are known as part of the 'we' (face, modesty and harmony) orientation (Cohen & Gunz, 2002). It is corroborated by Mohamad (2008). His own view, even as he stresses the perceived negativity and harm in the frankness of westerners is that it is valuable and Malaysians need to adopt it for their own progress.

Asian cultural values have been explored extensively in the literature (Cortazzi & Jin, 1997; Holmes, 2004), but in Langguth's Asian Values Revisited (2003), he questions

the validity of these perceptions being attributed to Asian values. He argues when multi-ethnic, multi-cultural and multi-faiths are involved, what is clear is that Asian values are opposite to Western values and ideas (Mohamad, 2008).

2.7.5 Individualism-collectivism

Cultural dimensions of individualism-collectivism have been used to refer to a person's relationship to the group, and to characterise varying beliefs, norms and social values to illuminate and explain differences in behaviour among cultures (Triandis, 1995). Normally, western cultures are classified as individualist and described as autonomous and independent whilst eastern cultures are termed collectivistic due to individuals deriving their identity from their role within the community (Fiske, 1984). This one-dimensional dichotomy of each cultural orientation at opposite ends of a continuum has been rejected. Not all individualist cultures engage in low-context interaction that is straightforward, explicit and self-serving neither do all collectivistic cultures have high context communication that is indirect and implicit (Hall, 1976).

In addition, with the present global environment, no country has a single or homogeneous individualist or collectivist culture. Instead, it is multidimensional; personal characteristics, communication styles and preferences from both individualistic and collectivistic structures are used in different situations (Singlis & Brown, 1995). What is evident is that all cultures share human mentality (Hofstede, 1980), emotional belief systems (Trice & Beyer, 1993), value systems (Turner & Trompenaars, 1993) and behaviour (Harris, 1968) within their different perspectives and meanings.

In relation to TNHE programmes, it is important to recognise that Malaysian society is defined as vertical collectivism (Singlis, Triandis, Bhawuk, & Gelfand, 1995; Triandis, 1995) due to the expectation that orders given by powerful leaders and those perceived to have authority are accepted without question. These are developed in parallel with the domain (identity defined by shared interest), community (learn from each other but not always working together on a daily basis) and practice (shared resources of experiences and problem solving). As nurses are represented from a range of ethnic groups in this study, it is vital to point out that the

strength of the cultural values of collectivism and power has a slight variance within each ethnic group. However, nurses' classroom interaction and experiences may be dictated by their different communal values, beliefs and behaviour patterns or shared patterns as these are ingrained and often acted out unconsciously and involuntarily.

Hence, it is pertinent for western academics to recognise and gain understanding to ensure appropriate strategies are used to mitigate misunderstandings in the teaching and learning process and classroom management. This is to facilitate the application of theoretical knowledge in practice.

2.7.6 Masculinity-femininity

Opportunities for men and women in Malaysian society differ with men generally being privileged and having more power than the submissive women. In recent years, the Malaysian government's position has appeared to promote greater gender equality as it signed the Putrajaya Declaration at the Non-Aligned Movement (NAM) Ministerial Meeting on the Advancement of Women (1995). Changing the way gender roles and power relations are enacted requires challenging long-held and deeply ingrained societal beliefs about the role of women in Malaysia, especially when cultural, religious and traditional practices remain influential in dictating the role, image and privileges of women in society.

With most societies, the role, status and positioning of nursing is a clear reflection of global factors that influence all nurses i.e. women's work, image and stereotype. In some countries including Malaysia, nurses also have to contend with traditional structures and oppression due to religion, tradition, cultural and institutional barriers (Bryant, 2003; Ministry of Women, Family and Community Development, 2004) that has resulted in the perception that nursing is a menial task (Birks et al., 2009).

In the TNHE classroom environment, a mix of both male and female western academics may be part of the flying faculty delivering teaching in these programmes and with regards to the nurses attending these programmes. It is necessary to point out that there are only 361 males in comparison to the 67,988 female nurses (International Council of Nurses, 2008). This major gap in the nursing workforce based on gender was solely due to traditional myths and misconceptions of nursing

being a female-segregated profession (Alexander, 2010) and Bryant's (2003) view that nursing was considered a menial job. This appears to be changing with the wide scope of career opportunities available in nursing.

2.7.7 Long term versus short term orientation

Long term orientation was formerly known as Confucian dynamism as it looks on the extent a society maintains traditional values (Hofstede, 2001). There is a tendency for an Eastern country like Malaysia to ascribe to the values of long-term commitment and respect for tradition. So, in relation to work, long-term rewards are expected. In contrast, employees in Western countries expect short-term rewards from their work. It can be argued even within a culture like Malaysia's, there are certain ethnic groups that prefer short term commitment whilst others prefer long term commitment.

In relation to the TNHE classroom environment, it was relevant to consider the significant insights and cultural perceptions between Malaysian cultural rules and the western context using Hofstede's dimensions as it allowed exploration to enable awareness and understanding. As both the western academics and nurses may have their own assumptions and expectations about the nature of their world and the others' world, the only way this context may be communicated is via interpersonal interactions. If this is not achieved, the extensive variation may result in shock of the new teaching and learning environment. Having understood the cultural values of Malaysians, readers will now be able to understand the potential impact TNHE experiences may have on the nurses and their behaviour.

2.8   Culture shock and learning shock

The term culture shock was first defined by Kalervo Oberg (1960: 68), an anthropologist in the 1950's. He defined culture shock as:

> "*precipitated by the anxiety that results from losing all our familiar signs and symbols of social intercourse. These signs or cues include the thousand and one ways in which we orient ourselves to the situations of daily life*".

Pedersen (1995) believes as culture shock applies to any new situation, relationship, job or perspective, people assume their way of thinking or behaving is the only way and is correct human nature. Often they are unaware of having learnt their cultural ways or how much it shapes their attitudes towards time, space and interpersonal communication. Initial shock may be replaced by the inspiration to self-reflect.

The literature on culture shock in HE is focused on international students leaving their own country and travelling to study at a university in another country (Ballard & Clanchy, 1997; Robertson et al., 2000). Only recently has the literature started to focus on the home international students (c.f. Pyvis & Chapman, 2005). The phenomena relating to culture shock, specifically to the academic context is learning shock (Ballard & Clanchy, 1997), study shock (Burns, 1991), cognitive dissonance (Festinger, 1957), and intellectual culture shock (Ballard, 1987). These describe the experience of acute frustration, conflict, disbelief and disorientation experienced by students when exposed to new teaching and learning methods. Irrespective of whether the students travel to another country or are in their home country, the unexpected and different cues that are difficult to decode, familiar signs which harbour unfamiliar meanings, conflicting expectations, cultural and learning clashes especially in the university context affect the students psychologically and emotionally with implications on their coping strategies (Ryan & Hellmundt, 2003). The level of emotional disturbance varies from individual to individual based on their previous experiences, preparation for the new environment and their expectations.

The TNHE top-up degree programmes are still quite new in Malaysia and are provided to nurses who would be returning to study after a protracted absence. Previous research has shown the shock reactions of adults and mature students when they return to education after many years based on their earlier experiences (Griffiths et al., 2005; Pyvis & Chapman, 2005). They relied on proven routines, methods and memory to pass examinations and may now find the diversity of teaching methods and learning styles distressing (Sadler-Smith, 2001). A fear of failure and a lack of confidence in their ability with academic writing skills may also result in feelings of insecurity and inadequacy (Chasseguet-Smirgel, 1976). But, often they are committed and work hard to transform their previous learnt or existing beliefs to integrate new learning (Cleveland-Innes, 1994; Kasworm, 1997) to make it

more satisfying in its achievements (Fraser & Titherington, 1991). Cross-cultural adjustment or adaptation is required to engage in a new academic environment or learning culture.

2.8.1 From shock to adjustment or adaptation to transformation

Many theoretical models have been developed to capture the nature and process of adjustment or adaptation and have been described and measured in varying ways and from several perspectives. Although there is no consensus on a single definition or clarity to what adjustment or adaptation means, I have chosen to use the construct from Anderson (1994) as it refers to adjustment as a unique process that occurs between an individual and the new environment. In contrast, adaptation is directed towards a psychological and socio-cultural achievement of fit between the individual and the new learning culture (Anderson, 1994). The difference between the two concepts as succinctly explained by Shaffer and Shoben (1956, cited in Anderson, 1994) is that adjustment is related to short-term encounters whilst adaptation is useful for long-term survival. Whilst it clearly demonstrates the differences, according to Berry (2005) and Savicki et al (2008) appraisal and coping strategies of individuals are related to both adjustments and adaptations along a continuum with individuals exhibiting varying degrees, modes and levels of adjustment or adaptation when faced with different situations in the new environment.

People have little control over inherited characteristics and when they assimilate into a culture, group members expect them to observe, learn, adopt and conform to the social beliefs, norms, values, self-identity and behavioural responses of that culture (Dumont, 1986). Members of the culture define and describe themselves with the internal reality gained through years of socialising experiences. This affirmed and reinforced knowledge that has become their way of life is shared with new members.

Thus, both adjustment and adaptation require a conscious learning process as initial emotions and thoughts generate responses that usually result in 'flight or fight' reactions to new ways. A person may adjust quickly. Over time, as the person continues to face these differences, they will learn and become accustomed to the ways of the new culture and thus will "adapt" to cultural differences. The pertinent

point is that it requires a gradual transition as people move from a state of familiarity to unfamiliarity when immersed in a new environment over a long period of time (Shakya & Horsfall, 2000; Sanner, 2002).

Kim (1988) in her stress-adaptation-growth model identified two main trends in reviewing adaptation processes i.e. problem-oriented perspective, such as culture shock studies, and learning and growth perspective. These demonstrate the intercultural learning experience as a transitional experience reflecting movement from low self and cultural awareness to high self and cultural awareness. According to Kim and Ruben (1988: 299), from a social psychological perspective, an integrative model of intercultural transformation focuses on the internal change process where "*individual's cognitive, affective and behavioural patterns develop beyond their original culturally conditioned psychological parameters*".

Intercultural identity was later referred to by Kim (2001) as an acquired identity, by Grotevant (1992) as adopted identity and by Phinney (1993 cited in Kim, 2001: 191) as achieved identity. The development of intercultural identity is a stress-adaptation-growth process (Kim, 1992) that indicates it is not static, but the strain and pressure to comply may lead to change in one's intercultural identity. When individuals mix with members of other cultural groups, they adjust to different identities utilising integration strategies by blending important aspects of both cultures. Kim's assumption was also that maintaining cultural ties and communication with the originating culture will interfere with the adaptation process as it may highlight the incompatibility with one's own values or traditions. This makes adaptation difficult. So, often a person adds valuable resources to their original cultural resources rather than relinquish these original attributes. The adjustment process to the new environment improves the longer individuals reside in the new environment (c.f. Wilton & Constantine, 2003).

Most studies focused on Asian students from a traditional collectivist culture that is more didactic, structured and hierarchical with educational success measured by ability to reproduce knowledge. On transfer to the individualistic culture of western HE, these students were challenged by their language ability, different learning styles, academic study skills and pedagogical cultures (c.f. Furnham, 1997). In

addition, the HEIs inability to provide sufficient support, contributes to stress (Carty et al., 2002). Despite this, a perceived transformation of self was acknowledged with improved confidence that may be due to the sense of achievement (Wang & Lethbridge, 1995).

I argue that even when one moves to a new environment or another country, it is difficult and it takes time to accept different cultural rules, let alone to internalise changes when one remains in one's own country (Crew & Bodycott, 2001; Ryan and Hellmundt, 2003; Chapman and Pyvis, 2005). This complexity is also highlighted by my experiences as an international student nurse in section 4.3. In this regard the difference between adjusting as a survival strategy and adapting in terms of cultural negotiation are discussed in section 2.9.

In relation to my study, I argue that in consideration of the nature of TNHE programmes that involves a short one or two week period of face-to-face or on-line study undertaken every semester over two years, the tendency is for these nurses to be adjusters rather than adaptors. Despite a shared code of professional values and behaviour, the differences in language or culture in the classroom, educational and health care may cause communication barriers. This is because Malaysians have a strong and well-defined set of cultural values which may affect how nursing students adjust to the western cultural rules. Not all will follow or practice these values. The tendency for nurses in my study may be to adjust to meet the assessment criteria and achieve their degrees successfully.

However, I argue that, in order for TNHE learning which focuses on the professional ideals of the western world to have an impact, and for the knowledge to be integrated, accepted and sustained in practice settings; these nurses would need to make adaptations rather than adjustments. This would take time. They would need to reflect on their values and beliefs when they are initially faced with unfamiliar teaching and learning experiences.

Effective coping strategies would need to be used. Individuals will have to use their own resources to cope with the challenges they face, whilst also appreciating and integrating new cultural practices into their own resources. Further, to understand

the complexity of the nurses' adaptation, an integrated perspective involving intellectual, personal, social and practical changes must be considered. It is also important to point out that an overall picture of what is important in society as a whole may affect adaptation. In relation to my study, the adjustment and adaptation aspects are pertinent as they will identify the nurses' learning in line with their previous nurse educational experiences.

2.8.2 Adjustment towards change from TNHE teaching and learning

My study aims to identify whether TNHE theoretical knowledge has changed nurses' personal and professional selves to enable implementation in clinical practice whilst also coping with others' acceptance to change. Change is movement away from a present state toward a new way (George & Jones, 1996) or a response to some significant threat or opportunity arising outside of the organization (Gilgeous, 1997).It has been pointed out that values within oneself must change to enable a shift in belief (conscious or unconscious thought a person holds) and attitudes (beliefs influenced by upbringing and socialisation in a society) that are displayed by behaviour (invoked from memory based on knowledge and experiences) towards a situation (Sampath, Bankwala & Sampath, 2006). As values are learned preferences that provide standards against which people act and events can be judged, they tend to change as the environment changes. But, sometimes people prefer to maintain values despite pressure to change as they find it challenging to adapt to a new context that places greater stress (Kim, 2001) on them. For example, in my study the stressors could be the self-directed learning, problem solving and critical analysis.

Acquisition of knowledge and competence in a foreign language is:

"*not an evolutionary improvement on what precedes it; rather, new knowledge enter adversarial relationships with older, more established ones, challenging their position in the power play of understandings, and in such confrontations new insights can be provoked*" (Fiske, 1989:194 cited in Kramsch, 1993: 238).

As people struggle or are confronted with unfamiliar ways in the educational process of the intercultural encounter, it leads to change (Kramsch, 1993). It would appear

that after an initial culture shock and acculturation period, students adjust and begin to appreciate their increased independence, freedom and responsibility in study.

2.9   Discussion of the contextual literature

In this chapter the literature related to the research questions and issues examined during the study have been presented. TNHE and the new developments in HE share certain common characteristics, mainly in terms of the way they cross the borders of national HE, and are thus identified by the generic phrase of TNHE. Knight (2004) believed a rational application of the definition of TNHE will exclude twinning, joint degrees and credit transfer programmes. In reality, the Australian definition of education and training offered in international education (onshore), distance mode (offshore) and virtual or distance or e-learning delivered without a physical presence of instructors, should not be regarded as part of TNHE education and training. Their definition does not apply as western HEIs are non-specific.

These contradictory definitions have led to terminological and conceptual confusion as a variety of relationships, types of providers, delivery, mechanisms, and programmes and /or awards are continually developed to reflect the individual institutions directions and trends. Despite their differences, the different forms of programmes discussed earlier are components of an international education system, with different emphasis on the mobility of people, programmes or HEIs. Further, there has been a rise in unscrupulous providers of HE who promise quick returns, degree mills (web based companies selling certificates based on life experiences with non-delivery of educational programmes) and rogue providers selling bogus qualifications, which has caused mayhem for international qualification recognition (Garrett, 2005).

It has been argued that the UK and Australian TNHE exporting countries appear to have failed to adopt a planned approach that relates to the needs and demands of a specific country (Leask et al., 2003; Knight, 2004; Ryan, 2005 cited in Ryan & Carroll, 2005); Naidoo & Jamieson, 2005; Wihlborg, 2004). As I highlighted an example in Chapter I, there are TNHE universities that teach off the shelf modules with minimum changes to meet the needs of the Malaysian nurses. Whilst it appears to be a blatant commercialisation of an existing educational programme and is

disrespectful to the students (Doobar & Bateman, 2008 cited in Dunn & Wallace, 2008); it also shows cultural values that affect culturally influenced behaviour have not been considered. It leads to what Crismore (2003) and Buchy and Ahmed (2007) describe as teaching down to communities that are culturally different from that of the teachers. Crismore (2003) also argues it demonstrates colonialism and commoditisation of education with low quality standardised packages of information.

There is a need to recognise and demonstrate sensitivity, by making adjustments to the programmes in line with cultural issues, to enable application of knowledge gained to practice (Schuerholz-Lehr, 2007) as offshore teaching is both an intense intercultural and educational encounter (Leask, 2005). This is evident from Fitch and Surma's (2006) view that in their keenness as academics trying to achieve equivalence in learning outcomes, their assumptions had been that their teaching and learning approach will automatically be understood by TNHE students. Only later did they recognise that students' cultural and educational experiences meant they had different expectations. However, the constraints of institutional processes and practices had prevented them from making the required adjustments crucial to developing a genuinely international approach. Offshore teaching requires more than delivering all the material in the textbook or providing an identical course to the one being offered at the home campus (Bretag, 2005).

Biggs (2003) argues that these students have been identified as seeking a western education, and whilst Gribble and Ziguras (2003) agree, they argue that exporting universities' concern is quality assurance and standardisation, hence, the same education is delivered to all students. Dunn and Wallace (2008) state that the assumption of TNHE providers is that one size fits all.

Nurse education in the early years was similar within each of the three countries discussed here, with nursing skills acquired through hospital based training. Although nurse education to Diploma level was transferred to HE, like degree programmes for both the UK and Australia, in Malaysia, diploma nursing remains hospital based with limited numbers of universities providing degree programmes. As nursing is a practice discipline, following pre-registration nurse education of either diploma or degree level, all three countries emphasise CPD/CPE/MCPE as a

professional requirement for nurses. This is to ensure continued updating of their knowledge and skills to ensure practice is relevant and future orientated for competent and high quality patient care.

Chiu (2006) and Birks (2005) believe post-registration courses in nurse education must enable the academic skills and nursing knowledge to develop from and underpin nursing practice, especially in the national context of Malaysia. This will enable the nurses to make important links to assess, plan, implement and evaluate directly or indirectly, to improve patient care in the multi-ethnic, multi-cultural and multi-lingual dimensions of Malaysian society (Pandian, 2001).

The establishment of degree programmes leading to registration provided the option for nurses with diplomas to upgrade their qualifications. The literature shows that those who chose this option usually had both professional and personal motives, seeking to keep up to date, to advance their careers and to gain personal satisfaction. Also evident from the literature was that having support and good coping mechanisms was crucial to surviving the journey, as they face many challenges such as returning to education with added family responsibility and lack of workplace support. The effects and outcomes of having a degree were usually considered from a personal, rather than a wider professional perspective, leaving another gap in the literature. It was also evident that whilst information on motives, barriers, support and outcomes for undertaking top-up degree exists, the country specific contexts also had an influence.

Sturdy and Gabriel (2000) and Knight (2004) point out that resistance to Western practices in Malaysia is due to former colonial status, whilst Juhary (2007) argues it is due to keenness to construct a unifying national identity and culture to support economic growth and political stability among ethnic groups. Cross-cultural issues usually arise when shifting from an open western environment to a more traditional eastern background and cultural adaptation or adjustment is required (Jones, 2007). Kim (2001) argued that cross-cultural adaptation is a lifelong process. Yang's 2006 study (cited in Huang, 2006) notes Western TNHE providers or programmes may have an impact both educationally and culturally on the students, to shape their

identities towards Western values but education is influenced by the national cultures of both providers and students.

An international perspective recognises the movement of people and information that embraces another's cultural space. It cannot be assumed both cultures share similar contexts, meaning and application of the teaching and learning experience. Now, more and more Western HEIs are starting to recognise Ogbu's (1992) view that they cannot expect eastern students to conform to western models of education, due to the different influences of race and culture on perceptions and beliefs in education (Niu & Sternberg 2001; Chan & Elliot, 2002). As Birks et al (2009) asserts that attempting for uniformity of practices with uncritical imitation and adoption is neither practical nor desirable; these insights will be considered throughout my study in order to uncover and examine the power and responsibility of using reflexivity within the context of this research, as identified by Skeggs (2002).

Research on overseas students is now extensive and focuses on the stages of their adjustments and adaptations (or not), the difficulties they face and the factors that influence their adjustment and adaptations (Gaw, 2000; Furnham, 1997). Since the 1990s there has been a shift in theorising the interface of learning and culture. Culture influences learning but learning itself is a process of transformation as patterns of social interaction, understanding of the world and cognitive capabilities are challenged. Learners use their learnt cultural values to make sense of their world but the learners' engagement and participation in new activities often result in re-learning, modifying and creating new forms of cultural perspectives. The willingness to learn and adapt is necessary when one faces a new context, especially when it takes place between societies with differing cultures, political systems and levels of economic development.

2.10   Overview of chapter

It has been pertinent to explore here the internationalisation agenda, TNHE provision, the national and culturally specific aspects of education and nursing in the UK, Australian and Malaysian societies in order to compare and contrast these. It was also necessary to explore how they might come together, amicably or in tension with each other, within the TNHE nursing programmes. Consideration of certain

significant insights and cultural perceptions of Malaysians is important as understanding the cultural context could act as a foundation to facilitate appropriate teaching, uptake of learning and provision of culturally competent care. Failure to recognise, understand and respect culturally sensitive ingrained language, traditions, customs and practices of each ethnic group, education and health care system when teaching nurses may have implications on the application of nurses' learning in practice. Neither the participants nor I will be able to deny them, as we will be influenced by them when judging situations. Personal engagement with the literature has been significant in my in-depth understanding of the issues to provide an emic view and to present a neutral etic perspective to the reader in Chapter 5.

The issues raised from the literature review for my research question are the potential differences in expectations and assumption in the teaching and learning environment and gap between Malaysian and Western pedagogic and professional values. Based on these differences, the question then is to what extent did these nurses apply the taught theory in clinical settings or was the degree as Furnham (1987 cited in Anderson, 1994: 304) states "for instrumental reasons" only.

3.0   CHAPTER 3   ESTABLISHING THE RESEARCH FRAMEWORK

3.1   Introduction

This chapter aims to describe and justify the research process undertaken for my study. Challenges I faced and the strategies I adopted will be exemplified by extracts from reflexive and reflective, personal and analytical notes, and interview data. Figure 2 (below) presents an overview of the research process and the various decision points and actions taken.

3.2   Interpretive research paradigm

A paradigm implies "*a pattern, structure and framework or system of scientific and academic ideas, values and assumptions*" (Olsen, Lodwick & Dunlop, 1992: 16). Selection of the paradigm was determined by my research aim to explore and interpret Malaysian nurses' views of the extent to which they have been able to apply theoretical knowledge taught in TNHE post-registration nursing degree programmes in clinical settings. Within the research phenomena, I was interested in participants' experiences of the intercultural exchange between different cultures (UK, Australian and Malaysian), specifically, their cultural interpretations.

All these fit within the philosophy, strategies and intentions of the interpretive research paradigm (Guba & Lincoln, 1994; Merriam, 1998). As individuals perceive or experience the same situation differently, participants will interpret or make sense of the situation based on their own context and personal frames of reference. In turn, the researcher as a unique individual will also bias the research and research text by their perceptions, referred by Crotty (1996) as multiple constructed realities. Hence, "*the text is never a record of what happened, only an expression in interpretation and re-interpretation*" (Mann, 1992: 273).

Researchers within the interpretivist paradigm access interact and engage with participants to uncover how they felt, thought and acted and what they expected. Within the interpretive process, the biases, interests, motivations, assumptions and perspectives of the researcher with their different roles or positions in relation to the issues being researched must be identified and explicitly acknowledged. This is due to their potential influences on the research process.

Figure 2: Overview of the research process.

Research Title

A Defining Moment: Malaysian Nurses perspectives of Transnational Higher Education

Small-Scale Study

Explore lecturers' knowledge and understanding of the influence cultural values have on nurses' preference to learning?

Focus Groups
Findings: Lack of knowledge, insight and understanding

Planned Study

Ethics Clearance

Paradigm

Interpretive Paradigm

Design

Hermeneutic Phenomenology | Ethnographic principle of cultural interpretation

Methodology

Quantitative & Qualitative

Methods

Bristol On-line Survey

Convenience Sample n=22, **Respondents** n=17
Findings: Lack of and poor written comments

Focus Groups and/or Interviews

Review of data collection tools

Pilot Study

Semi-structured Interviews

Convenience Sample n=4 participants
Finding: Suitable tool to elicit nurses' views

+

Demographic Survey Questionnaire

To identify 'what 'or 'how many'

Main Study

To what extent have Malaysian nurses applied theoretical knowledge taught in TNHE post-registration top-up nursing degree programmes in clinical settings?

Total Sample n=18 participants, **Sample - Convenience** n=6 &**Snowball** n=12
Number of Universities: 2 United Kingdom n=12, **1 Australian** n=6.
Research Tools: In-depth Semi-structured Interviews & Demographic Survey Questionnaire
Qualitative Analysis: Microsoft Word, thematic coding by hand & findings emerged from data
Quantitative Analysis: Manual and Microsoft Excel

Pre-defined key areas

Personal development, professional transformation, implementation and acceptance of nurse-led changes

Emerged sub-themes

Pre-registration experiences	Reasons for undertaking TNHE degree	Language, teaching & learning issues	TNHE degree requirements guidance & support	Shock, coping strategies	Acclimatisation
Post-basic experiences					Nurses' evaluation

Extent TNHE theoretical knowledge is applied in clinical settings (to improve TNHE programmes in order to enhance patient care).

The researcher uses his/her pre-conceptions to discern and draw inferences to unravel and generate meanings and new understandings, as opposed to predicting behaviour (Guba & Lincoln, 1994). In addition, it is pertinent to view the position and relationship between the researcher and participants. Although both are positioned by their different social realities, the relationship, within the method of data collection and the nature of the questions chosen by the researcher for interaction, generates participants' subjective views that are articulated "*through the casting of a linguistic net*" (Tuan, 1991: 686) to provide deep and rich insight into the context under study.

In using an interpretive stance, the researcher attempts to move to a neutral position to reflect objectively on these realities to generate findings, make judgements, access meaning and translate for readers of the text (Denzin & Lincoln, 2005). By selecting this paradigm, I accepted certain assumptions, namely theoretical knowledge and application in clinical practice are complex cognitive (tacit) and interactive (subconscious) processes that are contextually bound. Personally, I viewed the interpretive position as suitable as it allowed me to unravel and illuminate nurses' TNHE experiences to enable the reader of the text to understand their perspectives. Next, the research design that would support this aim was considered.

3.3   Hermeneutic phenomenology and ethnographic principle

Bradshaw and Stratford (2000) identify a research design as a coherent plan of investigation that fits with the theoretical perspectives and aims that underlie the research. In considering the design, I looked for a people-centred approach that involved in the early stage, identification of nurses' views, supported self-reflexivity and would locate the researcher as part of the research and the research process. This was then to be followed-up with an in-depth culturally related interpretation of the phenomena to facilitate explicitly an emic (insider's view of their reality) and etic (outsider's understanding of the phenomena) perspective (Pike, 1967).

Initially, my research lent itself to phenomenology, with its concern for everyday lived experience and its suitability for investigating personal learning journeys. In looking in-depth into this type of research, I realised it is descriptive and concentrates on the essence of the experience. Preconceptions based on prior research, pre-reflective

thoughts, feelings and experiences must be "*bracketed out*" as suggested by Husserl (1964: 9), in an attempt to allow the collected data to speak for itself rather than be a reflection of the researcher's perception. Although illuminating, it obscures the phenomena itself by isolating the researcher's valuable insights.

I personally would find it difficult to bracket out my interpretation of the phenomena under study and agreed with Merleau-Ponty's (1962: 5) argument that "*we are caught up in the world and we do not succeed in extricating ourselves from it in order to achieve consciousness of it*". Further, I believed not acknowledging my background as a Malaysian and UK resident, previous international student nurse, UK trained and based nurse, academic and researcher would affect the authenticity of my study. An exploration and interpretation of my subjective reality would support the validity of the descriptions of the text. This conclusion led to consideration of hermeneutic phenomenology, informed by the work of Max van Manen (1990).

Within hermeneutic research, the participants are required to re-visit and critically reflect on their experiences and bring into focus not only the everyday issues, but also that which is unseen, unheard and unknown. The interview process is used to explore and gather participants' experiential viewpoints as the voice is illuminated from within based on details of what is said (Koch, 1996), what is said between the lines (Kvale, 1996) and silence (van Manen, 1990). Each interviewee's perspective is considered as a representation of the experiences of one group of people within a specific context which is illuminated through strands of language or patterns shared by members of the group. It also confirms the social and cultural processes that add new insights or dimensions to similar kinds of social and cultural experiences.

My reflexive thoughts reveal my personal insights and theories from the literature which are questioned when returning to participants' experiences to uncover and comprehend the participants' multiple viewpoints. The transcript highlights the interpretive role of the participant in selecting or omitting events in their interviews. It also reveals how researchers use their perspectives and value systems to connect with the shared experiences to uncover participants' reality as it is experienced, and interpret subjective views participants verbalised and had difficulty to articulate. The researcher writes with a pedagogical stance to explicitly develop an awareness of

new meaning patterns within the experiences to provide a richer and deeper research text for the reader to enable better understanding.

The hermeneutic phenomenological perspective is core to my research but the ethnographic principle of cultural interpretation also informed my study. Agar (1986: 19) defined "*ethnography as neither subjective nor objective but interpretive, mediating two worlds through a third"* to enable "*thick description*" (Geertz, 1973: 3) for insight, translation and recording details. Ethnographers can study communities as strangers (outsiders) or as natives (insiders). The researcher's insider or outsider status influences the degree to which participants voice their opinions which ultimately results in somewhat different kinds of detailed accounts. Despite the emic or etic stance of the researcher, they will provide or express the reasoning and meaning about individuals' and communities' way of seeing, reacting and doing.

My personal role within the cultural interpretation of ethnography was to utilise my status as a Malaysian insider. Immersed in the culture for many years previously, I was sensitised to its social cues and fluent in the language spoken by the participants (Bahasa Malaysia). This helped me to interpret participants' views as I was proficient at "*grasping a proverb, catching an illusion or seeing a joke*" (Geertz, 1973: 45) in the native language. My UK residency and professional stance as a nurse, academic and practitioner-researcher enabled me to remain open and non-judgmental about respondents' beliefs, actions and perspectives. This in turn helped me to construct and communicate a more distant, or objective, outsider's interpretation of participants' experiences.

As communication and language are intertwined, cultural interpretation using an emic and etic perspective provides a way of understanding experiences through the use of language, shared meanings of the way of seeing, reacting and doing within a culture and specific context within which it occurred (van Manen, 1997). Readers will then be able to see how these vivid and explicit descriptions of social meaning and reason are part of a system of shared beliefs, conventions and mutual expectations between the individuals involved.

The interpretative, hermeneutic and ethnographic principle of cultural interpretation, all position the researcher within the research process (Agar, 1986; van Manen, 1990; Guba & Lincoln, 1994; Merriam, 1998). As researchers engage with the research, they explore participants' perspectives and incorporate their own views to enable the reader of the research text to understand. Interpretivism addresses shared patterns of meaning or multiple realities embedded in the experiences of participants (Denzin & Lincoln, 2005). The researcher reveals these and articulates an explicit description of the individual, cultural and societal expectations of the situation under investigation to provide richness of experiences.

In being reflexive, readers are able to see how the researcher's background, multiple roles, biography and different stances influenced the strategies adopted and decision-making throughout the research process (Savin Baden, 2004). In addition, the voices of nurses' are enriched by the researcher's reflexivity as findings are interpreted either through reference to nurses personal lives and situations or cultural nuance of Malaysian society or through thoughts of the researcher. The methodological framework that underpins this study is described below.

3.4   Quantitative - qualitative methodologies

Quantitative and qualitative methodologies address and challenge different understandings of the world, the role and intellectual abilities of the researcher, data collection tools, types of data, methods of analysis and findings which are determined by the context, purpose and nature of the research study in question. Quantitative research is "*a formal, objective and systematic process with numerical data used to obtain information about the world*" (Cormack, 1991: 140). The main features are objectivity, generalisability and numbers used by the impersonal role of the researcher to explain the knowledge discovered. In contrast, Creswell (1994: 161) asserts qualitative research uses "*an investigative process where the researcher gradually makes sense of a social phenomenon by contrasting, comparing, replicating, cataloguing and classifying the object of study*". Within the interpersonal situations of qualitative research, the researcher uses a personal approach to analyse and interpret the data to construct knowledge as the focus is on readers of the text to understand the phenomena.

There is some overlap between these approaches and neither methodology is intrinsically better than the other nor are they mutually exclusive. Both are useful and valid when fit for purpose or used appropriately. Either methodology can produce results that are ends in themselves or be used to inform subsequent phases of data collection. Bias is usually associated with subjective qualitative methods but objective quantitative methodologies are just as likely to have hidden bias. People are incapable of total objectivity as they are situated within subjective experiences.

Thus, both methodologies have a degree of objectivity and subjectivity due to a cyclical interaction between data collection and analysis (Phillips, 1993). Distinction between them is mainly at the stage of the research process, as quantitative methodology searches for a detached perspective or facts e.g. age, work locations etc. whilst qualitative perspective aims to bring richness or meaning to a situation.

The location of a study on a quantitative-qualitative continuum shifts depending on the quantitative and qualitative mix chosen by the researcher. The results remain independent as the methodologies do not support each other, but when used together, the findings must converge to provide a concluding generalisation (Patton, 2002). Initially, I chose to utilise both a quantitative (questionnaires) and qualitative methodology (interviews and/or focus groups) for my research. A quantitative approach was selected in relation to my research question, to identify recurring data on certain human responses and reactions. However, as this would not allow respondents to go into depth with answers, a follow-up qualitative methodology was planned to probe, illustrate, clarify and further develop an insight of nurses' outlook. The data collecting methods considered follow.

3.5 Data collection tools

3.5.1 False starts and dead ends

Data collection tools influence participants' responses, thus, in order to select the most appropriate tool, it was essential for me to first identify and consider the contextual framework that was key to achieving the Malaysian nurses' views of the extent they have applied the theoretical knowledge attained in TNHE post-registration programmes in clinical settings. These have been discussed in the previous chapter. A critical review of the findings and feasibility of the studies in

relation to my research aim highlighted the aspects I had to consider and address. These were distance, access to sample, completion time, effort required of participants and ability to gain views of Malaysian nurses (Polit & Beck, 2006). Quantitatively, there are different modes of data collection by questionnaire, for example, method of contacting respondents, delivering the questionnaire and in the administration of questions (Oppenheim, 1998; Burns & Grove, 2005). Paper or on-line survey questionnaire was deemed a viable way of obtaining data from a large number of respondents.

An on-line survey would enable ease of access to the sample group, irrespective of their geographic location. Also, it will incur minimal financial resource implications (no postage or printing), reduce time and effort in terms of data input, transcription and presentation of statistical and comparative analysis. But, both lack control over the way respondents choose to reply which often show they either click through the questions or skip over the open ended questions (Oppenheim, 1998).

An emic insight into the suitability of questionnaires with Malaysian nurses is evident from the comments below of a Malaysian academic on a visit to a UK HEI when she pre-pilot-tested my Bristol On-line Survey.

> My only concern is that not many respondents (especially Malaysians) like to write down their responses (probably because they have difficulty in expressing themselves in a second or foreign language, can they use the Malay language?) You may get a better picture – if you ask these questions during an interview. They usually prefer giving their responses based on Likert or dichotomous scales where they just have to tick or circle etc. They may leave a few blanks or may provide very short responses to open ended questions. Perhaps to make it less intimidating you can include one Likert or dichotomous scale section.
>
> **(Analytical notes from MGS: 5th October 2009)**

Her views were confirmed when I undertook the pilot study using the Bristol Online Survey (BOS) Questionnaire, to identify the feasibility, appropriateness and ease of completion of the questions (Appendix C). Unfortunately, it failed to elicit qualitative comments or feedback from Malaysian nurses. I had to accept that it supported the cultural differences I highlighted earlier in section 2.7 which is also in line with the

views of the Malaysian academic above and the nurses may have clicked through the survey. It confirmed Oppenheim's (1998) view that the decision to click through versus answering open ended questions that requires time to think through answers has a highly negative influence on data quality.

Focus groups are focused on a particular issue, thus, shared or disputed opinions, thoughts and impressions of individual group members in the group can coalesce into a shared reflection of the social realities of a cultural group (Kitzinger, 1995). Also, they activate forgotten details of an experience and release inhibitions that may otherwise deter participants from disclosing information. Interactions within these groups draw on multiple sources of information to produce data that are difficult to achieve with other research methods. But, the benefits of group interaction to promote information disclosure, security and convenience (six to eight interviewees in one group) also have negative effects. There is a tendency for the stronger personality to dominate or silence the weaker personality, and for the weaker personality to follow the stronger personality's view; as one opinion starts to emerge, other similar viewpoints follow (Krueger & Casey, 2000). It is also difficult to extract the standpoint of individual members and so threatens authenticity.

This was reflected in the small scale study I undertook in the first year of my EdD. Only two academic staff were part of the focus group, clearly insufficient for the ideal number of six to eight participants recommended by Krueger and Casey (2000), but they were useful for pilot-testing this approach. In the first focus group, the weaker personality became quieter when the dominant personality voiced her views. When the focus group was re-done, due to failure of recording equipment, the weaker personality not only became more vocal but also followed the stronger personality's point of view. The consensus between the weaker and dominant personality in the second focus group clearly indicated a false representation of the weaker personality's perception based on the interaction that occurred in the first focus group, rightfully questioning the accuracy of the data collected.

Interviews, states Tuckman (1972, cited in Cohen, Manion & Morrison, 2007: 351) are relevant to find out on a one-to one basis what people know (knowledge or information), like or dislike (values or preferences), think (attitudes and beliefs) and

experience. It shapes their perceptions and how they interpret and order the world. Patton (2002) outlined that interviews rely on participants' willingness to articulate their experiences to provide explicit description, compared to focus groups where there is a tendency to provide socially acceptable responses. In a one-to-one interview, participants may be more confident and relaxed to express their personal views about a topic which they might be reluctant to discuss in a group. But, there is a tendency for individuals to sanction responses as they may feel insecure with the status of the researcher. The sensitive or intrusive and time intensive nature of interviews may also prevent them from voicing their views.

3.5.2 Focus groups versus interviews

Initially, I planned to utilise a mixed-methods approach for my study. Following the failure of the BOS pilot study, I was forced to re-consider the use of the quantitative approach which I eventually abandoned. In selecting the use of only a qualitative methodological approach, I had to identify whether focus groups and/or interviews would be appropriate tools in an attempt to collect context sensitive data for my research. Focus groups and interviews are not substitutes for each other as they yield different information. But, the tendency for participants to alter their behaviour or react differently to provide socially acceptable responses is similar in both (Patton, 2002). My insights with regards to the suitability of focus groups and interviews are revealed below.

> I know Malaysian nurses' will smile politely and keep quiet in a focus group. I can just see it! I myself still do it when I am uncomfortable in a group situation, despite being in UK for years! Furthermore, they will also be reluctant or fear to say too much in English as they will be very conscious of their English in front of everyone, especially me a Malaysian now based in UK.
>
> (Reflective Notes: 20th February 2010).

My aim was to hear Malaysian nurses' voices and probe in an attempt to really understand their perspectives. I acknowledged, due to pertinence of saving face, of self and authority, the nurses may not have felt comfortable to speak in English, voice their opinion or express their views openly in a group situation, or in front of other senior nurses and myself, irrespective of whether their perspectives were

shared or not. This may have resulted in participants feigning agreement or expressing thoughts and opinions that they think are expected of them, or which limit disclosure. Also, participants may have feared negative consequences, such as being perceived with a bad image amongst others in the group, or subject to reprisals or repercussions due to socially unacceptable responses.

Consequently, following the investigation of the literature, my insights and the emphasis of interpretive research for in-depth understanding of the phenomena, I drew on Reason's (1988: 79) suggestion of using an approach that would express "*the liveliness, involvement and even the passion*" of nurses' experiences and also my quest for insight into their experiences for rich and detailed description.

Interviewing, compared to focus groups, was ideal to gain, develop, validate and ascertain in-depth understanding. The nurses may perceive it as less threatening within the expected modes of cultural behaviour explored in section 2.7, which was also supported by the emic view of the Malaysian academic cited in section 3.5.1.

3.5.3 Semi-structured interview guide

Since interviews may be conducted in many formats (structured, semi-structured or unstructured), it is vital the researcher selects a suitable tool to answer the research question. Semi-structured interviews provide richness in data and the ability to share insights across interviews. In comparison, structured interviews follow a set order of questioning whilst unstructured interviews lack the same context questions and produce voluminous amounts of data. It is suggested that the type of interview chosen by the researcher is determined by the degree of influence they prefer to exert on the views of the interviewee (Phillips, 1993). Selecting the approach based on knowing what is vital is criticised by Creswell (1994), but I intentionally chose the semi-structured approach as it allowed a conversational way of using the same questions rather than having a strict pre-set interview format.

My thoughts were clear and I was able to clarify exactly what information I wanted to obtain, but it proved more challenging than I first anticipated. It was difficult to compose questions that directly related back to the research question, avoided using language, words or phrases that were common in Britain but not in Malaysia, or

language that was difficult or too complex to understand. Creativity and precision were required to translate the English to align with the language, values and culture of Malaysians. I found my own use of words and language as a Malaysian had changed during my time in Britain, and it had in some ways become a hybrid Bahasa Malaysia (Malaysian language / English) over the years to adapt to the British English. I also had to demonstrate sensitivity to motivate participant response, and avoid causing offence due to cultural differences of language, etc. Whilst some of these are issues faced by qualitative researchers everywhere, questions being phrased or aligned with Malaysian English and their cultural values and beliefs as identified in Chapter 2 were significant for me to consider.

An eight-question interview guide was developed from the review of the literature, personal insights and experiences, and employing principles related to developing interview questions put forward by Merriam (2009) for targeted data collection (Appendix D). The structure of the conversation guide was around four sub-themes: personal development, professional transformation, implementation and acceptance of nurse-led changes in order to identify the theory-practice link. The pre-pilot testing of the interview guide follows.

3.6 Pilot testing
3.6.1 Pre-pilot testing
In the pre-pilot stage, I showed the draft interview guide to five Malaysian educationalists that I randomly selected at an International Conference on University Learning and Teaching hosted by a UK university in partnership with a Malaysian university. They supported my intention to speak both in English and Bahasa Malaysia to enable participants to accept me as a Malaysian. It would encourage nurses to reveal in-depth viewpoints supporting Spradley's (1979) belief that as language is a learned cultural behavior it can be used to generate and interpret speech. They agreed using interviews compared to focus groups was more appropriate due to the sensitive nature of the research. A semi-structured approach would enable a conversational mode of interviewing with all participants being asked the same questions to elicit the data that was required. Their advice and guidance with the language and approach to both the questions and questioning style for the

interviews was invaluable and a good reflection of issues I needed to consider due to entrenched Malaysian cultural values, beliefs and ways.

In order to ensure reliability and validity the interview schedule was pre-tested. For the first pre-pilot test, I used five academic staff from various ethnic groups including Brunei and Malaysia. They were specifically selected from my Faculty of Health and Human Sciences to obtain a variety of opinions in an attempt to refine the language and data collection tool. The second pre-pilot involved three student nurses in a Diploma in Nursing Programme and a Senior Nurse in Malaysia via telephone to identify if they could understand my accent, confirm the correct use of both English and Bahasa Malaysia words, and the appropriateness of my style of questioning.

The purposeful pre-tests were invaluable as they helped me refine the tool and improve the interview process dramatically. For example, they enlightened me about the potential that participants may be reluctant to give certain views, and may have difficulty understanding either my accent or certain English words. I developed an acute awareness for appropriate word usage, for example to use 'rendered care' rather than 'provided care', 'must' instead of 'can' and 'hard' instead of 'difficult', as they were more commonly used terms in Malaysia.

In addition, I recognised the need to narrow the focus of my study, memorise all the interview questions to enable a conversation mode that allowed me to use Bahasa Malaysia, colloquial words and Malaysian humour in an attempt to put the interviewees at ease, and appear and remain neutral. Conversely, the preliminary interviews also identified the lack of a snapshot of collective details for the purposes of generalisation. It was pertinent through quantitative methodology to complement the qualitative nature of the investigation and the small number of interviewees. I constructed a one page demographic quantitative questionnaire with pre-defined choices (Appendix E) to reveal the representativeness of participants' multifaceted views, to add value to the interview data, not to yield confirmation but completeness (Jick, 1979) to enhance reliability and validity.

3.6.2 Pilot study

A pilot study, claim Treece and Treece (1986) is to try out the data collection method

selected to detect any errors because people may attribute different meanings to certain words and questions. But, Shipman (1997) asserts pilot studies are often more useful in identifying possible problems for the researcher in comparison to problems for the respondents. Although I accept Treece & Treece's (1986) argument, for my study, Shipman's assertion had immense impact. At the initial stage of my study, I faced many sudden and unexpected issues, including UK universities either withdrawing at short notice or refusing, or verbally agreeing to participate but failing to provide written consent. As an inexperienced researcher, it shocked me as I saw my well-laid out plans come to a sudden halt. Following these experiences, I set in place alternative plans and strategies for any untoward eventualities.

The pilot study for the interviews in Malaysia aimed to determine the clarity of questions, whether the instrument would elicit useful responses in line with the study and provided the opportunity to practice my face-to-face interview technique to ensure useful and reliable responses were elicited. A convenience sample of four Malaysian nurses' were approached randomly during their lunch break, whilst they were on their teaching period for a UK TNHE post-registration top-up nursing degree programme. There were no refusals. The interviews were conducted in the evenings at the teaching venue and were recorded.

It became obvious when conducting the interviews that despite re-assuring the nurses that they were reading the information sheet and signing the consent forms (Appendix F and Appendix G), only as part of the pilot study, they appeared quite apprehensive to reveal their experiences. At first, I assumed they were disguising their response behind a facade of saving face. When their responses remained the same, after I had re-iterated a few times the purpose of the pilot study and assured them of anonymity, three key aspects became evident. Firstly, I realised it was due to my perceived status as a Malaysian, now based in UK. Secondly, despite stating they were allowed to express themselves in Bahasa Malaysia, they had chosen to speak in English but became self-conscious in front of me. Thirdly, they may also have feared being perceived as having a bad attitude and facing negative consequences as they had not yet completed their programme of study. My view was supported by Preedy & Riches (1988), Brydon-Miller & Greenwood (2006),

Gagliardi (2007) that participants may refrain from truth or comment on issues that might result in negative repercussions, affect their final grades or impact on professional relationships that have to continue after the research is completed.

I quickly reverted to using an indirect or gentle approach, with a pleading tone that Abdullah (1992: 8) calls "*verbal seduction,*" to encourage participants to narrate their experiences. With this approach, the underlying values of politeness, softness, humility and a 'we' orientation is maximised to enable them to feel comfortable with the interview interaction. I also started to speak in Bahasa Malaysia using colloquial words and Malaysian humour, with only occasionally using an English word. They became more relaxed and increasingly animated in their Bahasa Malaysia dialogue. On completion of the interviews, I transcribed the recording but it was not analysed.

To further enhance my interview techniques, I took Hammersley & Atkinson (1995) and Kvale's (1996) advice. The transcription was scrutinised to identify aspects that may improve responses, for example my tone, pace and style of questioning. I further learnt the use of certain common English and Bahasa Malaysia words in Malaysia relevant to my study, for example, to use 'patient warded' rather than 'hospitalised' and 'slang or pronunciation' instead of 'accent'.

Again, I realised the need to speak more in Bahasa Malaysia rather than in English, and the pertinence of using Malaysian humour, as I recognised the threat I presented to nurses due to my status and language. They were either self-conscious, lacked confidence or had difficulty expressing and/or articulating their views fully in English. I noticed only positive responses or a reluctance to provide feedback. Hence, I added the question 'Would you recommend this programme to your close friend and why' as a final question to the interview guide. The pilot study in Malaysia helped refine the interview guide and enabled an initial practice run in interviewing. I felt confident that the tool was suitable to get a sense and insight of nurses' perspectives in relation to the research question. In view of the interpretative nature of my study, the research process will be discussed next.

3.7   The research study

My research aimed to interpret Malaysian nurses' perspectives on the extent they have applied TNHE post-registration theoretical knowledge in clinical settings.

3.7.1   Accessing participants

To gain permission from the four UK universities identified to be part of the research in Malaysia proved to be a complex, lengthy process with largely negative responses. Eventually, only one university provided written consent to participate in my study. At that time, due to poor response, I begrudgingly had to accept that my research would utilise a case-study approach to obtain nurses' views. Stake (2005) claims that the case study is a meaningful, disciplined qualitative approach of inquiry that will provide rich description, clear explanation and in-depth understanding of the phenomena. I personally was not convinced and agreed with Carr & Kemmis (1983) of the restricted transferability, reliability or generality of findings, as it is context bound, thus, cannot claim an outsider's critical gaze.

3.7.2   Sample group for my research

I took Oakley's (1981) advice that self-reflective accounts have meaning when they are closer to the experience in time rather than when the event had taken place sometime before. My decision was also based on enabling nurses' to remember exactly the meaning of the experience to increase the accuracy of recall to obtain an insight of the theory-practice link and reducing any fear of negative consequences with regards to completing or obtaining their degree.

Miller (1997) warned that even with advanced knowledge, the insider must question and negotiate objectivity with the same rigor as an outsider before approaching the research setting. Despite Miller's warning, I falsely assumed that, as a Malaysian, I knew it all and would easily recruit nurses for my study. Initially, a convenience sampling approach was used with the participant selection criteria narrowly defined to a highly selective group of forty-four Malaysian registered nurses completing the last module in their TNHE post-registration nursing degree programme from the only participating university.

The invitation letter to participate in the study was placed in the participating university's Managed Learning Environment, followed by emails and letters (Appendix H). Eventually, only ten out of forty-four potential participants made the conscious effort to contact me, expressing their willingness to participate. I assumed this problem was a result of my UK practitioner-researcher role being perceived as exuding power, status and a threat, instantly making me as an outsider.

Despite further attempts, the number of volunteers remained static. Following emails to request their contact data (name, postal address, telephone number, e-mail address), only six responded with contact details. The experience was emotionally dissatisfying, unproductive and de-motivating. It left me convinced if I was in Malaysia, a higher participation rate would have been obtained.

This was later confirmed when undertaking my interviews in Malaysia, as interest was shown by some nurses who had studied from other TNHE universities. To increase the number of interviewees that had initially been accepted to explore the research question, these additional nurses were accepted, and also asked to further suggest or introduce others who had been in similar programmes. This method to locate information-rich participants is known as snowball sampling (Merriam, 2009), where nurses suggest others who studied in similar programmes, as they were not accessible to me through other sampling strategies. The nurses recruited via snowball sampling were from two additional providers of TNHE post-registration nursing degree programmes in Malaysia i.e. UK, a second provider and one Australian. Table 2 below shows a brief summary of the TNHE universities programmes in this study.

Table 1: Different TNHE post-registration nursing degree programmes in my study

Universities	Number of modules	Type of delivery	Qualification	MQA Approval
University A	4	Face to face	Honours Degree	No
University B	4	Face to face & distance learning	Degree	No
University C	4 & research project	Face to face & distance learning	Honours Degree	Yes

Based on the interviews with the convenience sample of nurses from the first participating university, it became evident that new themes, thematic trends, similarities and data saturation were emerging after six interviews. Hence, six nurses were recruited from each of the other universities, resulting in a total sample of eighteen nurses. With the increase in the number of universities participating in the study, I no longer needed to use the case-study approach that I had initially begrudgingly accepted prior to data collection due to the participation of only one UK university. Now, I was convinced of the suitability of the final research design.

I had not been partial in choosing the convenience sample, or the follow-up snowball sample group in terms of good or bad experiences. Instead, the method of sampling is consistent with interpretive paradigm research as they were participants who were representative of the mixed ethnic groups in Malaysia and who could illuminate the phenomenon being researched. But, I acknowledge the procedure resulted in sampling bias as a result of their self-selectivity. The next section will identify the ethical processes considered.

3.7.3 Ethical considerations

In all aspects of this research, the essential ethical considerations of methods employed are discussed throughout the thesis but have been summarised in this section. Higginbottom (2004: 4) advises to leave "*ethical footprints*" so that future researchers following the research journey may tread in our footprints, knowing the research was ethically conducted. Cohen et al (2011) state the researcher has a moral and intellectual responsibility to ensure the validity and reliability of their research. Van Manen (2011) agrees. He indicates for research to be sound and trustworthy, the culture being investigated must be considered as all stages of the research process impact on how the culture is depicted. I also acknowledge due to the interpretive nature of my research, it was difficult to pre-empt all ethical and practical issues as some were easily identified in advance, whilst others only emerged during data collection.

According to the University's Policies and Regulations (UPR), any research project conducted by students or staff involving human beings requires Ethical Approval before it can start (University of Hertfordshire UPR AS/A/2, 2010-2011). For my

study, formal written approval was given by the University of Hertfordshire's Faculty of Law, Humanities and Education Research Ethics Committee (Appendix I) and guidelines were adhered to. In addition, the key principles from the British Education Research Association (BERA), (2011) advice about ethics were also acknowledged in the work: voluntary, participants were fully informed of the process, informed consent and rights to anonymity.

The invitation letter to participate was placed in the participating university's Managed Learning Environment (Appendix H), followed by emails and letters. All interviewees were provided with information sheets detailing the aims of the study, research process, potential risks associated with collecting personal data and measures taken to avoid these risks for both my pilot (Appendix F) and main study (Appendix J).

Robson (2002) suggests that, before undertaking research, informed consent from all participants should be obtained. All interviewees were given the consent forms: for the pilot study (Appendix G) and main study (Appendix K) that they were required to sign. This was after they were allowed the opportunity to ask questions and/or opt out from the research at any time without negative consequences, and to use a voice-recorder for the interviews. Assurance was given that the recording would be used only for transcription, checking transcription and then destroyed following completion of the research. Only then was the ethical consent form presented for signing prior to interviews for the pilot and main study (Appendix G and Appendix K).

An important ethical consideration in educational research, according to Creswell (2007) is that the data presented should only enable participants to recognise themselves whilst the reader should not be able to identify them. This ethical consideration is supported by Cohen et al (2007) to protect the rights, welfare and dignity of the participants. I ensured participants' anonymity to safeguard and conceal their identity and ethnicity and their university's identity to ensure readers did not guess either the individual or their HEI. This was achieved by using a system of mixed number coding or code numbers. It also later prevented any bias in analysis of the in-depth replies and in presentation of the data as suggested by Creswell (2007), as identifiable quotations were shortened or made less transparent.

Quantitative demographic data was uploaded immediately into the computer on completion of interviews. After this, the only link between the demographic and interview data was a common code number. All data held on computer complied with the requirements of the Data Protection Act 1998 (Her Majesty's Stationery Office (HMSO), 1998) and were password protected. The survey demographic questionnaires and consent forms were stored in a locked drawer. Assurance was given that the data stored will be destroyed at the earliest possible time after the end of the overall study. The personal and analytical notes I completed after each interview were expanded and typed into a computer file. Both the notebook and hard copy of the typed data were stored in a secure location.

Interviewees' permission and agreement was sought, to read, comment on and/or amend or retract statements as they saw fit on transcripts sent via email for verification. This was to ensure rigour by verifying the credibility of the interview data (Polit & Beck, 2010). Apart from the need for academic supervision with the data collected from the interviews, due to the issues raised, only I and another bilingual researcher listened to the audio recordings and verified the transcriptions of the conversation.

3.7.4 Semi-structured interviews

The interviews took place in Malaysia between mid-august and mid-September 2010. Due to my professional work commitments in the UK, I was unable to consider the cultural calendar in Malaysia and ended up being there during the Muslim fasting month (Ramadan), followed by the Muslim celebrations (Hari Raya Puasa). It meant my data collection period was shortened by two weeks, one week prior to the festival and another during the festival as nurses were busy with preparations and celebrations, were on leave or were short staffed in their clinical settings to spend time being interviewed.

The literature suggests interviews should take place in a quiet environment without interruptions (Silverman, 2006; Patton, 2002; Polit & Beck, 2006). Mutual agreement as to a time and venue, in spite of my best intentions, meant interviews did not always take place under these conditions. Most participants opted to be interviewed during their lunch breaks or after their shifts at work for convenience. Hence, I had

many interruptions to contend with, including the challenge of recording. I had to often remind myself they were assisting me with my research, and their lives did not revolve around my research in the same way that mine did. Despite these challenges, none of the nurses appeared rushed or pressured from tasks left undone or had to be done that limited either their contribution or length of participation.

Anspach & Mizrachi (2006) stated conventional research design assumed limited information in relation to the research and should be disclosed by the researcher to minimise the research effect, resulting in more natural answers and behaviour. This view is disputed as the key to obtaining informed consent is disclosure (adequate information) and comprehension (understanding of the information) to enable competence (ability for rational decision making) for voluntary (no coercion) participation (Powney & Watts, 1987). But, Bosk (2001) questions the degree to which participants are informed for consent. Often they are unaware that certain interview methods are chosen to encourage disclosure and that recorded data could be manipulated. However, Bulmer (1984: 260) contends that all research involves "*giving misinformation, some information or even mild deceit to some extent*".

Prior to the interviews, all interviewees were provided with information sheets as described in section 3.7.3. Verbally, they were informed of exactly what I was trying to establish: a realistic account of their experiences. Following verbal consent of interviewees, interviews were recorded as stated in section 3.7.3 to ensure information gained from the interaction was not lost or interpreted differently than intended and to counter criticism of bias.

After a few minutes, as the interview progressed, I noticed some nurses did not seem to be aware of the recorder or that some conversed mostly in English. Initial reserved responses offered were also replaced with more confidential, detailed and revealing accounts. A number of them even stated they were telling me things in strictest confidence. Thus, the potential threat to credibility was diminished. Also, when the interviews commenced, I subtly shifted influence away from myself by inviting them to share what they thought was relevant to open questions such as [translated] 'Why did you become a nurse', or 'Tell me why you went into nursing?' It

provided not only a common starting point but also a way of getting the nurses to talk and break the ice.

Further, as indicated by Drever (1995), the freedom and flexibility of the semi-structured interview format allowed me to alter the sequence, and phrase questions according to their responses to direct, stimulate conversation, probe responses for depth, clarify ambiguous responses, and aid recall of events and meanings assigned to participants' experiences. On reviewing the transcripts, I realised the questions in the interview guide were rarely asked exactly as written, but all participants were asked the same questions, to facilitate comparing answers.

As a sole interviewer, to maintain an atmosphere of a lengthy conversation, I refrained from using "*confronting, doubting or instigating tactics*", which Douglas (1976: 178) argues are poor probing tactics. Instead, I revealed aspects of my identity and my own experiences as an exchange for nurses' views, to develop trust and encourage them to share a more personal opinion, or further expand or offer valuable insight. It also prevented me from exercising a power relationship, despite the potential for data contamination. However, I kept my experiences to a minimum, to reduce distraction of the interviewees from constructing their own meaning to the conversation, and to avoid contamination of data or data being dismissed.

Reflecting on this experience, Hawkins (1990: 417) believed minimal responses such as "*Hm ... yes ... Hm, ha*" used to elicit information could be misinterpreted as a lack of interest. Personally, I opted to strike a balance by sharing experiences only to strengthen our rapport and encourage nurses to contribute further. It was in line with Agar's (2000: 251-252) tactics for cultures where "interpersonal harmony, Implicitness and understatement are valuable".

In reality, there were occasions when participants controlled and used the interview to pursue their own agenda or to vent their frustration. Also, during the interviews, the participants sometimes wandered off the line of enquiry. As the interviews aimed to understand nurses' views of their experiences, I waited when required for the opportunity to refocus the interaction. Occasionally, I myself became immersed in the interviewees' conversation and followed particular leads with supplementary

questions. But, when I noted the time and realised I could not pursue everything, I forced and disciplined myself to re-focus to achieve the purpose of my research.

Initially, I constantly reminded myself to avoid the urge to fill the void by talking excessively. I quickly realised if I waited, the nurses completed their sentences with the words I had been tempted to provide during the intervening pause.   It is noteworthy that not all were willing to take up the invitation to share their experiences immediately. Some were more open and emotionally engaged than others. A few kept silent until prompts, humour, probes, silences and encouragement were used as strategies for interviewing.

It was neither straightforward nor easy to balance research interest against protecting what to reveal or conceal due to assurance of anonymity. I offered anonymity due to the perceived threat of my research by assuring interviewees that code numbers will be used. They were also informed that their ethnic group orientation and specific contextual details that could reveal their personal identity and their universities would be omitted. I also mixed the numbers used for coding interviewees from all universities to ensure they were unidentifiable when reporting the research. The anonymity I guaranteed during pre-research negotiations enabled disclosure by interviewees as my personal account illustrates.

> When I reached the hospital, the interviewee took me to see a Manager, to inform and seek permission for me to undertake the interviews in the hospital. The three of us sat in the Manager's room and had a long and interesting conversation. At no point, despite his attempts to question me in a conversational way did I reveal who my volunteers were nor which universities were involved or of things I may have seen or heard. I truly feel the interviewee felt reassured as the moment I started the interview, she instantly appeared to trust me and voiced her true feelings with regard to a UK TNHE programme.
>
> (Personal notes: 21st August 2010).

During interviewing, sometimes I encouraged nurses to elaborate on certain points for the benefit of the recorder which produced some valuable data to ensure relevant and sufficient data was collected for analysis.   I also questioned whether or not to use free and detailed conversations that occurred prior to interviews or after pressing

the stop button. To remain faithful to participants, I decided against it and also did not include these in my personal and analytical notes, choosing only to use data recorded during the interviews. Thus, some interesting underlying data were consequently lost.

Out of eighteen interviews, sixteen lasted for approximately 60-90 minutes, except for two, where interviewees became quite animated in their conversation and carried on for over 120 minutes. I did not stop their rich narratives as I wanted them to feel I was interested in the issues that were salient to them and in their expert opinion, taking away any sense that I was in control, and to enable them to feel they had gained from being part of the interview. I was also afraid I may be discarding relevant data that may be deemed pertinent at analysis. On completion of the interviews, the demographic survey questionnaire was handed to interviewees. To reduce the risk of missing data due to distance, time restrictions and past experience of poor response to emails, I ensured each demographic detail was completed prior to terminating the interview.

Incentives are recommended, not as a transaction but to encourage volunteers and to establish a relationship (Curtis, Roberts, Copperman, Downie, Liabo, 2004). To ensure the incentive for taking part was neutral in terms of the sample group, study and bias, on completion of the interview I gave nurses a souvenir from the UK as a token of gratitude.

3.7.5 Personal and analytical notes

Throughout the hermeneutic phenomenological research that was also informed by the ethnographic principle of cultural interpretation, I recorded impressions, ideas, memories, key points, opinions and experiences in a journal to show a decision or audit trail that would assist me to consider and reflect during interpretation of data (van Manen, 1990). Koch & Harrington (1998) believes it adds value to establish rigour as the reader is informed of the thoughts and decisions of the researcher.

During the interviews, I resisted the temptation to make notes to maintain and keep abreast of the interaction by using appropriate language and supportive prompts.

So, I spaced each interview to allow time for me to record two types of field notes, a personal (detailed information of nurses, reflective notes on methodological and interview experience including potential influence on data collection) and analytical (insights and emerging ideas) recording that added another subjective element to the study. At times when I was exhausted, it was challenging to render the verbal and non-verbal conversations accurately on paper. I wrote short notes to help prompt my memory later. When I eventually tried to write detailed notes, I was surprised how my memory of the details, ideas and observations that I thought I would never forget had faded, leaving me with only skeletal notes. All notes were transcribed onto a word processor.

3.7.6 Semi-structured interview transcriptions

In order to organise the approximately 26 hours of interview recordings, I only transcribed what was said in relation to my study, eliminating pauses, gossip, words only partially said and other aspects of conversation. Even then, it proved both labour and time-intensive. Eventually, each transcribed interview was reviewed against its recording to validate and identify errors (Silverman, 2006), and to ensure it captured the significance of each phrase and expression to enable understanding.

I chose to return transcripts to encourage interviewees to read, amend and verify the accuracy of the dialogue of the interview. It enabled them to confirm they had said what they meant, and allowed them the option to expand and explain their answers (Kvale, 1996). This ensured rigour by establishing the reliability and validity of the interview data (Polit & Beck, 2010). Also, when I read some transcripts, I occasionally questioned myself 'Did I really say that?' I recognised that participants may also experience shock when reading the interview transcription and reflecting on what they had said. I argue it is easy to misconstrue what had been said in an interview about the meaning of a word or phrase, or even about the way something had been said, as multiple meanings exist in any situation, and that meaning is different for the researcher and participant (van Manen, 2011).

Out of the eighteen interviewees, only ten responded to the returned transcripts, despite my sending three emails. Some personal email addresses were no longer operational, as notification of failed delivery returned to my email inbox whilst others

simply failed to respond. The returned transcripts appeared to help re-connect nurses with their TNHE post-registration journey, and all confirmed the accuracy of the record like the interviewee below.

> Interviewee **006** Sorry for late reply. I has read the interview transcript and satisfied with it. The dialogue of the interview is accurate and I agreed with it. I verified that this transcript is accurate.
>
> (Email: 26th June 2012)

None of them asked me to add, amend or remove any details. One nurse, who had previously identified in her interview that she was keen to implement changes, now stated she had not implemented them without stating any reasons for this decision.

3.8   Research data analysis

Analysis, the last phase of the research, is the process of bringing order to the data by identifying patterns, categories, themes and the relationships between them. My study used a qualitative approach to uncover the extent Malaysian nurses applied theoretical knowledge attained in TNHE post-registration degree programmes in clinical practice. The demographic data obtained via a survey questionnaire complemented the qualitative findings.

3.8.1 Qualitative analysis

The interpretive, hermeneutic phenomenology and ethnographic principle of cultural interpretation that informed this research recognised that data collection and analysis are intertwined (Agar, 1986; van Manen, 1990; Guba & Lincoln, 1994; Merriam, 1998). The tool chosen must facilitate the nurses' voice to enable in-depth data collection. The semi-structured style of interviewing used for this research delved into the experiences of nurses in TNHE programmes. I also reflected on my actions during interviewing to develop shared meaning that would enable me to analyse the data, shape the findings and interpret the perspectives of participants. In Chapter 4, I will describe my influence on the research process, to facilitate contextual situated meaning and provide in-depth knowledge and reasoning of the nurses' views.

Data analysis for my research was developed from Benner's (1994) hermeneutic analysis that identified three key steps of (a) isolating paradigm cases, (b) identifying repetitious themes from within and between cases and finally (c) selecting quotes to illustrate themes. In addition, to enable meaning and experiences to be extracted from the interview data and expressed, the hermeneutic phenomenological process which involves the back and forth movement of the researcher and the text that van Manen (1990) advised for the analysis and interpretation of participants' experiences was also used. He suggests three approaches for isolating thematic statements; detailed (researcher looks at each statement and questions what they reveal about the experience), selective (which sentence reveals the experiences) and holistic (phrases that capture the meaning of the text) to attribute meaning to the data.

The initial stage of analysis involved a quiet time where I adopted a reflexive stance as required by qualitative research. My focus was on my personal insights, data generated from previous studies, relevant literature and pre-determined categories that would act as a template against which all interview data would be compared (Appendix L). It has been recommended that analysis of transcripts should be done in the language of the interview to ensure openness in the research (Twinn, 1998). I took Twinn's advice and immersed myself in the experiences of the nurses by listening repeatedly to the recorded interviews. I also familiarised myself by reading and re-reading line by line all the transcripts which were in their original language of Bahasa Malaysia and English. This allowed me to dwell with participants thoughts, feelings and experiences as I employed van Manen's (1990) three approaches during data analysis. My personal and analytical typed accounts that were mainly in English with occasional Bahasa Malaysia phrases to emphasise a vital issue also denoted that ideas I had formed during data collection had changed or were confirmed during the reading process.

According to Coffey and Atkinson (1996) coding is undertaken to break up and divide the data into simpler categories and to formulate new questions and interpretation. The annotating-the-scripts by hand approach (Miles & Huberman, 1994) was used to search, elicit and capture emerging key words, phrases, events and statements that would provide greater visualisation, as they were written in two different languages with different grammar and sentence construction. I began by inserting a column on

the left-hand side of the transcript page for participant codes. Then, a column was inserted on the right-hand side margin of the transcript page to record initial significant concepts that emerged, ideas, interpretive thoughts and instructions for seeking clarification. To complement these remarks, personal and analytical reflection notes of each interview transcript were also annotated as memoranda or to reduce mistakes and oversights when I reflected later. This is evident in Appendix M where I have taken a section of the transcript of three interviewees (randomly chosen), each from a different TNHE university of their experiences in the Intercultural teaching and the TNHE learning environment. The relevant statements or sentences and phrases were colour coded to identify categories from the template in Appendix L.

I began the analysis process by initially considering and selecting statements and words that were considered of significance to the research question from each participants transcripts individually. These were highlighted and a word or phrase was colour coded according to a category in the right-hand side of the transcript. This was done for each of the eighteen participants' transcripts individually. These formed the early categories. Then, as van Manen (1990) and Coffey & Atkinson (1996) suggest I reviewed, questioned and considered it against all eighteen interviewees' data to identify shared and conflicting viewpoints, the phenomena being investigated and also to explicate meanings that nurses did not articulate to enable interpretation. Subsequently I cut / removed short paragraphs or sentences or phrases from each of the eighteen transcripts. These similar ideas or key words (links) were pasted / grouped / clustered together and tabulated into sections in a series of tables in Microsoft Word documents (Appendix N).

With the data reduced into categories that were similar or different, I abandoned them, and only returned to them as ideas started to form. This meant my approach achieved a sense of freshness when I returned to enable the emphasis to shift from recognising key phrases to identifying explicit sub-themes and themes from the earlier concepts and categories (Appendix O). Heidegger (1962: 104) reminds "*we never come to thoughts, they come to us*". Also, as I transcribed my interviews a year after data collection, I realised I was reconstructing another perspective to the interactions and experiences. I felt I was extracting meaning from the data by

filtering it through participants' interpretive processes, rather than my view to establish the context of the study (Patton, 2002). To judge the frequency of patterns and themes to make contrasts and comparisons, I devised coding sheets for numerical recording of recurrences for the concepts that had emerged (Appendix P).

The demographic data obtained via a survey questionnaire were analysed using a combination of both manual and computer techniques. The data were manually inserted directly onto Microsoft Excel. No stipulated criteria was set for eligibility to classify data as invalid or missing since all demographic detail were checked before the interview session was terminated.

3.8.2 From analysis to interpretation

Patton (2002: 480) describes interpretation as

"… *going beyond the descriptive data. Interpretation means attaching significance to what was found, making sense of findings, offering explanations, drawing conclusions, extrapolating lessons, making inferences, considering meanings, and otherwise imposing order on an unruly but surely patterned world.*"

I chose hermeneutic phenomenology informed by the cultural interpretation of ethnographic principle to write the research text (Agar, 1986; van Manen, 1990). Personally, I struggled during the shift from analysis to interpretation as I had to move away from the connection between my experiences and the nurses', to focus on the voices of the nurses as experts of their experiences. It appeared a daunting task. But, I used my insights, knowledge and theories from the literature to go through the data from each interview through selected excerpts to emerging sub-themes and themes and back to the whole interview. This enabled me to reveal unseen, unheard and unknown or hidden aspects of value from the analysed data to interpret through reflection a vivid and faithful description of nurses' experiences for the reader to understand.

In doing as Krueger & Casey (2000) suggested, I re-visited the aim of my study, design and implementation to ensure congruence between question formulation, literature, recruitment, data collection strategies and analysis. In addition, I spent a

period of time to continually read, ponder, uncover, write and reflect on the essential key words (links), concepts, categories or sub-themes and finally themes identified from the interviews. The hermeneutic circle framework (van Manen, 1990) allows one to move backwards and forwards between the experiences of individual interviews to all interviews and back to each interview and returning to all interviews to look for patterns, repeated or shared experiences of the individuals. I moved within the hermeneutic circle in an attempt to make sense of individual nurses and all eighteen nurses' experiences.

Initially, whilst interpreting the analysed data, I felt issues relating to the research context slipped in and out of focus as I saw glimpses, but not the whole picture. Personally, the analysis of the data required the development of new skills, patience and time. During this repeated stages of interpretation, an unfolding and infolding occurs which enables patterns to emerge from the data to produce a description. Then, the researcher supported by the literature moves beyond the surface to a depth that captures similar, conflicting and overall meaning and impression within a larger context. It was an anxious time to articulate the research findings as it required making sense of the feelings, thoughts and attitudes of individual quotations and needed me to be creative and analytical to see the relationship between the extracts, research question and literature without using my assumptions. Slowly, by keeping nurses at the centre of data interpretation, I began to bring together fragments of views and experiences to make sense and unravel meanings in relation to the four initially chosen sub-themes and newly emergent categories.

As a hermeneutic phenomenologist, I took heed of Newkirk's (1996) view in the article 'Seduction and betrayal in qualitative research'. He claimed interest shown towards participants was an act of seduction that is followed by betrayal of their trust when the research text is created. Often participants feel the researcher has misrepresented them, but Savin Baden (2004) explains there are multiple meanings in any situation, so they differ for both the researcher and participant.

I chose to use verbatim extracts of nurses' voices to ensure their views were heard. Strands, patterns, experiences and behaviours were used to illuminate, weave together glimpses to reveal something which has authenticity and significance. It

was to ensure the meanings attributed by nurses were represented fairly and accurately and the interpretations were faithful to participants' experiences (Koch & Harrington, 1998), and the findings were trustworthy (Denzin & Lincoln, 2000).

I acknowledge I retained authority over the interpretation of the interview data, the quotations used to support my claims, and the theoretical framework that I used to analyse, interpret and shape the final text presented. Thus, there was the initial tendency to fit what participants had said, while resisting data that will not fit into these categories and ignoring issues that I did not understand. But, I interwove the literature with the findings to ensure I did not mis-represent or ignore participants' views, nor discount the different views expressed within the pre-defined and emergent research categories. Any assumptions from personal experiences were constantly cross-checked with the transcripts. The coherence of ideas and the different components pieced together formed a comprehensive picture of nurses' individual and collective experiences.

My study also highlighted the conflicting responses of participants within the same interview, thus, supporting Mann's (1992: 273) conclusion in section 3.2 about the research text. I chose a paradigm and design that allowed different perspectives, incorporated a quantitative demographic questionnaire to complement the findings, provided an audit trail, reflexivity and thick description to enable the reader to comprehend the process, understand, and judge the motivation of the interviewer and authenticity of the research for themselves. The clear portrayal or descriptions of the experiences allow participants to recognise the descriptions or interpretations as their own, whilst readers who are confronted by the same experience will be able to recognise it after reading the research findings.

During the period of analysis, I presented part of my research findings at an International Teaching and Learning Conference in Malaysia (McIver & Arunasalam, 2011). The feedback following the presentation helped refine the research themes I had identified and to explore other previously unnoticed and unacknowledged interpretations, for example, nurses' suggestions for TNHE academics to reduce cultural incongruities and dissimilarities by cultural immersion.

The use of data excerpts to illustrate the themes and the comparison of others' interpretations add credibility to this research. The following chapter provides authenticity, as my personal reflexive account and personal and analytical notes have been used to identify how my position privileged or affected the research process. The decision making and strategies and audit trail I provided enables the reader to recognise the rigorousness of my research approach. To further ensure the main study analysis is rigorous and transparent to others, I identified another bilingual researcher to listen to the audio recordings, verify my transcriptions of the dialogue, and check my translations, interpretations and analysis of the findings. This was to minimise any possible misconceptions or elements of cultural bias.

I acknowledge how my views changed over the course of undertaking the research, and how I developed the ability to think dispassionately, and was prepared to embrace alternatives and not be partial to either TNHE providers or Malaysian nurses or my pre-conceptions.

The translations and interpretations following analysis, in the context of the write-up of the thesis, were also checked by two other Malaysians. Four western academics and a researcher checked the transcripts with my analysis of the findings to confirm the study data was transparent to others and was thorough. The bilingual researcher (a Malaysian academic), two Malaysian nurses (not part of my study), four western nurse academics from three UK university schools of nursing and a researcher from a UK university were all unaware of the names of the participants as only code numbers were revealed and any identifiable details like the name of universities were removed from the translations, transcripts and interpretations.

Ideas that I had written in my journal during the course of my study became clarified during writing and re-writing, and in reading and re-reading. Constant questioning and reflection enabled me to revise and refine my thoughts and allowed a deeper understanding of the lived experience. I feel what I have articulated in my study makes my researcher bias transparent. Participants' bias is evident in their selection of facts based on their views. There is always bias in the way one considers reality and selects the facts which one wants to convey, for example, Malaysian nurses presenting facts that they want readers in TNHE nursing academic arena to

understand about their world. The development of sub-themes and themes, while distinct from the initial approach, shared many similarities but also changed many times before those presented in Chapter 5.

3.9   Overview of the chapter

In this chapter, I have critically reviewed the interpretive paradigm that identifies hermeneutic phenomenology and an ethnographic principle of cultural interpretation as supporting investigation of the research question. The reasons and pertinence in studying lived experiences, focusing on everyday issues and unseen, unheard and unknown aspects and my ability to reflect on my own experiences to provide an emic and etic view were explained and defended.

Given the nature of this study, I detailed and justified the research process that included trials and errors with participant recruitment, ethical issues, data collecting tools, pre and pilot studies, transparency, credibility and methods of data analysis, etc. The chapter concluded with a discussion of analysis to interpretation. Chapter 4 serves to centre my personal, professional and research position by uncovering the beliefs, values and experiences that influenced my research, research process and shaped my interpretation of participants' views, to facilitate contextual, situated meaning and in-depth understanding.

4.0   CHAPTER 4   PERSONAL, PROFESSIONAL & RESEARCHER STANCE

4.1   Introduction

In this chapter, the reliving and recording of my struggles, memories, knowledge and lived experiences are explored through reflexive engagement.   Six threads of influential experiences that stem from my position as a Malaysian, a former international student nurse and UK resident, nurse, nurse academic and practitioner-researcher are categorised under the stance (1) Personal, (2) Professional and (3) Researcher to contextualise where I fit within the research.   Illustrative reflexive, reflective, interview, personal and analytical extracts have also been chosen to further offer the reader a "*reflexive account ...... concerning myself and the impact on my research*" (Denscombe, 2000: 212).

4.2   Reflexivity

In using reflexivity, I questioned the need to narrate my personal story when the research concerned others.   To me, writing the personal 'I' text appeared to be confessional to make explicit to the reader that thoughts about my experiences were imperative and interesting to be presented in an academic work.   But, reflexivity, as Skeggs (2002) explains, is more than simply the telling of the self or writing a paragraph about self in a research text.   These types of gestures assume that by adding a piece about the self, the problems of power, perspective and privilege are dissolved.   In reality, "*selfing*" (Skeggs, 2002: 360) or "*what counts as evidence*" (Skeggs, 2002: 349) is to reflect critically on one's identity and feelings within social, cultural and political roots and lived experiences embedded in communities, language and relationships with other people to maintain difference or distinction, either to penetrate and reshape or to attempt to share experiences.   Skeggs' thoughts were similar to Wenger's (1998) in that, speaking and writing about familiar lived experiences provide opportunities to deepen, explore, scrutinise and rethink. These arguments were consciously considered in selecting my research design and in the actions and strategies I adopted throughout my research process. These are discussed in more depth next.

4.2.1 Personal reflexivity

Personal reflexivity involves reflecting on one's "*values, norms and concepts that have been assimilated during a lifetime*" (Denscombe, 2007: 333); to provide "*a public account of the self which explores the role of the researcher self*" (Denscombe, 2007: 69); to declare the "*authority used to claim knowledge*" (Fox, 1999: 220). In doing reflexivity to authorise myself to shape the study, I consciously included key aspects of the connection between my own past and present self, the previous 'me' and the current 'I' but not my possible or future self.

Despite Parker's (1999: 92) warning to avoid the "*spiral of passivity*" that focuses only towards certain painful constructions, and Skeggs (2002: 360) assertion of "*indulging in a fascination with self*", I intentionally reflected to elicit and illuminate certain relevant, painful and exhilarating Malaysian and British experiences that had remained hidden. Engaging in on-going critical self-questioning allowed me to bring to the surface my 'taken for granted' beliefs, values and pre-conceived assumptions. This enabled me to acknowledge and challenge them to either make new choices or let go and make explicit the ways in which I was and am positioned within my study. Although some may challenge the notion that just because it was difficult for me to adapt to British culture, I was making an assumption that it would be the same for these TNHE Malaysian nurses. I agree I cannot assume it.

4.2.2 Professional reflexivity

Professional reflexivity involves recognising one's professional identity and adopting a reflexive approach to examine the knowledge, ideas, values, attributes, attitude and skills that characterise the role and the self-in-role (Taylor & White, 2000). As the identity of an individual is assessed by their behaviour within the profession; the self-in-role is required to alter performances, to reinforce to a degree some similarity between one's identity and the identity that is imposed by the profession. These ascribed attributes or profession identities are achieved by learning the necessary theoretical knowledge and skills. They are also shaped by building relationships through interactions between self and others, within and outside the profession group, and comments from users of the service. Succinctly, the self-in-role chooses actions that reinforce and confirm the meaning of the performance within the profession.

The impact of my personal self as a Malaysian and personal self as a UK resident and professional self as a nurse, academic and practitioner-researcher on my research will be made conscious, and challenged as their influence will appear throughout the research, research process and in analysing and interpreting the findings. As a Malaysian, I recognise that expectations and preferences with regards to provision of care in Malaysia are determined by individual ethnic groups based on traditional non-western perspectives. These health beliefs involve values, physical, emotional, social, political aspects and their relationship to the environment. Whilst healthcare providers in Malaysia focus on the importance of adhering to the WHO standard practices, they also outline appropriate strategies for integration of traditional beliefs within modern approaches of care (Chiu, 2006; Chee & Barraclough, 2007; Hishamshah, 2011). Thus, all nurses are aware of the importance to acknowledge the multicultural, multilingual and multi-ethnic patients' cultural and traditional beliefs that complement their professional care.

In adopting a reflexive approach, I point out that I lived and studied for my nursing qualification and worked as a nurse, nurse academic and practitioner-researcher exclusively within the UK. Hence, my memories, thoughts and viewpoints are based on the UK nurse education, healthcare delivery approaches, professional status of nurses, shifting demands and technological advances. I am fully aware that I immersed myself in UK nursing values, beliefs and expectations in line with the requirements of the professional body, NMC.

My personal and professional self, influenced my practitioner-researcher self and underlie and emphasise my location within this study and its influence throughout my research. This is highlighted in the preceding, present and forthcoming chapters to ensure it is evident to the reader.

4.2.3 Researcher reflexivity

Epistemological reflexivity encourages constant thought of the "*interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings*" (Finlay, 2003: 108). My research identity was grounded in myself as a Malaysian, UK resident and my work as a nurse, nurse academic and practitioner-researcher. All these factors impacted the decisions I

made when representing and positioning my identity. They helped shape my knowledge, question and challenge personal experiences in Malaysia and in Britain that would privilege both understanding and interpreting participants' experiences. In addition, they would highlight my assumptions that otherwise could remain hidden and impact unknowingly on my research. I was also aware that certain aspects of my identity, practices and status as a UK nurse, nurse academic and practitioner-researcher appeared to heighten levels of distrust during the interview process, but I was able to create a persona that was less likely to be perceived as a threat.

Researchers often position themselves as either insiders (emic) or outsiders (etic) within the qualitative research domain, to enable questioning to occur at each stage of the research process. It acts as a sign-post to readers of what is going on in the research, and to formulate conclusions to make it transparent to the reader. The insider is someone whose biography or personal characteristics (gender, race, class etc), some inherent and some not, gives them a lived familiarity with the intrinsic cultural aspects related to members of the group being researched to enable a valid emic description. In contrast, researchers who do not share knowledge with the group, community and cultural environment being researched rely on extrinsic categories and concepts prior to entry into the group, are outsiders (Kitzinger, 1995; Etherington, 2004). Succinctly, insiders "*cannot escape their past*" whilst the outsider is "*without a history*" of the research setting (Schutz, 1964: 34).

The primary motivations of native researchers are either to seek social justice or satisfy their own identity quest (Narayan, 1993). In her study of gays and lesbians in her native Hawaii, Kanuha (2000) agreed and admitted her reason for researching her own kind was because traditional theoretical explanations and conceptual frameworks failed to consider the stigmatised social identity and experiences of being a lesbian of colour. In contrast, my reason to research nurses within my own social identity group was to provide meaning, clarity and insight when viewing the TNHE context, one which appears to take little note of the cultural variations between Western providers and Malaysian society. The findings will enable me to conclude if the nurses' expectations from TNHE programmes were similar to my pre-conceptions. Also, if their TNHE experiences were similar or different to my own earlier experiences when as a Malaysian I first came to Britain (UK) and was an

international student nurse, to claim a reflexive 'I' for me as a researcher and the researched.

From an interpretivist position, the social world is subjective and can only be understood from the point of view of the participants (Guba & Lincoln, 1994; Denzin & Lincoln, 2005). The interpretive, hermeneutic phenomenological approach informed by the ethnographic principle of cultural interpretation was also selected to enable subjective viewpoints and self-reflexivity. Hermeneutics positions the researcher within the research process (van Manen, 1990), and I as the researcher was allowed to bring my assumptions to the fore, and determine how my study developed, by incorporating the discourses that provided the context and my perspectives throughout the research, mainly within the interpretative process.

In addition, reflexivity in the context of ethnographic principle of cultural interpretation (Geertz, 1973; Agar, 1986) that informed the research will enable me to note the many different social practices, and illuminate the reasons behind nurses' views, or arguments with regards to the extent Malaysian nurses had applied TNHE theoretical knowledge in clinical practice. My personal insights and viewpoints both as a Malaysian and resident of the UK privileged me, rather than introduced bias, and enabled me to understand and interpret the voices of Malaysian nurses to enhance the findings.

Having to position myself within the research with the interpretive hermeneutic phenomenology and ethnographic principle of cultural interpretation meant I was continually in reflexive mode as I had to consider my own biases and assumptions, justify reasoning behind my actions and inter-cultural perceptions on data collection and interpretation (Agar, 1986; van Manen, 1990; Skeggs, 2002; Denzin & Lincoln, 2005). My identity, personal experiences, interest, norms, beliefs and values are ingrained and influence the research process, strategies and assertions that developed throughout the study and the meaning I would ascribe to situations and what is being said.

As a result of this, I argue against the view of the tendency to unconsciously choose what issues to pick up on, ask questions during the interviews and put my own slant

to shape the interpretation of nurses voices. Prior to data collection, I had formulated four key aspects that will focus the interviews towards answering the aim of this study so that the reader of the research can be aware of them whilst using and interpreting the data.

Taking Skeggs' (2002) advice that in using reflexivity, power and responsibility within the contexts to be researched can be examined, I integrated the meaningful personal, professional and researcher knowledge, insights and experiences gained through reflexivity throughout the research process, and included these insights in the analysis stage of my study. Next, my personal, professional and practitioner-researcher stance that situated me in my study will be addressed as it influenced the process, how I analysed, interpreted and reported my findings.

4.3   Influential personal stance

Personal stance is the position which "*each of us takes up in life and our experiences that reflect its social and relational aspect*" (Salmon, 1989: 231). My stance is rooted in my experiences as a Malaysian and international student nurse in the UK and is portrayed below to enable the reader to capture its influences on the research question, context and process of my study.

When I first came to the UK, I was fascinated by all the differences in life, culture, habits, sights-sounds-smells and tastes, but soon realised its strangeness in relation to my childhood/adult memories and experiences of being a Malaysian. My previous daily life was centred on, and embedded within the traditions, food and religion of the Tamil culture, in the midst of other diverse ethnic groups of Malays, Chinese, Indians, Eurasians, Babas, Dutch and Portugese. Relationships between groups are maintained by mutual respect and a shared tradition of tolerance among and between each race, which has led to Malaysia's uniquely diverse heritage.

In Malaysia, English speaking or Western education is depicted as modern, superior and prestigious. However, a post-colonial statement with regards to educational policies introduced Bahasa Malaysia, to replace English Language, as a medium of instruction in all Malaysian schools. English was just a subject as part of the curriculum like Geography or History. Now in Britain, the threads from my own

taken-for-granted childhood and adult memories that were subtle and ingrained in me, and often unconsciously applied in my everyday life, became visible to me for the first time.

Consequently, intense feelings of uncertainty arose as to what was expected of me, or what to expect from others in my personal or student nurse life, due to the contrasts in many ways of life. A difficult and lonely time compounded with painful and fearful emotions followed, as I grappled with my attitudes, values and habitual ways of speaking, thinking and behaving. Culture shock set in as I became overwhelmingly aware of being an outsider to the UK culture. Initially, these different ways of doing things and cues of interpretation led to stress and disorientation.

In addition, the tell and test teaching approach that promoted the objective of remembering as much as possible from the teachers and textbooks in order to pass exams (see Chapter 2), was the only pedagogy I knew and thought existed. Demands of academia in British nurse education, with a learner-centred culture where the teacher instructs how to access, evaluate or critique knowledge were frustrating. There was a mismatch between my entrenched conceptions of saving face, listening to learn and memorising, and the British approach of talking to learn.

The English language as spoken in the UK was a problem for me as supported by Cronin & Rawlings-Anderson's (2004) assertion that languages of the world differ in their auditory qualities, written form and cross-linguistic similarity, so societies, cultures and subgroups attach different meanings to words used in communication. My experiences clearly indicate what Ballard and Clanchy (1991) described as learning shock, a difference between new modes and one's belief system of teaching and learning as argued in section 2.8. Often it was compounded by my feelings of uncertainty and uneasiness, as I did not know what to say or do, due to lack of the necessary cultural knowledge.

I remember clearly as if it had just occurred. The first time during my Diploma in Nursing, we were all given photocopies of an article and were asked 'WHAT OUR THOUGHTS WERE'. My own first thoughts were THINK! I have never had to think during my studies in Malaysia! All I used to do was listen to the teacher in class, jot down in my exercise book the key aspects relevant to the specific subject and focus on what the teacher told us was important for our examinations. When I went home, I would go through the notes, read the relevant textbooks from cover to cover and memorise the information to re-gurgitate for my exams!

So, when we were put into small groups with me being the only international student in an all English group of six, I did not know what to expect. When one student had finished reading, she just started giving her opinion and others got involved either asking questions or giving their views. I had not even finished reading the article nor had I understood what I was reading! I was impressed by their highly articulate and assertive conversation but struggled to keep up with the discussion due to their accents and my own poor English and lack of subject knowledge. Only after awhile did they realise that I had not said a word! How could I! Then suddenly all attention was directed to me - What do you think? You have been very quiet! Oooo...h! I remember wishing I was not there! I SMILED, LOOKED DOWN AT THE ARTICLE and KEPT QUIET.

(Reflective account: 23rd June, 2008).

I do acknowledge these were my own feelings and inhibitions in relation to speaking up in class or when I entered a mixed group. I admit another Malaysian with a different personality and experience may not have shared similar emotions or reacted in the same way. In Malaysia, recognition of the advanced western ways of teaching and learning is respected and considered by most, if not all, as prestigious. So, I anticipate these nurses may still have inhibitions and react in the same way.

Writing assignments in English for the first time was a challenge, and caused anxiety, as assessment criteria, reflection, critical reasoning, referencing and plagiarism were concepts I had never heard, or thought of, or considered. Having come from Malaysia where I had written in the first person in Bahasa Malaysia, I had to learn to write academically using English language in the third person and to create an illusion of objectivity; learning what being critical meant and the subtleties of how to be critical to add value to analysis.

Clinical learning experience is stressful and anxiety provoking for all students, but for me it was more complex as I had arrived in the UK just in time to begin my studies. I did not have adequate time to be exposed to, or become acculturated to the UK culture, education and healthcare system and concept of nursing before the

commencement of my programme. The English language as spoken in the practice settings also became a problem for me. Firstly, because of the speed at which nurses spoke, secondly, the jargon and colloquialisms used were strange and thirdly, I had a tendency to misunderstand common expressions or I translated them literally as not all languages have direct translation of these terms and even when they exist, they are not used in the same way.

I encountered a range of different clinical practices and faced a variety of situations that strengthened my identity as a student nurse as I learnt to apply the professional knowledge, skills and language taught in the classroom in practice settings. Clinical practice assessments also required the transfer of taught theoretical knowledge for provision of patient care. I emphasise the assessment criteria may have been clear and appropriate to demonstrate theoretical and clinical learning outcomes had been achieved, but it totally baffled me as it was a new educational experience. My learning in the clinical environment was impeded by the disparity between my own beliefs and values of the heavily culturally influenced contexts found in Malaysia about nursing, and the disconnection between the nursing approaches in UK practice settings. Nurses in TNHE programmes may face similar challenges as the Malaysian education system still does not require one to write assignments, use English or have western critical and reasoning skills. The teacher and books are still considered authoritative sources of knowledge.

As nursing is a practice-based profession, the theoretical knowledge taught is developed alongside clinical practice in the academic programme all around the world (Eraut, 2004; Chinn & Kramer, 2004). Personally, I also feel that only with this theory-practice link will the student nurse be able to internalise and contextualise the knowledge, for provision of patient care in an integrated and meaningful way in either UK hospitals and/or community settings. I was aware that students who did not have the opportunity for hands on experience found it hard to apply the academic concepts in practice settings. The professional knowledge, skills, diversity of values, behaviours, and social and health structures in the delivery of patient care are overwhelming in the clinical environment. I acknowledge that student nurses in any country including Malaysia would admit to similar thoughts, feelings and experiences (Higginson, 2006; Barnett, Namasivayam & Narudin, 2010).

Like others who came from Malaysia, where activities of daily life involve integration and maintenance of values and practices of cultural rules and traditions, a further adjustment was required on my part. Initially, a part of me resisted the differing values due to my desire to preserve my cultural identity, so I attempted to use only purposive strategies to adjust to the ways of the new culture. Falsely, I believed at that stage it would help my survival through the theoretical and practice needs of my pre-registration nurse education. Quickly, I realised everywhere I turned, I was confronted with my taken-for-granted and habituated ideas, thoughts, beliefs, values and behaviour. Only then I realised I could not remain as my former self and just use selective adjustment. The confusion, challenging attitudes, problems and experiences I was facing were eye-openers; an essential emotional, social and intellectual part of my intercultural learning experience. This is clearly in line with Berry's (2005) view, that adjustment is related to short-term encounters, whilst adaptation is for long-term survival.

Over the next three years, the experience of living in the UK affected my attitudes, values and behaviour. Consciously I adapted to fit into the new culture by using my own resources and integrating new practices into my cultural ways (Anderson, 1994). I gained knowledge and confidence and understood words, interpretations, socially constructed cues and patterns of communication within the context in which they were referred to in daily living, HE and nursing practice in the UK. Mainly, these were vital to succeed, relate to patients and for professional relationships.

In the work setting, I also gained understanding, observed other peoples' interactions and behavioural strategies (e.g. the use of touch and body posture) and cultural tools in their work (e.g. jargon). Personally, I selectively edited or let go of only certain of my socially learnt and established patterns, confronted some difficult issues and enhanced my personal and cultural characteristics to have a sense of independence, responsibility, competence and personal strength to perceive myself in a new and positive way. This fits the stress-adaptation-growth model identified by Kim (2001) of people from different cultures who often opt for being selective with new alternatives of being in their new environment. It assisted me to re-define and establish my priorities and my personal and professional identity in a different context. People learn from experience, anticipate, act with intent and then adjust accordingly as they

go along (Grenfell, 1998). Kramsch (1998) identified even when one moves away from their community, they tend to retain their previous ways of behaving and perceiving which confirms changes in beliefs and thinking take time and will only occur when intercultural competences are acquired.

I stress only with time, constant exposure, guidance and support to alternative ways of knowing and doing, was I able to develop the skills and confidence to write in a different language. Also, I had to adjust, adapt and change my speaking, thinking and behaviour, through bad and good experiences, pleasures and pain, to bring about what I felt was a necessary change or reconstruction of my previous cultural patterns to fit a different cultural context.

In clinical settings, I felt more assertive and confident in myself to adjust to a less formal working environment and accept the importance of best practice that was backed up with policies, procedures, professional standards and evidence. Being successful academically and professionally was mainly due to my compensating strategies related to motivation, and effort. At the point of qualification, my identity as a nurse emerged as I was deemed to have developed the knowledge, critical thinking skills, understanding and skills required academically and in clinical practice.

My experiences support Rudmin's (2009) view that intercultural adaptation and change requires support, sensitivity and guidance, over a period of time, as the cultural shift demanded of international students cannot happen overnight. As an international student nurse, I found that western academics appeared to misinterpret the differences in values and behaviours. This lack of understanding of the social, academic, emotional, and psychological challenges led to poor pedagogical adjustments to support the learning needs of international students like me to make that transition to change.

The degree of adjustment or adaptation one makes within the culture of the new environment depends on an individual's goals in life. I believe it also varies according to the needs of the situations, and/or type of environment one faces or encounters in the new culture.

Kim (1988) assumed that maintaining cultural ties and communication will interfere with the adaptation process, (see section 2.8.1), but I argue against it. Throughout my nurse education, I retained close ties with family and friends, even travelling back to Malaysia. This did not negatively affect my adaptation to the new culture, rather it motivated me to excel in my theoretical and practice assessments, to save face of both my family and self. I argue the original attributes that contradict with the cultural rules of the new environment remain dormant rather than become relinquished, as valuable resources are added to the original cultural rules. These re-surface when one faces a similar situation or interaction, or when one returns to the former environment. Like many others, I quickly reverted to my old ways or cultural traditions when I returned to Malaysia, or even when I met a Malaysian settled in the UK. Sometimes, certain qualities are consciously replaced by new idealised cultural rules. It remains questionable whether one can truly leave their previous identity, but I believe some have abandoned their original culture in favour of an adopted culture.

Personally, I welcomed and appreciated many aspects of my changed identity. But, I have to admit I regarded certain aspects, such as confronting and handling conflict, to be unintended side-effects of studying, living and working abroad and becoming part of a new community of practice (Wenger, 1998).

4.4 Influential professional stance

Professional stance describes the position one takes "*toward knowledge and its relationships to practice*" that occurs within social, historical, cultural and political contexts (Cochran-Smith & Lytle, 1999: 88). My professional stance integrated a reflexive account of my nurse and academic self to embrace the wider issues raised by both western and Malaysian society.

4.4.1 As a Malaysian and UK nurse and academic

On completion of my nurse education, I worked in a variety of specialist clinical areas. Initially, as a newly trained nurse, the focus was on providing direct patient care activities at the bedside. As I progressed in my career, my role moved away from the bedside to carrying out other care-related activities such as management duties which led to changes in my cognitive domain and attitude, and challenged my values and beliefs.

Both the theoretical knowledge and clinical experience gained during my nurse education enabled me to provide care and teaching in line with the UK values and beliefs, HE and the health care system. Prior to my transition to academia, I became involved in aspects of teaching in clinical settings for other health professionals to update and maintain their CPD (NMC, 2008). My UK experiences enabled me to facilitate others to prioritise and organise nursing activities for safe patient care in clinical settings. Even with my adaptation to the UK culture, I still needed to be mindful in every aspect of my work to avoid unconscious use of my former habitual and entrenched values and practices. Having lived my nursing life only in the UK as previously pointed out in section 4.2.2, this connection directed my career and informed my own research.

In comparison, for nurses in TNHE programmes, their teaching and learning experience for each module with the western culture is only for a short one or two week period every semester over two years. Habitual ways of thinking, speaking, expectations and behaving may be challenged during the teaching period but due to their short nature, the tendency to only make minimal adjustments is high, as they eventually return to clinical settings where they are confronted with ingrained traditional and cultural, social, political values and ways. Again, as the focus is on completing the assessments, there is a tendency nurses may only adjust their thinking, writing and speaking to meet the assessment criteria to obtain the degree.

The option to implement change in clinical practice depends on the individual, as no practice component is attached to their programme of study. I argue intercultural adaptation is critical to empower nurses to apply taught knowledge in clinical practice for improved provision of patient care in Malaysia. I now refer the reader to the point I raised in my rationale that the theoretical knowledge taught in the UK nursing programmes is relevant to UK clinical practice with professional values and beliefs transcending most nurses' traditional, cultural and religious practices.

The national priorities of nurse education in the UK universities since the Dearing Report (1997) recognised the contribution of HE to a skilled workforce. In nursing, this ethos provides the link between the theories taught in classrooms to enable

nurses to carry out their role, understand what they are doing and why, and applying them within the boundaries of the workplace.

Previously, I acknowledged the theoretical knowledge taught in HE enabled me as a student nurse to rationalise, learn or identify practices as I observed other health professionals doing or saying, delivering patient care within the workplace in either UK hospitals and/or community settings. Now, in academia, again I became aware that students who did not have the opportunity for practical experience for various reasons, found it hard to apply the academic concepts when they eventually went into practice settings.

Working within nursing and teaching and then the educational field, I realised that my previous perceptions of nurse education as a Malaysian were pertinent. I had to learn the subtleties of using the eastern model as described by Cohen and Gunz (2002) within the openness and learner centred approach of the UK education. I also had to learn to re-define my teacher-student relationship from the previous acceptable way. I emphasise that the gradual broadening of my knowledge, skills, ability, confidence and adaptations over time enabled me to teach within the western learner-centred teaching system.

4.5   Influential researcher stance

To clarify the motivation in using hermeneutic phenomenology informed by an ethnographic principle of cultural interpretation, researchers often position themselves as either insiders or outsiders within their research domain as stated in section 4.2.3. Both Merton's (1972) insider-outsider doctrine and Olson's (1977:171) two "*mutually exclusive perspective frames of reference*" circle around the researcher's relationship to participants, and contributes to an uncompromising dichotomous cause and effect framework.

In identifying it as an either or duality, the binary implies that being an insider or outsider is a fixed attribute, one is better than the other, or the researcher's position is either an achieved or ascribed status, or that a final level of understanding can be reached. This duality view was rejected by Hockey (1993). To determine either the in or out status, a combination of different dimensions must intersect. These

dimensions include certain features of the researcher's identity (gender and ethnicity that are innate and unchanging), other features (age) that are innate but evolving, plus time, place and topic of the research, personality and power relationships between the researcher and researched who co-exist in the research (Hockey, 1993). These latter dimensions are not fixed, neither do they occupy a single position; instead they intersect at different times and under different circumstances. Neither position is privileged to see the "*real truth as social experience and perception are continuously created by the social actors*" (Cerroni-Long, 1994: 135).

Also, Merton (1972) defines the insider stance as based on the researchers claim to the hidden knowledge of the community, to enable privileged access to the participants. The outsider stance is defined as one who experiences the setting under study as a visitor who can create a picture of the setting for identified readers by being objective. However, I agree with Pike (1967) that both insiders/outsiders share a similar process in developing principles and theories that require continuous introspective inquiry to monitor and evaluate the phenomena under study. In a social group, argues Burns and Grove (2008), not all may share similar perceptions, so they cannot be easily categorised, nor is the researchers' relationship with the researched static. For the "*public interpretation of reality*", it is useful to consider the insider and outsider at either end points of one, or a multiple series of parallel continuums with the researcher sliding back and forth between either, or within one topic, moment, location, situation or interaction to the next, and/or in both places and both directions at different points during the research process (Heidegger, 1962: 19).

In reality, the differences are not clear. Both positions have advantages and disadvantages. Both reveal participants reality, neither are purely achieved nor ascribed. They keep interacting, are ever-shifting on different dimensions, and are complementary to each other, involving a process of on-going evaluation, depending on the type and purpose of the relationship between the researcher and participants. Both are "*permeable*" (Merton, 1972: 37), "*highly unstable*" (Mullings, 1999: 338) with lines of separation that are not distinct, so it is hard to tell explicitly where emic starts or etic stops. Further, in 2007, Breen identified another aspect of the in versus out debate i.e. with the researcher being in the middle.

There are also "*multiple insiders and outsiders*" (Deutsch, 1981:174) and "*every view is a way of seeing, not the way*" (Wolcott, 1999: 137). To identify the perceptions of those being researched within the researcher's positional status and their influence, there must be a move beyond a dichotomous cause and effect framework that focuses on which position is more important, or a fixed middle position. In the next section, the hidden value and dilemmas of my emic and etic position from my personal cross-over and mixing between Malaysia and the UK challenge the notion of absolute insider or outsider. It involved me constantly shifting between the multiple axes upon which my identity rested and is utilised to inform and to shape the text of the process and experiences I faced through my research journey.

4.5.1 Malaysian and UK researcher as learner

The researcher as learner stance identifies my struggle throughout the research process with my lack of confidence in what I was doing for various reasons. Firstly, despite this study being of personal interest, after reading the literature, I felt I was in a maze for a long time. I kept venturing in different directions, returning to my starting point on numerous occasions, only to then head off in another direction. I appeared able to explain my research thoughts to others with clarity, but writing in English at this level was fraught with difficulty, as I struggled to convey ideas and feelings in a precise manner. Eventually, I realised none of my previous study experiences had challenged my reading, thinking or writing with such focus and depth. Only when I started to design my interview guide and undertook pre-testing did my thinking start to align with my writing. The limited evidence of nurses' views with regards to the theory-practice link in TNHE post-registration top-up nursing degree programmes also became clear.

At every supervision meeting since starting this study, I am repeatedly told that my research questions don't reflect what I say I intend to research! Aaargh! Why do I seem unable to co-ordinate my thoughts with my writing when I KNOW WHAT I WANT TO LOOK AT!

(Reflexive Notes: 3rd August, 2010).

I did not come to my research value-free. Instead, I had many pre-conceived assumptions, confirming Skeggs' (2002: 348) view that in all research, "*the self of*

the researcher always or already exists". Initially, I could not exclude my own voice as I constantly referred and compared my data with my experiences as an international student nurse, UK nurse, academic and practitioner-researcher for cross-validation. Over the course of undertaking the research, I developed the ability to embrace the perspectives of the Malaysian nurses rather than my own views based on my personal experiences.

4.5.2 Malaysian and UK researcher within Malaysian culture

In Malaysia, the prerequisite for being an insider would be being part of the main ethnic group (Malays). A Malay is defined as meaning "*a person who professes the Muslim religion (Islam), habitually speaks Malay, conforms to Malay custom* and is born and/or domiciles in Malaysia (Constitution of Malaysia, Article 160, 1957). In reality, there are differences between the historical and socio-cultural factors, but despite these variations between the definition in the constitution and the historical and socio-cultural context, both are usually considered together (Ali, 2008).

Accordingly, an outsider is anyone who does not meet all the conditions of being a Malay, thus the other ethnic groups, including myself as a Tamil Malaysian, do not meet the requirements of the Malay definition. As I was born in and had only ever known Malaysia as my home until I came to the UK, my position, like many other non-Malays, was strange, as we had a dual stance; an insider by being a Malaysian and an outsider as a non-Malay. Despite not fitting the constitutional and socio-cultural definitions, in reality of daily life and living, we were considered and treated as Malaysians. My study involved nurses from all ethnic groups, so it was pertinent to position myself within the Malaysian tradition, not as a single us versus them dichotomy, as implied by the official definition of being Malay. I take a stand by stating I intend to research my previous social identity group who had similar earlier life experiences to mine, until I came to the UK.

Having often travelled home, I saw extensive developments taking place throughout Malaysia in an attempt to improve the status and progress of the country. Despite this, upon my return to Malaysia to conduct my study as a practitioner-researcher, I saw myself negotiating the hidden dilemmas of entry that my previous cultural, social, political and historical background had 'sensitised' me to. Schutz, (1976: 104)

identifies "*every social group… has its own private code, understandable only by those who have participated in it*". But, I was conscious of a distancing that had taken place in me about the "*strange and … intriguing behavioural patterns and thought processes*" of the people there (Ohnuki-Tierney, 1984: 584). I was confident this personal distancing or unintentional stepping back would enable me to selectively utilise my personal insights and experiences to minimise bias and provide objectivity, clarity and new understanding that van Manen (1990) referred to as hermeneutic alertness.

In reality, certain of my personal and professional behaviours, values and cultural perspectives as a Malaysian were deep-rooted and ingrained. Sometimes I was unaware of being insufficiently detached from certain concepts I described, as they influenced me unconsciously. It was a revelation when these taken-for-granted assumptions were challenged by my supervisors, or became evident in my on-going reflexive journal, as I had felt I had adapted well to fit in with the western culture.

4.5.3 Malaysian and UK researcher collecting data in Malaysia

When I planned to undertake this study, I was aware of my dual stance within Malaysian society. But, as stated in section 3.7.2, prior to returning to Malaysia for data collection, I also realised my UK practitioner-researcher role was perceived to exude power, status and a threat. This meant I may be considered more an outsider than insider, so I was unable to confidently short-cut the mutual familiarisation phase, as personal relationships are vital to Malaysians. To create a positive impression, I proceeded to contact and meet with some nurses (others opted to forego this meeting due to restrictions on time due to changes in working hours for the fasting month or personal and family commitments). Their reactions to being researched were mixed - fear, pride and curiosity. I overcame it by negotiating my relationship with each participant, using an interactive format to instil trust and maximise exchange. On reflection, irrespective of whether nurses met with me or not, initially, all appeared self-conscious, and appeared to display an appropriate front (Goffman, 1959). It meant they politely answered my questions with limited words in Bahasa Malaysia, as depicted in my reflective account.

It is obvious they felt intimidated to say anything to me against the programme in fear it may even after receiving their results affect them receiving their awards. They appeared tense and started off by checking if the interview was going to be in Malay. When I started the interview, the classic Malaysian 'smile and silence' attitude was very obvious. I felt frustrated!!!!!! Slowly as I started to speak in Bahasa Malaysia, used colloquial words and Malaysian humour, told them a bit about my own experiences as an international student nurse in UK and not forgetting, forthrightly telling them I was not evaluating the TNHE programmes or lecturers, they suddenly opened up. Information was revealed without me having to ask the question! As the interview progressed, I suddenly realised that I was speaking in Bahasa Malaysia whilst some were speaking in English and some even asked my professional opinion about certain situations.

(Analytical notes, August 23, 2010).

I was confident that, being a Malaysian, the face-to-face interview technique would enable rapport and an atmosphere of a lengthy conversation, due to my extensive knowledge, shared past history, ability to blend and become part of the social setting by observing the culture and conventions. Further, it would also allow me to observe, recognise and interpret the unspoken but implied non-verbal cues that would enable me to probe further. As my above reflexive account depicts, being a Malaysian, the strength of my interviewing lay in my extensive knowledge, the shared past history, ability to blend and become part of the Malaysian social setting.

I considered that I was privileged to question these nurses, and admit at times during the same interview, when certain issues were being discussed, nurses appeared to view me as a temporary insider, or partial insider, due to my cultural identity. It appeared to relax them a few minutes into the interview, and my position shifted towards the insider end of the continuum in line with Patton's (2002) belief that the willingness to talk, and what is said, is influenced by who participants think the researcher is.

At other times I was made to feel an outsider, due to my adaptation into the western culture as sometimes nurses appeared to withhold information, perhaps as a defence or being careful not to be frank or comment on issues that may be harmful or have negative repercussions (Gibbs, 1997; Gagliardi, 2007), as my reflexive account demonstrates.

> She kept saying that what she learnt was fun and useful, I got the feeling that she appeared to be saying what she felt I wanted to hear rather than what she really felt or maybe to avoid offending me. Finally, 45 minutes into the interview she admits that 'not really anything I learnt I applied. The lecturers focus on, useful for assignment what we learn but can't apply in practice'.
>
> (Reflexive notes: 25th August 2010).

Participants may still align their responses to insiders in other ways, for other reasons warned Patton (2002), as evidenced below where a nurse was hesitant to share certain information for fear of being judged by me. As an insider with insights based on shared lived experience, I was able to cut across ethnic lines and encourage her to voice her views, enabling the "*focus not on my own knowledge … but on the students' knowledge*" (Belenky, Clinchy, Goldberger, Tarule, 1986: 218). Initial reserved responses offered were also replaced with more confidential, detailed and revealing accounts. This contradicts Cerroni-Long's (1994) view that there are no benefits to being an insider, as understanding the group dynamics is not based on the insider or outsider status but on the perspectives of the researcher.

> I will call them, of course you will get angry and say 'always late coming to work ..., but … **laughed, blushed and appeared embarrassed and was reluctant to continue. I encouraged her and after a few minutes she continued.** You need to tone down actually, for example I sometimes hem ... many, many times will tell, without you knowing it, right in front of everybody, so you actually aiming for and she pointed to her jugular vein **she laughed and again appeared embarrassed and very hesitant to demonstrate her weakness so she stopped. I encouraged her to continue.** She then said sometimes you are actually bogged down with many, many things. You are abrupt… sarcastic. Sometimes you cannot control, we human, we have our own problem, families, stresses, and dealing with young student, they are very restless, you tend to be very abrupt, but deep inside I know this is not right…
>
> (Interview and personal notes: 21st August, 2010).

Clearly, due to the sensitivity of the question under investigation, they said things I do not believe they would have said to a non- Malaysian, as they informed me they were telling me things in strictest confidence, and said 'you tahu lah' translated as you know lah what I mean, confirming they considered me as the person in the know! Further, it was unlikely the nurses would have voiced their views to a

detached outsider, who Schutz (1976) stated had not been socialised into the group. Specifically, in my study to a westerner who is regarded to have a higher status. I also stress that as outsiders would not have engaged in the experiences that make up the life of these nurses, they would not have the innate sensitivity that enables empathic understanding (Merton, 1972). I accept the nurses may have provided more detailed information to a Malaysian within their own ethnic group or similar hierarchy level. It is noted the insiders positioning and the establishment of trust for disclosure are hidden dilemmas decided only by participants (Beoku-Betts, 1994 in section 3.7.4).

Often when I heard Malaysian nurses' responses, similar to that identified in the reflective account below, I was careful not to show any sign of surprise or agreement or disbelief. On occasion, nurses' views were self-contradictory, as what they said at the outset was in conflict with their views after a few minutes into the interview. Again, I remained as neutral as I could. This was the result of my past experience with the small scale study I undertook in the first year of my EdD. Then my assumptions were revealed in my facial expressions and body language during the interaction and it impacted the findings.

> I was careful when listening to her, making sure my facial expression and body language remained neutral. Sometimes I was tempted to shout 'yes! I was so excited at what she was telling me as issues I had faced as an international student nurse were being highlighted or issues that I had looked at in my rationale for undertaking the study were identified.
>
> (Reflective Note: 14th September, 2010).

To increase the validity of the interviews, Spradley (1979) warns researchers to have an open mind and not influence events to avoid misinterpretation. To enable this, Gergen (1999) suggests that researchers first recognise, and then suspend their cultural assumptions to see and understand another's. Initially, in my research journey, I fell into the insider/outsider dilemma with regards to my loyalty to both the TNHE universities and my interviewees, often taking on the role of sub-cultural spokesperson (Bennett, 1977). Hunt (1981) argued there is no middle way in research; the researcher is either committed to serving the interests of one group

(TNHE University) or committed to serving the interests of the other (Malaysian nurses). I argue, over the course of undertaking the research, I became detached from the concepts being researched, thus, reducing subjectivity, insider bias and unreliability. I started to embrace alternatives to reshape attempts to share the voice of nurses, rather than form an attachment to the TNHE universities, the nursing profession, academics or Malaysian nurses.

I developed the ability to adopt a stance to think dispassionately, as my priority was to portray the voice of the participants accurately in the research text. I remained mindful not to allow my views to misconstrue what I heard or to rule out other possible data and interpretations that arose. This enabled me to move beyond my previous understandings, to construct an intellectual inquiry of discourse and avoid a "*detour of my own or other's making*" (Wolcott, 1999:348). My stance shifted between and along the insider and outsider continuum, with me looking from the outside in and from the inside out to understand both.

When in Malaysia, I desperately wanted to maintain a low profile and be perceived as an insider researcher based on my shared history. Unfortunately, whilst I attempted to represent myself in ways that would minimise any threat that aspects of my identity would create, I had little control over the ways the nurses interpreted and reacted to my identity as previously stated. I was perceived to carry a certain status resulting from the influence of Malaysia's colonial past. I struggled and was uncomfortable with the noticeable way the nurses proudly introduced me to other nurses, or informed others of my presence and of their participation in my study. It made me stand out and people knew of me even though I had not interacted with them. But, it enabled me to recruit more participants for my study.

I sometimes noticed that, without thinking, I presented a professional front to the nurses in both my appearance and manner (Goffman, 1959), mainly to allow nurses to have confidence in me and my research. By creating my front, I used the same professional mask I would use in my work with other academics and students in the UK. Thus, my words and actions carried powerful meanings that appeared to maintain and perpetuate a Western approach, that may also have confirmed their views that they already know (or think they know) about my (interviewers') opinions.

This is just another example of how certain Malaysian cultural values and beliefs and some UK professional expectations and experiences were imposed on the study although they were mostly intertwined and somewhere in between.

When I was transcribing the interviews from the audio recordings, I became aware of the audibility of my voice and the clarity of my speech in Bahasa Malaysia. I realised as a multilingual Malaysian, I have always lived my life across languages and code switching was part of the way I have always communicated (see section 4.3.2). Interaction across languages involves a transfer of facts, ideas, concepts and position to ascertain cultural meaning (Temple & Young, 2004). Following transcription of the interview conversation, I translated the bilingual Bahasa Malaysia and English interviews to English. According to Temple and Young (2004: 167),

> "*translation itself has power to reinforce cross-cultural relationships but that power tends to rest in how translation is executed and integrated into research design and not just in the act of translation per se*".

My location shifted between being in the centre, fully or partially belonging or not belonging during the interviews, but I soon realised to accurately represent participants' views through their language, I needed to research from inside the language and culture. Thus, my research stance was influenced by the power relationship between researcher-participant and researcher- translator/interpreter.

It was obvious I had slipped effortlessly and unconsciously into a Malaysian insider role that connected with my biography, as I used colloquial words, gossip and humour with ease when I observed any reservations or interviewer effects. The advantage of being an insider was evident, irrespective of the socio-cultural context or the Malaysian government's definition (Ali, 2008). Shared lived experiences led to communication between myself, the different ethnic groups in my research sample to occur easily and naturally. It is impossible to tell definitely whether it demonstrated mutual commonality, but my friendliness and familiarity to them, appeared to encourage candour and laughter. My reflective account describes a joke I shared with one of the interviewees.

> Whilst interviewee **016** was talking about others' acceptance to changes, she mentioned some staff
> will follow what she tells them to do, whilst others 'will make noise'. She continued, as a unit manager
> I would call them into my office; ask what the problem was for not following my instructions. Hmm…
> and they will come up with a thousand excuses, "macam-macam" [translated different types]
> excuses, some not even related with work ... We both started to laugh at the same time and it
> appeared to encourage her to further demonstrate her feelings through her facial expressions, the
> way she expressed and emphasised certain words and by what she said. She laughingly
> continued, 'I tell staff before you open [clinical area] door make sure your personal problems,
> you leave outside door, when going back collect it and go home'!
>
> (Interview data and personal notes: 25th August 2010).

Another reflexive note below identifies my personal conflicts with this research, as I remained anxious, and constantly questioned the relevance of the data both during and after data collection and about representing them fairly and accurately.

> I'm not sure if I am doing the research 'correctly'! Am I asking the right questions? Will the interactions in
> the interviews answer my research question?   Am I recording the relevant points in my field and reflexive
> 'scribbles'?   By the time I realise they are irrelevant (on return to UK), will I remember key issues that are
> important to them? I am sure of the idea and the premise behind it, but I am unsure of how my study will unfold
> or whether I will represent their view fairly and accurately or what impact the research will have?
>
> (Reflexive note: 14th September 2010).

Through writing in the first person, I was able to use my multiple voices to write, re-write and reflect to situate myself in relation to the data I collected to understand nurses' experiences. Sometimes my past and present self, led to a dilemma. Memories of challenges I faced as an international student nurse returned whilst trying to understand nurses' TNHE experiences. Some resonated with my own whilst others were different. I realised I could not know what the research would become until I had time to reflect, analyse and portray the voice of participants accurately in the text.

The critical thinking, problem-based approach, and reflective skills emphasised in the western approach to nurse education, as a nurse and academic, assisted me in writing the academic research text. Critically reviewing my beliefs, frustrations and

the complexities inherent within cross-cultural experiences of living and studying in a foreign country such as the UK in my reflexive journal, helped me to provide authenticity as "*knowing the self and knowing the research subject are intertwined due to historical and local knowledge*" (Richardson, 2000: 929). Also, as my research progressed, my journal was a useful outlet for my frustrations, challenges, mistakes, successes and differing views. It enabled me to revisit and record an on-going self-critique, self-appraisal and provided an audit or decision-making trail of the various phases of my research; how my position privileged or affected the research process, and the decision making strategies I adopted whilst remaining diplomatic and professional, to protect and preserve the interest and well-being of TNHE providers and interviewees. I also enhanced the rigour of my research approach by exploring how my views changed over the course of undertaking the research, and how I developed the ability to think dispassionately, and was prepared to embrace alternatives, and not be partial to either TNHE providers or Malaysian nurses.

When writing the text, I questioned if I selected certain interview extracts to fit my assumptions, as the focus for analysis and interpretation were selected by me as the researcher and interpreter. I point out that although I was able to retain authority over the interpretation of the interview data, the choices I made about including or excluding certain viewpoints or decisions I took with regards to what data to bring forward were influenced by the selected paradigm, design and methodology, as they only enabled me to inform, rather than dominate the interpretations. I was also convinced of their suitability and benefits as a third viewpoint, fashioned from the intersection of two views or positions shaped the interpretation and presentation of the research. I was able to illuminate the unique voices of these Malaysian nurses by directly using their interview extracts. Although I was subject to my judgement and interpretations and may at times have been unable to be completely neutral when I identified interesting data that emerged, my focus always remained towards answering the research question. I support my claims as the unique voice of the Malaysian nurses is central to this research. My ontological belief is confirmed as the interview extracts articulated through the voices of participants determined the insights, beliefs, values and experiences, which were influenced by their cultural context. These needed to be made explicit ultimately in the final text presented to provide an emic and etic perspective for the reader.

As an insider and outsider to both the Malaysian and British culture, I was empathetic to assumptions within both cultures. But was confident as an insider, I would be able to elicit underlying values and assumptions revered and upheld by Malaysians. This would enable me to identify unstated hidden facets or transcripts to interpret and articulate the similarities and differences in behavioural patterns. Enhanced insight and comparison of the accepted mode and process of conducting activities will make it visible to the reader to enable better understanding.

4.6   Overview of Chapter

In this chapter I attempted to unravel, examine and illustrate my personal, professional and researcher roles within my thoughts, feelings and views as an expert in my experiences. My professional reflexivity was also grounded in my work as a nurse, academic and researcher as I used interpersonal and intervention communication skills gained from these experiences which were UK based and meant a growth in UK cultural rules. Authenticity was achieved by my reflexive account and personal and analytical notes that brought to the surface assumptions and questioned and challenged hidden insights and experiences which would have impacted on my research.

In being reflexive, I adopted and contemplated my multiple identities to make clear through self-conscious and critical introspection explicit evidence of my positioning an engaged approach to research. I also stated how my position privileged or affected the research process, decision making and strategies I adopted to either negotiate or accept, facilitate contextual, situated meaning, in-depth knowledge and understanding of nurses' views. It helped shape my interpretation of their experiences to simultaneously reveal the TNHE universities to the Malaysian world and the Malaysian world to the TNHE universities. In addition, they enrich the Malaysian nurses' voices as they interpret the authentic and significant findings either through reference to their personal lives or situations and through thoughts of the researcher.

I also enhanced the rigour of my research approach by exploring how my views changed over the course of undertaking the research, and how I developed the

ability to think dispassionately, was prepared to embrace alternatives, and not be partial to either TNHE providers or Malaysian nurses.

The unique voice of the Malaysian nurses is central to this research and my ontological belief is that the personal identity of nurses will influence how and what data is produced. Thus, my decision to use interview extracts which were articulated through the voices of participants enabling them to speak for themselves.

5.0 CHAPTER 5   UNFOLDING MALAYSIAN NURSES' PERSPECTIVES

5.1   Introduction

The impact of TNHE theoretical knowledge in the classroom and clinical settings is depicted through the voices of eighteen nurses. These nurses provide the reader with a sense of who they are as they illuminate their pre and post registration nursing journey which in turn gives significance to the reality of their TNHE experiences. Their reasoning behind certain of their beliefs, values and actions reveal the extent the pedagogy informed processes in clinical settings. With the emphasis currently on evidence based practice, it is beneficial to question the underlying wisdom behind any practice where the reason for carrying it out is not immediately apparent.

The findings that emerged from the demographic survey questionnaire are presented first. The interview data follow using extracts of the unique voices of the eighteen nurses. Quotes are presented using italics and left in their original state or as close to their authentic state (for those that needed translation) to demonstrate grounding in the data. When Bahasa Malaysia and English were used, only the Bahasa Malaysia part of the conversation was translated (Appendix L). So, despite the fluency of the speakers during the interview, some extracts will appear disjointed. Slight discrepancies may also be evident due to the different use of language and because some quotes were edited to maintain anonymity of the nurses and TNHE universities. To clarify, in the extract the collective pronoun 'we' is often used to mean 'I', and the particle 'lah' has no denotative meaning but is used to indicate the emotive attitude of the speaker (Tongue, 1968: 83).

Drawing on cultural interpretation of nurses' views and my insights, I will articulate an emic and etic outlook. Through this, the meanings and cultural nuance of beliefs, values and behaviour are depicted to provide clarity for cross-cultural comparison.

Initially, the reader will be taken through the nurses' pre-registration training and post-basic education journey to offer an insight into teaching and learning and clinical

practices. Emergent findings of the TNHE post-registration top-up nursing degree programmes that encompass their reasons for undertaking the degrees and the intercultural teaching and TNHE learning environment experiences follow. Then, the four pre-determined sub-themes of personal development in nurses, professional transformation in nurses, implementation of theoretical knowledge in clinical practice and acceptance of nurse led changes will be presented under the heading, Impact of TNHE theoretical knowledge in clinical practice. Finally, I provide the nurses' evaluations of the outcomes of TNHE experiences and qualifications.

5.2   Semi-structured interview data analysis and interpretation

This section explains how the data was analysed in line with the hermeneutic phenomenological analysis strategy informed by Benner (1994) and van Manen (1990). This strategy was chosen due to its applicability to my study and because it allowed me to interpret meaning through each participant's description of the TNHE experience. A reflexive chronological account with reference to Appendices outlines how the findings represent what was found within the interview data and how the interpretations presented in this chapter were constructed.

Initially, a template based on my personal insights, relevant literature and pre-determined categories was developed to compare all interview data (Appendix L). The interview recordings were listened to repeatedly. The transcripts in Bahasa Malaysia and English were read and re-read line by line and I questioned what they revealed about the experiences, which sentences revealed the experiences, and which phrases captured the meaning (van Manen, 1990).

Having read the annotating-the-scripts by hand approach by Miles & Huberman (1994), I began by inserting a column on the left-hand side of the transcript page for participant codes. Another column was inserted on the right-hand side of the transcript page to record concepts, ideas, questions and personal and analytical reflection of each interview. In Appendix M I have taken a section of the transcript of three interviewees (randomly chosen), each from a different TNHE university to demonstrate how I started

to analyse the interview data of their experiences in the Intercultural teaching and the TNHE learning environment. Initially, relevant sentences and phrases were highlighted and a word or phrase was colour coded according to a category in the right-hand side of the transcript. This was done for each of the eighteen participants' transcripts individually. Then, these sentences and phrases were cut / removed, grouped together and tabulated before categories were developed (Appendix N). The hermeneutic phenomenological process that involves the back and forth movement of the researcher from the transcript of each participant individually and as a whole led to data being reduced to concepts and categories that were similar or different (van Manen, 1990). All these were abandoned until ideas started to form and sub-themes and themes emerged from the earlier categories. (Appendix O). I acknowledge that these sub-themes and themes changed many times before those presented in this chapter became clarified. To make contrasts and comparisons, I also devised coding sheets for numerical recording of recurrences for the concepts that had emerged (Appendix P).

In using Benner's (1994) and van Manen's (1990) framework of hermeneutic analysis, the research text focused on capturing the descriptions and essential meanings of the Malaysian nurses' experience that are presented in this chapter.

5.3 Demographic characteristics

This section presents the demographic survey questionnaire findings of gender, age, years of experience, role in nursing and reasons for studying on a TNHE programme. The questionnaire and pre-determined categories were based on the review of the literature for continuous professional development and life-long learning in nursing.

All eighteen participants were female. Although it could be argued that a balanced gendered perspective was not obtained, the sample mirrored the Malaysian nurse workforce i.e. 99.5% of the total nursing staff in Malaysia are female (International Council of Nurses, 2008). The female only sample was unintentional and was the result of snowballing from the initial volunteers who were a convenience sample. The age of participating nurses ranged between 21 to 50 years with two thirds of the interviewees

aged between 31- 40 years (12/18). No interviewee was aged over 50 years, maybe because in Malaysia, most nurses retire at the age of 55. All interviewees were from private hospitals. Again, this was unintentional. It was the result of the initial convenience sample of private hospital volunteers who then suggested others that studied on similar programmes.

According to Day, Sammon, Stobart, Kington and Gu (2007), years four to seven mark the second phase of a professional or experienced life. Almost all nurses (17/18) had 5 or more years experience. Thus, they were in and beyond this phase and may be considered experienced. Only one in the sample group had less than five years of experience and none had more than twenty years' service or experience. In Figure 3, the majority of interviewees (17/18) held senior positions including the one member of staff under the category 'Other' (role not stated to ensure anonymity).

Figure 3:   Role of interviewees in nursing
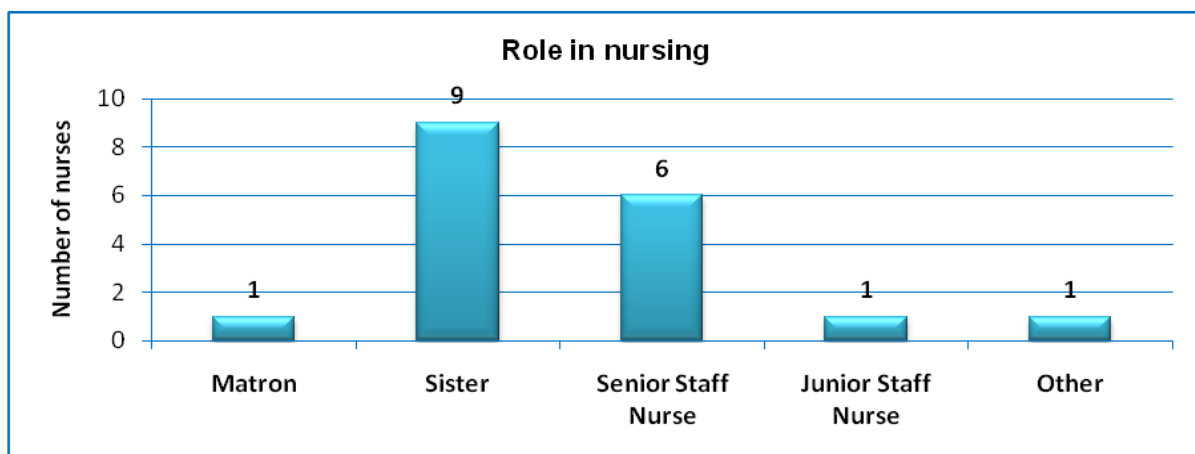
There were no restrictions on the number of choices participants could select for their reasons for attending the TNHE degree programme. In the pre-determined answers, an 'Other' option was also included to enable nurses to specify their reasons. In Table 2, the main reasons cited were to update or upgrade themselves i.e. interest (14/18), career development (12/18) and improving practice (11/18). Under 'Other' the reasons included self-satisfaction and encouragement by father.

Table 2:   Reasons for studying on TNHE nursing degree programme

Career Development	12	Improving Practice	11
Interest	14	Work Requirement	6
Promotion	6	Other	2

The data on age, years of experience, role in nursing and reason for attending TNHE post-registration nursing degree programmes confirm the relationship identified in the literature between age and academic development in terms of mature and younger students as discussed in Section 2.8. As the sample group was solely female, the relationship between gender and academic development could not be ascertained. The interview findings will be presented below.

5.4   Pre-registration training and post-basic education

In the next two sections the focus will be on nurses' experiences in the classroom and clinical settings during their nurse training and post-basic education. They were taught by Malaysian lecturers from a mix of ethnic groups in Malaysia.

5.4.1 Pre-registration classroom and clinical experiences

Teaching and learning methods in the public and private colleges of pre-registration nursing will be outlined next, including the participants' experiences of the theoretical knowledge taught in parallel with clinical skills.

From the explicit description of analysis of the data in section 3.8.1 and a summary in section 5.2, Appendix M demonstrates how significant phrases with regards to participants pre-registration nursing journey have been identified. Further, Appendix N shows how similar keywords of classroom experiences from each participant was grouped together. The screen grab sample of a coding sheet in Appendix P highlights the frequency of nurses who experienced the same mode of teaching. Coding sheets

were used throughout the analysis process to identify the frequency of recurrence to unfold precisely the Malaysian nurses' perspectives.

Fourteen participants stated the teaching and learning patterns were mainly supported by the traditional teacher-oriented mode (Section 2.7.3). Teachers used pedagogic power to exert influence on what students need to know (theory) in the classroom and how students need to do it (procedures) in simulation or skills labs. Then, students were expected to study the nursing reference books to enhance knowledge. In clinical practice they had to rationalise and demonstrate the taught and practised procedures or skills. Interviewee **018** pointed out:

> *"They will teach everything, we write short, short notes, read textbook, read, read, read. In ward, I take list for procedure, get this, this, this, just follow orders* [of lecturers]*. Clinical tutor want us do procedures, just do what they tell us* [in skills or simulation labs]*. Explain why* [rationale] *also must exact lah how they tell* [in class]*. If no, fail lah."*

According to the responses, questioning or challenging the teacher is often taken to be personal within the didactic style of teaching as it may imply disrespect to the teachers' authority or a lack of faith in their expertise. Projecting a good impression and conforming to the teacher is vital to obtain good marks. Showing confidence overtly is likely to be frowned upon. Saving face of the teacher and self is perceived to be the proper attitude towards intellectual and interpersonal learning (Abdullah & Pedersen, 2003; Ahmad et al, 2005; Jedin & Saad, 2006).

Just as teachers were considered authoritative sources in imparting knowledge (Wong, 2004), information in books was accepted as reliable and undisputable. The supposition was that there was no need to argue or challenge the theories, as they had been tested in practice. The student's purpose was merely to explicate, refine and support taught knowledge (c.f. Li, 2001).

Again, as highlighted previously, in section 3.8.1 and 5.2, Appendix N identifies that some nurses had different teaching experiences in the classroom. Also, the screen grab sample of a coding sheet in Appendix P provides numerical recording of recurrences for the number of nurses identified (next) with these experiences compared to the nurses who are mentioned earlier. Only four nurses had a mixed teaching and learning mode. This included face-to-face lectures, question and answer sessions, group work and presentations; indicating some nursing colleges adopted a different style from the traditional way. Colleges that used a more interactive method, disseminated their pedagogy through conferences, publications etc. For example, one such college led the International Teaching and Learning Conference where I presented my interim findings (Mc Iver & Arunasalam, 2011). This college also had its own journal with evidence based research of the effectiveness of the interactive methods.

Another difference identified was the language of instruction; as eleven out of eighteen nurses raised the point that some colleges taught in English whilst others in Bahasa Malaysia. It is common and acceptable practice for dwi bahasa [translated as mix or hybrid of Bahasa Malaysia and English] to be used to clarify any uncertainty when the language of instruction was English. It did not solve all comprehension problems as reference books were only in English. Interviewee **014** explained her predicament and coping strategy: *"When everyone went to sleep, I take dictionary and page by page, No! word by word looking for meaning for first 3 months ..."*

To fully embrace all the above, lecturers encouraged students to approach them individually. Students also chose to privately seek clarification of comprehension to save face. Hence, it was usual after the lesson for students to cluster round the teacher with questions. I argue that none of the above implies these students are passive. Instead, in using my emic viewpoint, I confirm that my own student experiences were similar. As the theoretical input was teacher-led I did not ask questions in class but engaged by concentrating. Any lack of understanding or questions I had was addressed by accessing the teacher after the lesson or privately, often on a one to one basis.

Despite this respect and humility, all nurses spoke of the interpersonal relationships they had with certain of their nurse lecturers, pointing out this affinity and harmony enabled them to have fun:

> *"For Anatomy and Physiology, I enjoying, interesting to learn your own body system. Bonding with lecturer is very good, every weekend she bring to her house to bake cakes"* (**Int: 003**).

Others described it had been useful to assist them overcome difficult and demanding issues either with the taught theory, procedures or skills in clinical practice. Their view of the teacher-student relations lends support to Widdowson's (1990) belief of students' high expectation towards the teachers' role as the source and knowledge imparter. Also, Biggs' (1996) thoughts that teachers must be respected for being able to exercise authority in the classroom as well as having a relationship with students in daily life is supported.

On completion of a period of theoretical input in parallel with clinical procedures taught and practised in simulation or skills labs, they moved into clinical practice. Clinical tutors from their colleges of nursing observed, supported and assessed their competence, instead of senior nurses. The perceived focus of pre-registration nurse training is the theory-practice link. But, in reality according to the nurses', theory and practice remained separate entities in their minds:

> *"For Diploma, we didn't know how to link theory to practice or question anything e.g. taking a pulse - was just taking a pulse. When I did ward round and I heard Doctor saying the patient had thready pulse or weak pulse, looks like not much volume, I used to think, what are they talking about?"* (**Int: 015**).

This also establishes these student nurses were surface (Marton, Dall'Alba & Beaty, 1993) rather than deep learners (Kirby et al, 2003).

Theoretical knowledge, procedures and skills were assessed by the Objective Structured Clinical Examination (OSCE), identified by previous research (Jay, 2007) as an effective clinical examination for practical skills acquisition. Other assessment tools took the form of closed-book examination with multiple choice questions, written exams, group presentations and short answer questions related to patient care.

All participants reflected and gave similar statements: "*They teach us all, give us all we need for exam, not giving us to think*" (**Int: 014**), a situation also referred to as *"spoon-feed"* (**Int: 009**)*.* Interviewee **015** quoted a phrase commonly used to depict this style in Malaysia: *"Here they cook the rice, they serve it and they will come and literally feed you and show you how to chew and swallow it."*

A sense of resentment or dissatisfaction seems evident in the interviewees above, with regards to the teaching methods that control and deliver information on a need to know basis. Their outlook shows analytical thinking processes, but the question that arises is did these nurses prefer the TNHE teaching style that focused on independent learning that required questioning, critical and reasoning skills? Later in the chapter, I will refer the reader to their viewpoints.

In the Malaysian cultural framework, it is accepted that to be successful one has to work hard, thus these student nurses diligently spent long hours memorising, also known as "*mugging or cramming*" (**Int: 008**) the required concepts to reproduce for their theoretical examinations regardless of their understanding. Hard work and repetitive practice were necessary to repeat exactly the skills and procedures and the taught rationale that interviewee **014** referred as *"like parrot lah."* This was expected to demonstrate their competence in clinical settings and OSCE. Clearly, rote and repetitive learning by memorisation were accepted strategies for learning.

Qualitative data from the interviews indicate these beliefs are fundamental common features amongst the nurses and the hard work and persevering qualities that must accompany them are valued cultural resources that can be transferred when studying in

a new environment. Apart from the achievement-focused mode, another aspect in their belief system is the hierarchical structure of knowledge.

What is evident is that pedagogic styles varied. Nurses perceived these variations to mean that lecturers had a choice as to whether or not they wanted to accommodate the Malaysian teacher-in-charge approach. Irrespective of experiences, participants' conceptions about knowledge, the teacher and textbooks were consistent with previous qualitative findings discussed in section 2.7.3. This was that learning is based on reproducing teacher-taught subject and textbook knowledge. Both were deemed authoritative sources, confirming the belief that the teachers and their taught theories are inseparable (Li, 2001; Wong, 2004). This also aligns with Malaysian learners' characteristics and behaviours in a classroom (Jedin & Saad, 2006). The belief that reflection, questioning and critical thinking were irrelevant was evident.

Despite the challenges they faced in developing their knowledge and skills, all eighteen nurses voiced views similar to that of interviewee **010**: *"I want to pass my exams and be a nurse, proud lah and for family …"* It reveals their motivation was to be successful and underlines the high value and status accorded to achievement. My own reflexivity in section 4.3 identified this.

On completion of their programme, nurses obtained jobs in either public or private hospitals to consolidate their training. To further develop knowledge and skills or specialisation, post-basic education was encouraged and will be discussed next.

5.4.2   Post-basic classroom and clinical experiences

In public and private hospitals, following the period of consolidating their three year training, nurses were encouraged to specialise in a chosen clinical area for career progression. The six months or one year post-basic education is pedagogically designed to provide the advanced knowledge needed by trained nurses for a chosen specialty. For their clinical practice experience, they were required to spend a period of

time in the chosen clinical specialty to enhance their knowledge, skills and competence in provision of patient care.

Sixteen nurses who attended the post-basic education indicated that their motivations to undertake these courses were to be educationally and professionally suitable for career progression. Again, some colleges of nursing had maintained a didactic approach to teaching whilst others utilised a mixed method. But, the teacher-student relations, didactic approach, memorisation to pass exams and the ways in which support was sought remained the same. Key differences identified were that in pre-registration training the theory taught was *"touch and go"* or superficial (**Int: 012**) whilst with post-basic education, these nurses noted the knowledge had depth to support the rationale for management of patient care in a specific speciality. Also, specialised senior nurses in clinical settings supported them to make the theory-practice link. Their skills were assessed in parallel with the supporting knowledge, prevailing professional and social attitudes and values for provision of care. Participants believed these enhanced their insight, confidence and competency.

Interviewee **015** reflected on her earlier inability to link the theory taught to practice during pre-registration training (section 5.3.1). Later, regarding the theory-practice link in her post-basic education she said:

> *"I learnt taking pulse is not just taking pulse, you can actually look for strength, volume. I also learn to speak and link body systems to report, because what I say will reflect what is happening to the patient."*

Their theoretical assessments were related to the use of knowledge for reasoning or rationalising the management of patient care. For their OSCE examinations, their ability to utilise the taught knowledge and demonstrate safe, high levels of skills and expertise in the chosen speciality areas were assessed.

In summary, these nurses' three year pre-registration nurse training provides insight into a) didactic teaching, b) the use of bilingualism when English was the language of instruction, c) rote or repetitive learning by memorisation which was used both in the classroom and clinical settings and d) assessment methods. It appears that these factors did not require or disallow decision making or critical thinking about the taught knowledge and procedures or skills. But, this amplifies the lecturers and student nurses' ideas about respect and avoidance of risk taking by asking or inviting questioning, except in private. In Malaysia, the idea of avoiding risk by remaining in a safe zone is known as saving face of self and teacher.

In contrast, their post-basic journey centred on practice. Taught knowledge was in-depth to enable them to rationalise management of patient care in their chosen specialty. The clinical experience of being in specialised areas enabled them to observe, practice and gain competency with essential practices and skills. Senior nurses supported them to use deep-level thinking for integrating relevant theory to practices and skills necessary in specialised patient care.

So far, the differences between learning styles needed by nurses in pre-registration training in contrast to post-basic education have been explored. Some confirmed patterns in the literature emerged from my findings. First, the common perception of Asian students using a surface approach to learning is confirmed during their pre-registration nurse training (Marton et al, 1993; Biggs, 2003). Rote learning by memorisation remained a legitimate way of learning in their post-basic education. But, these nurses reported they developed in-depth knowledge and comprehension of the relevant theories to rationalise patient care, and they gained competency with practices and skills, combined with support from senior nurses in the specialty. This confirms what Kirby et al (2003) identify as the salient features of deep learning styles and also Gow and Kember's (1990) belief that a deep method to learning can be attained by using memorisation as a tool to improve insight as discussed in Chapter 2.

From the evidence above, it is clear these nurses used memorisation combined with clinical experiences to gain in-depth understanding. However, the perception of good reasoning skills is influenced by identities, culture and values, not just of these nurses, but of their lecturers and their communities as well (Egege & Kutieleh, 2004). This finding raised an important point in relation to my research question. It appears that reasoning skills were developed during their post-basic education to enable them to rationalise the management of patient care in specialised settings. In effect, it seeks to ascertain what TNHE academics recognise as evidence of critical thinking and analytical skills. It is also pertinent to identify what kinds of coping strategies nurses might be calling upon when they faced the short, intensive TNHE programmes and the factors which successfully assisted them to transition smoothly from one mode of learning to another. Here, it would seem to be the direct linking of TNHE theory to practice settings. My research question also seeks to explore the connection, if any, between their prior teaching and learning experiences and the nurses' ability to internalise what they learnt in TNHE programmes, their ways of knowing or their ability to embrace and rationalise actions in practice settings.

To identify the extent TNHE theoretical knowledge is applied in clinical settings, it is important to first explore key sub-themes that may affect the transference of taught theory to practice. These will be discussed next.

5.5   TNHE post-registration top-up degree programmes

In this section, initially, nurses' reasons for studying in TNHE programmes will be identified. Their experiences within the TNHE teaching and intercultural learning environment will then be presented within four different sections.

5.5.1 Reasons for undertaking TNHE programmes

In the demographic questionnaire, fourteen nurses indicated their main reason for attending the TNHE programme was their interest, whilst twelve stated it was to update or upgrade their qualifications. Although this question was not part of the interview guide, it was used during the conversational interview to link their prior teaching and

learning to TNHE experiences. In the face to face interviews, all participants had views similar to that of interviewee **013**: "*My ambition to do degree*" and interviewee **012**: "*standard isn't it western degree."* Still others thought of a western degree as prestigious as suggested by interviewee **010**: *"UK, I always find higher quality."* None of them mentioned their entitlement to a graduate allowance in their responses to the demographic survey questionnaire, but all, like interviewee **018**, verbalised: *"I want RM$400 monthly allowance"*. Both these features were disclosed as an incentive.

It was suggested in section 3.5.1 that data collection tools influence participants' responses. This was evidenced by the fuller, more reflective reasons obtained during the semi- structured interview compared to the answers in the Demographic Survey Questionnaire for Question 6 – 'I attended the course for' (Appendix E). It showed an anomaly between my interview and demographic questionnaire data.

The interview data confirms the assumption of status accorded to western education (in section 2.7.3), and Hofstede's (1984) long term orientation in relation to work, where long-term rewards are expected (section 2.7.7). However, it is in conflict with Chong et al's (2011) findings where Malaysian nurses' motivation to participate in local top-up degree programmes were to update knowledge and improve skills to raise their professional status and to provide quality patient care.

Six out of the eighteen nurses interviewed self-funded their study with a TNHE university that had MQA accreditation approval. Their preference was not to have a contract with their employer which entailed working for them for double the time period taken to study. Priority for these nurses was to seek employment or career progression immediately after completing their degree, away from their current jobs and employer. Their lack of entitlement to any employment-based benefits led them to purposefully select TNHE universities that required attendance for a short teaching time-frame (to ensure only a minimum use of their days off or annual leave). They selected universities that offered theoretical knowledge only, with no clinical practice component.

Other factors considered were low fees, no written exams and being a HEI with a good reputation and offering modules similar to those offered by other HEIs.

In comparison, employers determined the type of TNHE programmes they were offering their nurses i.e. twelve in my study. It appears that in choosing the programmes, employers had failed to recognise the pertinence of a practice component in parallel to TNHE theory. These programmes also did not require MQA approval. The reasons nurses disclosed for choosing these programmes were the attraction of an overseas degree, paid fees, study leave and free accommodation close to the study site during the teaching time-frame. Six nurses also had the additional benefits of having English Language tutors to enable them to obtain the IELTS qualification and the support of a local co-ordinator throughout their programme of study.

This raises four issues in relation to my research. Firstly, as theory and practice is considered inseparable in nursing, the knowledge gained from reading, questioning and critical reading may have inspired evidence-based practice in clinical settings. This is evidenced by the literature that highlights as professionals acquire knowledge, they learn to problem solve in routine or adaptive ways and move towards skill-based expertise (Ericsson, 2004; Mylopoulos & Regehr, 2011). Next, the internal and external influences over their choice to study in these programmes will also have direct implications on their ability, motivation and decisions to apply theory in practice. Thirdly, when the taught theory is combined in clinical settings, any resistance or challenges they may have faced would have benefited from guidance, advice and support from TNHE academics. Finally, it aligns with literature that suggests the difficulty of integrating classroom knowledge in clinical settings (Hardwick & Jordan, 2002).

5.5.2 Intercultural teaching and the TNHE learning environment

In the following four sections, I will discuss nurses' views with regards to language and teaching and learning issues; TNHE degree requirements, guidance and support; shock and coping strategies and acclimatisation.

5.5.2a   Accent, language, teaching and learning styles

The participants were initially not deterred by the anticipated differences between the eastern and western traditions. Instead, all indicated they were mainly positive despite mixed feelings of anxiety, fear and lack of confidence in their English Language skills and western academic practices.

Fourteen participants highlighted their difficulty in understanding a pronounced accent from the UK and/or Australia.   Interviewee **018** related her UK TNHE experience.

"She introduce herself, this, this, this thing, that time also we didn't know what the thing exactly. Then she said ok, you all can go and have your LOONCH [accent], *we all were sitting there, we didn't know what she said. She looking at us and we all looking at each other, then I saw time was 12 noon, so I think she telling LUNCH lah. Their pronunciation is different, that is the thing."*

Another nurse from the Australian university stated:

"I found it difficult to the language, I trying to figure one word, she has finished sentence. She said one die [accent], *I thought Oh dear! Who has died? Then I realise she actually meant one day!"* (**Int: 016**).

Two nurses embraced the variations in accent and expression whilst another two did not face difficulty as they had previously worked in different countries with westerners.

All participants acknowledged the difficulty of coping with English as the medium of instruction. Even though nurses were familiar with English, it was not their first language but a second or third language for some. Interviewee **009** stated: *"At Malaysia we not speaking English only, we mix everything, all mixed language ..."*

Their spoken English freely incorporated a mix of words or code-switching from the languages of diverse ethnic groups' mother tongues. A coping strategy utilised is exemplified here: "*During class, all of us have the dictionary beside, ...*" (**Int: 011**).

As a previous international student nurse, my etic view is that the pronunciation and enunciation of similar words and the slang used in the spoken English of western academics, made it appear like a new language. Also, certain expressions used in casual speech are not found in dictionaries.

The western academics with their fluent English, subject knowledge, critical thinking and talking to learn approach, questioned nurses on their silent classroom behaviour *"You all very quiet, never ask anything. ... We understand or don't understand we keep quiet only"* (**Int: 006**).

A combination of reasons contributed to their behaviour: a) deference to authority: *"We cannot be open, we have our national style, hierarchy, very, very obvious!"* (**Int: 013**); b) culture of listening to learn or save face of teacher: *"We give respect, we don't criticise or argue or give opinions"* (**Int: 010**); c) potential for repercussions: *"We have to accept, if we argue, they will say 'You are a bad student'. Then they will aim you and cut your marks"* (**Int: 006**); d) miscommunication: *"... when we ask question they explaining but we cannot catch what they are telling. Lastly, we give up"* (**Int: 002**); e) lack of comprehension: *"If we don't understand anything we don't know what to ask, right"* (**Int: 017**) and f) student saving face: *"If we ask then lecturer and others will think 'she is stupid lah to ask this question!' You don't want everyone to think you stupid so you keep quiet"* (**Int: 006**).

A key impediment nurses identified to connecting with the academics was their feelings of inequality. Past colonial influence and their idealised merits of western education that was deep-rooted in their minds affected them in line with Ahmed's (2000) views. Interviewee **004** expressed *"We have English person coming to teach, we feel inferiority complex."*

Questioning to make sense or justify knowledge was done privately or mentally which is evidenced by interviewee **006**'s statement:

> *"She spoke about Indian patients in UK, but our nation, we used to Malays wear Malay clothes, Chinese, Cheong Sam and Indians, sari, they wear their traditional clothes. The lecturer said, 'Oh! No, let them wear their own traditional clothes'. I thought 'Why the big fuss about their clothing'? In Malaysia we have already done it."*

Even when they recognised the academic was totally unaware of the cultural rules of Malaysians, for example, as she was telling them about practices that were normal in their daily lives, but which the academic thought was new information**,** the cohort responded as per Malaysian etiquette. They kept quiet to save face of the academic, as interviewee **006** explained: "*Oh, never mind lah, she's a UK lecturer. ... she doesn't know or understand our culture, her culture is different. We have to accept her cultural diversity."*

Interviewee **004** explicitly describes the acceptable way of interacting within communities and its direct influence behind their classroom behaviour:

> *"We're brought up to abide, listen to higher ranking. Indirectly, by showing respect, we cannot be extrovert, we become 'timid as a mouse'. UK, they teach to be outspoken that's why they are more forward compared to us. We will think first whether we gonna hurt your feelings and pull ourselves backward. This has been ingrained in us, this is in our blood."*

The literature identifies differences between Malaysian and western learners in the classroom and typifies Malaysian learners as passive versus active (Biggs, 2003; Jedin & Saad, 2006). I refer the reader back to section 5.3.1 where fourteen out of the eighteen nurses had experienced the didactic teaching mode that encouraged a silent learning style. My Malaysian emic view clarifies that students apply respectful listening

and attention when the teacher speaks. My emic view also had produced the assumption that TNHE academics seemed to have failed to identify the extent of nurses' hidden narratives and how it was affecting their learning experiences. Volet and Renshaw (1996) stress certain hidden aspects of one's culture encourage or discourage classroom behaviour. Recognition by the TNHE academics of these cultural rules was vital as they influenced the nurses' expectations of the TNHE learning and teaching and so created difficulties in the intercultural teaching environment. From my UK academic stance, I highlight these nurses were expecting TNHE academics to give them all the relevant subject information to elicit a correct answer for their assessments rather than require them to verbalise their thought processes to develop enquiry skills that are key to independent learning.

There is an accepted assumption and a sense of security among Malaysians that not being active in the classroom does not mean lack of academic ability. Likewise, participating does not indicate academic prowess. Nurses focused on knowledge as the main goal of learning and were behaving exactly as they would in a Malaysian classroom. Their polite, silent behaviour (Abdullah & Pedersen, 2003; Ahmad et al, 2005) is attributable to their acceptance of power distance (Hofstede, 1984) and their need and acceptance to conceal negative emotions for social harmony (Durkin, 2004). This reveals that interviewees' reluctance to participate was due to classroom etiquette as desired and defined by their home cultures rather than their approach to learning or abilities.

Two TNHE universities, one UK and another Australian, provided a mixed teaching and learning approach of face-to-face and distance learning. All nurses questioned the purpose of these intensive short contacts. It created confusion and feelings of being overwhelmed as they struggled with the accent, language, differences in nursing terminology and comprehension of the subject matter that were discordant to them and for some nurses more than others. Also, their inability to communicate with the flying faculty academics was evident:

"They teach us very fast. We will be like quite lost, because we will not have chance to [ask questions during] *9-4.30 or 5pm, they will be teaching only. When do we go and ask we don't understand this? They expecting us on the spot to ask, you know, we Malaysian we need time to go and personally to ask, you know. So we will be like keeping quiet only. When they finish, they say- ok, ok, see you all tomorrow. My lecturers all staying in hotel so they will be rushing, the time 4.30 or 5pm, the driver will be waiting there, they will be rushing"* (**Int: 018**).

My immediate insider opinion is that the teaching style described here conflicts with the more measured lifestyle and slower approach preferred by Malaysians.

Twelve nurses had common views regarding the challenges of using other teaching and learning methods: *"Distance learning difficult especially if one is not IT savvy or have facility"* (**Int: 003**)*.* Similar conclusions were also obtained from other nurses:

"Long distance learning, very tough lah because language problem. The media used is computer, we Asian we don't use computer that much. We only open when we need otherwise we don't even open" (**Int: 007**).

The lack of computer literacy was a significant issue in nurses' arguments against the notion of online options. Learning to use technology, a key skill that most had to learn for the first time, prompted the question as to whether it must be stated as a required criteria for being accepted onto the programme. Personally, it clarified a possible reason for the poor response to emails I sent requesting participation in my study and the lack of comments I received with the BOS pilot study.

These participants expressed that teaching within the modules was very UK or Australia centric rather than having an international focus, as interviewee **007** commented:

"I thought, why they don't give Malaysian examples, it's good we can know their ways but all from their practice. But here, we didn't see that, we don't know. Even if we know, we are not practicing, then how to relate. Especially when they give examples of equipment overseas, you know here we don't have and to get it is difficult, and the meaning is very different."

The six nurses from the Australian university, like interviewee **001,** pointed out:

"Certain lecturers whatever topic they teaching they can relate to us, they give example about Malaysian nursing culture and use overseas to compare, to show us difference, to widen knowledge."

Unfortunately, Caruana and Spurling's (2007) argument that their learning experiences need to be supported by an international awareness and competence curriculum was not evident amongst all the lecturers from both the UK universities or amongst certain Australian lecturers. Some academics when they overheard certain cultural aspects of care being discussed within small groups appeared genuinely interested. Interviewee **015** exemplified: *"They don't know, they ask … were enquiring from us. We told them, Malaysia Code of Conduct for nurses still based on 2002"*. Others, like interviewee **017** reported: "*… they ignored it, as they seemed disinterested or not see a reason or value and made no attempt to participate."*

Based on the above, all participants reported that it was obvious apart from some Australian exceptions (as cited above), the majority of TNHE academics had limited insight. Nurses assumed their knowledge was based on "*internet info, isn't it*" (**Int: 014**) and "*she Google lah*" (**Int: 013**). This appeared to signify the lack of preparation of academics for their TNHE experience. So, Badley's (2000) proposal to use students as a source of information for local contextualisation instead of insensitive communication of western values to avoid intellectual imperialism did not seem to be applied. Pyvis and Chapman's (2005) belief of the importance of promoting culturally open attitudes and communication between educators and onshore international students also seemed

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to be ignored. Generally, nurses said: *"If they want to teach, they need to know our culture. Only then we can feel we can trust, easy to talk"* (**Int: 007**).

The suggestion by interviewee **007** above appears to be a desire to make transparent the significant culturally sensitive insights which I identified in section 2.7 as pertinent. This is because of their potential impact on learning and application of theory in practice. It could be argued that western academics were operating on the basis of their own particular academic models from which they were failing to acknowledge the above differences. Neither did they identify the extent these hidden differences affected nurses' learning. The findings confirmed Hofstede's (2001) view that in intercultural situations different values and beliefs exist and these influence one's perception of conversations and behaviour. The data also confirmed Cronin's (1995) summary of issues that may affect international students. It is also evident from the findings that despite TNHE academics and Malaysian nurses having ways that may appear odd and amusing to each other as outside observers, the TNHE academics appear to have failed to cultivate intercultural "*savoirs"* (Byram, 1997: 148).

This raises the question of the need for educational preparation of academics prior to teaching in TNHE programmes. Also, it is clear that Australia's impressive amount of literature (Knight, 2003; Crichton, Paige, Papademetre & Scarino, 2004; Leask, 2005) on the importance of educational preparation for TNHE teaching and website information for their academics, appears not to have made much difference. This will be addressed in section 5.7.

5.5.2b Theoretical knowledge, assessments and guidance and support

Participants were challenged by the subject-specific or specialised language and unfamiliar concepts in their modules. Additionally, the assessment criteria were difficult to decipher. The TNHE taught theory was assignment focused. After the teaching time-frame, participants expected follow-up guidance and support via email to complete their assignments. This section discusses this further.

Fourteen nurses were perplexed by the lack of clear-cut answers, one standard version of an answer or a single correct method to tackle their assessments which their previous pedagogic culture had provided. Nurses in section 5.3.2, reported their post-basic education had developed their reasoning skills to rationalise management of patient care. In Benner and Tanner's (1987) study of nurses' judgement, the findings showed that with experience, nurses developed a method of reasoning that provided them with an intuitive understanding of the clinical situation in addition to their knowledge, skills, competency and experiences.

However, all felt challenged by the western critical analysis skills, to reflect on their knowledge in a cross referencing style and to re-evaluate information from the perspective of the TNHE knowledge. Also, to criticise others' work, to discern the value of evidence found, be convinced or remain unconvinced by the evidence and to reason logically were difficult concepts understand and master. This was because the notion of critical thinking and analysis is absent from the language and cultural frames of Malaysian society. Interviewee **018** stressed "*in our culture we don't really challenge, you know if authority says that's how you do it then that's how, what we do it, there no debate.*"

These participants could not make sense of this academic competency as they were not equipped or prepared for the need to take social and intellectual risks in terms of exploratory thinking that is critical, analytical, evaluative and responsive. Neither were they supported to understand it in western terms.

They appeared to resent the short time span of teaching and the lack of sufficient academic support as it resulted in this skill being poorly defined and illustrated. Participants felt they did not have the opportunity to develop, comprehend and achieve a good command of this essential and useful rational thought and decision making skill. This is illustrated by the views of interviewee **017**: "*I did nursing long time ago, our mentality is totally different, we need guidance. Capturing is not the issue but understanding is.*"

My emic UK academic outlook recognised that Malaysian nurses' reasoning skills that are fundamental to management of care provision, reveal a distinction between how nurses reason in practice and the critical analytic skills required as an academic endeavour in the TNHE programmes. Also, what TNHE academics considered as appropriate language, method and evidence to support critical thinking and analysis skills were western in nature and different to what these nurses were used to.

Irrespective of the HEI, all participants categorised the taught modules as:

(1)   very useful and relevant to practice:

"We learnt a lot how to become a good nurse" (**Int: 011**).

(2)   relevant for gaining knowledge but irrelevant in clinical practice:

"Topics provided … unsuitable to our culture but suitable to UK, cannot use practice but I learn and interesting" (**Int: 010**).

(3)   problematic in terms of style of teaching:

"*On-line … Ooo difficult, everything have to learn, … face-to-face teaching, our time so packed and we have to do everything. Maybe that is their way* [delivery of teaching via on-line and short time-frame for face to face teaching]*, but we here they have to teach more* [give in-depth and explicit information with increased face-to-face contact hours for delivery of teaching] *only then we will understand*" (**Int: 013**)

(4)   insufficient time to gain in-depth understanding:

"You not given the time to study something [short teaching time-frame for each module]*, discuss and openly understand what is taught, we have info* [information], *its just info only"* (**Int: 017**)*.*

(5)   totally irrelevant:

"Was like library reading, ... management and research, waste." (**Int: 003**).

However**,** interviewee **005** had a philosophical viewpoint: *"We in one class, not all modules will suit everyone but you have to catch what suits you."*

A few nurses expressed contradictory views. Interviewee **016** initially stated: *"Don't feel degree given me more knowledge, I can go to Internet. Wasted! Don't know right or wrong, we have to study ourself, so lack understanding."*

Later in the interview she took a conflicting standpoint: *"Cannot use does not mean it is not good. One, we want to improve knowledge, even if cannot apply, at least you have knowledge and can check."*

Finally, at the end of her interview she appeared to clarify her own thoughts and concluded: *"Extra, extra* [knowledge] *to make change. If you go for a degree you need to learn more, not one or two things but substantial."*

In these programmes, the assessments were mainly assignment based; thus the criteria for successful completion were given on the first day of the teaching period:

> *"Time was short, actually at that time I wanted teaching to finish quickly, I didn't want to be with the lecturers because I didn't understand. I wanted to go back and finish my assignment. My focus is my assignment only, I didn't care about anything else"* (**Int: 008**).

Clearly, learning behaviour and outcomes are related to the type of assessment. My emic Malaysian notion is that learning by memorisation demonstrates mastery of the knowledge gained from the teacher and textbook to pass examinations. Western assessments required nurses to seek information from a variety of sources, to then debate and justify by using academic writing conventions. The nurses felt they received limited guidance and support with this process, apart from broad explanations in the classroom.

The face-to-face teaching or distance learning period was followed by email contact with the academics for any queries with regards to their assessments, which were then submitted on-line. Only interviewee **004** reported support that enhanced her

experience: "*I am very satisfied with some of the lecturers who are following you closely*". Others reported inappropriate and/or insufficient support:

> "*Through email we can ask but how much can we ask, right. Even when we ask you see there is another cultural and language barrier. The way we ask they don't understand what exactly we want and they will be understanding different thing and they will be replying different thing*" (**Int: 017**).

Interviewee **008** said: "*Here we really want someone, not to say spoon-feed but to guide us … *" Interviewee **002** stressed the academics' western orientation was evident by their lack of insight into Malaysian ways of support and guidance:

> "*They don't understand our culture. When break, we go to see them, they tell us sorry we having break and when finish class, they gone. Even when they come and teach other groups we cannot go and disturb. They don't entertain, they say email. What we don't understand, when we email often, they don't like it, … we become a nuisance. They tell us to wait for response, then email, but sometimes no response for weeks! We felt abandoned.*"

Regarding TNHE academics' assumptions, Malaysian nurses suggest that:

> "*Their perception is, it is distance learning so we have to take all the effort and do. I can't be asking another third party to come and teach me, because I am doing it with you and I am paying you so it is your responsibility*" (**Int: 017**).

Exploration of support or lack of support provided for classroom experiences and assessments highlighted several questions; namely, a) what did the Malaysian nurses consider to be support?, b) how would they normally seek academic support?, c) why did most participants feel they did not get reasonable support? and d) in what way did the type of support received by one nurse enhance her learning experience.

More detail about what these participants considered as support was revealed by interviewee **018** in section 5.4.2a as needing time to go and personally ask. Interviewee **002**'s point above further illustrates the typical way these Malaysian nurses sought support, which was during the break and when they finished the lesson. Also, interviewee **002**'s and interviewee **017** views and experiences with email support above identify why they perceived there was poor support. Interviewee **004**'s opinion of support that enhanced her learning is also evident above. I will further discuss this under section 5.7.

The difference is, in western countries, outspoken confident students generally ask questions of academics during the teaching, and only a few silent listeners approach the academics at the end of the session. These silent listeners are not necessarily all international students (Bista, 2011). Further, students in western countries are often provided one-to-one or small group tutorials for completion of their assessments or in preparation for their examinations.

These Malaysian nurses felt they were being perceived as a nuisance. The academics had informed them not to email them repeatedly but to wait for responses. Often these nurses did not get an immediate response, and, they stated sometimes their questions had been misunderstood as the academics responses did not reflect their queries. Another complaint was that they had moved on with their assessment which meant they constantly had questions unanswered. Their lack of subject knowledge, poor response from academics or lack of understanding of their accent, language and questions, led to beliefs there was a failure on the part of academics to support their learning needs.

5.5.2c *Culture and learning shock with coping patterns*

Participants described how initial excitement quickly gave way to a sense of shock and disorientation that exacerbated their feelings of anxiety, frustration, uncertainty and self-doubts. The TNHE experience proved more demanding, compared to their previous class contact hours and pace of teaching delivery, than they had expected. In section 5.4.2a, I made an assumption, based on nurses' views that academics had failed to

identify the extent that hidden beliefs and perceptions affected their learning experiences. Two distinct types of nurses were affected by learning shock (see section 2.8) according to my study. These were 1) mature students working within their home culture, and 2) students returning to study in an unfamiliar teaching and learning environment:

> *"Wah, I nearly felt like giving up … I don't know anything. I thought why did I take this course? If I know this is a very difficult course, I shouldn't take. I kept thinking to myself, why, why, why?"* (**Int: 006**).

My findings confirmed previous research data (Griffiths, Winstanley & Gabriel, 2005; Sumer, Poyrazli & Grahame, 2008) of feelings of fear, insecurity and inadequacy when adult mature students return to education after many years. They are challenged when their previous proven styles of learning e.g. memorisation to pass exams have been replaced by a diversity of teaching and learning styles.

Their experience of each module was summed up by all the nurses as similar to using a *"remote control"* (**Int: 010**) - "*switch on, switch off*" (**Int: 011**). Interviewee **016** clarified this succinct portrayal of the TNHE teaching as *"talk, talk, talk, fast, fast, fast then bye-bye"*. The "*compressed*" (**Int: 012**) or *"tooooooooooooo short"* (**Int: 017**) teaching time-frame resulted in *"everything was like a blur"* (**Int: 009**).

Nurses' feelings were compounded as they perceived that the modular framework of TNHE delivery took place against what they understood to be good learning and teaching practices, as too much subject knowledge was taught within an unrealistically short time-frame. Nurses were deprived of a honeymoon period which Oberg (1960) points out is necessary and provides time for a gradual adjustment and acclimatisation to the new thinking, writing and academic practices like those required for TNHE programmes. My data supports that initial transitional experience in any different cultural environment is a "*painful and testing process*" (Brown & Holloway, 2008: 243).

All eighteen nurses stated that the real problem began when the assessments and criteria were given (section 5.4.2c), especially for the fourteen nurses for whom it was their first experience of writing assignments. Initial reactions included anxiety and uncertainty that they could rise to this challenge. These early doubts were followed quickly with questions of how to meet the criteria for assessments as explained:

"*You know our English standard here, speaking and writing how we will be writing our essays. 500 words also we will be struggling to write in English. In diploma we answering a,b,c,d - that's what we learn; suddenly to do essay style 2500, 3000, 5000 words is quite hard. You know to make up a word, to make up a sentence, to make it longer, we find is very difficult*" (**Int: 018**).

All participants attached importance to academic achievement. Thus, after their initial flight response, they quickly recognised the need to use coping strategies to fight and overcome their shock and confront the challenges. The tendency for international students to take flight or fight when confronted with obstacles was acknowledged by Anderson (1994).

Keeping a dictionary beside them in the classroom was a major coping mechanism that continued throughout their programme of study (18/18). They also talked to others in the cohort, family, colleagues, friends (18/18) and if available, the local co-ordinator (6/18). It was evident the main purpose of talking was to come to terms with their emotions and gain advice and support, as consistent with research findings on coping with culture and learning shock (Adelman, 1988; Schmitt, Spears & Branscombe, 2003). A third and parallel coping strategy was their seeking help from others or getting together in small groups with nurses in their cohort for discussions.

5.5.2d Selective adjustments and adaptations

Their own traditions of learning (section 5.3.1) were incompatible with these new approaches. The idealised Western qualification that these nurses deemed superior pressurised them to adjust thus, motivating them to selectively explore, develop and

change to new ways of learning for the instrumental end. They used information-technology to gain access to the in-depth knowledge and planning required, questioning and thinking through principles and theories to add to their original repertoire (18/18). Their beliefs about effortful and respectful learning (section 5.3.1) were valuable cultural resources. Participants resorted to and transferred these across learning cultures in dealing with adjustment demands. It remained the main coping strategy with their academic work.

The skills required for academic achievement are generally acquired over a period of time, as identified with my emic view as a Malaysian in section 4.3. As nurses' previous learning focused on assimilation of information and providing correct answers, they struggled with the new academic literacy skills. Further, these nurses had to fast track their learning to complete the assessments within the short period of time allocated for each module in the programme. Systematically working through the reading materials assisted them in completion of assessments as exemplified by interviewee **006**:

> *"I follow the book lah, I worked very hard. I draw like a mapping, what I need to do and I had to follow, after this I need to do this, after this I need to do this. That's the way I learn lah, if not, sure I am out"*.

Those who studied with the Australian university said the assignments given were the same with only slight changes every year. Interviewee **016** stressed:

> *"Some staff said, for us it is easy, we just take the senior's assignment and copy or cut and paste', change the sentence slightly. Some of us struggle to do the assignment! The way we are taught and assessments must change."*

Six nurses studying with one UK university were required to complete a dissertation for the honours component of their programme. These nurses expressed there was no teaching, insufficient guidance and just unsatisfactory email contact with supervisors.

There was an imbalance between student self-direction and academic prescription or constructive support. They were angry!

> *"They didn't teach but expect us to do, they totally don't have idea. Very difficult, for a culture that hadn't written assignments, to do research project no support! Keep asking people around, who done masters, lecturers who done PhD, like a nuisance going around asking. ... they question you, didn't they teach you? Not worth, RM$18000"* (**Int: 015**).

This interviewee's previous didactic teaching and learning ways were still impacting on her new learning (section 5.3.1).

Feedback for the assessed submissions illustrated that despite hard work and attempts to conform, for some, unfamiliarity remained:

> *"Till now I don't understand, we followed Harvard referencing. When the result came, comment was the reference was not appropriate. When we ask them they say 'please refer to handbook' but I follow handbook!"* (**Int: 002**).

For others, like the six participants from the other UK university, their lack of understanding of the required criteria, assessments and the poor face to face, on-line and local co-ordinator support, led to their having to re-submit their work. The drastic variance in academic writing style only became evident after submission of the first assignment. When the academic realised that none of the nursing students had met the criteria, she arranged via their local co-ordinator to meet with all the nurses. They had stunned reactions when informed of their failure to meet western academic standards of demonstration of a certain standard for their English language, inadequacy of their study skills and critical evaluative thinking in their assignment.   This shock was expressed by all, as verbalised by interviewee **010**:

"Very hard, most of us doesn't know what we doing, we had to write 5000 words, it's not medical words but this is totally different. First module we all didn't meet criteria, so all had to do it again. Only then knew our English not good. She said be more critical, not descriptive – how? Reference list, key point in each paragraph and some other things and plagiarism taught on another extra three days. This was not told in the 2 week teaching period."

The culture of simply memorising text rather than critiquing and rationalising affected how they completed their assignments:

"Guidelines given on database, but not useful. No, it is a struggle. I put in A-Z whatever I know or feel I want, just pour it in my paper, I have to open book, see what is in their content and then I copy in to my content" (**Int: 003**).

Interviewees **006, 016, 002, 010 and 003** above highlight the implications of poor TNHE academic support. This will be addressed later in this chapter.

The reality of their TNHE experience was summed up by interviewee **014** as she compared what it might be like for students in similar programmes in the UK:

"Tough! In UK they learn for a long period, three four months, but here in Malaysia it is for only two weeks, everything has to enter immediately. We are like blank, blank! Not enough [time to gain understanding of knowledge or discussion], difficult to cope, teach, teach, we want to ask questions no time."

Overall, so far, there appeared a mismatch in expectations and pedagogical context between the western and eastern cultures. It caused anxiety, and nurses perceived it as a source of culture and learning shock (Ballard & Clanchy, 1997). Further, the qualitative data confirms Widdowson's (1990) assertion that to communicate with an individual from another culture, there must be awareness, understanding and interpretation of cultural differences. Eventually, it led to the nurses using coping

strategies. This supports Kim's (2001) theory that communication is key to facilitating transition from one culture to another. It also supports her stress-adaptation-growth dynamic model of adapting only to meet essential conditions of the new learning system, whilst maintaining cultural rules. My opinion is that her theory is relevant to both nurses and the TNHE academics.

The above sections have critically reviewed participants' perceptions of their TNHE teaching and learning experiences. It also identified how they dealt with the demands of their study programme in the new academic context. Based on the data, it appears: a) classroom experiences were short, overwhelming, western centric and assessment focused; b) TNHE academics appeared unaware of the reasons for these nurses' classroom behaviours, their education and health care systems; c) among the taught modules, only certain theory had been of interest, understood and added value and depth to their existing knowledge and practice; d) preferred method of asking questions was face-to-face, in private or on a one-to-one basis after teaching; e) email contact needs to be enhanced; f) writing assignments was a new experience for most nurses, g) academic standards varied but too little explanation on how to meet them was given, and h) explicit assessment criteria was desired. Key issues are raised here regarding the influence of these factors on nurses' motivation and ability to transfer and apply the TNHE taught theory in practice. These become evident in the next section.

5.6   Impact of TNHE theoretical knowledge in clinical practice

In relation to the research aim, it was essential to identify if and how nurses were making sense of the taught theory, in what ways it helped shape their identities and how they translated the knowledge across populations (western to eastern) to apply it into practice. To address this, four inter-related sub-themes i.e. personal development, professional transformation of nurses, theory-practice link and acceptance of nurse-led changes were initially formulated.

5.6.1 Personal development of nurses

A sense of personal achievement and recognition by others was evident with all these nurses as stated by interviewee **011**: "*everyone respects you more because of degree*". In addition, nurses who studied with the UK TNHE programmes admitted feeling a higher level of pride as theirs had an added title of honours degree.   Interviewee **006** said *"When I passed, I felt relieved, happy and proud. My son said Wah! Mother you also have a degree. I said yes, not just degree but UK honours degree."* The six nurses from the Australian TNHE programme still valued their achievement: *"… proud I have degree, even if only degree"* (**Int: 016**).

Intellectual outcomes noticed were improved knowledge, English language proficiency, keenness to read and interest to question. There was also increased understanding of their ability to access and gather information, and improved academic writing skills. Attaining the degree was considered by fifteen nurses as an indicator of their intellectual ability which boosted their self-confidence: *"I changed a lot, … read more and more, more knowledgeable. So I am more confident. Before I went to work and came back, like a robot"* (**Int: 006**)*.* Their previous routine ways and practices that helped them maintain a sense of personal comfort and security were challenged and led to personal growth. This echoes West's (1996) view that learning enables letting go of a past identity and perceiving the self in a new and positive way. The other three nurses felt they had always been self-confident, for example *"No change, I always confident"* (**Int: 016**).

Information Technology skills (ICT) contributed to intellectual growth, enhanced their sense of achievement, improved self-confidence and autonomous ways of knowing. Using on-line learning, resources and support was considered extremely difficult by some nurses. In fact, those frustrating experiences had positive results for some in clinical settings, as evidenced by interviewee **011**'s point:

"Interest to find out, certain terms I don't understand, I will go and search in the internet. Before, I just ignore or not my job or ok if I don't know that, as long as I can understand what I need to understand."

Critical thinking was reported by a few nurses to have become part of their daily lives since their exposure to the questioning required for analytical thinking processes to meet the criteria for their assignments. Interviewee **017** explained: "*Even choosing my indoor plants for my new house, I question, gather all the evidences, I looked for the right plants not just simply buy any plants."*

The learning behaviour of Malaysian adult learners indicate an emphasis on short term and immediate motives such as career advancement or to save face rather than for an intrinsic valuing of lifelong learning (or extrinsic value of extra pay) as Tan and Pillay (2008) posit.

However, exposure to TNHE programmes, for all their nurse-reported shortcomings, did appear to have transformational effects on the nurses' relationships with aspects of learning. For one nurse, it increased academic options: "*I finish degree then started masters*" (**Int: 001**). A few others related it has given them the confidence to consider furthering their study (**Int: 002**, **Int: 003**, **Int: 005**, **Int: 008 and Int: 013**). This is counter to what Tan and Pillay (2008) stated. However, Tan and Pillay (2008) are right in that the motivating factors for all nurses were their personal achievement, recognition of status accorded to a western degree, the extrinsic financial reward and career advancement. There is some evidence here that the nurses' motivations had a more lasting impact on at least some of the nurses' learning behaviours.

The data indicates an overlap between personal achievement, enhanced intellect, development of information technology and critical thinking skills which led to improved confidence and personal growth as an outcome of the TNHE experience. A question that emerged: was their development solely for individualistic and extrinsic reasons or for the collective good of the profession and patients? The next section will provide

some indications to this key question and it will be discussed in more depth later in this chapter.

5.6.2 Professional transformation in nurses

For twelve nurses the sponsorship of the programmes by their employers enabled them to achieve their personal aim and career promotion, or the potential of a promotion when a vacancy arose. The six nurses who self-funded were motivated by their future career prospects and employment mobility.   Malaysian culture considers academic qualification to be synonymous with status: *"I was a senior but was not recognised by management.   When I finished my degree, only then I recognised"* (**Int: 008**).   This recognition for interviewee **007** also draws attention to her previous self-perception in contrast to her newer self-image: *"*[In the past, I] *accept I am a nurse, just a nurse, not a professional."*

Similarly, interviewee **014** noted: "*Before when I work, I follow what I learnt at my School of Nursing, that is what I follow, no name, just do. After doing degree, only then I know, name and why doing"* (**Int: 014**).   This personal and professional shift was further emphasised by interviewee **005**: *"Before I didn't think, no critical thinking, just do and do only, now I think."* And yet again by interviewee **009** who said:

> *"When management e.g. collect data, last time questionnaire, we so busy, we just tick, didn't even go through it! Now we learn, we understood, collect data to improve work, not give extra work, so we take time, read and do properly."*

Recognition for change with regards to the doctor-nurse relationship was noted:

> *"We are timid, like a mouse with doctors, I think we should emulate western outspoken kind of attitude, little bit into our society and health care settings. Sometimes we need to tell off the doctors for the patient's sake"* (**Int: 004**)

A changed attitude led towards professional accountability: "*Before, I instantly follow doctors' orders. Now, I ask, reason and give view to Doctors*" (**Int: 007**).

It can be seen so far that personal development was linking directly into enhancement of their professional interpersonal skills:

> "*More sure of myself in problem solving, … how to give orders, I'm more confident with my communication, diplomatic way. When I handle students and staff, I use sandwich technique, hopefully they learn something lah. In the past and now the same but the thing is now I polish up my way*" (**Int: 004**)*.*

Questioning, reasoning and their newly learnt knowledge enabled some nurses to engage with nursing care decisions: "*Now, I feel more complete the way I nurse the patient, not just do and go. I take the initiative to spend time with the patient, … find out their views or their needs*" (**Int: 011**). For others, it enhanced respect for patients differing beliefs and values:

> "*Before I go for course, I keep quarrelling with patient during fasting month, your diabetic condition not suit you fasting, they don't like. I don't know how to talk. Now I refer to their Islamic leader to speak rather than me*" (**Int: 008**).

In other words, this nurse was acting more strategically. Certain nurses developed the ability and confidence to test out new interests in their daily working life. Several developed positive professional attitudes towards their capabilities: "*Initially I don't like management post, don't like me be in charge, not on management. After course, … why not try, give a try, now I manage unit*" (**Int: 002**).

My study findings confirm Davey and Robinson (2002), and Lillibridge and Fox's (2005) study that most nurses who gained a degree attained increased self-confidence. The reality of transforming oneself versus altering others' attitudes towards change were agreed by all in the following terms: "*Change easier in me than being able to change*

others" (**Int: 003**).   This often has indirect benefits for patient outcomes, for example, nurses are able to interact more equally with other health professionals to enhance patient care.   Also, the qualitative data supports Des Jardin's (2001) and Darbyshire's (2006) view that as nurses acquire knowledge and skills they become empowered. Opportunities to apply taught knowledge, when supported by their employers, were found.   "W*e have a journal club in hospital, who study research in degree, we meet and discuss"* (**Int: 014**) and *"I get involved and learning from others, now I trying to use my knowledge"* (**Int: 010**)*.*

Whether they applied the theoretical knowledge they had acquired through TNHE to benefit provision of patient care in clinical settings, is the question to which I now turn.

5.6.3   Implementation of theoretical knowledge in clinical practice

Interviewee **004** together with interviewee **015** (they had studied with 2 different UK TNHE universities), sought to use their new theory about evidence based practice:

> "W*e did observational studies, we go all around the wards … we analyse, tabulate and present during meeting and our … was impressed.   And the results were circulated to all the unit managers.   Having evidence from your place, we able to speak out and make comparison with WHO standards, they were like Wow!"* (**Int: 004**).

There were inconsistencies in viewpoints, throughout individual interviews, with regards to whether nurses had made changes in practice settings.   For example interviewee **015**'s account of changes she had implemented: *"nothing really can apply in practice".* And this does support Silverman's (2000) warning of a gap that exists between beliefs and action.   Yet this same interviewee talked about using her learning and confidence in strategic ways:

> *"… helped me a lot how I talk to Doctors in meetings.   When I say it is the National Health Service UK evidences actually said …, many of us like to use*

that to present to Doctors, because they don't ask any more questions! Back to culture and this perception that British are best. Because we colonised, their influence is still there and we look up to them, their very good reputation still remains. Immediately, Doctors say is there anything that we can adopt."

Here is a clear disparity between opinions in relation to actions (Weber, 1947). Amongst other interviewees, acknowledgement of professional responsibility also led to reflection on previous practice:

"The importance of incident reporting e.g. infections or diseases. In the past we keep quiet" (**Int: 009**) and *"sometimes we know it is important but we don't do e.g. to maintain documentation. We have to change our own way"* (**Int: 013**).

Clinically related modules prompted interviewee **007** to consider reducing the risk of pressure sore development:

"I said, turn patient every hour or two hours, before every three or four hours. I explain why we do, our care must be quality. I tell them record on form when turn patient."

What was evident was that most did not accept certain aspects of status quo they had returned to work in; they had the confidence to make changes to management of patient care. Areas to which nurses were directing their attention included the clinical environment, handling and managing of other health professionals, student nurses and patients, and reporting of patient information and documentation. The extent to which TNHE theoretical knowledge was now being applied in clinical settings remains unclear and cannot be ascertained, due to differing views and the limited number of examples given. This in turn indicates the difficulty of ascertaining where and how theory and practice were linked. In terms of scale, interviewee **003** suggested: "*Implementation of change, o*n a smaller scale, yes, but in a big scope, no."

5.6.4 Acceptance of nurse-led changes

Before I can discuss the acceptance of nurse-led changes, there is a need to review the status of nursing in Malaysia. I refer the reader to Chapter 2, where Bryant (2003) is cited as saying that in Malaysia nursing is still considered a menial job. Interviewee **007** confirms this as she related her relative's comment:

"… do you need degree to clean faeces? You don't know, I really felt it. People look at nurses as the lowest, they only see we look after others, … faeces, vomit, … Despite degree, peoples' perception has not changed, still think dirty job, culture lah. They don't see nurses help them recover, they think its Doctors."

Another nurse interviewee **001** had a different viewpoint: *"Status perception has changed, in the sense of education level, even though performance not good. Most Malaysian nurses already done Masters, PhDs!"*

With regards to management, four nurses thought they would accept change if it benefitted patients and staff. Others, like interviewee **016** argued: *"Management don't like if we develop … culture and politics. You talk no use, they don't listen."*

Questions emerged from this data of why employers buy into TNHE programmes for their nurses but resist changes for best practice that the nurses offer them.

Attitudes of other health professionals affected their keenness and motivation:

"… they saying it should be based on evidence but if culture does not support nurses verbalising and thinking out of box then it is not leading to patient safety. Here, there are nursing managers who have done degrees and yet their degree stays at home. The knowledge stays at home, it doesn't come to the workplace, they are still the same, as how they were. They happily walking about and not implementing anything. My leaders are different from the leaders from the book" (**Int: 015**)*.*

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Most nurses had views similar to interviewee **015** above, and my insider emic view supports the reasoning of interviewee **002**:

> "*Culture in Malaysia, they don't see change will give them any benefits, they only see reward. If I do this, what is my reward, they don't see the higher reward like job satisfaction.*"

Deference to authority was also demanded as interviewee **006** was told: *I'm the unit manager, I'm senior than you'. Then you cannot overrule her, our hierarchy level is different. ... I felt frustrated.*"

Hierarchy seemed to persist and was a difficult challenge for nurses to overcome, as overruling hierarchy was unacceptable:

> "*We tried to go and meet the ..., She said she can accept the change but you have to inform your unit manager. Your unit manager will have to complete the paperwork and give me*" (**Int: 006**).

Bryant (2003) asserted the medical profession in Malaysia regards nursing more favourably than does the public. Nurses expressed the view that doctors who updated themselves and were trained overseas respected nurses and their opinions. This is confirmed by Bryant (2003). In comparison, those who followed traditional ways or who had been educated in Malaysia preferred to maintain the status quo as "... *they still think they are God"* (**Int: 012**), and we like their "*handmaidens*" (**Int: 001**).

Interviewee **007** further points out: *"Doctors look at nurses like stupid, you just follow what I say, like nurses no brain lah".* She further voiced her frustrations as she summed up her reality: *"Some doctor don't want this, don't want that, don't want this. Here Sister you do like this, you follow my style. Three Doctors three styles so …"*

All eighteen nurses believed their newly achieved graduate status had little impact upon acceptance of change by nurse colleagues. They found senior nurses, commonly known in Malaysia as *"hard core"* (**Int: 004**) with their *"rigid mind-sets"* (**Int: 001**) were more *"difficult and stubborn"* (**Int: 012**) towards accepting proposed changes. Reasons cited were satisfaction with their senior status, long service and complacency. Also, their confidence with the routines resulted in their preference to remain within their comfort zone. Interviewee **005** said: *"Even with their eyes closed they know what to do, to re-learn a new way of doing things, they don't like."*

Nightingale's (1859) comment that experience is not conducive to learning and Shiffrin and Schneider's (1977) experimental data support this. This is because habituated thinking and actions are unconscious and difficult to unlearn.

Some junior nurses too opposed change, as interviewee **003** said: *"They see as extra work or extra paperwork e.g. this year another new chart, to them is hell. They don't see importance of compliance. Their attitude, if I don't do so what?"*

Interviewee **003** reported that sometimes changes that were implemented in practice failed to continue:

> *"They take idea, initially accepted but not well implemented e.g. I doing a project, quality improvement benchmark with a lot of references, to use form for … but staff don't record. It remain a form!"*

Similarly, interviewee **007**, noted above as trying to make changes to patient turning to reduce the risk of pressure sore development found that staff *"… didn't do, or not doing correctly, or do only when see me."* Again, professional transformation was clearly linking into shifts in personal communication styles: to encourage compliance for implementation of change, participants who held management positions reported that they used: *"diplomatic discussion, first; if don't listen then I say I manager you have to follow"* (**Int: 005**). It was known that nurses followed instructions out of deference to

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managers' authority, rather than their education and knowledge. Some senior nurses were said to be disinterested in furthering their own studies, but were resentful of the degree holders' academic attainment that resulted in immediate rise in status and salary, and the expected changes that the new graduates would introduce to their comfortable work practices. A senior nurse herself, interviewee **006**, dealt with resistance from anti-degree nurses' as follows:

> *"We have to talk to them with respect, because they are senior but we have to be positive thinking. Another thing, they don't like when you say it is based on research. They will say 'Yes lah, you went for course, so you know lah, I didn't go for course. Their thinking is, I have learnt higher than them, better to just follow lah. We use gentle approach and they follow like they are forced."*

With regards to patients, all participants concurred that: *"… patients, whatever you want to do, they will agree"* (**Int: 009**). This is an important point as it indicates that patients generally trusted nurses with their care and had a positive approach to change, irrespective of whether that change was instigated by nurses who had a degree.

Whilst the sub-themes above have reported the nurses' views with regards to the research question, there were other supplementary aspects that nurses also considered impacted on the theory-practice link. These are identified below.

5.7　Outcomes of TNHE experiences & qualifications: nurses' evaluations

This section will outline the participants' retrospective evaluation of their assumptions, expectations, classroom and clinical setting experiences. In addition, the impact of TNHE qualifications on themselves and on others including in practice will also be discussed.

Participants' initial perceptions were that teachers and book knowledge were authoritative sources (see section 5.3.1). Based on the findings, it seems that when they became aware of the value of being a critical reader and writer using evidence for

practice, being only taught the theory without application was not appreciated. Interviewee **010** said: *"She didn't link research to practice, even if Management give chance, don't even know where to put it because didn't show me."*

Throughout the programme, these nurses were primarily focused on attending the classes or undertaking on-line sessions to complete their assessments for achieving the degree. At a personal level, they did not give the application of TNHE knowledge in clinical practice any serious consideration. On completion of their degree, they became aware that the lack of a clinical practice component inhibited their ability to apply the learning in practice. Interviewee **001** said:

> *"I can't even remember* [TNHE theoretical knowledge]. *How we can remember? We learn and put into practical we can remember always. Is not related to our work, no ... cannot apply in practice!"*

The six nurses who self-funded, purposefully chose TNHE programmes with only a theoretical component. Post-course, they realised: *"Culture is different, difficult to understand. Understanding of theory is different when you can apply in practice. Must have practice, this is nursing not accounting"* (**Int: 014**)*.*

Nurses in programmes provided by their employers argued:

> *"They didn't mention about practical so we kept quiet. We learn theory because you want to do something about your practice because there is a problem. If you don't know how to use the theory or cannot use in practice to settle the problem, why do you want to learn the theory"* (**Int: 005**)*.*

Her view is supported by interviewee **018**: "*We are not entrepreneurs, we provide service to patients."* Participants believed if a practice component were part of TNHE programmes, when facilitating change with the new perspectives, the flying faculty academics' guidance and support would be on hand and could be called upon during

their clinical experience or placement. This would enable them to learn different strategies to overcome challenges they may have faced.

Another interviewee **001** who studied with the Australian TNHE programme stated:

"… our employer take it not for quality, just [accept] *for ranking and qualifications. To advertise all nurses have degree."* Her view confirms that international partners may be selected to gain prestige and ranking by association (Williams, 2012).

Some nurses also stated they were disappointed by their academic achievement, as it did not accurately reflect their knowledge, understanding and ability to consolidate and apply their learning in practice. This is illustrated by interviewee **017** who self-funded:

"If you ask me about [how to apply] *research* [at work]*, sorry I not able to tell you, even with doing research project, because my understanding is not good enough. So I feel embarrassed in that way. I even now thought of going for short research methodology courses in Malaysia. You have to pay quite a lot of money and you go like one week course but again what is the point of taking it from this TNHE university and now I have to pay again. It's a waste!*

Certain nurses from the UK university that were sponsored by their employer were dissatisfied: "*We didn't do research project. I know, other UK university did research project for honours. Our honours degree like Australia, four modules only*" (**Int: 012**).

These nurses appeared resentful that their learning did not reflect the knowledge required to achieve the honours title. Instead they felt it was similar to a general degree rather than reflecting a higher level honours degree. Hence, it was perceived to be of a lower status compared to the other UK university.

All participants accepted provision of TNHE programmes in Malaysia as interviewee **013** stressed : "*provided an opportunity to obtain a degree"* but some like interviewee **008** stated: *"… want the degree to learn"* and stressed the need for quality programmes rather than those that were as interviewee **017** said : "… *two weeks, assignment based, I give you certificate degree and finish".* Others, *"… just want the paperwork".* Six nurses said that they were pleased when one UK academic, on their first day and whilst introducing the programme, said: *"don't worry end of the day you will get it, get a degree!"* (**Int: 002**)*.* Interviewee **001** from another TNHE university stated:

> *"Personally, I think everyone don't mind because they still get their degree and RM$400 allowance. Knowing and not knowing the depth of degree studies not important, so long as they got the rank and the qualification."*

The consequence of a theory-practice gap was voiced by interviewee **015**: *"Danger of learning theory but no practice – don't know how to adopt theory and blend into our culture or what you are doing, why we doing it, can put a patient at risk - safety".* There was also reluctance to apply TNHE taught knowledge in clinical practice as they preferred to retain their original cultural values: interviewee **007** said: *"I want to learn but want to keep my culture."* It confirms Wenger's (1998) belief that resistance within communities can be implicit, subtle and informal. It further highlights, as previously noted (section 2.7), the importance of recognition by TNHE academics of culturally sensitive insights that Malaysian nurses have.

Interviewee **009** explained "… *we need to follow what patient say, we need to follow their culture. They from small have been taught, so that is their belief, then we have to follow, we cannot argue with them.*" This comment reveals how far Malaysian culture and diversity affects nurses' professional practices which may have been poorly understood by the flying faculty of TNHE academics. These perceived cultural differences contributed to the "theory-practice *gap"* (**Int: 007**). All participants gave specific examples of ways of caring that differed between the eastern and western culture. One interviewee **013** said, *"Here we don't have hired translators in hospital.*

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Family members will be the translators, they want to know everything. There is no privacy." Another interviewee **006** said:

> "*We studied the patient has rights, but in Malaysia, the rights are given to the children. When the Doctor asks for consent or anything, overseas, they will say 'I will think about it first' but here 'wait until I speak to my children'."*

Relatives tend to make decisions on the patients behalf which overrides the patient's autonomy and the right to know. Gardner (1993) explains it is not just paternalism but deeply held beliefs surrounding individual choice and rights. Specifically, I ask the reader to consider the cultural connotations of the values above. Interviewee **006** stated "*When we are young our mother cares for us, we look to her for everything. Now our mother is old, she will look to the children for decisions,*" which interviewee **012** expressed as "*It's our way of bonding with our family, ... showing we care.*" Interviewee **005** added: "*… it also protects our relative from the truth.*" With my emic perspective, I confirm this is one of the shared attitudes about families between all ethnic groups in Malaysia. Parents provide for their children in return for unconditional loyalty and obligation.

These examples highlight how Malaysian nurses are required to integrate their clinical practice in line with the WHO's and MNB's (2002) professional standards while providing care alongside the cultural traditions and rules of the diverse ethnic groups.

Nurses outlined how the western professional standards appeared to override local cultural and religious practices whilst they were expected to integrate western professional standards alongside the Malaysian philosophy to fit the cultural context of the diverse ethnic groups within society. "*They don't know our way, they just come and teach their way and go back thinking we can do, but no, we can't*" (**Int: 010**)*.

Interviewee **002** further explained:

"We learn UK culture and in UK hospital it is UK culture. In Malaysia, they teach UK culture but difficult to blend UK culture in our health care, because patient, other staff and management must all want to change."

The status of TNHE degrees and their impact afterwards in the nurses' clinical settings, irrespective of the theory-practice link is illustrated by interviewee **004**:

"Before this, we have been doing this for long, long time nothing happened. Since came back from UK course [sarcastic]*, they don't say 'with honours', they say 'with horns'* [referring to shortened word for honours – hons.] *so the horns have appeared* [she demonstrated with her fingers to signify horns].*"*

The final interview question "Would you recommend this programme to your close friends and why?" was added after the pilot study because nurses had provided only positive feedback or were reluctant to give any feedback. As an insider, this question shows I was using a subtle Malaysian way to obtain their actual views about the programme. It was unnerving to them as personal relationships (close friends) are highly valued in Malaysia. Out of eighteen nurses, only interviewee **004** said she would recommend her university to her close friends: *"Even though, … it is not easy, you know, yes, I will recommend this university. Why not, they get degree, hospital paying."*

Eleven participants had views similar to that of interviewee **008**: "*I won't recommend any university, I ask to go and survey other universities, see got practice* [clinical component] *and follow our culture."* This option was preferred either because they did not want to tell them directly not to study with the same university or to save face or because they felt a practice component was essential for the theory-practice link. Six of the nurses had views aligning with that of interviewee **001**: *"I won't recommend this university"*. Six out of eighteen nurses added: *"… do it full time better than two weeks together"* (**Int: 010**)*.*

All accepted the benefits employers provided as key determinants of the university their close friends might choose to study in.

The self-funding nurses' TNHE university had MQA accreditation whilst the employer-funded TNHEs did not have MQA accreditation. But, nurses only became aware of this fact on completion of the programme. Opportunity to undertake a research project as a means to demonstrate practical applicability of the taught theory and eligibility for the honours title were also influencing factors.

However, the TNHE degree award entitles all nurses to the financial incentive and the potential for promotion regardless of whether their programmes had been accredited by MQA. The long term consequences of having the degrees that did not have MQA accreditation would need to be seen. At present the employer-sponsored nurses are bonded or have a contract for four years. In contrast, the choices and prospects for promotion for the self-funded nurses were varied and extensive.

5.8   Issues arising from analysis of data

This section aims to discuss key aspects of Malaysian nurses' experiences in the TNHE classroom and their clinical settings. The extent the TNHE theoretical knowledge has been applied in Malaysian clinical practice has been determined from their views. The nurses proposed how the TNHE programmes could be enhanced.

The general consensus among the eighteen nurses was that the culturally constructed status and role of nursing, hierarchy, financial resources and time implications failed to offer the opportunity or support for applying learning in clinical settings. Difficulty in changing the resentment, attitudes and performance of nurses who were recruited without a degree and preferred not to study further was a source of frustration. But, they were optimistic that with the increase in the number of degree nurses, there will, in time, be less resistance and increased motivation to apply TNHE learning in practice. Their belief supports Hardwick and Jordan's (2002: 530) view that "*a workforce … en route to becoming an all graduate profession*" reduces resistance to change.

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As eleven out of the eighteen participants in my study held managerial positions, a key point highlighted by interviewee **002** must be considered: *"… usually with health care those who do higher education, you not by bedside but in office."* From my etic point of view I argue that in time, as more and more nurses attain degrees, there will be limited promotions available and these nurses will be required to provide direct hands-on patient care as is evident in the UK and Australian health care system.

Interviewees outlined a conflict between their assumptions and expectations of the TNHE programme and the assumptions and expectations of the TNHE academics. There were mismatches between western and Malaysian pedagogic and professional values and clinical practices. Associate Professor Dr Hamidah Hassan, Chairman of the Nursing Education Task Force of the MoHE (2010) confirms that in Malaysia, nursing is still influenced by the old British system. Most colleges still use the teacher-centred and didactic approach whist in clinical settings nurses remain submissive to doctors' orders. Previously, this was also confirmed by Chiu (2005) and Birks et al (2006) studies which indicated participants had to bridge from their existing learning mode to a new educational paradigm when studying with the international universities. This resulted in Malaysian nurses perceiving the academics as being unprepared for their TNHE experience. The reported lack of guidance and support for their assessments caused concern and posed difficulties in their classroom experiences and in completing their assessments. The participating nurses reported that western academics' lack of intercultural awareness also led to miscommunication and misunderstanding in the classroom, on-line forums and email exchanges.

Despite the lack of a practice component, it appeared TNHE academics assumed the nurses would easily translate and demonstrate practical application of the western theory and professional values into local clinical settings. Research undertaken by the MoHE Nursing Task Force on the Basic Nursing Competencies for New Graduates of Diploma Programmes showed that critical thinking to apply the nursing process theory to practice was not taught in the didactic teaching approach in classrooms nor in clinical training (MOHE, 2010). It seemed insufficient consideration had been given to the

personal, professional and cultural shifts that nurses would have to make to ensure provision of care was consistent with the culturally different contexts in which that care had to be delivered. This further convinced the nurses of the flying faculty academics' unpreparedness to support the Malaysian nurses.

In addition there were questions whether the degree was primarily for "*instrumental*" Furnham (1987 cited in Anderson, 1994: 304) or individualistic reasons which were motivated by intrinsic or extrinsic factors. The answer to that question is a resounding yes to individualistic reasons and to extrinsic factors. I remind the reader that the nurses' motivation to study in TNHE programmes was mainly influenced by their desire to get a high status western degree, financial incentives and promotion; basically individualistic and extrinsic reasons rather than embracing the learning to improve patient care (section 5.4.1). I also point out that in their personal quest to achieve the degree, they indirectly met the Ministry of Health's, MNB's, Vision 2020 and their employers' objectives to upgrade Malaysia's nurses to graduate status.

On completion of the degree, it was evident from their views that irrespective of whether they felt learning had taken place or theoretical knowledge could be applied in clinical practice, all acknowledged they had attained a western degree, graduate status, financial reward and enhanced career prospects. Yet again, this confirms that their degrees were undertaken primarily for individualistic and extrinsic reasons.

Next, I reveal the view of interviewee **011**, a nurse who had just been promoted on completion of her degree when I undertook the interviews. She reported that she was planning to implement changes from her TNHE learning in her new role. When the transcripts of the interview were emailed to her, she responded to confirm the accuracy of the interaction that occurred during the interview, but also stated she had not implemented the planned changes. No reasons were provided. This nurse had been promoted and so like others who had also been promoted, or were already in managerial positions, she was in a good position to make changes. She could do this with the knowledge and authority needed. A re-examination of her earlier interview data

revealed her primary motivations had originally been to obtain a degree with a western status, benefit from the allowance of RM$400 and gain promotion. Her initial reasons as recorded in the demographic survey questionnaire were interest and promotion. They were not for collective purposes of transforming thinking or mindsets, nor changing practice for public good, or for empathic grounding, as is usually assumed in nursing.

In spite of many nurses' negative feelings towards TNHE programmes, with their language and academic difficulties, the nurses demonstrated resilience to the cultural and learning shock of such an intense programme. One such example is their silent behaviour in the classroom. In that silence, was the determination and resolve to attain the degree. Following the lectures, they went on-line and researched the topic, worked hard, persevered and conformed to the new learning norms. They started self-help groups to discuss the criteria for assessments and submitted the required work. The nurses appear to have made the necessary adjustments to meet the assessment criteria and achieve their degrees successfully.

It also appeared that certain nurses used their acquired knowledge and their agency in practice. But, there were no clear links as to what coping strategies nurses used that enabled them to internalise what they learnt, nor were there indications as to their ability or motivation to apply or implement some of their learning in practice settings. Neither was there any clear indication as to how far a positive impact of the TNHE knowledge in practice settings would require nurses to make adaptations over the long term and not just in the short-term.

In a theoretical study, Volet and Jones (2012) addressed the issue of the transferability of study approaches from one learning context to another. It concluded that some aspects of student learning transfer well across cultures, while others reflect ambivalent, difficult or inappropriate transfer. This is supported in my study as certain nurses became strategic in this agency by borrowing almost Anglo-centrically from their association with TNHE programmes. The changes in attitudes, perceptions and

decision making skills from their acquired knowledge increased some nurses' status and power in their practice settings even amongst doctors.

Having pointed out the lack and inefficacy of TNHE educational preparation to ease cultural conflicts in section 5.4.2a, I now point out that the Australian Vice – Chancellors' Committee (AVCC) (2003) recommendation for cross-cultural training is specifically for TNHE academics. Yet clearly, students have not been considered sufficiently. Neither have the implications of western universities marketing their existing degrees whilst only customising or adapting them to meet certain regulatory frameworks in the receiving countries. Intercultural awareness and sensitivity training for both academics and nurses may make the unknown appear less surprising. Notably, website information for Australian TNHE academics only provides superficial cultural advice and information about politics, values, 'what to do' and 'what not to do' practices. This enables a tourist experience, rather than supporting academics to build links or integrate into local communities. Integration with the community would be a key connecting factor for the intracultural with the intercultural in TNHE environment (Knight, 2004; Muller & Hawkes, 2010).

I now draw on Colin's (2006) argument about education for the future. He stresses the outcome of globalisation demands that learners be highly sensitive to cultural changes and flexible to learn, work and live together in various challenging environments. His views are similar to **P1**'s view in my small scale study about not needing to evaluate her teaching (Appendix B).

It also seems that there is no recognition that the nurses studying in their own country, within their national context, and a major challenge lies in breaking with tradition to change beliefs and old habits which are often resistant to change. Further, after the short teaching period these nurses would return to the same social environment where other professionals, patients and communities still hold those strong cultural values. They also have a responsibility to provide appropriate care for these multicultural, multiracial and multilingual patients in a culturally sensitive manner. I emphasise that

relevant care to patient needs can only occur when culture care values are known and serve as the foundation for meaningful care (Leininger, 1978). I also remind the reader of interviewee **006**'s outlook (section 5.4.2a) when the cohort of students recognised the UK academic was totally unaware of the cultural values and ways of Malaysians.

In taking a pragmatic stance, some like Biggs (2003) argue for the TNHE educational experience to be the same as western programmes. He argues good teaching relies on the universality of the learning process in which the ethnicity of students is largely irrelevant. He stresses this is not the same as devaluing or being dismissive of students' cultures. Others like Okolie (2003) believe western countries tend to expect eastern students to conform to their models of education which Crismore (2003) identifies leads to 'teaching down' to communities that are culturally different from that of the teachers. A few like Knight (2004), Mohamad, Rashdan and Rashid, (2006), McBurnie and Ziguras (2007) and Muller and Hawkes (2010) believe western academics need to adopt the intercultural educational stance. By rethinking and confronting their beliefs and biases in considering cultural proclivities and linguistic factors, they can connect the intracultural with the intercultural for enhancing students' experiences. Dawson & Conti-Bekkers (2002) and Heffernanan, Morrison, Basu and Sweeney, (2010) argue TNHE programmes are intentionally chosen in Malaysia based on the assumption that western education and nursing tenets are superior. Adaptations may conflict with MNB, employers' and nurses' expectations whilst also compromising academic standards. Hence, only superficial changes are made by TNHE providers to internationalise the curricula towards Asian countries' social, cultural and educational values (Leask, 2003; Tikly, 2004; Wang, 2008). Despite these views, Cortazzi & Jin (1997) point out students appear to adjust successfully to achieve in their studies after an initial culture and learning shock and acculturation period when they face the new western educational experience.

However, I argue in relation to the six nurses from one UK university where the lack of recognition of their previous experiences led to all nurses failing to meet the assessment criteria. Then, extra teaching days were organised to deliver the required

academic skills.   This has implications against both eastern and western academic standards.   The quality of the programme is not assured through following models of knowledge that worked in the UK.   It also confirms Abdullah's (2010) belief that only by understanding unconscious assumptions that people's behaviour can be accurately assessed and appropriate strategies developed to maximise learning.

Participants in my study disagreed with being taught and assessed in exactly the same way as western students.   The reasons given were the short-time frame, lack of subject knowledge, differences in classroom culture, education and health care system.   These nurses believed as they were in their own country and studying for a foreign degree, the curriculum could be changed to make it meaningful so that what is taught has contemporary relevance i.e. to internationalise their existing knowledge and skills but still enable them to maintain their national identity and cultural rules.   This was to keep them firmly rooted within the Malaysian context.

In this sense, the nurses were aligning with Birks et al's (2009) assertion that attempting to achieve 'uniformity of practices' with uncritical imitation and adoption is neither practical nor desirable.   This view is further highlighted by Abdullah (2006) that Malaysians who adopted and practised western values instead of integrating western ways of knowing within Malaysian values were considered culturally ruthless, over-trained and brainwashed.   Hence, nurses suggestions were for TNHE academics to reduce cultural incongruities and dissimilarities by cultural immersion: *"*[Lecturers need to] s*tay here six months, study our social life, cultural … to know what is relevant to teach and what is not relevant"* (**Int: 016**).   All eighteen nurses felt that links and cultural engagement with the local community is necessary as it would enable western academics to be aware of their own revered values and the nurses' unconscious and conscious ideals to assess their behaviour and ways accurately.   Only then can contextually appropriate strategies be developed to teach knowledge that relates across cultures.   It would also help them to stimulate global views and knowledge transfer adaptable in Malaysian clinical practice and culture of nursing.

Another suggestion from seventeen out of eighteen nurses was for TNHE academics to include those with an Asian background. Firstly, this similarity would enable them as interviewee **004** said: *"…to be more congruent, feel more at ease to talk and learn how to be critical".* The nurses believed as these Asian academics would have understanding of their cultural values, unconscious ways and know the culture of Malaysian patients, they would be able to "*show or guide how and what* [western] *theory can apply to practice".* Alternatively, fourteen participants felt like interviewee **014**: *"No need for them* [TNHE academics] *to come here. Only we know what will be accepted and can adapt the content for us".* Nurses preferred for Malaysian lecturers to be sent overseas to study. On their return, as they are aware of the culture, ways and how to care for the multicultural, multiracial and multilingual patients, they would be able to teach these nurses the western theoretical knowledge appropriately.

The dichotomy between the programme as a theory-based degree and the ability of participants to link the TNHE theoretical knowledge to their everyday clinical practice was evident in the limited experiences they described. There were few examples of how it had directly influenced care. My findings support Hardwick and Jordan's (2002) study that showed self and professional perspective transformation, but changes in practice and patient outcomes were inconclusive. The data confirms Wenger's (1998) belief that failure of expected learning in a given situation still results in learning of another kind. The journeys described are unique to these Malaysian nurses but many issues they raised have been reflected in previous studies of post-registration nursing degree programmes (Chiu, 2005).

The restricted number and nurse-led examples they provided led to difficulty to ascertain the extent TNHE theory was applied in clinical settings. It validates the complexity to measure these empirically and highlights the multi-faceted nature of the issues surrounding the relationship as depicted by Figure 1. The interview data presented in this Chapter reflected the voices of the TNHE nurses who have now become part of a new community of practice within the Malaysian post-registration top-up nursing degree, health care system and society.

5.9   Overview of chapter

Overall, the data demonstrated culturally different ideas or expectations, mismatches in pedagogic and professional context of academics and nursing students in the TNHE environment that impinged on the application of learning in practice. Nurses identified TNHE academics had made assumptions with regards to their abilities for independent learning, subject knowledge, critical analysis and academic writing tasks within the short time-frame. According to nurses, it was due to academics' lack of knowledge of the culture and education of nursing in Malaysia. Other issues that emerged were the nurses' transition from their entrenched teaching and learning to the new western thinking, styles and approaches. Again, these may include identities, values and culture, but with their TNHE experiences, the perceived status of western academics and education must also be considered. These issues will provide answers to my research as they will focus on the experiences of shock and the conflicting ways of another culture. Although the features and cultural resources I stated during their pre and post basic nurse training are examples of ways they coped, they demonstrated other coping strategies to show the adjustment and adaptations they made during and as a result of this experience.

It was evident the TNHE taught knowledge that focused on intellectual outcomes had enhanced their self-confidence, improved their interpersonal communication skills, professionalism and academic knowledge. There were contradictory views with regards to the implementation of changes in their practice as reflected in previous sections. The restricted number and nurse-led examples they provided led to difficulty to ascertain the extent TNHE theory was applied in clinical settings. Organisational and environmental factors, resistance to change, lack of acceptance of changes, and the apparent resentment towards graduate and honours graduate status also impeded the opportunity to bridge the theory-practice gap.

Questions emerged in relation to my research aim as to why there was an issue with TNHE theoretical knowledge being applied in clinical practice given that patients accept developments in care. Also, why employers buy into TNHE programmes for their nurses

but resist changes and do not set out strategies to ensure the acceptance of changes for best practice that the nurses offer them? These questions will be discussed in the next chapter, along with recommendations for TNHE providers' practice.

**6.0   CHAPTER 6   A Defining moment: Malaysian nurses' perspectives of
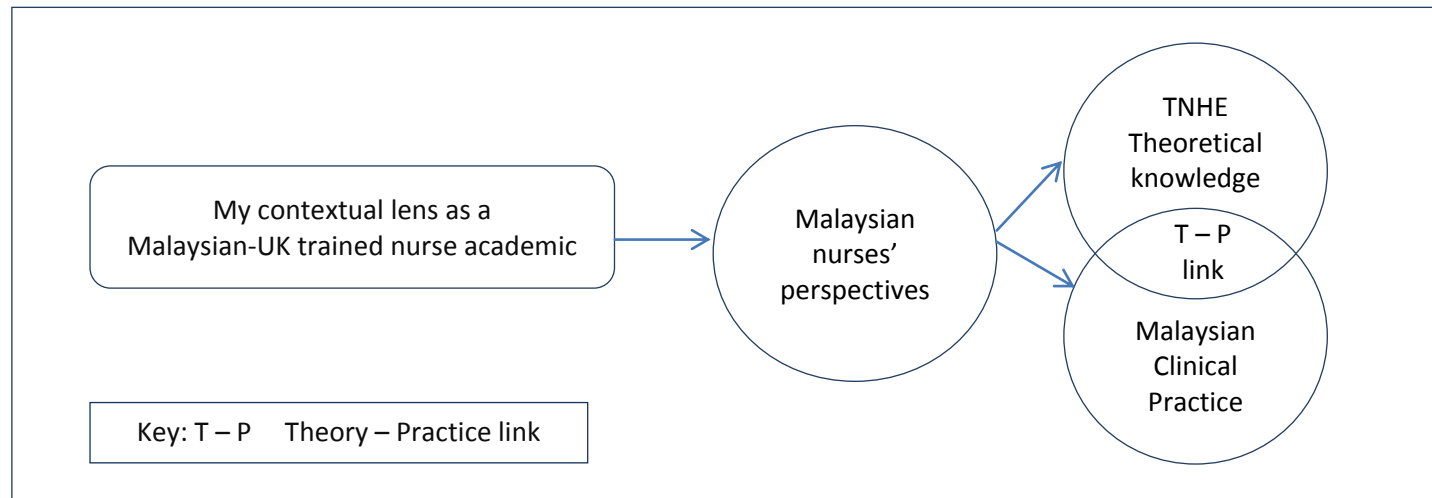   TNHE & theory-practice links**

6.1   Introduction

Unfolding Malaysian nurses' perspectives through their own voice was key to my research, analysis, findings and interpretation. Their TNHE experiences and extent taught theory was applied in practice is initially identified. Recommendations to improve TNHE programmes follow, before I reflect on my methodological approach. Then, suggestions for further research are outlined. Finally, a summary of the study's contribution is offered.

6.2   Basis of my thesis

Nurses' perspectives of their experiences with TNHE post-registration nursing programmes highlighted the gap between Malaysian and Western assumptions and expectations. There was a dichotomy in teaching and learning outlook and behaviours; as well as mismatches in professional values and clinical practices between the nurses and the western TNHE academics, although both were based on the WHO standards. Figure 4 (below) presents my changed contextual focus and the factors determining application of TNHE theory in clinical settings.

Despite available literature regarding differences in the western and eastern culture, education and health care system (Puteh, 1998; Hashim & Abas, 2000; Ahmad et al, 2005; Jedin & Saad, 2006) and emphasis on the theory - practice link in provision of care (Leininger, 1978), the Malaysian MoH and MNB had accepted TNHE programmes that had western-based academic content, assessments and learning outcomes with no practice component. In addition, all three universities involved varied in the form, quality and standards of their study programmes. Variations in the programmes existed because of loopholes in the Malaysian government's regulations, and the lack of clear guidelines and rules governing the TNHE degree programmes. As a result of this, all three TNHE providers were able to bypass some stipulated regulations and provide programmes as they saw fit.

Figure 4: Factors determining application of TNHE theory in clinical practice

In the top diagram:

My contextual lens as a Malaysian-UK trained nurse academic → Malaysian nurses' perspectives → TNHE Theoretical knowledge / T – P link / Malaysian Clinical Practice

Key: T – P   Theory – Practice link

Factors determining application of TNHE theory in clinical practice			
TNHE Programmes	**Acceptability of nurse-led changes, in practice**	**(De)Motivating aspects for nurses**	**MoH, MNB, Employers**

Deficits in design
 	
• Cultural considerations
  o Delivery time too short
  o Differences in L&T practices
  o Differences in professional values and clinical practice
  o No practice component
	Power/Authority relationships
	
	Management, Doctors, Senior nurses Junior nurses
	
	• Resources
		Motivation:
		• Self -identity as professionals; responsible and accountable.
		
		Demotivation
		• Did not comprehend from TNHE how to apply theory to practice.
		
		• Priorities/incentives had been:
		  - Status of western degree
		  - Financial
		  - Promotion
			Degree of commitment to nurse-led changes:
			
			• **Focus on**
			  - Award of Western degree
			  - Organisational reputations/ Western-associated status
			  - Local institutional ranking systems
			
			• Lack of institutional follow-up support post TNHE delivery for nurses to implement change in practice.

Figure 4: Factors determining application of TNHE theory in clinical practice

The lack of recognition of some of their degrees by MQA did not seem to make a difference as these nurses were still entitled to the financial incentive, promotion and opportunities for further study.

The nurses felt that the TNHE academics had taken a one size fits all approach with no appreciation or recognition given to cultural disparity between western and Malaysian clinical context. This is in line with Hall (1976) and Hofstede's (1980) observations of intercultural situations. With no practice component and within the short teaching time-frame, according to the nurses TNHE academics were unable to provide appropriate support to facilitate knowledge transfer adaptable to Malaysian clinical practice and culture of nursing. This partly contributed to these nurses' inability to apply theoretical knowledge in practice. It must be highlighted that the issue of theory-practice gap in nursing is prevalent world-wide, and is not solely related to TNHE programmes in Malaysia (Hardwick and Jordan, 2002).

All nurses stated that in Malaysia, TNHE programmes with western academics are considered superior in credibility, integrity and expertise, and as a status symbol compared to programmes by local universities. However, shortcomings in the TNHE teaching and learning environment and applicability of the taught theory in clinical settings led to participants questioning the validity of these programmes. Nurses reported these programmes offered limited theoretical knowledge within the intense short time-frame and no clinical component.

The Malaysian nurses' motivation to study had been for individualistic and extrinsic reasons. Their initial transitional experience was a painful and challenging process as they had to fast-track their learning in an assessment focused mode with less support than expected. The desire to succeed spurred them to overcome the culture and learning shock with effective coping strategies. However, the financial incentive, increased chances of career progression through promotion and the valuable qualities that inspired them to complete the degree had only a marginal effect on their ability to make and sustain change in practice

The extent TNHE theoretical knowledge was applied in clinical settings was unable to be determined due to conflicting perceptions, contradicting views, restricted number of nurse-led examples which also highlighted the difficulty to ascertain if and how theory and practice are linked. It remains nurses' prerogative to decide whether they want to apply their learning in clinical settings, how and to what extent. One major flaw getting TNHE theory to contribute to changes in clinical settings, or impact on the provision of patient care could be that neither TNHE academics, Ministry of Health, MNB nor employers offered guidance or support or experiential learning in doing this.

The instrumental preoccupations of many stakeholders were met. TNHE providers succeeded in obtaining and fulfilling their income generating contracts and raising their international profile and influence in Malaysia. Private hospital employers who funded these programmes raised their ranking by working towards ensuring their nurse managers and nurses are western taught graduates. The Ministry of Health's goal to improve the nursing workforce to graduate status by giving a financial incentive raised the percentage of nurses with degrees. Thus, the government's 2020 agenda was closer to being realised. MNB's aim for part-time top-up degrees to upgrade diploma nurses, attain a western degree at reduced costs and improved CPE opportunities were also attained (Jantan et al, 2005; Morshidi, 2006; MNB, 2008). Vision 2020's objective to enable Malaysia to achieve a developed country status by having a graduate level workforce also appears to have been advanced, on way to being met. The agendas of key stakeholders above appear to be generally met, directly or indirectly, except, the government's 2020 agenda of changing the mind-set of nurses. The Ministry of Health's anticipation that nurses would utilise western expertise and innovation to enhance standards of care and MNB's objective to improve patient care were not fully met. In other words, everybody appears to win except the patients.

Exposure to the programme, for all its differences and nurse-reported shortcomings, does appear to have had transformational effects on their relationships with aspects of learning and clinical practice. The programme empowered them (Darbyshire, 2006), enhanced their confidence (Davey and Robinson, 2002; Lillibridge and Fox's, 2005),

and improved their intellectual, information technology and critical thinking skills, enabling them to portray themselves more positively (Des Jardin, 2001). Their ways of knowing changed as they became interested to read, learn and research even though during their degree programme they had difficulty to comprehend.

6.3   Recommendations

Despite their previous spoon-feeding or teacher centred style and exam focused learning, the nurses demonstrated degrees of resilience to the cultural shock of such an intense Westernised educational programme, coping with the differences, and adjusting accordingly. This demonstrates that learning styles are contextually rather than culturally based. It raises a key point for my study i.e. although an individual can adopt new ideas, values and modes of teaching and learning, it takes time to adjust and adapt

In TNHE programmes delivered in Malaysia, the short teaching time-frame restricts nurses' ability to adapt to UK and Australian HE styles of teaching and learning. Other factors such as differences in assumptions, expectations, outlook in classroom and professional ways of working in practice resulted in a lack of impact on patient care. Also, it appears that TNHE providers, MNB, universities, employers and nurses all focused on the award of the degree, rather than the structure or organisation to ensure that what is learnt is carried forward into practice settings.

If the design and delivery of these TNHE programmes are improved, in addition to nurses personal and professional development, clear evidence based practice could be developed. This is apparent because of evidence of application of TNHE theory in practice despite the factors outlined that were working against it. It is not surprising, given these factors, that nurses were not explicitly acknowledging uptake of TNHE theory. Nevertheless, the contradictions in their accounts suggest there was some uptake. Over time, this uptake might diminish or develop with additional nursing experience, post TNHE.

Drawing on the discussion of nurses' experiences and evaluations, I put forward some suggestions for improvement as listed below:

- Academics may need to undertake cultural immersion or engagement with the local community prior to teaching in TNHE programmes, to build knowledge and insights of cultural rules, values and the environment of the host country.

- Flying faculty TNHE teams would benefit from including those with an Asian background as cultural similarities may enable nurses to feel more at ease to question and talk to learn western approaches.

- Malaysian lecturers would benefit from visits to TNHE provider countries to learn western methods of delivery and on their return to teach in TNHE programmes delivered in Malaysia.

- The hidden values of western classroom practices should be made explicit, e.g. an induction module providing nurses with a clear outline of the course structure over the two years, the requirements, method of teaching delivery, assessment approaches and an initial essay writing practice to become familiar with new teaching and assessment approaches.

- Language grading workshops for TNHE academics would enable them to grade their own language usage and adapt pace to compensate for accent and language in order to enhance comprehension.

- Continuous evaluation of academics teaching would help to gauge nurses' understanding, e.g. Electronic Voting System (EVS) to check understanding and provide anonymous feedback.

- Nurses who intend to study in TNHE programmes should have appropriate Information Technology skills and an internationally acceptable level in the International English Language Testing System.

- Lectures should be uploaded into an e-learning environment prior to teaching, possibly through narrated PowerPoint presentations with subtitles, to enable nurses to adjust to the academics' accent, pace, and language.

- Support for academic study skills should be time-tabled into the programme and commence pre-teaching.

- More time and allocated time should be available for synchronous on-line support and discussion forums, with all nurses in the cohort together for distance learning and face-to-face communication and support.

- Short exercises in critical thinking should be included at the initial stages of the programme to introduce questioning skills required for analytical thinking processes.

- Assessment criteria should be clarified and step-by-step instructions or guidelines to follow from the very beginning to the end provided.

- Adequate policies should be set in place to support and facilitate implementation of TNHE taught theory in clinical settings and in clinical placements in Malaysia if they are part of TNHE programmes.

- International clinical placement in the TNHE provider's health care system should be considered, for nurses to gain further knowledge, skills and insight. This opportunity may enable them to further develop their professional approaches to enable theory-practice links, and provide an international perspective, developing strengths in the Malaysian health care system.

6.4   Reflecting on the study

The title "A defining moment" for my research was chosen, firstly because the unique voices of nurses emphasised their reality. Secondly, their views contradicted with my initial pre-conceptions that these nurses would identify that the TNHE programmes were irrelevant to them due to the lack of the practice component and theory – practice link. Thus, when all participants reported that achieving the western degree was their aim as it was perceived as more prestigious than a degree acquired locally, it challenged my assumptions and caused me to confront this reality. Although there were similarities in our experiences, I had lived in the UK and attended a normal degree programme: I had a different set of experiences and, therefore, different knowing which was not relevant to these nurses.

Methodologically speaking, hermeneutic phenomenology allowed me to use the verbatim extracts of nurses' unique voices to speak; to represent their difficult experiences in the TNHE classroom environment during the short, intensive teaching time-frame, to explain the level of instrumentality and motivation, and the emotional and psychological adjustment these nurses undertook, to successfully attain their western degrees. I took Skeggs' (2002) advice to use reflexivity in order to examine power and responsibility within the research. I integrated meaningful personal, professional and researcher self, knowledge and experiences to empower and create meaning. Also, I point out how the research findings developed through a reflexive approach linked with my personal practice throughout the thesis as required by the professional nature of this doctorate. The ethnographic principle of cultural interpretation allowed emic and etic views that would enable the reader to appreciate nurses' values, views and actions.

Initially, during the interviews, participants gave reserved responses due to my perceived outsider status as a UK academic. My insider knowing guided me to slip effortlessly into a Malaysian insider role by using Bahasa Malaysia, colloquial words and humour to reveal my personal experiences as an international student nurse to create a persona that would encourage or cajole them to disclose more confidential and detailed accounts (Merleau-Ponty, 1962). Whilst interviews may have provided a degree of security for nurses to reveal their private or hidden transcripts (Scott, 1996) I do not believe they would have disclosed certain details in the same way with an outsider or non-Malaysian. It confirmed the emic position and trust for disclosure are hidden dilemmas decided only by participants (Beoku-Betts, 1994). Using my insider Malaysian insights, I also stress that these findings may not correlate with the module or programme evaluations the nurses provided at the end of the short period of face-to-face or on-line teaching of a module or programme. This is because of the tendency for Malaysian nurses to provide more socially acceptable responses to save face, of self and authority, and because they may have feared negative consequences, such as being perceived with a bad image or being subject to reprisals or repercussions.

The research carried out here resonates with the suggestions from Race (2011) and Burton and Kirshbaum (2012) that attention needs to be directed to identifying and working with cultural differences in Western teaching and learning relationships with international students. The contribution my study makes to this assertion is to have found what these cultural differences appear to mean in the Malaysian nursing context. I have explored overlapping layers of these cultural differences in: teaching and learning practice, social aspects, educational system and professional values, attitudes and beliefs.

6.5   Suggested further research

TNHE is currently developing fast in Asian countries including Malaysia, China and Singapore; a fact evidenced at the 3rd International Conference of Teaching and Learning (International University, 2011) in which the interim results of this study were presented (Mc Iver & Arunasalam, 2011). My findings suggest possible further research focusing on a longitudinal study looking at the degree of impact of taught knowledge in clinical practice one year, two years and four years post-TNHE post-registration nursing programmes. This would provide valuable information of the long term impact on nurses and their clinical practice to inform the Malaysian government and TNHE providers. This is based on the assumption that all stakeholders and participants wish to move beyond their short term gains into the area of actually maintaining CPE, personal and professional transformations and improving patient care.

A further point for research based on the findings is to determine why certain nurses are able to internalise what they learnt in TNHE programmes, into their ways of knowing and their ability and motivation to apply learning in the care of patients.

Another line of research that is directly suggested by my findings is to identify why employers are now resisting changes for best practice that these nurses are offering them. These employers had intentionally collaborated with TNHE providers in the first place to provide these programmes for their staff development.   Undertaking this

research may identify strategies that would be suitable to ensure others are more accepting of changes proposed, planned and implemented.

6.6   Contribution of this research

This thesis addresses the gap in research where the voice of the offshore student "*is conspicuously missing from the research literature*" (Chapman & Pyvis, 2005: 40). The original contribution my study offers is the unique insights through nurses' own voices into their personal and professional transformation, which led them to succeed (through conflicts, struggles, experiences, adjustment, adaptation and successes) and become part of a new community of nurses.

The research undertaken also adds to the limited literature on TNHE post-registration nursing programmes in Malaysia and the theory- clinical practice link (Chiu, 2005; Birks et al, 2005; Chong et al., 2011).   Previous studies undertaken in Malaysia by a combination of insiders, insider/ outsider like me and outsiders using questionnaires in one study, semi-structured interviews in another and semi-structured interviews and focus groups in the other showed nurses' motivations to undertake post-registration were for personal and professional development to improve practice and patient care. Their data indicated attainment of knowledge had led to positive changes in practice and enhanced patient care. In contrast, my thesis demonstrates that the key motivators of nurses to undertake TNHE programmes were their desire to get a high status western degree, financial incentives and promotion; basically individualistic and extrinsic reasons rather than application of theory in practice or enhancement of patient care. Therefore, I ask the reader to consider the findings of previous studies in relation to the outlook of nurses in my study about completing questionnaires, their spoken English, the concept of saving face of self and others, and the perceived threat in voicing their opinions to westerners.

My role as a UK based Malaysian academic instigated this study. I attempted to put forward robust emic and etic standpoints, as both reflexive insider and outsider, with respect to interpreting Malaysian nurses view, specifically to the extent they have

applied TNHE theoretical knowledge in clinical settings. It enabled me to illuminate western TNHE as delivered in Malaysia, from Malaysian nurses perspectives. The findings are not quantifiable but they enable a new synthesis or a third view to emerge, one that was hidden or not previously revealed.

The findings revealed the elevated status accorded to western degrees by these Malaysian nurses, their experiences in TNHE programmes and in clinical practice. It is worth noting that improving the status of the nurses and the nursing profession may not necessarily equate to improving the standard of patient care, unless implementation in provision of patient care is directly addressed in its own right.

Partnerships and collaboration appear to be ways forward. This research provided a platform for Malaysian nurses to voice their perspectives about TNHE post-registration nursing top-up degree programmes. The findings and lessons learnt identify key aspects to be considered by schools of nursing that intend to, or already provide collaborative TNHE programmes. It is also a useful tool for MNB as it will help select TNHE programmes that promote nurse education, transform healthcare delivery approaches and ensure improvements in the provision of patient care. The data is also relevant to all those engaged in international collaboration and higher education, including other professions, and all TNHE programmes delivered in Malaysia, and in other South East Asian countries, where strong cultural factors continue to affect society.

Competition between HEIs is being compounded by world economic downturns. There are marketing advantages for Western TNHE providers due to the perceptions in some Asian countries of the elevated status of western degrees. These are advantages that may not have been exploited in the past in quite the way they are now. The lines between what is ethical and effective, and what is not, may be blurring under the current economic pressures on HEIs to compete abroad.

A complete text of the Working Paper - The Way Forward
presented by His Excellency
YAB Dato' Seri Dr Mahathir Mohamad at the Malaysian Business Council

The purpose of this paper is to present before you some thoughts on the future course of our nation and how we should go about to attain our objective of developing Malaysia into an industrialised country. Also outlined are some measures that should be in place in the shorter term so that the foundations can be laid for the long journey towards that ultimate objective.

Hopefully the Malaysian who is born today and in the years to come will be the last generation of our citizens who will be living in a country that is called 'developing'. The ultimate objective that we should aim for is a Malaysia that is a fully developed country by the year 2020.

What, you might rightly ask, is 'a fully developed country'? Do we want to be like any particular country of the present 19 countries that are generally regarded as 'developed countries'? Do we want to be like the United Kingdom, like Canada, like Holland, like Sweden, like Finland, like Japan? To be sure, each of the 19, out of a world community of more than 160 states, has its strengths. But each also has its fair share of weaknesses. Without being a duplicate of any of them we can still be developed. We should be a developed country in our own mould.

Malaysia should not be developed only in the economic sense. It must be a nation that is fully developed along all the dimensions: economically, politically, socially, spiritually, psychologically and culturally. We must be fully developed in terms of national unity and social cohesion, in terms of our economy, in terms of social justice, political stability, system of government, quality of life, social and spiritual values, national pride and confidence.

Retrieved: http://www.wawasan2020/vision on 4th December 2010

Appendix B

Summary of findings from small scale study

A small scale study was undertaken to explore lecturers' knowledge and understanding of the influence cultural values have on nurses' preference to teaching and learning. It was anticipated that having such awareness will inform lecturers' and help them to develop effective approaches to teaching on TNHE programmes in Malaysia. Two interviewees P1 and P2, prior to teaching in Malaysia, were involved in a focus group. On completion, with both participants identifying the need for educational preparation, I picked up on 'issues that emerged' from the discussion. I briefly gave information on cultural values, anticipated responses to lecturers, non-verbal communication, use of language, teaching strategies and learning preferences which, initially, both lecturers' were unable to identify. These lecturers lacked awareness of the influence of cultural values on nurses' preferences to learning and its effects on their professional roles, as lecturers. This is illustrated below:

P1 *'...the students that we have in the UK are multicultural and they have to accept our teaching and get on with it so it should be the same'.*

P2 outlined a variety of teaching approaches she had considered but admitted she felt unsure of how to apply them in relation to the nurses' needs.

To evaluate TNHE experience, their approaches are stated next:
P1 *'I am not looking for feedback on my teaching, it's more about evaluation of their learning'.*
P2 *'I plan to do quite a lot of work formatively which hopefully is less threatening and unchallengable. If I do it daily, I will be able to evaluate my teaching and their learning and change my teaching accordingly'.*

Appendix C

Bristol On-line Survey questionnaire
Exploration of Malaysian Nurses' Perspectives of United Kingdom Trans-national Higher Education Post-registration Nursing Courses (Pilot Study)

Welcome

This survey is designed as an opportunity for you to provide an insight into your views of United Kingdom Trans-National Higher Education (TNHE) post-registration courses delivered in Malaysia. As part of my pilot study for the thesis of my Education Doctorate, I intend to **explore Nurses' perspectives of United Kingdom Trans-National Higher Education post-registration courses**.

Your awarding institution has agreed to take part in this pilot study. This study is **not** an evaluation of the university concerned, the course you are undertaking or your work or abilities. It is an opportunity for you to share your views of UK TNHE post-registration courses. The information you provide will enable me to identify the appropriateness and ease of completion of the questions and the feasibility of using on-line surveys. The responses will not be analysed but will provide a baseline for further consideration in developing my main study that will look at TNHE post-registration courses delivered in Malaysia, so do provide considered responses.

Completion of the survey, implies consent. The survey takes approximately 10 mintutes to complete and is on 3 pages. It is divided into two sections: the first section is the demographic section to only check the representativeness of the sample. The data cannot and will not be used to identify any individuals or institutions. Cookies, personal data stored by your Web browser, are not used in this survey. All the data collected will be held anonymously and securely. The second section requires you to provide your views, hence provides the space for you to do this. I would be grateful if you could respond to as many questions as you can. If you have any queries or would like to find out more about this study, please email n.d.arunasalam@herts.ac.uk

Yours Sincerely,
Mala Arunasalam

Please answer the questions below:

Section 1: Demographic Details

1. I am ....

Male ❑

Female ❑

2. I am .... old

21 – 30 years ❑

31 – 40 years ❑

41 – 50 years ❑

51 – 60 years ❑

3. I have been qualified as a Nurse for

0 – 5 years ❑

6 – 10 years ❑

11 – 15 years ❑

16 -20 years ❑

21 – 25 years ❑

26 + years ❑

4. I work in a

Government hospital ❑

Private hospital ❑

Other (please specify) .... ❑

Section 2: Your Views

5. Before attending this course, I thought I would learn

```




```

6. On the course, I learnt

```




```

7. Give two examples of learning that was useful

```




```

8. Give two examples of learning that was not useful

```




```

9. Give one example of your experience with one new type of teaching used on the course

```
(empty box)
```

10. I attended the course for :

Professional Development	❑	Promotion	❑
Work Requirement	❑	Improving Practice	❑
Interest	❑	Other (please specify)	❑

....
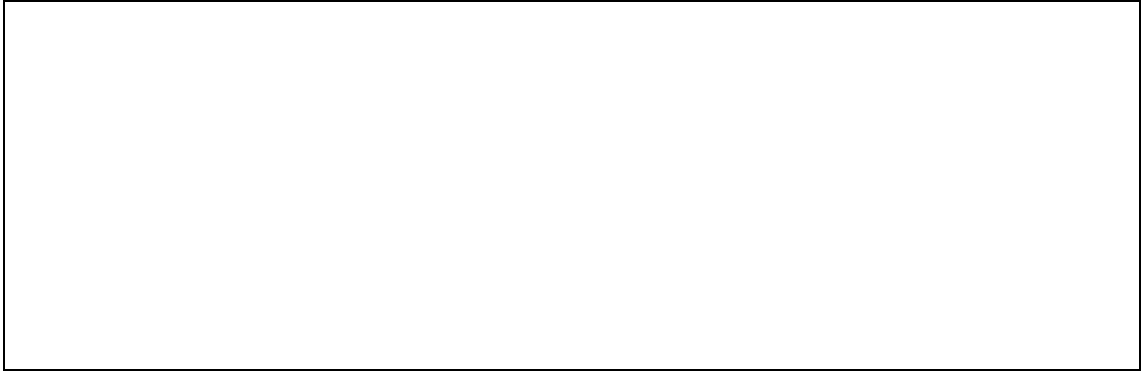
11. Write how the support given for your learning will help you change your practice?

```
(empty box)
```

12. Write how the course will help your practice

```
(empty box)
```
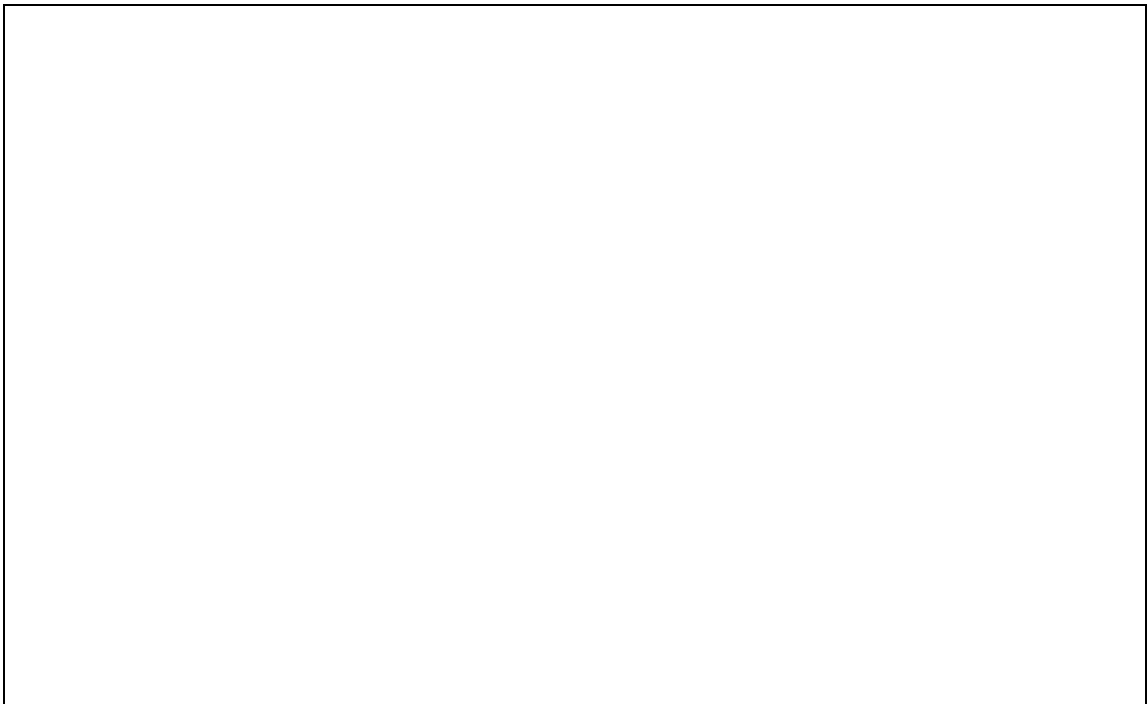
13. Write one situation where you will use what your learnt on the course

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```

14. Please give your comments for this pilot study on :-

the style of questioning
words and/or language used
relevance of the questions
set-up of the survey
ease of completion
any other comments

```



```

Thank you for taking the time to complete this pilot study survey and sharing

your experiences of a TNHE post-registration Nursing course taught in Malaysia.

Appendix D

Semi-structured interview guide

Malaysian nurses' perspectives of Trans-National Higher Education

post-registration nursing programmes

1   Why Nursing?

2   Expectations before starting pre-registration nursing programme

3   Teaching and learning experiences, assessments, support and theory-practice link etc

4   Why TNHE post-registration nursing degree programme

5   Expectations before starting TNHE post-registration nursing programme

6   Teaching and learning experiences, assessments, support and theory-practice link etc

7   Describe how you have changed?

8   How have you changed at work or professionally?

9   Have you been able to implement change from what was taught in practice?

10   How did others feel or accept changes?

11   Would you recommend this programme to your close friend?

Appendix E

Demographic survey questionnaire

Malaysian Nurses' Perspectives of Transnational Higher Education
Post-registration Nursing Programmes

The Demographic Details questionnaire is to check the representativeness of the sample. Completion of this 1 page survey will take approximately 1 minute and implies consent. The data will not be used to identify any individuals or institution and will be held securely.

Please tick the relevant boxes.

Demographic Details

1. **I am ....**

   Male ❑   Female ❑

2. **I am .... years old**

   21 – 30 ❑   31 – 40 ❑   41 – 50 ❑   51 – 60 ❑

3. **I have been qualified as a Nurse for …….. years**

   0 – 5+ ❑   6 – 10+ ❑   11 – 15+ ❑

   16 -20+ ❑   21 – 25+ ❑   26 + ❑

4. **I am a**

   Matron ❑   Sister ❑   Senior Staff Nurse ❑   Junior Staff Nurse ❑

5. **I work in a ……………..**

   Government hospital ❑   Private hospital ❑

   Other (please specify) .... ❑

6. **I attended the course for :**

   Career Development ❑   Promotion ❑

   Work Requirement ❑   Improving Practice ❑

   Interest ❑   Other (please specify) ❑

   …………………………………

Thank you for taking the time to complete this questionnaire.

Appendix F

1F 300 Wright Building
University of Hertfordshire
Date

Information sheet to participate in pilot study interviews

Title: Malaysian nurses' perspectives of Trans-national Higher Education.

Researcher: Nirmala (Mala) Devi Arunasalam

Aim: To identify the suitability of the interview guide and process and whether it enables insight into 'Malaysian nurses perspectives of the extent theoretical knowledge taught on TNHE post-registration nursing degree programme is applied in clinical practice.' The study will **not** evaluate the post-registration programme.

Method of Study:

This study will use semi-structured face-to-face interviews and a demographic survey questionnaire. The questionnaire consists of 7 questions and takes 1 minute to complete. The interviews will take approximately 60-90 minutes.

Use of data:

The data collected will be transcribed to identify ways to improve my interview technique, responses and the appropriate use of certain English and Bahasa Malaysia words. The data will not be analysed. Questionnaire data will be checked to ensure the pre-defined choices are suitable and provide a representation of nurses views and kept in a locked filing cabinet.

Participants:

Participation in this study is voluntary and you are able to withdraw at any time you wish without giving a reason. However, I would greatly appreciate your participation to complete this study. All information collected will be treated with utmost confidentiality. The university and participants involved in the study will remain anonymous. Thank you for taking part in this pilot study.

Appendix G

Informed consent form for participation in pilot study interviews

Researcher: Nirmala Devi (Mala) Arunasalam

Research Title: To be confirmed

_____

Have you read the Invitation Letter?   Yes/No

Were you given an opportunity to ask questions and discuss

the study   Yes/No

Are you satisfied with the answers to your questions?   Yes/No

Do you consider that you have received enough information about

the study to make your decision?   Yes/No

I have read and understood the above information. I understand that all information collected will be treated with utmost confidentiality and data collated will only be used for the analysis of this study and will then be destroyed. I am free to decline being part of the interview and to leave the study at any time without having to give a reason for leaving.   A copy of this research will be available to me on request.

....

          PRINT NAME

....

          SIGNATURE   DATE

Appendix H

Nirmala Devi Arunasalam

1F 300 Wright Building

School of Nursing and Midwifery

University of Hertfordshire

Date

Dear Sir/Madam,

Re: Invitation letter to participate in research

I am a Senior Lecturer in the School of Nursing and Midwifery of the University of Hertfordshire and am undertaking a study for the thesis of my Doctorate in Education. The aim of the study is to interpret **Malaysian nurses' perspectives of Transnational Higher Education Post-registration Nursing programmes**. The study will **not** evaluate the post-registration programmes. The sole objective of the study and the interviews will be to enable an insight into the Malaysian nurses' views and experiences in these programmes.

Participation in this study is voluntary and if you do not wish to participate, you can do so without having to justify your reasons. However, I would greatly appreciate your participation to enable me to complete this study. All information collected will be treated with utmost confidentiality. The university and participants involved in the study will remain anonymous. Thank you for taking part in this study.

Yours Sincerely

Nirmala Devi Arunasalam

Appendix I

Ethical approval for study

FACULTY OF HUMANITIES, LAW & EDUCATION

<u>Application for approval of a study programme involving human informants</u>

Applicant: Nirmala Arunasalam

Date: 14 December 2009

Title of study programme: Malaysian Allied Health Professionals perspectives of UK Trans-national Higher Education Post-registration Programmes (Pilot Study)
Malaysian Nurses perspectives of UK Trans-national Higher Education Post-registration Nursing Programmes (Main Study)

Protocol no 09-10.2

_____

Dear Mala

I am pleased to confirm that your application for the above study programme has been circulated to the members of the Faculty Ethics Committee and approved with an investigation end date of 31 August 2011.

If this investigation is ongoing as at 31 August 2011, we would like to remind you that your application should be resubmitted to the Faculty Ethics Committee for extended approval. I will contact you nearer the time asking you to confirm whether or not the investigation is still ongoing.

Kind regards

Appendix J

1F 300 Wright Building
University of Hertfordshire
Date

Information sheet to participate in research

Title: Malaysian nurses' perspectives of Transnational Higher Education.

Researcher: Nirmala (Mala) Devi Arunasalam

Aim: To interpret 'Malaysian nurses perspectives of the extent theoretical knowledge taught on TNHE post-registration nursing degree programme is applied in clinical practice.' The study will **not** evaluate the post-registration programme.

Method of Study:

This study will use semi-structured face-to-face interviews and a demographic survey questionnaire. The questionnaire consists of 7 questions and takes 1 minute to complete. The interviews will take approximately 60-90 minutes.

Use of data:

All data collected will be anonymised so that no comments can be attributed to an individual or their university. Questionnaire data will only use code numbers given to interviewees and will be uploaded immediately into a computer that is password protected and kept in a locked filing cabinet. All paper data will be shredded and electronic data deleted from the hard drive once the examination process has been completed.

Participants:

Participation in this study is voluntary and you are able to withdraw at any time you wish without giving a reason. However, I would greatly appreciate your participation to complete the pilot study. All information collected will be treated with utmost confidentiality. The university and participants involved in the study will remain anonymous. Thank you for taking part in this pilot study.

Appendix K

Initial template with Categories

NURSING **UK/ AUSTRALIA/ MALAYSIA** Status, provision of care, reasons for doing nursing **DIPLOMA NURSING** Teaching & learning Language Assessments Theory-practice link **TNHE POST-REGISTRATION NURSING DEGREE** Reasons for studying on TNHE programme	**TNHE THEORETICAL KNOWLEDGE** **Modules** **Western** teaching & learning support (TNHE) **Malaysian Learning shock** – language – understanding – time – teaching & learning – colonial Influence – entrenched customs, culture & traditions – assessments – guidance/language academic writing/ support **Health care system** – entrenched customs, culture & traditions – provision of care according to ethnic groups traditions – support to implement western care	**PERSONAL CHANGE** Focus on change in outlook or ways in their personal lives
PROFESSIONAL TRANSFORMATION Focus on their approach to work / nursing	**IMPLEMENTATION** Intercultural adjustment and adaptation Theory-practice link in clinical areas	**OTHERS ACCEPTANCE OF CHANGES** All health professionals Patients

Appendix M

Three extracts from transcripts of participants from each TNHE

Key: 1) Colour coding for different categories. 2) Bold type indicates interviewer's question. 3) Transcripts are faithful to participants words.

Extract from Interviewee 006

Extract Int: 006		Analytical notes
	Cerita sikit pengalaman awak semasa belajar

Too short lah. Dalam dua minggu dia pack semua sekali lepas itu dia hantar you balik. Bila you dah balik, you kena kerja, and then they expect you to work. At the same time you banyak assignment, and you kena baca, cuba faham dan buat assignment. Dia akan bagi tempoh dalam 3-4 bulan untuk buat assignment, tapi very stressful. Macam saya, saya ambil cuti sendiri, tiap-tiap bulan 3-4 hari. Because kalau you dah kerja, tak ada masa, nak kerja rumah pula, anak lagi nak pergi sekolah, husband lagi, nak kena masak, shopping lagi.

Lagi dia ajar dua minggu tu kan, lecturer yang ajar tu kan, dia ajar tentang cultural value dekat UK? Dia ada juga cakap tentang, let's say, Indian patient dekat UK, tapi that UK punya patient, tapi kita punya nation, sebab kita dah biasa dengan Melayu nak pakai baju kurung, China, Cheong dan Indian patient, sari, pakaian tradisional mereka, dia punya culture. Macam itu semua kita dah biasa, so kita benarkan, hospital benarkan mereka pakai. Lecturer kata "Oh no, let them wear their own traditional clothing' but I fikir dalam hati I, kenapa nak besar-besarkan perkara pasal baju. Dekat Malaysia kita memang dah buat dah pun".

Jadi awak cakap ke pada dia, kita memang ikut cara tu?

Tak lah, kita as a student, kita kena accept, "Oh, never mind lah. Lecturer ni daripada UK. Dia ajar tapi she doesn't know or understand our culture, her culture is different. Jadi kita kena accept lecturer punya cultural diversity. So bila dia ajar, kita fikir "Oh, nevermind lah, she doesn't know kita punya culture. | Analytical notes – appeared exasperated and spoke quickly

Use phrase : Too short – teaching time frame

Use phrase : Dia pack semua sekali

Assessments
Time-frame to complete assessment - 3-4 months

Disadvantage of part-time programmes
very stressful
- responsibilities - at work
                              - at home - husband, family,
                                     housework, children, schoolwork
- limited time to read, understand & do assignment
- use of annual leave to study & do assignment

Theory taught –   UK cultural values

Use quote - Lack of awareness and knowledge of Malaysian cultural practices & health care system
Culture – questioning to make sense/justify knowledge privately or mentally

Analytical notes - Appeared resigned to way of acceptable behaviour, 'idolising westerners' either because of colonial influence or perception of Malaysians towards westerners

Use quote -Cultural response to academics lack of awareness and knowledge
Culture of   -   respecting teachers
               -     not challenging
               -     'saving face' of teacher
               -     consensus rather than critique |

Extract Int: 007	**Apakah pengalaman awak semasa belajar ?**	
	Adult learning kan. Long distance learning, very toughlah because language problem. The media dia gunakan computer, kita Asian computer tak guna sangat. Nak open pun only bila nak, kalau tak tak buka pun. On-line books, susahlah, bila kita nak open and baca article, cannot go direct, download here, download there, takes time at least 15 minutes, then for second article again. Frustratedlah! Susahnya.	Use quote – long-distance learning & attitude

? include teaching & learning, resources, on-line support time taken to access |
| | Memang susahlah, cakap dia pun problem. Bila tak faham kita discuss dengan kawanlah, tak dengan dia, dia itu macam ada gap tu, macam different lah, how to say eh, gap tu sebab tu culture tak faham kita. Kalau nak ajar dia kena tau culture kita, baru kita feel macam kita, baru I feel ada trust, easy to talk. Dalam 2 minggu tak ada masa understand culture. | Use quote – to build trust to ask questions

Use phrase : Two weeks not enough time |
| | **Tapi dia datang memang untuk ajar degree level**
Rasa dia datang ajar aja, tak tahu apa-apa. Kita fikir, kenapa dia tak guna examples from Malaysia. It's good kan kita boleh tahu dia punya cara tapi banyak based on their practice. Tapi sini we didn't see that, we don't know. Even kita tahu, we are not practicing, then how want to relate. Especially bila dia bagi contoh-contoh equipment dia, negara dia, you tahu lah sini kita tak ada, nak dapat equipment tu memang susah, lagi pun the meaning is very different. Rasa wasted lah kita have to learn by ourself, tak tahu betul ke tak. | Use quote –
Theory taught – UK cultural values
Lack of awareness and knowledge of Malaysian cultural practices & health care system
Culture – questioning to make sense/justify knowledge privately or mentally

? Use quote – opinion of TNHE teaching |
| | **Jadi you rasa tak payahlah belajar TNHE top up degree sebab you nak ikut cara practice kita di Malaysia aja**
Memang nak belajar tapi tak mahu buang budaya. | Use quote – example of wanting to retain culture |

Int: 018	**How is the teaching in the TNHE classroom?**	

	They teach in more detail more than local lecturers teach but then we will not be understanding. We get confused the way they talk and also they trying to say something to us but we don't get. Maybe, the communication was not there you know. They will be saying tah, tah, tah everything and then they will be asking 'you all understand or not' end of the time we won't be understanding. We are lost, but then we will say yes, that is the Malaysian style' say yes for everything.	? Use quote -Cultural response to TNHE academics teaching
		Culture of - respecting teachers
		        - not challenging
		        - 'saving face' of teacher & self

	So they come here and teach for one or two weeks	
	Yes, they will come, they will teach us for two weeks. Two weeks for one module-Monday-Friday, 9-4.30 or 5 pm.	
	In the two weeks they explain everything you need to know for that module	Use phrase : Two weeks not enough time
	They do explain but we don't understand really what they want. First day talk about what they expect then teaching the next day (Tuesday), teach us very fast… They have one page notes where they will be explaining this, this, this, this is what we expect, this is what we need you to do.	

	They teach us very fast. We will be like quite lost, because we will not have chance to [ask questions during] 9-4.30 or 5 pm, they will be teaching only. When do we go and ask we don't understand this? They expecting us on the spot to ask, you know, we Malaysian we need time to go and personally to ask, you know. So we will be like keeping quiet only.	Use quote –Lack of awareness and knowledge of Malaysian cultural practices
		Questioning to make sense of western ways
		Culture of - respecting teachers
		        - not challenging
		        - 'saving face' of teacher & self
		        - listening to learn

	Why didn't you ask questions when they finish teaching?	
	When they finish, they say - ok, ok, see you all tomorrow. My lecturers all staying in hotel so they will be rushing, the time 4.30 or 5pm, the driver will be waiting there, they will be rushing.	

Colour coded individual extracts removed and inserted together

Categories	Teaching & Learning Styles	Assessments	Teaching Time-frame	Advantages & disadvantages of part-time programmes	Self-Motivation	Advantages & disadvantages of On-line teaching & learning methods
	Int: 006 Lagi dia ajar dua minggu tu kan, lecturer yang ajar tu kan, dia ajar tentang cultural value dekat UK? Dia ada juga cakap tentang, let's say, Indian patient dekat UK, tapi that UK punya patient, tapi kita punya nation, sebab kita dah biasa dengan Melayu nak pakai baju kurung, hina, Cheong dan Indian patient, sari, pakaian tradisional mereka, dia punya culture. Macam itu semua kita dah biasa, so kita benarkan, hospital benarkan mereka pakai. Lecturer kata "Oh no, let them wear their own traditional clothing but I fikir dalam hati I, kenapa nak besar-besarkan perkara pasal baju. Dekat Malaysia kita memang dah buat dah pun".	**Int: 006** Dia akan bagi tempoh dalam 3-4 bulan untuk buat assignment, tapi very stressful. **Int: 007** Rasa wasted lah kita have to learn by ourself, tak tahu betul ke tak.	**Int: 006** Too short lah. Dalam dua minggu dia pack semua sekali **Int: 007** Dalam 2 minggu tak ada masa understand culture. **Int: 007** Memang, nak belajar tapi tak mahu buang budaya **Int: 018** Too short lah. Two weeks for one module - Monday-Friday, 9-4.30 or 5 pm.	**Int: 006** Bila you dah balik, you kena kerja, … At the same time you banyak assignment, nd you kena baca, cuba faham dan buat assignment. Macam saya, saya ambil cuti sendiri, tiap-tiap bulan 3-4 hari. Because kalau you dah kerja, tak ada masa, nak kerja rumah pula, anak lagi ak pergi sekolah, husband lagi, nak kena masak, shopping lagi.	**Int: 006** … kena baca, cuba faham dan buat assignment.	**Int: 007** ? include teaching & learning, resources, on-line support time taken to access

Categories	Teaching & Learning Styles	Assessments	Teaching Time-frame	Advantages & disadvantages of part-time programmes	Self-Motivation	Advantages & disadvantages of On-line teaching & learning methods
	Int: 006 Tapi, kita as a student, kita kena accept, "Oh, never mind lah. Lecturer ni daripada UK. Dia ajar tapi she doesn't know or understand our culture, her culture is different. Jadi kita kena accept lecturer punya cultural diversity. So bila dia ajar, kita fikir "Oh, nevermind lah, she doesn't know kita punya culture. **Int: 007** Long distance learning, very toughlah because language problem. The media dia gunakan computer, kita Asian computer tak guna sangat. Nak open pun only bila nak, kalau tak tak buka pun. **Int: 007** On-line books, susahlah, bila kita nak open and baca article, cannot go direct, download here, download there, takes time at least 15 minutes, then for second article again. Frustratedlah! Susahnya.					

Categories	Teaching & Learning Styles	Assessments	Teaching Time-frame	Advantages & disadvantages of part-time programmes	Self-Motivation	Advantages & disadvantages of On-line teaching & learning methods
	Int: 007 Memang susahlah, cakap dia pun problem. Bila tak faham kita discuss dengan kawanlah, tak dengan dia, dia itu macam ada gap tu, macam different lah, how to say eh, gap tu sebab tu culture tak faham kita. Kalau nak ajar dia kena tau culture kita, baru kita feel macam kita, baru I feel ada trust, easy to talk. **Int: 007** Kita fikir, kenapa dia tak guna examples from Malaysia. It's good kan kita boleh tahu dia punya cara tapi banyak based on their practice. Tapi sini we didn't see that, we don't know. Even kita tahu, we are not practicing, then how want to relate. Especially bila dia bagi contoh-contoh equipment dia, negara dia, you tahu lah sini kita tak ada, nak dapat equipment tu memang susah, lagi pun the meaning is very different.					

Categories	Teaching & Learning Styles	Assessments	Teaching Time-frame	Advantages & disadvantages of part-time programmes	Self-Motivation	Advantages & disadvantages of On-line teaching & learning methods
	Int: 018 They teach us very fast. We will be like quite lost, because we will not have chance to [ask questions during] 9-4.30 or 5 pm, they will be teaching only. When do we go and ask we don't understand this? They expecting us on the spot to ask, you know, we Malaysian we need time to go and personally to ask, you know. So we will be like keeping quiet only. When they finish, they say - ok, ok, see you all tomorrow. My lecturers all staying in hotel so they will be rushing, the time 4.30 or 5pm, the driver will be waiting there, they will be rushing. **Int: 018** They teach in more detail more than local lecturers teach but then we will not be understanding. We get confused the way they talk and also they trying to say something to us but we don't get. Maybe, the communication was not there you know. They will be saying tah, tah, tah everything and then they will be asking 'you all understand or not' end of the time we won't be understanding We are lost, but then we will say yes, that is the Malaysian style' say yes for everything.					

APPENDIX O

Colour coded group extracts and developed sub-themes & themes

Sub-theme	Accent, language, teaching and learning styles	Theoretical knowledge, assessment, guidance & support	Theme : Nurses evaluation of TNHE programmes	? sub –theme re: part-time programmes	? sub-theme motivation	? sub-theme on-line experiences
	Int: 006 Lagi dia ajar dua minggu tu kan, lecturer yang ajar tu kan, dia ajar tentang cultural value dekat UK? Dia ada juga cakap tentang, let's say, Indian patient dekat UK, tapi that UK punya patient, tapi kita punya nation, sebab kita dah biasa dengan Melayu nak pakai baju kurung, hina, Cheong dan Indian patient, sari, pakaian tradisional mereka, dia punya culture. Macam itu semua kita dah biasa, so kita benarkan, hospital benarkan mereka pakai. Lecturer kata "Oh no, let them wear their own traditional clothing but I fikir dalam hati I, kenapa nak besar-besarkan perkara pasal baju. Dekat Malaysia kita memang dah buat dah pun".	Int: 006 Dia akan bagi tempoh dalam 3-4 bulan untuk buat assignment, tapi very stressful. Int: 007 Rasa wasted lah kita have to learn by ourself, tak tahu betul ke tak.	Int: 006 Too short lah. Dalam dua minggu dia pack semua sekali Int: 006 **Dia pack semua sekali** Int: 007 Dalam 2 minggu tak ada masa understand culture. Int: 007 Memang, nak belajar tapi tak mahu buang budaya Int: 018 Too short lah. Two weeks for one module - Monday-Friday, 9-4.30 or 5 pm.	Int: 006 Bila you dah balik, you kena kerja, … At the same time you banyak assignment, nd you kena baca, cuba faham dan buat assignment. Macam saya, saya ambil cuti sendiri,tiap-tiap bulan 3-4 hari. Because kalau you dah kerja, tak ada masa, nak kerja rumah pula, anak lagi ak pergi sekolah, husband lagi, nak kena masak, shopping lagi.	Int: 006 … kena baca, cuba faham dan buat assignment.	Int: 007 ? include teaching & learning, resources, on-line support time taken to access

Sub-theme	Accent, language, teaching and learning styles	Theoretical knowledge, assessment, guidance & support	Theme : Nurses evaluation of TNHE programmes	? sub –theme re: part-time programmes	? sub-theme motivation	? sub-theme on-line experiences
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Sub-theme	Accent, language, teaching and learning styles	Theoretical knowledge, assessment, guidance & support	Theme : Nurses evaluation of TNHE programmes	? sub –theme re: part-time programmes	? sub-theme motivation	? sub-theme on-line experiences
	Int: 007 Memang susahlah, cakap dia pun problem. Bila tak faham kita discuss dengan kawanlah, tak dengan dia, dia itu macam ada gap tu, macam different lah, how to say eh, gap tu sebab tu culture tak faham kita. Kalau nak ajar dia kena tau culture kita, baru kita feel macam kita, baru I feel ada trust, easy to talk. **Int: 007** Kita fikir, kenapa dia tak guna examples from Malaysia. It's good kan kita boleh tahu dia punya cara tapi banyak based on their practice. Tapi sini we didn't see that, we don't know. Even kita tahu, we are not practicing, then how want to relate. Especially bila dia bagi contoh-contoh equipment dia, negara dia, you tahu lah sini kita tak ada, nak dapat equipment tu memang susah, lagi pun the meaning is very different.					

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Appendix P

Screen-grab showing an example of a coding sheet

A sample of English Language – Bahasa Malaysia Translation

Int: 004	"We have English person coming to teach, we feel inferiority complex."	"Kita ada Mat Salleh, datang untuk ajar, kita rasa inferiority complex lah."
Int 004	"We're brought up to abide, listen to higher ranking. Indirectly, by showing respect, we cannot be extrovert, we become 'timid as a mouse'. UK, they teach to be outspoken that's why they are more forward compared to us. We will think first whether we gonna hurt your feelings and pull ourselves backward. This has been ingrained in us, this is in our blood."	"Kita rasa we're brought up to abide …, listen to higher ranking. Indirectly, by showing respect, macam kita tak both jadi extrovert, kita jadi 'timid as a mouse'. UK, they are, they teach to be vocal, outspoken itu sebab dia lebih forward compared to us. We will think first whether we gonna hurt your feelings, so we think and pull ourselves backward. This has been ingrained in us, this is in our blood."
Int: 004	"I am very satisfied with some of the lecturers who are following you closely."	"I am very satisfied dengan some of the lecturers yang following kita closely."
Int 004	"We are timid, like a mouse with doctors, I think we should emulate western outspoken kind of attitude, little bit into our society and health care settings. Sometimes we need to tell off the doctors for the patient's sake."	"We are timid, like a mouse with doctors, saya rasa we should emulate western outspoken punya attitude, little bit into our society dan kita punya hospital. Kadang-kadang kita kena tell off the doctors untuk patient's sake."
Int: 004	"More sure of myself in problem solving, … how to give orders, I'm more confident with my communication, diplomatic way."	"More sure of myself in problem solving, … how to give orders, saya lebih, I'm more confident with my communication, diplomatic way.