Facing Diversity

A study of Dutch community nurses and their experiences of working with patients from a Turkish and Moroccan background.

Aashild Stangeland
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University of Amsterdam
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LITERATURE

Annexes
Preface

This paper is a defining part of my master's degree in medical anthropology. I would like to use the opportunity to thank the Amma-staff and my student colleagues for their patience and willingness to listen to my various ideas during the process of deciding the topic of my final thesis.

The writing did not always proceed as wished, but changes were made and mistakes corrected in time. I thank my supervisor Els van Dongen for her valuable remarks and comments. I thank Marianne Vysma for editing my Norwegian English. Also I heartily thank all the nurses who were willing to set aside some time for interviews and openly share their experiences with me. I have analyzed the data from a critical point of view, and I would like to ask my informants not to take any criticism personally. In their position, my reasoning and actions would probably have been no different. I strongly admire the work they are doing.

Aashild Stangeland

14th of August 2000
1. INTRODUCTION

The face of Amsterdam is one of increasing diversity. The number of immigrants is growing and there are continuing challenges in health care due to an ever-more varied Dutch society. Health care workers are 'forced' to cross cultural boundaries as they interact with patients from other socio-cultural backgrounds than themselves.

This thesis sets out to be an exploration of nurses' working experiences with Turkish and Moroccan patients/clients in the Netherlands. I have interviewed Dutch community nurses to find out how they perceive their interaction with migrant patients in comparison to Dutch patients. I was curious to explore the nurses' point of view as well as trying to understand them (the nurses) in the context of their cultural and professional background. From the beginning of this study I had a hypothesis that the nurses share many common experiences, problems and challenges in their work with Turks and Moroccans. Having myself a background in nursing, it has been interesting to listen to other nurses' stories and experiences. Although my employment history as a nurse is from a hospital setting, many of the community nurses' perceived problems of working with ethnic minority-patients were recognizable.

The study aims at 'anthropology of nurses' rather than 'anthropology for nurses'. This distinction between anthropology of nurses and anthropology for nurses was emphasized at a gathering of nurses and anthropologists in London (Holden & Littlewood 1991:2). 'Anthropology for nurses' implicates that anthropology can be seen as a 'tool' for nurses and other health care workers demanding culture-specific information, to be used in their interaction with the patients. The 'tools' have been provided by anthropologists, using their fieldwork experiences to make the 'strange' behavior of migrants more or less understandable (Van Dijk 1989). 'Anthropology of nurses' suggest another approach wherein the nurses are 'study objects'. Nursing, having its own collective identity-features, provides an ethnographic field to be studied like any other (Holden & Littlewood 1991). The nurses and their experiences are in this paper the ones to be studied, interpreted and discussed.
This study has been carried out within the homecare sector in the Western part of Amsterdam during a period of six weeks. Amsterdam West has been my neighborhood for almost eight months. At least half of the population in this area is non-Dutch. When I first moved to the area, I had the feeling of being a ‘stranger’; someone who dressed differently from the majority of other females and someone who could not understand the language. My neighbors talk all kinds of languages. They dress differently from most Dutch people I know. A lot of women wear veils. You think they are all Moslems and wonder whether the food stores will be closed during Ramadan. You see phone services everywhere, advertising for cheap phone calls to Morocco, Turkey, Ghana, Surinam etc. There are people out on the streets any time of the day; children, women, men in long shirts reaching to their knees. The Dutch who used to live here have moved away to the outskirts of Amsterdam and migrants have taken over their flats.

“Ethnographers need to convince us... not merely that they themselves have truly ‘been there’, but had we been there we should have seen what they saw, felt what they felt, concluded what they concluded” (Geertz 1988:16). One of my personal objectives as an ethnographer has been to give a reliable, clear and vivid description of the fieldwork experience in Amsterdam West. The interpretations I have drawn from the data are of course a personal impression, as most interpretations are (Gramsci In: Sciortino 1992), but nevertheless interesting for discussion and further research.

“A good ethnography enlarges people’s understanding of themselves “ (Holden and Littlewood 1991:2). I hope that the community nurses in Bos en Lommer and Baarsjes who have been my ‘study objects’ as well as other nurses reading this paper, can take a step back and observe themselves from the outside. I think some of the questions that are being raised may trigger a discussion on the issue of working with migrants from another perspective than the usual ‘culture sensitive care’ - profile.
1.1. Background information

1.1.1. The health homecare system in the Netherlands

There has been a tradition of professionally organized home help and home nursing in the Netherlands for more than a century. Dutch home help services and nursing care are organized on two main levels (Kerkstra 1996:224):

National level: National Association of Home Care
Regional level: Regional Cross Association (provide community nursing only)
Home help organizations (provide home help services only)
Home care organizations (provide both community nursing and home help services)

There used to be two umbrella organizations for community nursing and home help services on the national level, but in 1990 those two organization merged into the 'National Association for Home Care' (Ibid). This integration is taking place on the regional level as well. Several home care organizations have already been integrated providing both community nursing and home help services. The integration is expected to result in more efficiency in home care and to avoid unnecessary overlap between home help services and home nursing. Home care is defined as “nursing care, family care, treatment and support provided in the homes of clients by professionals, and aided by self-care, informal care, and volunteers, and specially geared to enabling clients to remain at home as long as possible” (NRV, National Council for Public Health 1989 in: Schrijvers 1999). Under this umbrella, I have restricted myself to community nurses, who provide nursing care at home. Home nurses offer support and counseling related to illness, recuperation, disability, old age and death. Since 1980, approximately 85% of the costs of home nursing care have been covered by the AWBZ1: The Exceptional Medical Expenses Act (Schrijvers 1999). Under the provisions of the AWBZ, all residents of the Netherlands, regardless of age, income or family status, are entitled to receive community nursing care (or home help services), but the patients must be members of the regional home care organization. This means that, in order to receive home care, patients must pay a contribution of NLG 50

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1 The AWBZ is a health scheme for the entire population, covering psychiatric hospital care, outpatient mental care, community nursing, home-help services and nursing homes. It is financed by tax revenue.
annually per family. Patient membership fees thus are the primary funding for the remaining 15% of home nursing costs.

The demand of nurses and caretakers is growing, according to LVVC; ‘Landelijk Centrum voor Verpleging en Verzorging’.\(^2\) The shortage of nurses and caretakers is expected to be 37,500 in 2003, and the expected shortage is highest in the area of Amsterdam. Every year 11% of the nurses and caretakers in the Netherlands leave their job in health care. The average percentage of sickleave in general is 4% (excluded pregnancy leave), but within health care, the sick leave is 8%. Other reasons given for the growing demand of nurses and caretakers are partly demographic (population growth, more old people and less new born), partly epidemiological (more chronic illnesses and increasing variations in different forms of cancer) and lastly, sociocultural, with reasons such as an increase in single households, familycare under pressure, and more migrant people (chart 1).

1.1.2. Migrants in the Netherlands

Dutch society is often referred to as a multicultural society due to the many different cultures living together in a relatively small country. The Netherlands has been an important country of immigration since the 16th century. The increasing number of migrants in the Netherlands has lead to new challenges in healthcare. There are more than 2.7 million people in the Netherlands with a non-Dutch background according to CBS (het Centraal Bureau voor Statistiek per January the 1st 1998). Approximately 1 million of these come from Europe or America, and 1.7 million are originally from Turkey, Morocco, Surinam, The Antillians, Indonesia, Africa, Asia and Latin-America.

\(^2\) All the numbers and percentages presented in this paragraph are copied from notes taken on a course for nurses that was held in March 2000 by LCVV (Landelijk Centrum Voor Verpleging en Verzorging)
**Chart 1**

*Bevolking naar herkomstgroepering* (Windt/Calsbeek/Hingstma 1999:16)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Allochtonen</td>
<td>2.225</td>
<td>2.364</td>
<td>2.572</td>
<td>2.622</td>
<td>2.677</td>
</tr>
<tr>
<td>Turken</td>
<td>206</td>
<td>241</td>
<td>264</td>
<td>272</td>
<td>280</td>
</tr>
<tr>
<td>Marokkanen</td>
<td>168</td>
<td>196</td>
<td>219</td>
<td>225</td>
<td>233</td>
</tr>
<tr>
<td>Surinamers</td>
<td>237</td>
<td>263</td>
<td>278</td>
<td>282</td>
<td>287</td>
</tr>
<tr>
<td>Antillianen/Arubanen</td>
<td>81</td>
<td>91</td>
<td>93</td>
<td>94</td>
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| Totale bevolking              | 14.893 | 15.129 | 15.424 | 15.494 | 15.567 |

Of course, the various ethnic groups may be very different from one another. The situation might therefore differ for each ethnic community and even within one community. I have chosen to focus on Turkish and Moroccan patients because they are the largest groups of migrants in my study area. The Turkish and Moroccans lack the former colonial ties to Holland as opposed to Surinamers. The connection between the Netherlands, Turkey and Morocco can be traced back to the sixties. Many Turkish and Moroccan men entered Holland as factory workers due to a labor agreement (Mesquita 1993:65). Most of the immigrant workers never returned to Turkey or Morocco. In the seventies they obtained the right to family reunion. The Turkish and Moroccan groups are now among the largest ethnic minority groups in the Netherlands besides Surinamers.

The number of the migrant population is growing and many of them have a poor health. The results from an epidemiological research on ‘health, life styles and use of health care of first generation immigrants in the Netherlands’ show that ‘the prevalence of a poor reported health is almost consistently highest among Turks and Moroccans and lowest among Dutch’ (Rijneveld 1997:301). Factors such as socio-economic positions and poor living conditions among others, contribute to a poorer health status.
of these migrants than that of the indigenous population (Ibid). In turn, their poor health may also explain the report of higher use of health care such as general practice, pharmaceuticals and hospitalization. Migrants’ use of home care was not included in the research, but according to my informants the demand for and use of home care was higher among the Dutch people.

1.2. Research questions
I will concentrate on following research questions:

- What are Dutch nurses’ experiences (ervaringen) of working with Turkish and Moroccan allochtonen?
  I find the diversity in my neighborhood very fascinating. It aroused my curiosity to find out what it is like for a nurse to be working in such a culturally diverse area, which was at the root of designing my first research question. What do the nurses encounter when caring for ethnic minority groups? Do they share common experiences? What are the differences of working with migrants compared to Dutch clients?

- Which (socio-) cultural factors may influence the interaction between the nurse and the patient (and relatives)?
  My second research question was raised as an attempt to identify some factors or perceived problems nurses face when caring for allochtonen. Why are there for instance communication problems? Is it only because of a language barrier or may other factors influence? Is gender an issue? What is the role of relatives?

- How do the nurses view and perceive the patients’ expectations and demands for homecare?
  The third research question is closely related to and a distillation of my second research question because cultural factors will influence the way nurses perceive their clients’ expectations. What are the nurses’ explanations about expectations of care? How can this be understood in the context of their professional training and ideas about autonomy in the Netherlands?
1.3. Objectives

The main objective of the study is to explore community nurses’ experiences of working with Moroccan and Turkish allochtonen in Bos en Lommer and Baarsjes.

Specific objectives are:

♦ To identify conflicts and/or differences between nurses and patients in expectations of care, mainly from the nurses’ point of view, and why they think those differences exist.

♦ To point out (socio-)cultural factors that may influence what the nurse expects from the patient.

♦ To collect and write down nurses’ stories.

1.4. Literature review

A literature search soon revealed that there are innumerable books and articles from all over the world on ‘multicultural, cross-cultural, intercultural, transcultural, ethnocultural, culture-sensitive, culture-diverse, culturally competent nursing and healthcare’. Yet, I have found few books focusing on nurses’ stories. I came up with one descriptive article on nurses’ experiences of caring for ethnic-minority clients in London, conducted in 1993 (Murphy & Clark). The article highlights some problems nurses experience in practice, which is similar to my study. Their research focused on an area of nursing about which little is known (Ibid). I still think there is a need of writing down nurses’ experiences and stories to be able to analyze the nurse-patient interaction as it is, and not as it should be according to ‘culturally sensitive care’ theories.

I have found much of the literature about cross-cultural care too narrow in focus and interpretation. The literature provides a catalogue of ethnic practices, so that you can look up different health practices and ways of expressing pain of particular people. I have skimmed through “Nursing and Anthropology: Two worlds to blend” (Leininger 1970) and “Cross-cultural nursing: Anthropological approaches to nursing research” (Morse 1989). In both it seems that anthropology is mainly regarded as a useful tool for nurses to better understand their patients in multi-ethnic societies. In other words, ‘anthropology for nurses’. In the literature concerning healthcare and allochtonen there seems to be a trend of focusing on abnormal behaviors and illness rather than on
normal behaviors and wellness (Locke 1992). Factors such as ‘low self-esteem’ and ‘self hatred’ are assumed to be characteristics of ethnically diverse group members without any investigation of the basis on which such claims are made (Ibid:162). A study on Dutch training nurses and their views on migrant women, which support the idea of ‘negative’ stereotyping, was conducted in 1992. Joke van der Zwaard (1992:1137) was interested to learn how the huge amount of literature about Turkish and Moroccan migrants was used by nurses, in this particular case, to elaborate ideas about specific problems of migrant mothers and the possibilities of professional support in child rearing affairs. She found that concepts such as ‘ignorance’, ‘unequivalence in gender relations’ (male abuse of power and violence), and ‘isolation’ were central in the nurses’ construction of categories of Turkish and Moroccan mothers as problem groups. It is argued (Ibid:1137-1143) that the nurses’ definition and explanations of characteristics and problems of migrant women should be understood in the context of the literature about the population of ‘eastern’ countries, which is recommended in the professional training. A traditional topic in the literature adopted by the nurses, is the oppression of eastern women. A distinction is constructed by opposing the image of an ‘average Middle Eastern women, who is ignorant, poor, uneducated, tradition bound, religious, domesticated and victimized, and the self-presentation of Western women as educated, modern, as having control over their own bodies and sexuality, and having the freedom to make their own decisions’ (Ibid:1139).

Rob van Dijk (1989) has written a very interesting article on ‘the failures of health care to migrants in the Netherlands’. He comments on the way culture as an explanation-frame for the sickness behavior of Turks and Moroccans has been applied in health care to these two groups. Cultural knowledge that is restricted to the country of origin has become a pitfall and has proved to be an inferior tool. Van Dijk points out that the literature on health care to migrants ‘got stuck in a vision in which the static culture concept prevails’ (Ibid: 249). I agree with van Dijk that cultural knowledge has not lived up to its high expectations. Much of the literature I have read about migrants do not take cultural changes into account and fail to consider culture as a dynamic concept.
I question to what extent social scientists have devoted attention to the role of nurses. I think there is a need for anthropological studies focusing on nurses and their experiences. There is in general a lack of anthropological studies on nursing. Both Sciortino (1992) and Foster (1984) argue that social scientists should pay more attention to the study of health personnel. More specifically, very few anthropological studies have been conducted on homecare in the Netherlands as far as I know. Relatively little is known about how nurses perceive home care visits (Morgan & Barden 1983).

I have chosen to conduct my study in Amsterdam because it is a multi-ethnic society that is comparable with Oslo, where I have worked as a nurse for two years. I feel I am both an insider as well as an outsider. Being a Norwegian in Holland, people constantly assume I am Dutch, but the very moment I open my mouth the truth is revealed that I am in fact an outsider. I have met people from all over the world during my stay in Amsterdam. The diversity is sometimes striking, but I have also realized that my Turkish neighbor and myself for instance have a lot in common.

1.5. Definition of crucial concepts
1.5.1. Nursing:
In the Netherlands there has been a long tradition of viewing nursing as a 'vocation', which is rooted in the social, moral, religious values of Dutch society. Nowadays, nurses are struggling to improve their education. The pedal has shifted from nurse as a vocation to nurse as a professional occupation. Florence Nightingale, who has been regarded as a transitional figure in the professionalisation process, stressed that knowledge as well as character was necessary. (Deloughery 1977:50-62) She viewed nursing as being both a vocation and occupation. According to Leininger (1970), there is no unanimous definition upon which all members of the nursing profession can agree, about what is and what is not nursing. Nursing occupies an ambiguous position between the care and the cure domains. I have chosen to include a definition despite of different views of the nurse's role. “Professional nursing is recognizing, analyzing, advising and supporting on actual and potential outcomes of physical and mental
processes of illness, disability and development disorders and their treatment concerning the activities of life of the individual. Nursing action includes influencing people so that potentials are used for the maintenance and promotion of health” (Schrijvers 1997:17). The individual expertise of nursing professionals is emphasized in this definition.

1.5.2. Culture:
“If anything was made to be taken for granted, it is culture” (Gallagher and Subedi 1995:4). The concept of culture, being a more or less raison d’être for anthropologists, is complex and difficult to settle upon a single definition. Yet, we may think of culture as “a complex of knowledge, belief, art, morals, laws, customs and human capabilities and habits of thought, that is acquired by individuals as members of society” (Tylor 1871; quoted in Helman 1998:2). Culture is in other words a set of inherited guidelines. When it comes to expression of illness or pain, the cultural system has explicit and implicit guidelines on how to view illness, how to experience it emotionally and how to behave in it in relation to other people (e.g. what is acceptable and valued). The term cultural diversity recognizes that different ways of doing things exist.

1.5.3. Allochtoon:
Among my informants the term allochtoon was employed by some, but not all and there was obviously some uncertainties as to whom the term applies.

“I never call anybody ‘allochoone’. I call them Turkish or Moroccan or Surinam or whatever. I don’t know what this ‘allochtoon’ includes ...I don’t know where it starts or ends, you know. I wouldn’t include the Surinam in ‘allochtoon’ because most of the people who came here were born Dutch in Surinam...I don’t consider them ‘allochtoon’..also the people from the Antilles..I consider them Dutch..Like I consider the Turkish here Turkish-Dutch or Moroccan-Dutch...something like that” (Nurse)
The Dutch word *allochtoon* indicates a member of an ethnic minority in the Netherlands but the term, which in English is translated as 'migrant', is in this context used rather loosely. When talking about *allochtonen* or Moroccan or Turkish people, I think it is essential to keep in mind that ethnic groups and cultures are never homogenous or static. Other people around them always influence people, which means that there is a constant process of adaptation and change. What is true of a group one year, may not be true of it the next (Helman 1998), which is why I think questions concerning 'who is *allochtoon* and when is the *allochtoon* no longer *allochtoon*...’ are hard to determine. The terms *allochtoon* and migrant are used interchangeably in this thesis, referring to ethnic minorities.
2. METHODOLOGY

2.1. Study type
The study, being of short duration, is exploratory and descriptive. It gives a picture of community nurses' experiences and perceptions of working with Turkish (and Moroccan) patients in the home care sector in Amsterdam West.

2.2. Study area
The study was conducted in Bos en Lommer and de Baarsjes in the Western part of Amsterdam. The total population in Bos en Lommer and de Baarsjes is 65,679. A high percentage of the population in these two areas are from various ethnic backgrounds; 54.9% in Bos en Lommer and 40.8% in de Baarsjes (Het Amsterdamse Bureau voor Onderzoek en Statistiek 1999:57). One of my key-informants told me that the area is known for its social problems.

"The rich don't live here. The well educated don't live here. The houses are small. The city council is doing a lot to make it better. They are renovating houses and there is a lot of attention for the social problems. The general health care is poorer here than in other parts of Amsterdam"

2.3. Sampling and data sources
My study population was mainly Dutch nurses, working in home care in Bos en Lommer or Baarsjes. The nurses' age or sex was of no importance in selecting interviewees. The criterion for serving as informant was to be registered and having cared for a client from Morocco or Turkey within the last year. Information was gathered from interviews, observation, informal discussions and small talk, and review of literature. One manager and one nurse were interviewed as key informants. Ten nurses directly involved with the giving of home care nursing to allochtoon patients were interviewed as core-informants and two nurses participated in a small group discussion. These people were selected from the two nursing teams working in Bos en Lommer and Baarsjes through the so-called snowball method. Four nurses who were
asked to be interviewed refused. Two nurses were observed while carrying out their home care activities. In addition, I observed two meeting sessions where the nurses discussed a few patients and daily interaction between nurses at the office of home care nursing in Amsterdam West. I also visited ‘Centrum Mimoza’ which is a social service-center focusing on health-related issues for Turkish and Moroccan women. The center is located in Bos en Lommer. Another data source was reviewing literature in the development of the study prior to the fieldwork as well as during the fieldwork to deepen my understanding and get additional information.

2.4. Data collection
The data for this study was collected over a period of six weeks. Entering the field and starting the data collection process was exciting and at the same time frustrating. I made a work plan, scheduling the different activities that had to be carried out each week, but several changes were made to suit the informants. I have without doubt learned that flexibility is a keyword when doing fieldwork! I was planning to interview 2-3 patients with a Moroccan or Turkish background and their family. My motivation was to identify the patients’ view on the nurse-patient interaction, their perceptions of Dutch nurses and what they think of home care. Limited contact with patients and language problems prevented me from carrying out those interviews. As a substitute, I sought the literature to find authors who could give a voice to different perspectives held by the people with a Turkish or Moroccan background living in Amsterdam.

All interviews with the nurses were audio-recorded and transcribed for later review. I was interested in obtaining the most accurate and clear retention of details. The interviews aimed at open-ended questions to give the nurses the opportunity to talk freely about their experiences. I felt free to deviate from my interview guide if an unexpected, but relevant issue emerged. I often experienced that valuable information was given after the audiotape had been switched off. From the beginning I kept inconspicuous pocket size notebooks for all observations including the nonrecorded conversations. These notes were later elaborated into more detailed notes.
2.5. Ethical consideration
Throughout the whole data collection process I considered ethical issues. The manager gave approval for the study. I obtained informed consent from all interviewees and assured anonymity and confidentiality in all respects. Such a consideration was also taken towards patients. All audiotapes were destroyed at the end of my study.

2.6. Pretesting
I was introduced to one of the nurses working at the home care unit in Amsterdam West a couple of weeks before the start of my fieldwork. She expressed interest and curiosity in my study. This nurse proved to be an important person in making the access easier by establishing contact-links to other nurses. Trial interviews were done with a couple of nurses who have previously worked within home care, which indicated that communication problems may be one of the most prevalent problems for nurses working with allochtonen. As a result of the trial run my interview guide was adjusted in the sense that I included probing points on communication and misunderstanding. When I made the first draft of my interview guide I was not planning to focus on language barriers. However, communication seemed to be a prominently perceived problem by the nurses, which is why I thought it should be included as an issue in the interview guide.

2.7. Data analysis
All the transcripts were typed out and read thoroughly. Each transcript was coded into a few main categories (which were later grouped into smaller categories):

- Why home care
- Male/female
- Self care
- Expectations of care
- Communication
- Relatives
- Cultural knowledge
2.8. Validity and reliability

I was constantly aware of giving attention to issues of validity and reliability. The informants gave me the impression that they shared their experiences openly and honestly. A few of the nurses reviewed the data and confirmed the findings. I also shared some of the findings in a focus group discussion, which provoked an interesting discussion. The main trends of the discussion followed the lines of data gathered from interviews with individuals.

2.9. Study limitations

During the study I encountered several limitations. Firstly, the language. Although I am capable of understanding some Dutch, I chose to do the interviews in English to facilitate the transcription and to make sure I would understand everything. I might therefore have missed some valuable information. A few of the nurses felt uncomfortable with English which I think influenced the information in the sense that the conversation did not flow. Secondly, this prevented me from interviewing all categories of informants, most importantly patients. The balance of the study shifted to the experiences and perceptions of the nurses. On the other hand, I had the opportunity to crosscheck data from interviews with observations of the interaction between the nurse and the patient, which I think helped to improve the validity of the provided information. Thirdly, it is impossible to say whether my findings are a representative selection. They are based on working experiences in the Western part of Amsterdam, without knowing what the situation is like in other parts of the city or in other parts of the Netherlands.
3. THE DYNAMICS OF EXPERIENCE

The findings of this study reveals that community nurses in Baarsjes and Bos en Lommer share many common experiences, frustrations and challenges. Difficulties in communication due to language barriers and differences in expectations of care are issues that appear to be most conspicuous in the nurses responses concerning their experiences of working with *allochtonen*. I will also deal with factors for choosing homecare, experiences with male/female issues, the role of relatives, and cultural knowledge. I would like to stress that despite the occurrence of frustrations and misunderstandings, all of my respondents expressed that working with Moroccan and Turkish people is an interesting and enjoyable experience. The nurses are especially impressed by their outstanding hospitality in comparison to Dutch patients.

3.1. Organization

In Amsterdam *Thuiszorg Oudwest* there are eleven basic units of home nursing. Each unit has a head nurse (manager), 4-10 nurses and two or three auxiliary nurses. A basic unit is assigned to a defined geographical area. One of the head nurses told me that they are in the middle of the process of integrating home nursing and home help services. The two teams I concentrated on (Bos en Lommer and Baarsjes) were composed only of nurses, but the idea is to create VV-teams in the very near future. A VV-team is a combined team of *verpleegkundigen* (nurses), *verzorgenden* (qualified home-helpers) as well as untrained home-helpers who perform mainly household tasks. The nurses and home-helpers deliver care at daytime and in the evenings, nights and weekends if necessary. The first contact with home care is either initiated by the patients themselves (no referral is needed) or referred by hospitals or nursing homes. The assessment is carried out by a community nurse who discuss the need for home nursing (and/or home help care) with the patient and sometimes others such as family or referees (e.g. hospital- nurses). The nurses working in *thuiszorg* are responsible for continuous evaluation and duration of care.
3.2. Description of sample

Fourteen nurses (all Dutch) served as informants, eleven women and three men. Their ages varied from 25 – 40 years old. Four of them have worked in thuiszorg since they got their degree and have therefore limited or no experience of working in a hospital. Seven have worked in hospitals, but moved on to home care and three have other backgrounds. There are two types of community nurses within this group. Some of them are Wijkverpleegkundigen (Community nurses) who have either four years of higher vocational training or 3.5 years in-service training in a hospital, with an additional two years of intermediate training. The others are Verpleegkundigen in de wijk (Nurses in the community). They have had 3.5 years in-service training in a hospital to become a registered nurse, but did not have the two years of additional training in community nursing. Three of the my respondents are also specialized in chronic respiratory diseases, and they are therefore working especially with patients in home care who have asthma. They are so-called ‘cara’- nurses. All of them have some experience of working with allochtonen although the majority of clients requesting home care are Dutch. The main patient groups among the allochtonen are Moroccans and Turks. Many of them do not speak Dutch and they are dependent on their children for translation.

The community nurses perform following tasks:

- assessment of the need for care
- hygienic and other personal care such as e.g. bathing, help with lavatory
- technical nursing procedures (injections, dressings, stoma care, catheterization, etc.)
- patient education
- psychosocial support
- evaluation of care

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3 Asthma is a chronic lung disease characterized by coughing, chest tightness and shortness of breath.
3.3. At work with a community nurse

I have included an example of what a workday may look like, although a community nurse’s workday is never the same. It differs according to what kind of care that needs to be given to the different patients and the workload on any given day. During the six weeks I was ‘hanging around’, there seemed to be a quiet period because there were not many patients to see in the afternoon. The manager confirmed my observations and told me that due to limited staff in the weekends, they had to limit the number of patients during the week as well.

I had made an appointment with Inge (fictitious name) to go with her to visit patients. We meet at the office at 08.15 a.m. She is casually dressed in shorts and a T-shirt. I ask her about the dress code, and she tells me that she feels a bit insecure how to dress when she knows she will be seeing Turkish or Moroccan patients. The nurses have discussed this topic among themselves and they have decided to dress according to the Dutch dress code. “We’re in Holland, not in Turkey”. Before taking off we go through the patient record’s book and Inge tells me a little bit about the five patients we are going to visit in a time period of four hours. The area is nearby so we get on our bikes at around 08.40.

The first lady is from Surinam and speaks Dutch fluently. Normally, the nurse helps her with showering and stoma care, but when we arrive at her place she has already taken care of those things by herself. We sit down. She asks us if we want anything to drink. Inge asks her how she feels and gets an elaborate answer. She later tells me that this lady has been severely ill and needs a lot of psychosocial support, which is why she choose to stay for almost 45 minutes just talking.

On our way to the next patient Inge tells me that the people from Surinam are more integrated into the Dutch society compared to Moroccan and Turkish people.
At 09.30 we enter the house of an elderly Moroccan couple who live by themselves. Inge kindly asks whether we should take off our shoes and the husband quietly nods. Before we sit down, Inge asks if it is alright to sit on the couch. The Moroccan lady has been through a surgery and has lost a lot of weight. Both she and her husband speak some Dutch, but Inge asks them several times to repeat what they mean. The communication takes time. Inge helps the patient with her shower and dresses her wound. She also looks through her medication. She told me afterwards that she had to make sure the patient takes her antibiotics because her experience is that “as soon as they feel better they just stop taking the medication even though the doctor has told them otherwise”. The lady complains about itching due to the antibiotics and Inge promises she will call the doctor to see if she can get some antihistamines. While we are still there, the patient’s daughter calls. She speaks fluent Dutch and wants to know what Inge has to say about the state of her mother.

At 10.45 we move on to the third client, an old Dutch lady who lives alone. After a short greeting, Inge starts washing the wounds and changing the bandages. The whole process takes about 20 minutes and we leave immediately.

At 11.15 we enter the house of another Moroccan couple, living by themselves. The husband is 80 years old and needs supervision due to diabetes. His knowledge of the Dutch language is limited, but his wife speaks Dutch. Before entering the living room we take off our shoes. Inge asks him how he is doing and he says, ‘Well, today I feel 30%’. I was told in advance that Inge and the patient have their own code of implicating how he’s doing. Instead of saying ‘today I’m not feeling too good’ or ‘yes, I’m feeling all right’, the patient use a scale from 1-100% to indicate how he feels. Inge takes the bloodsugar and gives him the insulin. The wife, who is much younger than her husband, is constantly present, doing most of the talking. They plan to go to Morocco for three months and they discuss the possibility of taking a wheelchair to Morocco. Inge promises she will help them with the application process. Before we leave, the wife gives us each a small bag of cookies.
At noon we go to visit our last patient, an elderly Dutch man who has some wounds that need to be dressed. It takes half an hour, and we head back to the office. It is lunchtime!

In the afternoon there are administrative tasks to be taken care of (writing reports, making necessary phonecalls, etc.) Some nurses go to see patients in the afternoon as well.

I noticed that Inge was more cautious in the homes of allochtonen, such as asking ‘Shall I take of my shoes’ or ‘Can I sit here’. When I brought it up, she confirmed my observations and explained that it was due to uncertainty concerning their customs, beliefs and habits. I also observed that she spent more time in the allochtoon homes. She told me that she often ends up spending more time with allochtonen than with Dutch people because communication takes more time.

3.4. Why home care?
I chose to question the nurses about their choice of home care career to find out more about their personal and professional background. I will briefly present the most common motivating factors for choosing a home care career. Those include personal or educational background and job satisfaction/dissatisfaction.

3.4.1. Personal or educational background
Tom (fictitious name) has worked in home care for 17 years. He has worked 10 years as a manager and 6 years as a community nurse. His choice was influenced by family and friends who encouraged him to join a home care career.

“In the first place.....my sister is a nurse working in home care - she told me lots of stories, aroused my interest. My best friend became a nurse. My grandparents played a role in the whole thing; I liked to visit them. I became interested in elderly people, so a combination of people influenced me.”
Tom represents one example of several other nurses whose choice was influenced by other people. The encouragement coming from peers, teachers, spouses or other family members seems to have played an important role in the nurses' process of decision making.

Besides personal background, some nurses mentioned that their educational background was also a motivating factor for choosing home care. Many nurses told of positive experiences of working in home care during their training period as nursing students.

*During my studies, I did an internship in homecare, and from the start I felt at home. When I had finished nursing school I decided to work in home care to give it a chance. After a while it became very clear to me that this is what I want.*

3.4.2. Job satisfaction/dissatisfaction

Most of the nurses had some experience of working in hospitals. When I asked the question of why they had chosen home care, they often made a comparison to working in a hospital. Several nurses acknowledged the desire for autonomy in professional practice. The aspect of flexibility, working more independently and having more freedom in homecare as opposed to being a part of the hierarchy in hospitals was frequently mentioned. For many of the nurses working in home care it seems to be important to be able to make their own decisions. Many have experienced that nursing practice in hospitals is not autonomous and the possibilities to realize what they have learned as students are more absent in hospitals than in *thuiszorg*. Nursing students in Holland are taught to be responsible for the care of the patient. They learn to draw up, carry out and evaluate nursing plans (Pool 1995). Many of the nurses felt that their role in a hospital setting was restricted to 'the doctor's assistance,' which was not satisfying. Other undesired working condition in hospitals were the constant presence of rules, irregular working hours, and space limitations. David Kyaddondo (1998) points out similar findings in his research among community nurses in Bergen op Zoom. He (Ibid:24) identified flexibility of working hours and making more
independent decisions as leading factors for choosing a home care career rather than working in a hospital.

I had my own ideas about what good nursing was, being by yourself – to do the nursing the way you want it, instead of being under all those limitations in an organization. So that was the main reason for joining home care. Also the fact that you’re outside – I don’t like to be enclosed. It’s also the sense of freedom. There is more freedom than in the hospitals. In home care you go around on a bike. In the hospitals there are more rules, more protocols...more stress. I was fed up working day and night in a hospital – it was too busy.

As far as the nurse-patient interaction was concerned, the nurses felt that they got to know the patients better as a result of meeting the patient in his or her own environment, which was also a motivating factor for joining home care. In their experience of working with migrants they said that seeing the patient at home and meeting the family had a positive impact on the nurse-patient relationship.

Eva (fictitious name) is 35 years old. She used to work in a surgical ward and says she sometimes misses the technical work (infusions, etc.) Eva used to like her job in the hospital and her motivation for changing jobs was due to irregular working hours, which were hard to combine with being a single parent. She point out that it its easier getting a more complete picture of the patient when you see him or her at home:

Working in home care is very different from working in a hospital. You get to know the patient much better because you know how the person lives, how it looks like in the family. You get to know the social structure. You understand more about that person because you see them in their own context. I think it’s a bit easier for us to work with migrant patients because we see them in a context and we meet the family. So, it’s easier to be empathic.
3.5. Expectations of care

In the nurses’ responses concerning their experiences of working with allochtonen they frequently brought up differences in expectations of care as a cause for problems in the nurse-patient interaction. Firstly, I will present ideas of self-care to provide a background for understanding why expectations of care may sometimes be contradictory. Secondly, I will present the findings on how the nurses perceive a patient’s expectations and demands of home care by using several nursing stories as examples.

3.5.1. Self-care behavior

‘Self-care’ has been defined as a process in which people function on their own behalf in health promotion and prevention, and in disease detection and treatment at the level of the primary health resource in the health care system (Levin 1981). ‘Self-care behavior’ refers to the patient’s behavior that is guided by health purposes on his/her own behalf (Levin in van der Eerden 1992:42). “Self care as ‘basic’ health behavior may have a preventive, curative and rehabilitative function” (Ibid:43). In Holland, as well as in many other European countries, nurses are taught to encourage patients to play a very active role in managing their illness. The nurses interviewed have a vision of encouraging self-care and patient autonomy.

Nurses I know have the idea that a patient has to do for him or herself what he can do. It’s not good to do things for patients that they can do themselves... this is something that’s very deep. If there is for example a patient with hemiplegi, and he can wash himself with the hand that’s still functioning...you don’t do it for him or her. That’s not good – You don’t do that. Giving good care involves mobilization and letting the patient do as much as he possibly can without any help. And that’s very deep inside nurses in Holland, and I see it a lot in my team. You don’t do something for patients that they can do themselves, even if patients want you to do it.

The nurses’ focus is on teaching the patients, for instance a diabetic patient, to become independent. Diabetes is a chronic disease and the treatment according to the nurses
requires patients to play a very active part in its management. The nurse gives instructions concerning insulin administrations (injection technique, how many units to take, and time of day to take insulin, etc.), diet, recognition and prevention of hypoglycemia, foot care and urine testing. Teaching these tasks is a process towards self-care behavior for those patients, but there seem to be some difference in views on self-care behavior.

What I've noticed...people from other cultures – they don’t think like that. The way of thinking is different for Moroccans and Turks in the sense that ‘it’s my right to get help, I’m sick’ as opposed to the way of thinking in Holland. In Holland people will, as soon as they feel better, try to do as much as possible themselves. You stop complaining and you go back to work as soon as possible. I think Dutch clients are used to the health-policy that you have to do as much as you can do by yourself, and we’ll help you to do things yourself. I see that in allochtone, you’re allowed to be sort of a ‘victim’. It’s really true – you sense that.

Van Dijk did a research on somatic fixation and Turkish migrants in Amsterdam in 1987⁴ (De Bruyn 1989). He found that when the Turks become ill, a shift occurs in their self-concept. Self-concept is strongly connected with labor, their physical functioning, and the body. Van Dijk thinks that this orientation was strengthened among the immigrants because they were originally recruited to come to the Netherlands on the basis of their ability to perform physical labor (Ibid:897). When the Turks become ill their identity is based on illness rather than on labor because they are unable to work, which might partly explain the ‘victimized role’ as they wish legitimization of their sick role. Concerning care for the elderly, Yolande van den Brink (1995), points out that the meaning of good care for many Turks involves letting the sick person do as little as possible and not argue, helping them for instance to eat and to drink.

⁴ Dijk R. van. De dokter vertelde dat ik niet meer beter word (‘The doctor said that I won’t get better’).
The family help out a lot sometimes because they feel sorry for him or her, and they do too much. It's much better if the patient do it himself as much as possible.

The ideas about self care and meaning of what good care involves is closely related to the nurses' experiences of facing differences in expectations of care.

3.5.2. Contradictory expectations

Community nurses are confronted with questions and needs of patients which sometimes are contradictory to their own ideas of nursing care and perceptions of the patients' need for home care. Such a situation may cause conflicts as several of the cases presented to me from the nurses' perspective will illustrate.

Some of the patients have asthmatic and allergic problems and the nurses specialized in this domain aimed their care at teaching these patients to live with their disease. The education provided by the nurses focuses on self-support, understanding of the disease and how to prevent aggravation. All the three nurses working with asthma-patients could give examples of confrontations due to discrepancies in expectations of what a nurse can do. For an asthmatic patient to get better, good housing facilities is important, like for instance central heating, which many of the patients do not have. Such patients sometimes expect the nurses to help them getting a new house.

They think that if you have asthma, the authorities have to give you a better house, and that's not the case. Of course it would be nice, if you have asthma, to have better housing-facilities, but well, housing-facilities are very short in Amsterdam. You have to be very handicapped in order to get better housing due to medical reasons. But that is what people sometimes don't understand and they confront you with their problems. Well, I quite understand them because everybody would like a better house, but I don't work with housing-corporations, so it's not my cup of tea. People always think that if you do your best for them, it will help them. Sometimes that's true. I think it has to do with expectations...and that is something I think...well you see that a lot with people from Morocco and Turkey...they think if you personally do your best for them, it will
help them, and if you don’t do it it’s because of them that you don’t do it. You can explain ‘I cannot do that because I don’t work there...I’m a nurse and my job is to give you advice about the medication, and what you can do in the house you have now’. Well, their expectations are sometimes a bit too high, and that’s frustrating in a way. It can be very frustrating. Sometimes you can’t explain that to them – they see it as a personal thing that you personally don’t want to do the best for them...and that’s sometimes frustrating. They’re expecting something you cannot do. I know this because they ask and they keep asking, even if you have explained...they ask again.

Several other nurses could come up with similar stories and my observations were in line with their cases as well. I observed among all one of the cara-nurses giving advice to a Moroccan woman who had allergic problems. She was recently divorced and lived alone with her three children whom all had asthma. This woman (who spoke Dutch perfectly) was convinced that the humidity in her flat triggered the allergic reactions and aggravated the children’s asthma. The nurse agreed that humidity was an important triggering factor, but tried to lead the conversation into focusing on asthma management. The nurse was interested in educating the patient: What asthma in fact is, how she could prevent allergy and asthma in general, giving information on medication and reactions to medications, setting up a guide to health care plans, etc. The nurse was obviously aiming at educating the patient towards self-care behavior. The patient, on the other hand, seemed not to be paying very much attention to what was being said. She kept bringing up the issue of better housing, which was why she had contacted a nurse. She was after advice and help in order to find a better place to live with her three children. It was very interesting to observe the interaction between the nurse and this woman. It was as if they could not reach each other. The nurse expected the patient to understand and act upon her advice whereas the patient expected the nurse to help her find a new flat or house.

I believe the nurses try to act according to what they think is best for the patient. They persist therefore in their attempt to educate the patient so that he or she finally will manage without any nursing help.
Ellen (fictitious name), who has been working in home care for five years, was responsible for the care of a Moroccan man in his 60s who had a stoma. (A stoma is an opening created surgically to discharge body waste when disease or trauma have interfered with the body's elimination processes). Both he and his wife were very reluctant to take care of the stoma, and they thought it was a nurse's job to change the pouch, etc.

They couldn't do it, and they wanted a nurse to come twice a day to do that. But we told him he that he could do that himself, or his wife could help him. It caused a lot of problems to convince them that that was not our job, and that they had to do it themselves. We have of course this selfcare view; people should do as much as possible themselves, and the nurse only comes in when somebody really can't do it and then you have an educational job. This patient said 'Well, here it is and you do it for me! I'm not going to touch this. Now I need healthcare, it's all yours and I'm not going to do anything about it.' So that took a lot of conversation.. 'Listen, this is a simple thing to learn, so we'll come a couple of times, but then you have to do it yourself'. And that caused a lot of problems. We explained several times — finally they took over. But it took a long time.

Ellen questioned whether their reluctance could be due to their religion, notions of 'pure/ impure', but she did not really know. She tried to come up with a few hypotheses to make sense of the whole situation. When I confronted her about whether she had turned to the patient or his wife for an explanation, she simply replied 'no'. She told me she had tried to solve the perceived problem by explaining her idea or vision of selfcare, and that she was going to help these people as much as possible, but that eventually it was their own responsibility. Apparently she had had a real confrontation with them. Ellen was convinced that her own ideas of self-care was for the best of the patient and she got support from the other nurses. She gave me the impression that 'they' should adapt to the Dutch Health Care system. It was part of the price 'they' should to pay when settling down in Holland. On one hand Ellen was of the opinion that 'they must adapt to our culture'. On the other hand she reflected upon
her own stance in the confrontation, not knowing exactly why there was such a strong
resistance.

I noticed that in most stories the nurses made a comparison between allochtonen and Dutch patients to illustrate differences. The attention often goes to cultural differences and I believe it is because those differences interfere with the ideas of nurses’ provision of care.

What I noticed is that when you’re ill in Holland you say ‘ok we’ll have to work on something so that we can help ourselves to cope with this illness.’ This is a different attitude than what you see with Turkish and Moroccan (not all) people. ‘I’m ill, so YOU have to help me’. They stay in bed the whole day, and I tell them ‘it’s not good for you. Get up’ ‘Yea, but I’m sick!’ ‘Even if you’re sick, you have to get up and try e.g. to wash yourself.’ If you go and wash somebody...what we (the nurses) try to do is not doing anything at all, give some advice/tips, so they can do it themselves.

I have, at the moment, one Moroccan and one Turkish client with diabetes. One of the main challenges is to get them out of the victim role ‘I’m sick, I can’t do anything, you must give the injections...’ to a role of being in charge of your own situation... It’s really a challenge to get them out of this ‘victimized’ role... It’s a challenge – teaching the practical things, learning how to read the bloodsugar, etc... And of course they were able to do it...there is nothing wrong with the intelligence. It’s the drama and the victim role ‘Now I’m sick, I need all the health care I can get’. I try to explain them that this is what we’re going to do...Then they’ll call their children and say ‘ohh this is a worthless nurse, he doesn’t want to do anything...couldn’t they send somebody else...’

Although the attention often goes to fundamental differences, in all fairness I must say that some of the nurses attempted not to get lost in generalizations of ‘the Turk’ or ‘the ‘Moroccan’. They stressed that they do see the ‘victim’ role with Dutch patients as well, but that it is more frequent with allochtonen.
You also see this with Dutch patients. 'Hey, what is this – are you going to help me or not..'. Even the family..even if they sort of understand that the patient should do as much as possible himself, they say 'You have to help him, that's why you're here'.

All the nurses were of the opinion that it is good to teach patients to become independent. As soon as a patient is getting better, the nurse tries to withdraw, which sometimes creates objections and resistance. I will use one story in particular to exemplify that sort of confrontation and how three nurses look at the same situation. This specific patient was a woman from Turkey, and I have discussed her 'case' with three nurses who had been visiting her. It was interesting to listen to different versions of the story. I noticed that despite of the nurses’ common shared view on self-care, they differed slightly in their ‘demand’ for patient’s autonomy.

1st version of the story:

"I was recently responsible for a Turkish woman who has been in hospital for a long time. She had a very big wound (abdominal) and every day she had to take a shower to clean the wound, which was necessary at the time, but later on the wound was granulating and I said 'No, it's not necessary to shower the wound every day anymore – it's really not necessary. But she said 'NO,NO,NO..in the hospital it was necessary every day.' Well, that was then, but it isn’t necessary anymore, so it was a real fight. We had a long talk. She was very angry, her daughter also. Her daughter was at home taking care of her mother, and I said 'If you want to shower every day, your daughter can help you' and then she said 'No, no, you have to do that' and I said 'It's not necessary'. But now she has agreed with it, but it took a long time. We (the nurses) made a decision to go and see her only twice a week, and she had to agree with it. Sometimes you have to do that, I think. The daughter doesn’t live with her mother, but due to her situation she moved in for some time to take care of her, but I’ve never seen her helping her mother. I told the patient ‘Maybe your daughter can clean your back,’ Now it’s all right.

I think she reacted the way she did because in Turkey the word ‘care’ has another meaning. When she said you have to take care of my mother...I think that if someone is
sick...they don’t understand that care can be less...when you’re sick, you have the right to receive care. This woman... I told her that it’s not necessary to take a shower every day. They don’t understand. It’s easy to understand, but they don’t want to understand. The family think the same as the patient. The Dutch understand you better. Everyone wants to shower every day, but in homecare you don’t do that. You say two times a week they can shower, and you just have to accept this. The Dutch understand because they know there aren’t enough nurses. It’s a different way of thinking. I think. When you’re dependent on homecare, you are happy to shower twice a week...otherwise you can never shower”.

2nd version of the story:

“The wound had to be cleaned under the shower, but she could do it herself. Her physical condition was good enough for her to do that. But she expected us to help her with everything, like washing her hair, her back. When I came there I had the plan for what to do, and I said ‘Well it’s not my job now to help you shower’. But she just gave me the showerhead, saying ‘You have to do it’. It was a bit difficult, but I didn’t do it in the end. I explained to her that there was an agreement that she would be helped twice a week, but not every day. In the beginning it was a bit of a struggle between me and her. She wanted me to do it, and I said ‘I can’t’. I drew the line there. I made a decision. She was disappointed and a bit angry. She didn’t talk to me for like 10 minutes, but I explained her that she would be showered twice a week, that I had a lot of other clients to visit, etc. In the end she understood, and it’s not a problem anymore. I visited her today, and she was very glad to see me. It was nice to see her - she is a very nice lady. For me it was important that she understood why I couldn’t do it, and also that there was the agreement that she could be showered twice a week, and that on the other days it was good for her to try it herself...good for her wellbeing, and in the end she understood that, which was important for me. There is so little time to figure out why - sometimes it’s a pity to have so little time, because if you understand someone’s action better by talking about it, you can make better decisions and take better action. Sometimes you just have to make a decision - and that’s it.”
Both of the nurses in version one and two stick to their view on self-care. The patient should do as much as possible herself and not expect 'unnecessary' (as perceived by the nurses) help and care. The patient wanted to have more care and attention than the nurses thought she needed. She wanted the nurses to shower a wound which in the nurses' eyes was nothing. She said she needed their help, but she did not get in the end because the nurses thought that she did not need it. The nurses kept their hands clean because according to them, the problem lay with the patient. The third version of the story differs from the previous, because the nurse lets her reflections go beyond the vision of autonomy:

What's right and what's wrong? You have to talk to people and make an agreement on something, and it's not always that your professional attitude is the right attitude...because I think it's very important to find out what's behind the question of the patient. Then you see that this is sometimes a cultural thing, and in her case...she had been very ill and very sick, she had nearly died. The family was so shocked about it; saying 'no' to somebody like her was not accepted! She should get anything she wanted because she had been so ill, and if she wanted to shower these scars every day because she was afraid she would have a new infection...it was quite a good question to ask from a nurse, and the nurse said 'no, you don't need it...it's not necessary'. Well, that was hard for them all. I think it's important to find out what the conflict is really about, and it's not only about the patient asking difficult questions, but also about our vision. We have to question ourselves also.

This nurse recognized multiple viewpoints in the situation. She had the capacity to understand the viewpoint of the other, which I believe is essential in a nurse-patient interaction.
3.6. Male/female issues
Although the entry of men into nursing is increasing, the nurse is still quintessentially female in Europe (except for nurses in prisons and mental hospitals). The nurse is female both in actual statistics and in popular perception (Holden & Littlewood 1991). My three male informants told me that being a male nurse does create conflicts once in a while. Two of them had first-hand experiences, but the third one had never encountered any problems. According to them Amsterdam thuiszorg underlines that it is not important who of the nurses does the job or what the gender of the nurse is, as long as the job is done properly and professionally. Most of the nurses (females and males) were of the general opinion that if people want help they should also accept male nurses.

Arthur (fictitious name) has worked as a nurse for 10 years, partly in a hospital and partly in home care. Only a few minutes before I met him, he had tried to sort out a situation where he experienced male bias.

This is about being confronted with the fact that being a male nurse is not always easy. It was an incident with a Moroccan couple with a Moroccan child who is only 10 years old. It’s a girl who needs care; the hospital called us. I called them, and they said ‘Well, maybe not, not every day’ and this and that, and I sensed that this had to do with me being a man, a classical case.. I found out by calling the hospital, and the ‘transfer’ nurse said ‘Well, I’m pretty sure it has to do with this because they do need care, and they probably got frightened when you called, that you wanted to wash the child’. This is one of the issues being a male nurse and being confronted with especially female clients and allochtone women. To me it’s like ‘what?’, you know, can’t these people look at professionals instead of the male/female, you know- that is the reaction I have. Eventually the hospital said ‘No, they really need care, if you please could listen to these people and maybe you could send a female nurse’. I said ‘Well, we have to talk about it..we always listen to what people want, but it’s not our policy to not send male nurses unless you’re dealing with incest cases. In general, because it’s an allochtone woman, it’s difficult. We’re starting care on Sunday, and
the first day a female nurse will go. We have to see whether we can deal with that or say ‘Listen, you need care and you have to accept both male and female nurses’. So, that’s sort of in development. For now, we’ve decided that a female nurse will go the first day, and then we’ll see what happens.

I do not know if the 10 year-old girl minded a male nurse, but her parents objected. Dealing with the family is part of the job for a nurse and sometimes family members are those who are critical towards male nurses. One of the other male nurses told me a story about the husband of one of his patients who was very uncomfortable with a male nurse.

We have another woman, a Moroccan woman. I don’t think she minded, but her husband didn’t really like it – that’s another thing, another issue. I think the woman was more modern, you sort of sense it, I didn’t ask about it, but I think she is more modern in the way she deals with it. But HE is standing there like ‘What is this guy doing with MY wife’. So that is something you have to deal with. You don’t get that anymore with Dutch patients.

Most of the respondents were of the opinion that if there are, for instance, clients who for various reasons prefer a female nurse, the request should be considered, but not at all costs. If they want help they should also accept male nurses. If it is not possible to arrange for a female nurse, the patients have to make a choice whether they want to have a male nurse or no one. In the weekends, for instance, there are only two nurses on duty, and if those two happen to be male, the patients do not really have a choice.

A couple of the respondents pointed out that the male/female issue does not only apply for allochtonen. Sometimes they have elderly Dutch women who prefer female nurses, and they are treated the same way.

Yea, but people who are Dutch and old-fashioned, who don’t come from the city or come from the north or eastern part of Holland - it’s quite the same. I think only 25
years ago you had this also in hospitals...this gender thing. I had a client, female in her 80s who still lives at home, and she didn’t want a male nurse at all. She was Dutch, and a bit old-fashioned, so to say. I’ve washed her once in my time here, and that was because she was very, very sick and vomited in the bed...everything was very dirty. And still she said, lying in her bed ‘I don’t want you to shower me. I said ‘Well, come on. I will take you to the shower. I will help you, I will clean your bed and give you a clean pajamas, and that’s it. There is no discussion whatsoever!’ And it was ok....but later when I came on another day, and she wasn’t sick at all, there was no chance of helping her. Just that one time only.

With allochtone male patients it appears to be a different story. The male nurses often had a positive experience of being a male nurse dealing with a male patient. Some of the female nurses, for instance, felt very uncomfortable dealing with one of their Turkish male patients, but the problem disappeared when a male nurse started going there. It is hard to say whether this was the patient creating problems for females or the female nurses feeling threatened due to perceived biases about male authority. It seemed less difficult for an male nurse than for a female nurse in physical care.

For me it's easier with allochtone men. I can be physical, a 'therapeutic touch', like for instance touching the shoulder. I wouldn't do that with allochtone women, but with allochtone men I see that they are in general more physical than Dutch. It's sort of feeling safe – they open up a little bit. I could not see my female colleagues doing the same thing. I think that the male/female roles play a bigger part in Moroccan and Turkish cultures than in the Dutch culture.

3.7. Relatives
Several of my informants mentioned that they (Moroccans and Turks) often have an extended number of relatives. I did not encounter any allochtone patient with a lot of relatives being around during my fieldwork. Three of the nurses were of the opinion that the issue about allochtonen having extended families was overemphasized. They could not really see a difference between a Dutch elderly couple and a Moroccan or
Turkish elderly couple. The elderly live by themselves and the children have their own houses, which is in accordance with what I observed.

They (the other nurses) say that ‘allochtonen..they have so many children.’ Me, myself, I come from a family of thirteen children and I've never seen any allochtoon with 13 children – they have six or seven...they have many children. Well, in the village where I was born, it was quite common, I'm from a Catholic village where families are very big. So, I think ‘What's the point? What are you talking about?’ They have so short memory. Only 25 years ago it was quite common to have many children in Holland too.

The importance of family and kinship vary, and in many societies the family delivers much of the health care, especially at home. I was told that the nurses in general do not have to wash the patients in Moroccan and Turkish homes because family-members take care of it, but the number of exemptions was increasing. People at the Mimoza center told me that home care in Turkey is only available for those who are rich. Ordinary and poor people can not afford that sort of help, and relatives are carrying out much of the care for the patient. It seems that Moroccans and Turks who receive home care in Holland often do not need it when they go to their country of origin.

Soon a patient of mine who is diabetic will be going to Turkey for three months... I don't understand - in Holland they need a nurse and then they go on holiday and they don't need anyone. That's happening a lot of times. She is not the only one. We have more people where we come once a week, and many of them go to Turkey or Morocco for 2-3 months and then they don't need us. I think their family is helping them while they're there, and then they come back and they need us again.

Several of the nurses had experiences of relatives' constant presence around the patient's bed, especially if the patient was terminally ill. Some of them acknowledged that they found it disturbing and preferred to work without all those relatives around. They felt the relatives were watching them to see if they were doing a good job, and
they thought it would have been easier to care for the patient if there had been less people around.

I went to visit an elderly Turkish lady who was dying. She had brain cancer and was diabetic. When I came to the house the whole family was there. The patient was lying on the bed and there were maybe 10-15 persons around her bed. They were physically there, but while I was working with the patient, they were all babbling with each other as if they had nothing to do with it. I found it very difficult ... I really wanted to ask them to leave the room for 15 minutes, but I didn't do it because I didn't know if I could say that to those people, how to say it. Eventually I just tried to do my best, but for me it wasn't very pleasant working – I had the feeling that there were 15 pairs of eyes staring at her. So that was difficult for me.

Other nurses did not mind as long as the family did not interrupt them while they were carrying out their procedures.

For me, it's not a problem to have the family around. I wouldn't make a difference between Turks, Moroccans, Dutch, Surinam... if the family wants to be in the room and look, that's fine. If I have to concentrate, I will tell them. 'Please ask that question in 5 minutes, but right now I have to concentrate'. And that works very well, still. I hope I'm flexible enough to adapt to the situation at home and to try to cooperate with people, I hope.

Most of the time the family of allochtone patients were more involved with the patient's care and played a more conspicuous role than Dutch relatives, largely due to language problems. Respondents described their relationship with the relatives, especially with the children, as good most of the time. They perceived the children as building bridges between the two cultures. The children listened to what the nurses said and tried to explain things to their parents as best as they could. They were very helpful with the translation.
3.8. Communication

The respondents all stated that communication is a very important aspect of the nurse-patient relationship. When the nurse and the patient do not speak the same language the chances for misunderstandings increase. According to my informants it is mostly elderly migrants who do not speak Dutch. In a study carried out among Turkish people in the Netherlands in 1993, "32% of the respondents indicated that they were fluent in Dutch; 46% indicated speaking enough Dutch to get by and 22% of the Turkish people interviewed did not speak Dutch at all or spoke it very badly" (de Mesquita 1993:65). One of my assumptions, which was confirmed by only one informant, was that Turkish and Moroccan men speak better Dutch than their wives. When I visited patients I realized that this was not the case, and the woman sometimes spoke Dutch more fluently than her husband. Two informants told me that they did not find the language to be a prominent obstacle. The others indicated that the language barrier was a major challenge and source of frustration.

The language problem is very big..it's very big! It's so frustrating not to be able to communicate properly with the patients. It takes so much time..Sometimes you have like 4-5 allochtonen in one morning and you go from one language problem to the next. It's frustrating.

Many of the informants identified a link between language barriers and the quality of care. They felt that they could not do their job properly. Five of the nurses gave examples of coming up short when trying to teach important health-related issues to, for instance, diabetic patients.

I try to explain things, like what is diabetes..If they have to take their own bloodsugar, you have to explain exactly how it is working, what you have to do if the bloodsugar is too high or too low....All these kind of things you have to explain and make sure they understand. At the moment one of my patients is a Turkish woman. She is a diabetic

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5 It is important to keep in mind that this study was conducted seven years ago and that there might have been a few changes, but it gives some indication.
and she is quite young, 54 or something like that. She doesn’t speak Dutch at all so it’s very difficult to communicate. She injects herself... she can also take her bloodsugar, but she can’t write it down. Luckily, her blood sugar is all right most of the time. I visit her once a week and I check her blood sugar at the same time. It’s very hard if you start teaching someone to inject herself....to communicate. In the beginning it was very difficult. She couldn’t inject herself and she was forgetful. In the end she could inject herself and the blood sugar was stabilized. She doesn’t take the blood sugar a lot. She knows she has to do it when she doesn’t feel good, and I hope that when she sees it she’d know if something is wrong. If the blood sugar is below 5, she has to eat something. But because of the stabilization she doesn’t do it a lot lately. We just have to wait till things go wrong....(laughs) yea. At the moment when she takes her blood sugar, I hope, but I’m not sure, she knows what to do if it’s too high or too low. I think she knows - I hope she knows - I’m not sure..... I want to do my best..I simply can’t..I can’t do my profession..

There are interpreter services, but specific appointments have to be made and the interpreter can only stay a short time. One of my informants stated that she had used professional interpreters in ‘special’ cases, indicating cases where she had to discuss intimate issues with the patient. One of the nurses who had never used translation services indicated that she should have used it more often.

I think sometimes, especially in the beginning of a nurse-patient interaction or when giving important information and health teaching, I think it would be very helpful – to make thing clear, perhaps especially for diabetic patients. It’s so essential that they understand what’s best for them...but as I said I haven’t used the services, and as far as I know my colleagues don’t use it much either.

I was told that bilingual family-members, especially children, are used as interpreters 90% of the time. Translation is frequently done via the phone. Using children or other relatives was questioned by a couple of the nurses. Their concern was that the
information would not be understood correctly or that it would cause further problems, especially if there were underlying ‘rules’ of who can discuss what with whom.

Most of the time I communicate through a daughter or a son. Sometimes the children still live with the parents, sometimes they don’t, but then we use the phone. I know that if necessary, I can also use a professional interpreter, but it’s more convenient using the children. It’s easy if the children are at home. The thing is... You have to trust that they (son or daughter) explain things well, because health teaching is also new information for the son or the daughter.

Many of the nurses encountered uncertainties in how much of their information or teaching was actually transmitted and understood by the patient. They were not sure whether this was due to a language barrier or cultural customs.

‘Heeft U het begrepen?’ and they go ‘Jal’, ‘Wat zeg ik dan?’ and they go ‘???’.
It’s not always very easy... sometimes in their culture... it’s not good to say... ‘No, I don’t understand’. They say ‘oh yes, yes.’ Especially people from Morocco often say ‘yes, yes, yes’ and then later you notice that oh it was ‘no, no, no’... Turkish people are more open to say ‘no’ if they mean ‘no’. So if I say ‘Do you understand?’ ‘ye, ye..’ and then there can be some misunderstanding in the translation. One of my patients always nods her head, so then I think she understands, but I’m not sure. Sometimes I call the daughter, but still... I’m not sure if she understands. She should know because I tell her daughter and she translates. She always nods ‘yes, yes’, but I’m not sure whether that means that she understands.

The aspect of non-verbal communication could perhaps shed some light on why the nurses think the patients say ‘yes’ when they actually mean ‘no’. I inquired the Mimoza-center about nodding and shaking the head because in some countries people nod their head as a sign meaning ‘no’. I was told that with the Turks this was not the case. They have the same meaning for nodding and shaking the head as Dutch people. With the Moroccans there were some uncertainties. I did not get a clear answer, which
means that there could be misunderstandings in some cases due to differences in the non-verbal language. I personally think that some migrants may say 'yes' simply because they do not want to admit that they have not understood.

Misunderstandings sometimes pose major difficulties. The story below illustrates a recent incident of miscommunication. I am not sure whether the story is in itself representative of nurses' every day language barrier-problems, but it provides an insight into a nurse’s experience of facing miscommunication and how she dealt with it.

It just happened last week...it was horrible, it was the first time in my 13 years experience that something like this happened to me. I had already visited a Turkish woman for some months. I come only once a week. The family asked me if I could go there, and keep going to her place every week to check how things are going because every few months she had to go to the hospital because the bloodsugar was totally wrong. She had to stay in hospital some days to stabilize it. I’ve gone there already for several weeks, and every week there was a little something...And then on Thursday I came to her house again, and she said that she had gone to the hospital and the specialist told her she can change the insulin-units. Before we were giving her 80 units in the morning and in the evening 32. She was doing the injection herself I only came by every Thursday. We taught her how to use the insulin pen. And then on the paper her son had written 48 and 24, so the difference between 80 and 48 is quite big...and I thought this can’t be correct...so I phoned the son because she couldn’t give me the correct information. The son wasn’t at home, then there is the son’s wife who also doesn’t speak Dutch. Then I rang the specialist who was not there...What happened...I phoned the hospital and got the information from which the specialist had written down the status. So I explained him that she had been using 80 units for a long time in the morning and 32 in the evening. He looked in his papers and said 'In all the papers nothing is written about the 80 and 32.' He told me 'You see what happens after one day...You can give her the 48 and 24, and we check the blood'. It was very high the next morning. I phone the son, and I ask him 'You know about the 80 – did
you tell the specialist?’ He said ‘no’ – he didn’t tell, and that was a pity of course. This was in the morning – I woke her up. I checked her bloodsugar, and it was 16.6, which is very high in the morning. So I asked her whether she had eaten or taken the injection. I asked her by using movements of the hands so I understood from her that she hadn’t taken any injection or eaten anything. I phoned the specialist and he said ‘Oh there must have been at some point...the 80 must have come from the insulin combination (80/20) – I don’t know where the 32 came from.’ Then he said ‘Ok, we’ll give her 72 in the morning and 32 in the evening, and we’ll start doing the injection.’ I prepared the injection and I gave it to her, 72, and after this she phoned her son. Then later I got a telephone call and the son told me that his mother asked why she had to take two injections now in the morning. ‘Two? Did she already take one...I asked her...’ ‘Yes, she took 48’, which means that 72 + 48 is 120.... This is what happens when the communication is not very good.... This woman illiterate... Well I know other illiterate people who can think logically, but she is the kind of illiterate who doesn’t have logical thinking at all.

I phoned the hospital... and explained the situation, and the doctors told me I had to check her every hour, but I didn’t have time at all. Other patients were waiting for me. I had to go. Then the specialist told me to find a family member who can bring her to the first aid-department, and they can keep an eye on her there. If something really goes wrong, a hospitalization will be needed. In the afternoon, the son phoned me, which was really nice, and told me that everything was ok. I have seen her after this incident, in the weekend, and the bloodsugar was quite ok again. We are doing the injection. But the communication, you see.. (sigh). it makes it very difficult. You leave a message for the son, so lack of direct communication, and of course the language makes it more complicated.

Although the nonverbal communication used by the nurse in this particular story exacerbated the misunderstanding, it was employed by most of the nurses whenever necessary. Some of them said that using hands, making signs and facial expression were the only ways of communicating with the client if there was no one to translate. Eye contact as a non-verbal communication tool was mentioned as being very
important. The nurses were however not satisfied with the shortcomings of non-verbal communication, and they could not understand why not all Moroccans and Turks living in the Netherlands did not learn Dutch.

*Ohhhh...sometimes I get really frustrated – Why do they live in Holland. They live in Holland, so why don’t they learn Dutch??!! It’s difficult. I know they don’t NEED it because there are a lot of Moroccan and Turks living in Holland, so they can talk their own language, but when they need help, they need the language! I do think that the foreigners who come to live here should learn the language or at least make an attempt to learn it! It would be better for them as well – When you’re not able to communicate, you can’t fight for your rights. Well, it’s not ONLY the language...I have to explain more to them because they don’t know how the system works, like for instance insurance or transportation to and from hospitals etc. The Dutch know the system, they know who to approach for various services. The allochtonen need more assistance. Anyway, I hope the language-problem will be solved in the near future.*

Some of the informants think that the communication problem will disappear in 20 years. The 2nd generation of Moroccans and Turks who are born in Holland speak fluent Dutch and are perceived as being more integrated into the Dutch society than the 1st generation.

### 3.9. Recipe: Cultural knowledge?

Research carried out in 1992 (van der Zwaard), shows that nurses working in the old quarters of big cities in the Netherlands wanted more information about ideas and customs, living conditions, feelings and sensibilities of migrants to improve their work. A considerable amount of literature on Turkish and Moroccan migrants has been produced addressing health care workers (Ibid:1138). The nurses I talked to who had finished their education in the 1990s had received some teaching about giving care to patients from other cultures during their studies. The others had attended seminars concerning cross-cultural care organized by their manager or Amsterdam *Thuiszorg.*
One of the nurses I interviewed gave the impression that she was not very impressed by the written literature on so-called background information about migrants:

*Most of the time they talk about clichés... 'All Turkish people eat rice'... 'Muslim women wear veil'..., In my opinion all people are different. Not all Turkish are the same and not all Dutch people are the same.*

Peter (fictitious name) finished nursing school a year ago. He thinks that the teaching about migrants he received has been relevant and useful in his daily work as a community nurse.

*At nursing school we had some teaching about cross-cultural care/nursing. Especially in a big city like Amsterdam, it's good to have your mind on these matter. Especially in this area of Amsterdam there are a lot of allochtone groups, and you have to be aware of that. If not, you're very Dutch and act very Dutch... it won't be ok. But if you're open to a person different from yourself, then everything is going to be ok, I guess - I'm not sure. The teaching I had at nursing school was like in general 'These are some cultural groups with their own specific ways of doing things, own beliefs,' but at my school the emphasis was on 'Go out and see for yourself, investigate the differences, encounter things because every person is an individual with their own individual needs'. Some things are colored by their cultural background, so it's good to know of that. The teaching was general 'This is the general picture, go out and see for yourself'. That way of teaching works for me.*

Although the informants seem to be aware of some pitfalls of generalizing, most of the stories are colored by a distinction made between 'us and them'. One of the nurses told me that sometimes she forgot whether her patient was from Turkey or Morocco because she could not really tell the difference between the two cultures. I have been told that the Turks and Moroccans in Holland don't mix. They have totally different languages, etc. The way this nurse perceived the non-difference may be compared to
foreigners looking at Dutch people and listening to the language, thinking that it is German, a mistake which I believe would be perceived as an offence by the Dutch!

Some of the nurses think that information on the cultural backgrounds of migrants is still necessary and acknowledge the need for intercultural training programs. Others think that the main challenge is to look at individuals more than at one ‘static’ culture.

*I think the main challenge, if you look at the allochtoone population, is as a nurse to see every patient as an individual...whatever his background is, to try to give good care to that patient, considering his background, not to try to act on your own norms and value system. Try to be open to anybody, I think that’s the challenge. I think that’s the point in my thoughts about allochtonen, that everybody is something special. Some people are more special than others, but I don’t like to talk about ‘me’ and ‘them’, especially in Amsterdam, because there are so many different people. Everybody is special, and as a nurse, you always have to consider people’s background, not only with allochtonen, but also with Dutch people. There are Dutch people who have been in concentration camps in Poland or Germany, or who’ve lived in Indonesia while it was still Dutch. These people have a totally different background than for example me...I think the background is always something you have to consider.*

This nurse stressed openness as an important attitude for nurses. Bonaparte and Ruiz, using measures of open- and closed-mindedness, investigated nurses’ attitudes towards migrants (Murphy & Clark 1993). They found that nurses who were closed-minded were more likely to have negative attitudes than nurses who were less dogmatic (Ibid). Bonaparte supported by Frankel et al. suggests that ‘they’ (culturally different people) could be perceived by some nurses as threatening or as anxiety provoking (Ibid:443).
4. INTERPRETATION & DISCUSSION

None of my findings surprised me. I found what I expected to find, which may be due to biases grounded in my own background as a nurse. While working, I experienced language barriers and conflicting expectations of care in relation to migrant patients. More or less unconsciously I heard the stories of my informants in terms of my own experiences. However, many of my findings are similar to those of Murphy & Clark (1993) such as problems with communication, the use of relatives as interpreters, and feelings of frustrations. Murphy and Clark (Ibid) concluded that there was a distinct lack of knowledge on cultural differences among the nurses, in contrast to my study, where I found some cultural knowledge. The nurses tried to construct meanings around incidents by referring to what they assumed to be cultural explanation frames.

Many of the nurses share common experiences, not only with their peers, but also with colleagues who have been in the 'health care business' since the 1960s. The consistency in the various accounts was remarkable. Why are health care workers still dealing with the same problems when it comes to working with Turks and Moroccans as they did 20-40 years ago? What does this mean? If the health care to migrants had been successful, why are the nurses still dealing with the same frustrations and problems as they did 40 years back? I think Van Dijk (1989) in his article on 'Culture as Excuse' has pointed out some very important issues on why health care to migrants, mostly Moroccans and Turks, to a certain degree has failed in the Netherlands. We focus too much on interpreting the 'strangeness' in their appearance and behavior in terms of the culture of origin. Little distinction is made between, for instance, the culture of an inhabitant of Ulupinar and a Turkish migrant in Amsterdam (Ibid). At the most 'the migrant becomes more Moslem than Mohammed' (Bakker in van Dijk 1989:247). My informants including myself have done an excellent job in emphasizing on differences and 'problems' and hardly ever focused on similarities. At the same time, I got the impression that several of the nurses were increasingly aware of the need for a deconstruction of a static concept of the Moroccan or the Turk culture.
4.1. Why Home Care?

I think the factors for choosing home care as a career are linked to nurses' strivings for professionalism and grow out of the value people in the Netherlands put on independence. Nurses may be viewed as a professional group with their own values, theories and concepts. There are both social and cultural aspects attached to the profession of nursing. Foster and Anderson (quoted in Helman 1998:80) define a profession as “being based on or organized around a body of specialized knowledge not easily acquired and that, in the hands of qualified practitioners, meets the needs of, or serves, clients”. I think a keyword for nurses’ values and beliefs is ‘autonomy’, which is strongly rooted in the Dutch culture. Many of my informants chose a career in home care so that they could work more independently.

4.2. Expectations of Care

Facing different expectations of care is facing a dilemma. There is an ideal of patient autonomy, but in reality people are not equally autonomous and some people are more dependent on others for help. On the one hand, nurses are expected to enhance the patient’s autonomy, but on the other hand they are also expected to express a caring attitude towards the patients without being condescending or parental. According to Pool (1995) this tension constitutes a basic problem in the nurse-patient relationship in the Netherlands.

Ethnocentrism refers to using one’s own standards, values and beliefs as measurements against which others are evaluated or judged. In the nurses’ stories I find a tendency of ethnocentric beliefs on the superiority of Western ideas and standards on self care behavior. This should be understood in the context of their professional education. A nurse’s biases and stereotypes are grounded in beliefs (Rempusheski 1989). Nurses have their own beliefs about patients, health and illness, which is strongly influenced by what they have learned to think in nursing schools. There are nursing theories and nursing processes. In putting those beliefs and plans into action, nurses continually construct strategies designed to achieve specific nursing objectives (Kasch 1986). This means that their plan for action is often motivated by the need to get patients to do
things that will enhance their own goals (nursing objectives). The strong beliefs about maximizing self-care potential among the nurses in Holland may explain why the nurses experience frustrations in their interaction with migrants who have another view of self care, and why they try to 'convert' those patients to reason their way. Caring is a process of negotiation. Nurse-patient encounters involve the nurse’s goal pursuit, but also the patient’s action. “Through negotiation the nurse and patient attempt to create the shared understanding and common meaning upon which mutual goal attainment depends” (Kim In: Kasch 1986:227). From this it follows that care is attunement and the ability of the nurse and the patient to reach an agreement on what to focus on in their interaction. I would think that a compromise might be the result of attempting to construct an agreement. However, my informants’ examples illustrate that the nurses are often motivated by a need to get the patients to do things that will advance their own goals, their own beliefs about patients’ health etc. When this conflicts with the patient’s definition of his or her situation, I question to what extent there is room for compromise.

The change of shift in nursing over the last 20 years in Europe and America may shed light on why nurses are so concerned about enhancing patients’ autonomy and withdrawing themselves from giving care as soon as possible. From being a disease and illness- oriented practice, nursing has now moved to an orientation where the emphasis is on prevention of illness and maintenance of healthy lifestyles (Alderton 1983). WHO stated in 1981 that the nurses play a key role in teaching and enabling people to care for their health by listening to and understanding the needs of the community (Sciortino 1992). The present nursing-orientation points towards a more community-oriented educational focus.

The health care system in the Netherlands is highly specialized and institutionalized. There is a specialist for almost anything. Nurses may be confronted with questions and needs of patients which seem irrelevant to the nursing domain (e.g. better housing facilities) simply because of patients’ confusion concerning who to turn to for help. Even the ‘native’ Dutch face frustrations of where to go and what or who to ask for in
the health care system. I therefore question what the possibility is for migrants of orientating themselves on Dutch health care system.

4.3. Male/female issues
Resistance against care by a male nurse occurs among some *allochtonen*, but it also occurs among Dutch. One of my male informants had never encountered any problems in relation to gender issues, which means that the perceived problem is not an everyday experience. There are perhaps some general taboos and cultural rules for Turks and Moroccans concerning male/female issues, but those seem to have more flexibility than the literature allows them. Shadid and Van Koningsveld (in van Dijk 1989) think that the resistance against treatment by a member of the opposite sex is diminishing with the duration of stay in the Netherlands. Many ‘breaches’ of the cultural rules are accepted when the relationship between nurse and patient is good (ibid). Cultural knowledge about male/female issues may raise false expectations. The nurses might for instance think that Moslem women would mind being cared for by a male nurse whereas some Moslem women in fact do not mind. Most of the nurses stressed that the clients, Dutch or migrants, should accept male nurses. I think their views on migrant women accepting male nurses is related to integration in the sense that those women who do are more integrated into the Dutch society. One of the informants referred to a Moroccan woman who did not mind a male nurse as *modern*. The nurse might have thought that the patient coming from a *tradition bound* background had done well in the adaptation of ‘the modern Western women’. This way of reasoning should be understood in the context of literature about the women of ‘eastern’ countries (Van der Zwaard 1992).

4.4. Relatives
Surveys in Great Britain show that multi-generational households are more common in migrant communities than among the white British population (Ebrahim 1987). I do not know whether this is the case in Holland. The elderly migrant couples I visited lived alone. Although many of the patients going on holiday to Morocco or Turkey receive help from relatives while they are there, their situation in Holland seem to be
different. I think the relative’s role in providing care is different. My impression is that the lives of 2nd generation migrants are very similar to their Dutch peers. For a very dependent person, his or her children’s’ ability and time to carry out care may not therefore be realistic. From this it follows that it is a misconception to believe that ‘they (the migrants) will look after their own’. Family support from the extended family also relies on reciprocity of care (Ebrahim 1987), which means that when an older person is no longer able to fulfil obligations to the family, they might rather turn to the official health system (home care, nursing homes) than their own children.

4.5. Communication

Many Turks and Moroccans differ from the Dutch in their appearance, which I think is why their behavior is frequently interpreted in terms of a strange culture. The nurses have pointed out perceived differences, but on a second thought they gave the impression that every patient has a background you need to inquire about. I did not observe any remarkable differences in the nurses’ interaction with migrant patients in comparison to Dutch patients. With some migrant patients there is the language barrier, but talking the same language does not necessarily mean that the nurse and the patient understand each other. It is important to keep in mind that communication-problems and the feeling of not getting the message through also happen with Dutch clients. There are people who have had stroke or dementia for instance. One nurse said that it was much harder to communicate with a dement Dutch client than with any Turk or Moroccan person. I believe the nurse always has to consider the special circumstances in which care is given.

The nurses’ frustrations concerning migrants who do not learn Dutch may be closely in line with ideas on adaptation and integration. There seems to be a discrepancy in the attitude towards adaptation in Dutch society between the Dutch majority and Moroccan and Turkish allochtonen. Moroccan and Turkish people living in the Netherlands are of the opinion that they do integrate in Dutch society and do their best to learn the language. They stick to their original culture, but they have a lot of contact with the Dutch as well. (Prins/Oudenhoven/Buunk 1996) The right strategy for Moroccans and
Turks in the Netherlands is integration and language learning according to the Dutch majority. Their experience however is that the Moroccan and Turks do not always speak Dutch very well and are not looking for contact with the Dutch, but stick to their original culture (Ibid). This difference in perception between the Dutch on the one hand and the Moroccans and Turks on the other hand can probably be explained in different ways. Prins (Ibid) mentions that it is possible that the Dutch are prejudiced against Moroccans and Turks. At the same time, he points out that the relatively low chance of getting into contact with Moroccans and Turks may also have caused this.

Tolerance towards immigrants often appears to have a practical base. De Mesquita (1993) has argued that Turkish people who live in the Netherlands (and some of them have Dutch nationality), should still be regarded as culturally different. He claims that cultural interaction between the Turkish and Dutch culture has been minimal in the sphere of religion and language. Although the Turkish and the Dutch live in one society, they appear to be relatively closed groups (Ibid). When interviewing Dutch nurses I encountered descriptions based on this last view. The emphasis in many of the nurses’ stories is laid on the differences and far less on the similarities.

Misunderstandings may occur due to language barrier, contrasting cultures and values or different worldviews. The consequence of misunderstandings may be that the nurse has a feeling of coming up short as far as the quality of care is concerned. The result may be that the patient does not benefit from the care. Feelings of frustration may occur for both parties, and may even have consequences for the patient’s process of healing. The patient may, for example, not comply with the nurses’ advice as a result of misunderstandings. The nurses’ frustration may be a result of how they view their own performance, for instance ‘I’m not doing my job properly and the standard of care is not as good as it should have been’.

The Dutch Health care system promotes the use of interpreter services, but in reality most nurses (90%) turn to the patient’s bilingual family-members for translation. There may be various causes for why nurses do not employ professional interpreting resources more often. Many of the respondents seem to assume that the access to
interpreters is complicated. I think it is a matter of addressing nurses’ habits and their common practice of overlooking the available interpreter facilities. They are used to employ family members as interpreters and it works. They get by in improving the communication, so why bother making an appointment with strangers who can only turn up on specified times? The interpreters may not be available when the nurses most need them, which means that the accessibility to interpreting services is an issue to address as well.

4.6. Recipe: Cultural Knowledge?
Murphy & Macleod Clark (1993) suggest that there is an urgent need to develop cultural knowledge in nursing education programs. I question whether there is such an urgent need in Amsterdam. Culture as an explanation frame may be useful, but not at all costs. It appears that reading or studying e.g. Turkish customs and beliefs could easily lead to generalizations and stereotyping. Stereotypes may be defined as a set of beliefs about the personal attributes of a group of people (Ashmore & Delboca 1981). I would not say it is synonymous with prejudice, but they are related. The advantage of stereotyping might be that it provides some order to our own chaos. It simplifies a complex, sometimes incomprehensible, reality. However, through stereotyping people might come up with preconceptions and prejudices. A relative of one of the patients mentioned an incident she had experienced a few years back. It happened when the community nurse had come to see her mother for the first time. The nurse who was Dutch started addressing her in simple, slow talking Dutch, presuming she did not know the language very well. This Moroccan woman who had lived in Holland for the most of her life, felt both anger and resentment. It was as if she was crying out silently: *Listen to me and what I have to say before reaching for any presumptions.* She said she was tired of being put in a box of a stereotypical Moroccan or Moslem.

*My individuality, my family situation, my situation as a 2nd generation migrant is not seen. People look at my skin and how I dress. Health care workers write about how I feel when I’m sick, how important my cultural background is, my religion, etc.. I don’t*
recognize myself in their descriptions. I feel like shouting – this is not me, this is not what I feel like...if that's how you perceive a Moroccan woman. I'm not her!

This woman feels that her individual characteristics and particularities get lost in the label 'the Turk.' I do not think the nurse in this specific example is to blame. Her reaction as well as other health care workers who behave in the same manner, should be understood in the context of the literature they have read or the teaching they have received about the Moroccan or Turkish population.

Is it relevant to have a knowledge of the various cultural backgrounds in order to give adequate care to migrants? ‘Cultural knowledge which is restricted to mere knowledge of village life in Morocco and Turkey is full of pitfalls for the care provider and appears to be an inferior tool’ (Van Dijk 1989:246) Sieval (In: van Dijk 1989) points out that migration knowledge and the meaning attached to the migration situation is more relevant than knowing what certain cultural ideas were in the country of origin. Failing to take the effects of the migration situations into account and only focusing on traditional customs and beliefs, may only add to a misunderstanding. Such information only hampers rather than clarifies matters (Van Dijk 1989).
5. FINAL COMMENTS AND RECOMMENDATIONS

5.1. Conclusion
This study has drawn the attention to some of the challenges and problems nurses experience in their home care practice when working with patients from a Turkish or Moroccan background in Amsterdam. The nurses’ stories and opinions are colored by their personal, professional (including cultural knowledge) and cultural background. The nurses face challenges due to language-barriers and different expectations of care, issues of gender and relatives. Although the Turkish and Moroccan migrants have been in Holland since the 1960s, the challenges in providing nursing care to this group remain the same. This implicates that health care assistance to migrants has not been very successful in the Netherlands. It is important that patients, regardless of their cultural background, should achieve a good standard of care. From this it follows that there is still a need of working towards providing a better quality of health care to migrants. I am of the opinion, in accordance with Van Dijk (1998), that taking a step forward would be to move towards a more dynamic concept of culture. ‘Culture is related to the social context in which it is shaped’ (Ibid:249). The migrants’ culture has many faces and the influence of Dutch society is one of them. People create meanings and solutions here and now. The way migrants develop themselves in Holland may not even be compatible with their culture of origin. Nurses encounter people who think and differ radically from themselves and caring involves therefore negotiation. The cultural, professional, personal, etc. attributes of the nurse are just as important to address as those of the patient. I found some traces of introspection in the nurses’ accounts, such as for example ‘We have to question ourselves also’. Reflecting upon one’s own characteristics, training, concepts and values, and how these may influence the nurse-patient relationship, may bring new dimensions and understanding into the experience of working with migrant patients.
5.2. Recommendations for the nurses

Too often we point at them; this problem occurs due to their cultural background. We forget to consider our own personal and professional background and how it may affect the interaction. I think that those who are responsible for providing training on 'cross-cultural care' should reconsider whether generalized information on cultural attributes helps the nurses to improve their quality of care for ethnic minorities. Nurses are in a sense in a position like that of an anthropologist. Both disciplines aim at "being immersed in understanding the patient’s/ the ‘other’s’ world and seeing patterns and relationships in behavior and ideas that are intelligible" (Holden & Littlewood 1991:2).

The nurse-patient interaction, in fact any social interaction, depends on the capacity to understand the viewpoint of the other in order to be effective. Anthropologists sometimes speak for the ‘other’ as nurses speak for patients. “We must all do this with care and continual reflection on the contexts in which we work and on the consequences of our efforts” (Ibid:201).

5.3. Recommendations for further research

A) I discussed the integration taking place between home help services and home nursing with the manager because I was curious about the domains of nursing and caring. The nurses and the home helpers emphasize that they are two different professions although their activities as far as daily care for the patient is concerned, is strongly interwoven (Schrijvers 1999). At the moment the reorganization does not seem to have affected the nurses, which is simply a matter of time. In the near future questions related to how the reorganization affects the nurses in relation to their increasing call for professionalisation would be relevant to address.

B) If migrants from Turkey, Morocco and former Dutch colonies report a poorer health than the Dutch majority as some research results show (Reijnveld 1997), why are the majority of clients asking for home nursing in Baarsjes (40.8% allochtonen) and Bos en Lommer (54.9% allochtonen) Dutch? Are the home care services inappropriate for Turks and Moroccans living in the Netherlands? Is the structure of home care too fragmented for this group of users? Are the services complicated to access?
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ANNEX 1

Interview guide

• Introduction:
- Tell me a little bit about yourself (I'm interested to get a general picture of the name, interviewee; age, background, how many years she/he has been working as a nurse etc)
- Why did you choose to become a nurse? / What made you decide to take up nursing?

• Stories/cases
- Can you tell me about your experience in working with allochtonen?
- Can you recall a specific story or incident?
- How do you differentiate between various groups of allochtonen? What are the differences according to you?

• Activities:
- What are your daily tasks? What is a 'normal' working day like for you?
- How would you describe your actual activities in comparison with your ideas of what a nurse ought to do?
- Which aspects do you consider to be important in a nurse-patient interaction?

• Views on migrants
- What are the differences of working with allochtonen patients in comparison to Dutch patients?
Why do you think those differences exist?

Probing-points:
- Communication; verbal/nonverbal, misunderstandings
- Using family-members as interpreters, interpreter-services
- Expectations of care
- The role of the patient's family and dealing with the family
- Frustrations, feelings of coming too short or feelings of irritation,
  Feelings of doing a good job
- How problems were solved, who came up with solutions
- Time/ lack of time
### ANNEX 2

Comparison of traditional and community health orientations to nursing practice (WHO 1989 In: Sciortino 1992:41):

<table>
<thead>
<tr>
<th>Educational focus</th>
<th>Traditional nursing</th>
<th>Community-oriented nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Curriculum characteristics</strong></td>
<td><strong>Primary focus</strong> Sick individual (patterned on the curative model)</td>
<td>Community health (patterned on socio-economic health model for self-reliance in health)</td>
</tr>
<tr>
<td><strong>Target population</strong></td>
<td>Sick and disabled seeking health care</td>
<td>Total population, especially the undeserved and high-risk groups</td>
</tr>
<tr>
<td><strong>Primary settings for learning</strong></td>
<td>Hospitals, other institutions, homes</td>
<td>Communities, homes, schools, industries, hospitals, and other institutions</td>
</tr>
<tr>
<td><strong>Nursing role</strong></td>
<td>Specialized and interdependent within the health sector</td>
<td>Generalized and interdependent within the health sector and health related sectors</td>
</tr>
<tr>
<td><strong>Nursing concerns</strong></td>
<td>Conditions requiring hospitalization</td>
<td>Prevailing health problems and needs of the community</td>
</tr>
<tr>
<td><strong>Nursing practice</strong></td>
<td>Primary care (nursing care of individuals)</td>
<td>Primary health care approach Community/family/patient participation in care Identification and follow-up of vulnerable groups Health team approach to care</td>
</tr>
<tr>
<td><strong>Problem – solving process:</strong></td>
<td>Assessment of ⇒ ⇒ Individual and family needs and resources</td>
<td>Community/group/family/individual needs and resources</td>
</tr>
<tr>
<td></td>
<td>Intervention through ⇒ ⇒ Individual and family</td>
<td>Community/group/family/individual</td>
</tr>
<tr>
<td><strong>Objectives of practice:</strong></td>
<td>Prevention ⇒ ⇒ Focus on secondary/tertiary prevention</td>
<td>Focus on primary prevention</td>
</tr>
<tr>
<td></td>
<td>Therapeutic ⇒ ⇒ Patient well enough to be discharged</td>
<td>Improved patient, family, and community health; self-care, self-reliance</td>
</tr>
<tr>
<td><strong>Health delivery system</strong></td>
<td>Institutional and individualized care of patients</td>
<td>Primary health care for all; involvement of other sectors influencing health; health team approach</td>
</tr>
<tr>
<td><strong>Evaluation of nursing practice</strong></td>
<td>Number of patients discharged from care by diagnostic category Frequency and intensity of patient contact</td>
<td>Percentage health coverage of population Service utilization rates by high risk groups Rates of change in health status of high-risk groups/community. Rates of response in 'treated' groups, i.e., immunization, therapy complete, average length of hospitalization, self-care ability, and changes in health behavior</td>
</tr>
</tbody>
</table>