The Importance of Intercultural Fluency in Developing Clinical Judgment

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***Abstract*—The concept of intercultural fluency emerged from the data analysis of a recent study that explored internationally educated nurses' (IENs) experience and understanding of clinical judgment when engaged in a simulated clinical environment. I observed that one's prior sociocultural experiences and subjectivity have significance in the context of nursing care and patient outcomes. Further, this subjectivity can facilitate the development of expertise, which is a significant factor that can support IENs' transition to nursing practice.**

In this context, intercultural fluency refers to a process that allows one to regress and progress on the continuum of novice to expert, as identified by Benner (1984). Benner's model has been modified here to acknowledge that movement along the continuum is multidirectional and dependent on the social, cultural, or sociocultural context of a situation. The modified model illustrates that one may be a novice in one setting but an expert in another. The concept of intercultural fluency explains how one's expertise can regress when one is in an unfamiliar situation or when one encounters cultural differences.

This paper provides potential approaches to apply the concept of intercultural fluency in both the education of IENs and the nursing profession.

***Keywords*—Expertise, Clinical judgment, culture, intercultural flency, Internationally educated nurses**

I. Introduction

Although there is a robust body of research regarding clinical judgment, most of it describes the thinking of expert nurses [1] [2] [3] [4] [5]. Internationally Educated Nurses (IENs), however, are considered novices, specifically when introduced to the practice and culture of nursing within the Ontario health-care environment. This is reflected in my earlier study, Exploring the Experience and Understanding of Clinical Judgment of IENs Transitioning to Nursing Practice in Ontario [6], which explored IENs' experience and understanding of clinical judgment when engaged in a simulated clinical environment.

The research employed qualitative descriptive, open-ended exploratory and interpretive methods informed by constructivism and transformative learning theories. The four participants in this study were IENs, aged 27–37, who were attending a university academic bridging program in Ontario. They participated in a) a preliminary interview to assess their educational, clinical, and professional background; b) three interactive simulated clinical activities, using high-fidelity SimMan™ manikins; and c) three stimulated recall sessions followed by three focus groups. The interactive simulated activities were videotaped and stimulated recall and focus groups were audiotaped. Tanner's Model of Clinical Judgment was used to guide this process.

The concept of intercultural fluency emerged from the data analysis of the study; I observed that one's prior sociocultural experiences and subjectivity have significance in the context of nursing care and patient outcomes. Further, this subjectivity can facilitate the development of expertise, which is a significant factor that can support IENs' transition to nursing practice. This paper provides potential approaches to apply the concept of intercultural fluency in both the education of IENs and the nursing profession.

II. What is Intercultural Fluency?

The acquisition of professional knowledge can be aligned with experiential learning philosophy and constructivist epistemology, which acknowledge that clinical judgment is a process of building on previous knowledge or learning. From this perspective, learning comprises "multiple, socially constructed truths, perspectives, and realities" [7] (p. 207). Learners bring with them different experiences, backgrounds, and perceptions that build on existing knowledge and inform clinical judgment.

In this study, intercultural fluency emerged as a significant factor influencing IENs' experience of clinical judgment. In this context, fluency is regarded as a process that allows one to regress and progress on the continuum of novice to expert. The novice-to-expert model, first identified by [8], has been modified here to acknowledge that movement along the continuum is multidirectional and dependent on the social, cultural, or sociocultural context of a situation. The development of expertise through experience and exposure to different sociocultural situations is supported by this study's findings and analysis and by the literature on professional learning and the development of competence [9] [10] [11]; there is a need to acknowledge that individuals regress or progress from novice to expert, and vice versa, in relation to their current context.

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This movement between the novice-to-expert phases illustrates the need to recognize that one may be a novice in one setting but an expert in another, whether that setting is a country, unit, or organization. The concept of fluency explains how one's expertise can regress when one is in an unfamiliar situation or when one encounters cultural differences. Intercultural fluency represents expertise as being individually constructed and culturally defined.

III. An Overview of Benner's Novice to Expert Model

Benner's Novice to Expert Model of Skill Acquisition, which presents various levels of expertise within nursing practice [8], was adapted from the Dreyfus Model of Knowledge Acquisition. Benner's model asserts that individuals move through stages to develop expertise, and defines experts as those who can automatically respond to a clinical situation. It further observes that experts utilize intuition, while novice nurses move through a step-by-step process to make a clinical decision.

The Dreyfus and Benner models both identify five levels of proficiency—novice, advanced beginner, competent, proficient, and expert—through which one must progress to develop expertise [8] [13]. Reference [8] further identifies how and why nurses' attitudes, capabilities, abilities, and perspectives change and describes each stage and its characteristics.

This [8] model categorizes practitioners in terms of how they solve problems. The main criteria for categorization are knowledge, standard of work, autonomy, coping with complexity, and perception of context. The more criteria one meets, the closer one becomes to being an expert [1] [2].

Novice: The novice practitioner is described as one who adheres to taught rules or plans, and has little situational perception and no discretionary judgment. The knowledge base of the novice is minimal and mainly based on "textbook" knowledge.

Advanced beginner: The advanced beginner treats all aspects and attributes of a situation separately, gives them equal importance, and takes action in a series of steps.

Competent: The competent practitioner has relevant knowledge of the area of practice and is able to see actions in terms of long-term goals and to perform routine procedures.

Proficient: The proficient practitioner sees situations holistically rather than in terms of individual aspects, can identify what is most important in a situation, has an in-depth understanding of the discipline and area of practice, and is confident and efficient in making decisions.

Expert: The expert practitioner no longer relies on rules and guidelines, uses analytic approaches only when problems occur, and has a deep understanding of the area of practice, as well as an ability to apply authoritative knowledge of the discipline and see both the overall "picture" and alternative approaches to a given situation.

Each stage represented in Benner's model builds on the previous one: Abstract principles are refined and expanded by experience as the learner gains clinical expertise. Reference [8] also indicates that there are two types of knowledge, *knowing that* and *knowing how*. Knowing that refers to knowledge based on theory and empirical investigation necessary for knowledge development of the discipline; knowing how refers to an extension of practical knowledge. This reflects the education research on the acquisition of professional knowledge, which emphasizes that adult learners bring prior knowledge and past learning experiences, expectations, and attitudes to the forthcoming learning event [14] [15].

Thus, the development of expertise stems from experiential learning, and the significance of being exposed to experiential teaching methods (such as the use of simulation) becomes apparent. Both Dreyfus's and Benner's models reinforce the idea that the development of expertise is tied to experience. This connection underscores the need to explore both IENs' acquisition of clinical judgment and the role that intercultural fluency plays in that acquisition.

IV. Intercultural Fluency and its Contribution to Benner's Model

Although Benner's [8] theory provides a basis for understanding how novice nurses or nursing students develop clinical-judgment skills for nursing practice, it does not suggest how nurses attain expertise in dealing with situation-specific decisions. The notion that expertise is situation specific and that not all nurses are experts in every situation is significant [16]. It is important to acknowledge that expertise not only advances but also regresses, depending on the context and that, in the case of regressions, it is also important to identify catalysts for supporting IENs' move back toward expertise (Figure 1).

My study employs High-Fidelity Patient Simulation (HFPS), which is considered to be both a valid tool and a method of teaching for skill acquisition [12] [17] [18]. This use of HFPS sheds light on how IENs reach expertise, as the experience of being engaged and providing care to a particular patient requires situation-specific decisions. My study identified guidance as a potential catalyst to facilitate the transition toward expert, as guidance in the teaching and learning environment can facilitate the development of fluency. The analysis of my findings suggests that guidance helped participants to acknowledge that, while they were experts in their culture, they regressed toward the level of novice in the context of the clinical simulation environment.

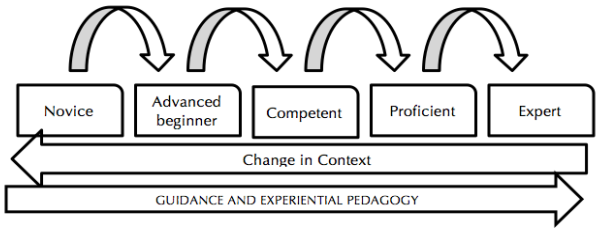

Figure 1. Developing Expertise in Nursing Practice: A Modified Version of Benner's Model. The arrows along the top reflect the single direction of Benner's original model, while the arrows below reflect a modified, multidirectional model.

With the guidance of the facilitator, participants in the study were able to interpret their experiences and recognize areas that presented challenges, which provided them an opportunity to reflect and to enhance their expertise. The need for guidance,

both within the curriculum and while transitioning on the novice-to-expert continuum, is illustrated in Figure 1. In this illustration, Benner's Novice to Expert Model of Skill Acquisition has been modified to reflect the findings of my study and indicate how regression and progression may occur, particularly when a practitioner is introduced to a different culture of care. The arrows on top reflect Benner's model. The arrows at the bottom of the model illustrate that the expert may become a novice when introduced to a different context but may also, with guidance, become an expert in the new context without having to move through all of the other phases of the model. The ability to move from expert to novice and back to expert, as illustrated in this study, is what I refer to as intercultural fluency; this notion incorporates the concepts of communication and culture and facilitates socialization to the professional nursing role and transition into practice.

The addition of the element of guidance and authentic learning situations, which are rooted in reflective practice, changes the dynamics of the original model and portrays guidance and experiential pedagogy as effective mediums in the transition to developing expertise. Guidance, from this view, provides the learner with a better understanding of knowing what and knowing how. This understanding is essential for developing professional competence, which [19] define as the "habitual and judicious use of common knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual being served" (p. 226).

The term *values* is critical, as values vary from culture to culture, and learning is culturally situated and individually constructed. One's actions and experiences are informed by one's values, which further influence professional judgment and meaning making. The effectiveness of most professionals is largely dependent on the knowledge they bring to each individual case or situation. For IENs who come from clinical backgrounds where expectations of professional learning or training may be different, a previous situation or experience may not be applicable in a new context. In this case, the nursing care provided also becomes different. Consider, for example, that in some countries nurses are not taught to use a stethoscope and may not have the knowledge to adequately assess a patient. If one lacks the basic skills of assessment, it becomes a problem not only in matters of intervention and evaluation of care but also in the application of leadership and advocacy associated with patient-care outcome.

Lack of experience to practice in this way becomes an issue for many IENs: Learning to think like this may be difficult for IENs, as adult learners have already developed a learning style. While some IENs have a self-directed learning style, others rely heavily on the educator's guidance. This emphasizes the need to understand IENs' varied experiences in applying clinical judgment, as IENs are not a homogeneous group and clinical judgment is not universal.

Although the majority of IENs may be experts in their own countries, many of them are practicing at the novice level in Ontario, thus exemplifying the perception that expertise is dependent on context. For example, obtaining informed consent for treatment and advocating for the patient are new practices for many IENs; this suggests that many IENs may lack knowledge related to culturally competent care for specific patient populations.

There is a responsibility to ensure that IENs successfully integrate into their adoptive community. Earlier studies observed that IENs from a variety of cultures received limited exposure to autonomous practice or to a culture of assertiveness before entering their adoptive countries, as these were not generally practiced in their native countries [20] [21]. As a result, these IENs were afforded fewer opportunities to make critical decisions, which suppressed their clinical judgment. It is essential, then, that we support IENs' intercultural fluency and we expose them to a different culture of nursing practice—one that provides opportunities for developing clinical judgment.

V. Observations From the Study That Underscore the Importance of Intercultural Fluency

IENs' transition to practice in Ontario can be supported through innovative pedagogical methodologies that utilize classroom guidance to enhance clinical judgment. This concept emerged during the study, in which the use of simulated clinical environment and stimulated recall were reinforced by the guidance of a facilitator. The study revealed that, although IENs were experts in their previous clinical settings, they were novices in their approach to the culture of care in the Ontario context. The participants' experiences during the study led them to an enhanced understanding of their shift back to novice in the context of this different environment.

IENs may be considered experts in their own countries; they bring a wealth of knowledge, experiences, and skills to their new practice area, which may be highly valuable in multicultural societies such as Ontario [22]. Participants' responses during simulated scenarios illustrated that they were knowledgeable and confident in performing clinical procedures, yet participants acknowledged that the approach to care expected during the simulation differed from the approach suggested by their prior clinical experience. This finding is supported by the literature [21] [23] [24] [25], which identifies the need to both accommodate and facilitate IENs' transition into the Ontario nursing workforce.

The participants' level of expertise when communicating and interacting with the patient and the interdisciplinary team identified them as novices in the Ontario context. To illustrate this point, consider this example: While one of the expectations of participants within the simulated clinical environment was to provide discharge teaching to the patient, the participants neither provided nor planned to provide it. When asked to share their rationale, one participant indicated that discharge planning and teaching begins only when there is an order by a physician. This provides valuable insight, as it emphasizes a difference in cultures of care and illustrates potential implications for practice.

Although it is the physician's role to write an order for discharge, it is the nurse's responsibility to conduct appropriate assessments at the time of care and determine if the patient is ready for discharge. Further, the nurse is to consider the patient when creating a plan of care; this acknowledges the need for individualized care, as two patients may have the same diagnosis, yet want or require a different plan of care. The

experience of IENs in the study illustrates that they were unaware of the nurse's role as teacher in this context. This lack of awareness may influence an IEN's decision-making process and have negative implications for patient safety.

According to the literature, clinical decision-making is aligned with a certain level of expertise [8] [13]. Reference [8] recognizes an expert as one who uses an analytic approach only when a problem occurs. Although the participants used an analytic approach in their care and demonstrated confidence in the way they performed during the simulated clinical experience, they presented characteristics of a novice practitioner in the context of their overall care, as illustrated by one participant's observation that discharge teaching begins only when there is an order by a physician. Moreover, all participants commented that communicating with the patient in this way was not practiced in their cultures. One participant noted, "It [the scenario] was hard practice for me because I never did patient teaching in my practice…I wasn't expected to do it. But here [Ontario] I never discharged patients and it was a good experience for me and showed me my gaps."

Reference [8] defines a novice as one who has no experience in the situation in which they are expected to perform; in this regard, IENs may be considered novices in the Ontario context. Further, the definition also refers to a novice as someone who lacks confidence to demonstrate safe practice and who requires constant verbal and physical cues. Although the participants in this study illustrated a level of confidence when providing care to the simulated patient, particularly in the way they performed nursing interventions and procedures, they lacked the ability to employ communicative and interactive skills—skills that are integral elements for entry to practice. For example, one participant noted, "Back home we don't usually talk that much to patients. We don't explain procedure itself and we just do it [provide care]…and the patient expects that as normal." Such responses reinforce the need to recognize the importance of intercultural fluency in nursing education.

Although the participants illustrated confidence in the way they provided care to the simulated patient, and while they may have been considered experts in their countries of origin, the level of expertise they demonstrated in the simulated clinical arena is not congruent with Benner's description of an expert. She describes an expert as one who uses analytic approaches; who has a deep understanding of the area of practice and an ability to both apply authoritative knowledge; and who sees the overall "picture", including alternative options and approaches [8]. Although the participants illustrated an analytic approach in their care and portrayed an understanding of the area of practice, they were not able to see either the whole picture or potential alternative approaches to the situation. For example, during one of the simulated clinical experiences, the participants identified that the patient had a stroke and determined how to assess his neurological deficits; however, they were unable to see the bigger picture and were unaware that communication with the patient could change the course of his care. The notion of understanding the need to communicate and its importance in providing effective delivery of patient care was evident in the study, as was the notion that communication is a dynamic process, determined by one's approach and ability to interact. Both these ideas suggest that importance of intercultural fluency. Further the study observes that both culture and communication can impact the delivery of care and that a difference in perception regarding delivery of care can compromise patient safety.

Through Benner's lens, IENs can be considered both experts and novices when they transition from one context to the next. Given this paradox, my study questions the definitions of expert and expertise. While Benner outlines the characteristics of each stage in becoming an expert, she does not explain how one transitions from one level to the next; the focus seems to be on becoming an expert, rather than on developing expertise. The notion of becoming an expert is very different from developing expertise and has implications both for practice and for the development of clinical judgment.

My study suggests that guidance may be the missing element in Benner's model; guidance emerged as a factor that supports IENs as they transition from novice to expert. Further, guidance from the educator facilitates understanding and developing clinical judgment and expertise. Given the lack of scholarly discussion regarding how one becomes an expert or transitions from one phase to the next, the idea of fluency, particularly intercultural fluency, emerges as an element of this transition. Intercultural fluency offers a way to interact across cultural contexts while appreciating the culture and needs of the adoptive environment. In this definition, culture refers not only to ethnicity but also to the culture of an organization or unit.

VI. Embedding the Notion of Intercultural Fluency in Nursing Education and Practice

All participants noted that their worldview changed due to their experience in this study; further, they illustrated this point as, through their participation, they gained a broader and more inclusive understanding of the influence of cultural differences and their overall impact on professional competence and clinical judgment. This understanding led participants to self-awareness and critical consciousness of the meaning of patient care and overall nursing practice.

Guidance should be provided to transitioning IENs in ways that allow them to understand the underlying concepts of nursing practice. Embedding realistic case scenarios within the curriculum is one means of providing this type of guidance, as the scenarios enhance understanding of the complexity of care, in which both cultural background and culture of care are critical factors. The role of the educator is to create and coordinate these opportunities as well as to facilitate the integration of these realities and, thus, portray the complexity of patient care.

It is important to provide an environment in which students can articulate and critically reflect on their assumptions, perspectives, and actions [26]. The study illustrated that the presence of a facilitator is essential in guiding learners to think accurately about an experience and to consider it from a realistic perspective. Further, the teacher, as facilitator, has a responsibility to warn of, or make reference to, areas that indicate risks for practice, particularly when these risks represent negative consequences of students' actions. Reference [27] advise that facilitators need to be prepared for, and alert to, negative consequences. They further note that the "most effective moment for this correction is immediately after the

error" [27] (p. 62); this underscores the value of direct and immediate feedback.

Clinical judgment, both in the context of this study and as a constituent to the transition to practice, encompasses the development not just of competence but, moreover, of capability. Feedback on performance and the challenge of unfamiliar contexts can enhance the experience and understanding of clinical judgment, as can the students' abilities to adapt to change, generate new knowledge, and continue to improve their performance. Moreover, the understanding of clinical judgment refers not merely to learning the norms of one culture, but to being able to adapt or develop fluency in the context of new circumstances.

The application of personal experiences allows the learner to make interconnections and further understand interrelationships between the individual parts. Without the ability to understand these interactions and relationships, it is difficult to apply learning in a unique context. Learning in this way fosters intercultural fluency and provides one with the ability to make subjective links and connections as a means to develop thoughts and understandings. This form of understanding occurs when students are able to identify and interpret salient information regarding a clinical situation in a way that is meaningful to them. The teacher's role is to provide an environment that generates opportunities to engage in higher-order thinking, thus facilitating knowledge production and enhancing students' intercultural fluency.

VII. The Role of the Educator Within the Context of Intercultural Fluency

The major goal of nursing educators is to develop programs and institute practices that allow nurses to develop a deep sense of professional identity and to act with ethical comportment. Intercultural fluency provides opportunities to appreciate and acknowledge values, experiences, and meaningfulness in the context of teaching and learning environments. Research in the area of nursing education indicates that nurse educators tend to overload the curriculum with content that focuses more on skills and knowledge and less on a deeper understanding of the material [28] [29]. Intercultural fluency enables learners to make meaning of the learning experience and transform their perspective, worldview, and understanding of constructs. Further, it invites integration of experiences, particularly nursing experiences, to enhance and challenge students to "think like a nurse" [5] (p. 210). Learning in this way allows students to cope with the realities that attend practice—realities that are often neither reflected nor represented in the textbook.

In this study, despite being introduced to concepts in class, participants were not able to apply and transfer the concepts to practice, particularly in their care to the simulated patient. One student observed, "Even though we take courses like communication, I was not able to apply the theories when providing care for the patient." This comment is of paramount importance to, and has implications for, the education of novice practitioners.

This finding also indicates the need for additional research to identify how experiential pedagogy can be incorporated in nonclinical courses, as the knowledge provided in these courses (e.g., nursing ethics, nursing theory, communication in nursing practice, and nursing leadership) was neither reflected in the participants' responses nor effectively transferred when providing patient care. While simulated scenarios expose learners to the realities and complexities of practice in the Ontario context, it is the application of guidance that highlights why, how, and when to apply the competencies in practice circumstances. Facilitated unfolding-case scenarios provide learners with educational experiences that reflect complexities of practice not commonly portrayed in textbooks. Approaching curriculum from this perspective recognizes the knowledge that IENs bring to nursing practice and allows for development of both professional expertise and competence through intercultural fluency.

VIII. Reflection and Stimulated Recall as Strategies in Implementing Intercultural Fluency

Another finding from the study highlights the need for reflection as a constituent to the development of expertise. A review of 29 studies on reflective practice in health-care professionals' education observed that mentors and supervisors' behaviours could either inhibit or encourage reflective thinking and that learners were able to make connections with assistance of the facilitator [30]. Reflection is vital to the process of understanding and growth, specifically in the education of professionals [11]. Yet, the research on "the effectiveness of strategies to foster reflection and reflective practice is still early in development" [30] (p. 609). According to the nursing literature, there is a need to explore how the use of reflection in the curriculum impacts the development of clinical judgment and reasoning [31].

Given the integral role reflection plays in developing clinical judgment and competence and attaining intercultural fluency, there is a curricular need for innovative pedagogical activities that incorporate reflection. Evidence from my study illustrates the utility of reflection and reflective practice through the application of stimulated recall, as it provides "an opportunity to step back and examine one's assumptions, question one's motives and objectives, and examine one's participation (or nonparticipation) in the learning experience" [32] p. 235). Participants reported that through stimulated recall, they were able to view themselves from a different perspective and to acknowledge what they had "missed", what they needed to learn, and, potentially, how they needed to learn. The findings clearly indicate that this self-observation facilitated the participants' understanding of clinical judgment and supported their development of intercultural fluency.

IX. Conclusion

According to recent studies, more than a third of novice nurses believe they are poorly prepared to improve the quality of patient care or to provide quality assurance [33]. The problem we face in nursing is that early nursing education often focuses on the tasks involved in providing patient care and does not provide exposure to a systems approach to care [29]. An

understanding of novice health practitioners', particularly IENs', experience and understanding of clinical judgment is critical in order to reinforce curriculum and pedagogical development, as the knowledge and skills embedded in judgment are key foci in nursing education.

This study illuminated the distinction between developing expertise and becoming an expert and underscored the complexities inherent in the notion of being an expert. Being so categorized may have the effect of impeding both individuals' subjectivity and their evolving professional learning, as it suggests a static goal, which, once attained, requires no further personal development or effort to maintain. But, while the term *expert* may limit or stop nurses' further development, both as individuals and professionals, the phrase *developing expertise* suggests a dynamic and ongoing process of attaining and augmenting professional competence. Intercultural fluency promotes this form of professional development.

Various forms of transition attend nursing practice including transition from a) student nurse to registered nurse, b) one nursing specialty to another, and c) practicing in one geographical area to practicing in another. Thus, *transition to practice* refers not just to the application of knowledge or skill but, potentially, to a transition from one practice style to another and to an appreciation of cross-cultural experiences. In this study, intercultural fluency was found to support such transitions.

Additionally, [31] indicates "additional research is needed to provide evidence that demonstrates the relationship between reflective learning and improved patient-care outcomes when guided reflection is integrated into a simulated or clinical learning experience" (p. 98). My research demonstrates that, from both an educational and practical perspective, engaging in stimulated recall as a form of reflection allows for the development of both clinical judgment and intercultural fluency.

Although my research illustrates how guidance from the educator may impact clinical judgment and development of expertise, it would be beneficial to conduct similar research on a larger scope, throughout the curriculum, or with a larger number of participants across and within different levels of nursing programs (e.g., collaborative and second-degree entry).

Moreover, organizations need to understand the importance of intercultural influences, as the integration of intercultural experience and intercultural understandings are essential constituents to "intercultural competency" [34] (p. 173). Having said that, organizations need to acknowledge and provide appropriate orientation to practice areas; they must also reflect the values and principles and demonstrate behaviours, attitudes, policies, and structures that enable IENs to work effectively and cross-culturally. Further study of intercultural fluency and its implications on nursing practice are needed. This indicates the need to acknowledge an array of experiences, skills, and perspectives that not only enhance the teaching learning arena but also are imperative to clinical nursing practice environment.

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AUTHORS'PROFILE

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