

Culture and organizational climate: Nurses' insights into their relationship with physicians

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Culture, Organisational Climate and Ontology: An International Study of Nurses*

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Abstract

Within any organisation (e.g., a hospital or clinic) the perception of the way things operate may vary dramatically as a function of one's location in the organisational hierarchy as well as one's professional discipline. Inter-organisational variability depends on organisational coherence, safety, and stability. In this four-nation qualitative study of 41 nurses (Canada, Ireland, Australia, and Korea), we explored their perception of how ethical decisions are made, the nurses' role in the organisation, and the extent to which their voices were heard. These nurses suggested that their voices were silenced (often voluntarily) or were not expressed in terms of ethical decision-making. Finally, nurses perceived that their approach to ethical decision-making differed from physicians.

Introduction

Culture operates in health-care at all levels through individual values, beliefs and meanings, group norms, practices, and organizational patterns.¹ The cultural, ethnic, and religious backgrounds of both the providers (nurses) and the recipients (patients) of primary health-care services have a significant impact on the determinants of health and on health-care decision-making.²⁻⁵ For example, nurse-patient interactions and the effective delivery of comprehensive, yet patient-specific primary health-care are profoundly influenced both by the socio-cultural and religious background of the nurse and the diverse determinants of health in the patient and his/her background (e.g., income, social status, cultural, and religious factors).⁶⁻⁸

As a starting point for this research, we argue that culture influences decision-making behaviour. Such a basic assumption may be at odds with traditional biomedical views of medicine as culture-free and, as Stephenson⁹ argues, “if it does play a role, culture is simply viewed as a contaminating variable to be excluded from analysis or included in a controlled manner” (p. 69). In contrast to this biomedical view, Orr¹⁰ suggests “cultural beliefs can influence a person’s understanding of life, health, illness, death and life after death” (p. 13). Cultural beliefs will also affect the manner in which ethical dilemmas are perceived and subsequent decisions are made.¹¹⁻¹² Further, although we can conceptualize societal and cultural influences from a macro perspective (i.e., as it pertains to a nation’s culture), we can also consider the micro view based upon professional and institutional factors such as organisational ontology and climate.

Varying ontologies (i.e., which refer to the how individuals perceive each other and the meaning of their actions) and ethical perspectives are not only a function of the

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individual's personal orientation and belief system, but also a function of the values and behaviours expected, socialised, and generally exhibited by the respective professional bodies and/or occupations or disciplines. One of the most powerful forms of organisational socialisation is linked to the educational system sanctioned by the profession (e.g., Canadian Nursing Association). The educational goal of any profession is to instil in the member implicit assumptions, values, behaviours, and knowledge necessary to be a certified member. While the content and thrust of the educational programs (and therefore the cultures) of physicians and nurses are fundamentally and necessarily different, there is an unavoidable point of convergence with regard to the context of health care practice.; there is a need for mutual inter-professional understanding in order for the patient/client to receive adequate and consistent care. For example, Van Maanen and Barley¹³ state "becoming a member of an occupation [e.g., a health-care professional] always entails learning a set of codes that can be used to construct meaningful interpretations of persons, events, and objects commonly encountered in the occupational world" (p. 300).

Organisational climate refers to the nature of the perceptions of values, beliefs, and behaviours of its members. More specifically, *ethical* climate refers to the collective perception of what is ethically acceptable within the context of an organisation. Research in the last two decades has demonstrated that ethical climate is not only an identifiable and measurable organisational phenomenon, but also a central variable in the promotion and socialisation of ethical and unethical conduct.¹⁴ Ethical climate represents the informal, yet collective perception of individual ontology and acceptable/unacceptable behaviour.¹⁵⁻¹⁷

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Health-care facilities (hospitals, healthcare homes, etc.), like other organisations, have climates and sub-climates operating in concert or in conflict with one another.¹⁸⁻²⁰ For example, Hadjistavropoulos et al.²¹ found that nurses' approach to ethics is more likely to reflect a caring (vs. a deontological) ethical orientation and they tend to take a less authoritarian approach to ethical decision making than do physicians. Further, recent research by Elder et al.²² indicates that ethical attitudes between Australian medical students and nurses differ significantly. They found that nurses tend to identify with the patients in their care; whereas medical students identify with their profession and the "establishment". Similar findings were reported in a Danish study²³ and a Canadian study.²⁴

Climates in conflict lead to misunderstanding, under-appreciation of work-related roles and responsibilities, and inconsistent decision-making.²⁵ Aarons²⁶ and Sawatzky²⁷ describe constructive versus destructive organisational cultures as follows:

Constructive cultures are characterized by organizational norms of achievement and motivation, individualism and self-actualization, and being humanistic and supportive. Constructive cultures encourage interactions with people and approaches to tasks that will enable staff to meet their higher-order satisfaction needs. In contrast, defensive [destructive] cultures are characterized by seeking approval and consensus, being conventional and conforming, and being dependent and subservient. Defensive cultures encourage or implicitly require interaction with people in ways that will not threaten personal security (p. 62). Seago²⁸, writes that "[a] number of environmental issues have been identified by nurses in hospitals that are correlated with stress in their work including workload and poor

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staffing, dealing with death and dying, conflict with physicians, and strain of shift work” (p40). Aiken, Clarke, and Sloane²⁹ describe an ideal organisational climate in which “nurses had more autonomy, more control over conditions of practice at the bedside, and better relationships with physicians” (p. 6). Further Gifford³⁰ states that

[t]he success of magnet hospitals¹ has been linked empirically to nurse autonomy, nurse control over the patient care environment, and close relationships between nurses and physicians enhancing the exchange of vital information. (p. 14).

Therefore, revealing and understanding the nature of healthcare organisational climates, their congruencies and their dissonance, is the first step in developing more cooperative, respectful, and meaningful workplaces which translate into reduced turnover, absenteeism, stress, and injury.³¹⁻³² The purpose of this paper was to explore, in a qualitative fashion, nurses’ perception of decision-making and their role in the nurse-physician dyad.

Ontology and Climate

Critical to our understanding of the collective perception of the working environment is an awareness of how individuals perceive each other and the meaning of their actions. This understanding is formally known as ontology, which also refers to the study of the essence of human beings. For example, if a patient is ontologically perceived as simply the ‘host of pathology’, then the mode of care will likely not involve a concern for the whole person¹⁷. If, on the other hand patients are perceived to be ends-in-themselves (as Buber [1970] suggest should be the case, i.e., I-Thou vs. I-It²), then the

¹ a hospital that has met specific standards according to the American Nurses Credentialing Center (ANCC)

² Buber (1970) suggests that there are two fundamental relationships – the I-thou and the I-It. The former sees the other as a being inherently possessing dignity and demanding respect. The latter views the other as a means to an end – a thing to be manipulated and exploited.

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mode of care would differ in terms of respect for the dignity of the other (i.e., the ethics of personhood).

More subtly, the perception of other professions, their jurisdiction and status in the hierarchy can profoundly influence our conduct towards them. When these perceptions are in conflict or misunderstood, such as when one undervalues the other – either as an individual or as a professional – then individual relationships and work satisfaction can become severely inflamed. When perceptions are shared among a group of professionals towards another group of professionals (e.g., “that’s just the way social workers think”), these perceptions formulate a collective ontology that may or may not result in an organisational milieu that is satisfying or meaningful.

Macro-Culture

Culture operates in health-care at all levels through individual values, beliefs and meanings, group norms and practices and organizational patterns.¹ The cultural, ethnic and religious backgrounds of both the providers (nurses) and recipients (patients) of primary health-care have a significant impact on the determinants of health and on health-care decision-making.¹⁻⁵

For our study we used, as a broad point of departure, Hofstede’s³³ typology in which culture is defined as “a collective programming of the mind which distinguishes one group from another” (p. 25). He identified five dimensions of culture, one of which, the Power Dimension Index, is perhaps the most salient to the nurse-physician relationship. He defines power as “the extent to which the less powerful members of organisations and institutions (like the family) accept and expect that power is distributed unequally” (p. 11).³⁴ Accordingly, countries with high power distance index (PDI)

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reflect emotional distance and conflict avoidance between members at different levels in the organisational hierarchy. In contrast, countries with low PDI exhibit more interdependent relationships with smaller emotional distance and readiness to approach and question authority. While the authors realise the potential for oversimplifying (or essentialising) the complexity of cultures by employing, a priori, a cross-cultural model, we contend that basing our hypotheses on Hofstede's³⁵ typology may be a starting point from which a qualitative cross-cultural study may embark. Other studies in health care contexts have used Hofstede's model in similar fashion.³⁶⁻³⁹ The purpose of this study was to explore the perceptions of a sample nurses in a four countries regarding their role in patient care and to determine whether cultural factors were pertinent in the relative strength of their ethical behaviour.

Methods

Participants and Procedure

This study is part of a larger international study of ethical decision-making and nursing. Focus groups were conducted with nurses in Canada, Ireland, Korea, and Australia from 2005-2007. This methodology is employed to allow for depth and insight into an issue that is most appropriately qualitative in nature.⁴⁰⁻⁴¹

The "nomination" strategy was employed as our method of recruiting participants.⁴²⁻⁴³ This approach is frequently used to identify expert informants for research purposes.⁴¹ Research partners within each country contacted experienced nurses from a variety of specialties to form two focus groups in Canada and Korea, three in Ireland and one in Australia. The average number of participants per country was 10.3 (i.e., 11 from Canada, 14 from Ireland, six from Australia, and 10 from Korea); years of

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experience ranged from 6.5-37 years (with a mean of 22 years). In addition, 63% of participants identified themselves as being specialists in geriatric care whereas the remaining 37% identified a variety of specialities including intensive care, oncology, bone marrow transplants, coronary care, psychiatric nursing (see Table 1). Table 2 identifies how each of these countries scored in terms of Hofstede's (1997) Power Distance Index (PDI).

Focus groups in Canada, Australia, and Ireland were led by the principal author; focus groups in Korea were led by Dr. Park from Seoul National University. All sessions were audio-taped and transcribed verbatim. The Korean focus groups were taped, transcribed, and translated into English. A moderator's guide consisting of 21 questions was used for all interviews; however the focus of this paper was limited to the questions and discussion pertaining to ethical practice and factors that contribute or hinder ethical decision-making.

--INSERT TABLES 1 & 2 ABOUT HERE--

Analytic Techniques

To categorize the nurses' responses into themes, the data was then analyzed by employing thematic content analysis.⁴⁴ This technique involves the systematic examination of data allowing for the recognition of potential themes and common elements within the interview transcripts. Thematic content analysis is more flexible than content analysis, which relies on repetition of words in the transcript.⁴⁵ The former allows the coder to code text that is conceptually and contextually related to categories, but repetition of specific words is not necessary.⁴⁶ Thematic content analysis allows for a

degree of objectivity reflective in agreement/trustworthiness calculations between two coders.⁴⁷

A qualitative software package, NVivo,⁴⁸ was utilized to assist in the identification of themes. Using NVivo, statements relating to physician-nurse interaction were extracted from each of the eight transcribed focus group interviews (n=79 statements). From this set of statements, the first author identified four dominant themes that emerged from the data. One of the researchers and one trained coder were then given a sample of 26 statements (33% of the extracted data, n=79 statements in total) and were asked to place them into the themes provided (or into additional themes that seemed more appropriate to the data) to determine if these categories withstood an independent assessment. The results of the three classifications were then compared (with 86.5% agreement) and discrepancies were discussed until consensus was met. The outcome was the consensual agreement to four themes to be discussed in the following section.

Results

The focus groups conducted with our nurse participants demonstrated that they perceived a marked difference in the organisational/professional climate with respect to themselves, physicians, and patient families. This gap was most often characterised by a sense of lack of empowerment due to the hierarchical nature of the nursing and medical cultures. As well, this gap appeared to be a function of the perceived differing views of the patient's ontology (e.g., science vs. care). From our analysis, four themes emerged from the data:

- Decision Process: Constrained Obligation;
- Decision Strategy: Care vs. Treatment;

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- Silent Voice; and
- Professional Respect.

Decision Process: Constrained Obligation. The first theme focuses on the perceived difference between nurses and physicians about how decisions are made regarding patient care. Nurses in this study reported frustration with the lack of power they had in contrast with the overwhelming power of physicians. This was an issue not only concerning the content of decisions but also the process of making decisions in which nurses felt constrained by established guidelines and the hierarchical nature of the nurse-physician dyad. The following quotations illustrate this theme:

The medical profession and the nursing profession. Nurses are trained to work under guidelines, or under standards of care. Have you ever tried to tell a physician there is the standard of care? They just, they almost they're like a salamander with salt on their tail, they shrivel up. Because they don't like a standard, because that says they have to do something that way. And they will never, ever, if they have their say change a standard of care. It's a guideline, it's a recommendation, but I'll decide what I'll do. (Canada)

...every doctor gets to make their own personal decision because they're independent practitioners work, I have to follow the policy of the agency but doctors don't. They are anointed above us. (Canada)

Value statement set by hospital doesn't seem to be effective because it's too general and too common sense like practice of love...So, pattern of physician's decision making process influence the most. Obviously, it changes as physician changes...(Korea)

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Decision Strategy: Care vs. Treatment. In each of the focus groups, nurses commented on the difference in patient-care strategies that were apparent between themselves and physicians. The nurses stated that their orientation was geared not toward treating the specific pathology but to caring for the patient from a medical and non-medical perspective. Nurses made many references to the physicians' science-based fight to overcome patient's natural decline and death whereas nurses were quick to understand medical futility and focus on quality of living and dying.

So there is no death anymore. That is how in my mind, to put it very bluntly, the medical profession sees it, and someone like myself who believes in end of life discussions with anyone at any time. I have many times been called onto the carpet by the physician saying 'you will never do that again to any one of my patients, I decide when it's time to talk about their end of life issues... there should be no hierarchy as to who can talk. It should be done in the pulpit, it should be done in the community, it should be done in the superstore, not in the emergency room. (Canada)

Well the physicians are angry because they're not into the prevention model they're into the treatment model. And then there are these people that are writing the books that aren't the health care people they're the, they're almost the accountants. That are into this, if we just keep preventing we won't have a problem. It's just the whole system is at battle with one another. (Canada)

Well...it sometimes affects our relationship with physician because from the physician's sake, they want to give patient treatment. (Korea)

Physician would never stop (treatment). {Laugh}. (Korea)

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...we still want to fix the machine, you know, and it you go to a place where either an ER or doctor emits you to ICU, even if you're 90 they try to fix the machine. I think that's so dishonouring to people because who are you really doing it for?
(Canada)

Silent Voice. This was a theme that these nurses returned to often. Despite their belief that they were aware of patients needs and wishes and capable of acting and/or recommending treatment, their voices were often silenced, albeit sometimes voluntarily. This theme varied somewhat based upon culture as Japanese and Korean nurses, while recognising their lesser voice, were less dismayed than were their Canadian and Irish counterparts.

Why are we still working in a system where everything has to be approved by the physicians when we're multidisciplinary. Why don't we have interdisciplinary committees that make decisions on what we're going to do in the system.
(Canada)

And I as a health care professional will at least speak up. And so you turn around and you look at people that are dealing with a system that they don't understand. And a lot of people are still in awe of physicians and will not question physicians. And they'll just do. (Canada)

...because of the medical model, they've been the only person. They've been the end decision maker for too long, and nobody will touch them. (Canada)

I think because Korean culture is still heavily influenced by Confucianism, patient's opinion counts the most. But, if the patient is older adult in the family, then usually family makes a decision on treatment because of financial insecurity

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of older adults. Nurse normally takes physician's recommendation...(not making decision). (Korea)

Some of the family, it depends really on the individual patient, some of the families would agree with everything the doctor would say. You know, they're the doctor (Ireland)

Sometimes I think the nurses are under heard if you go and you're telling the doctor, this patient is in pain, this patient is in pain ah yeah, we'll change this the patient is still in pain, sometimes they don't actually listen to what you're saying. It depends on how you say it, or who you're actually saying it to (Ireland)

Professional Respect. The final theme which emerged from this data set resonated with the notion of lack of respect for the discipline of nursing. Nurses expressed the view that patients and families looked to physicians for the 'truth' and that the nurses' opinions were not valued. There was also a sense of physician disregard for advice/recommendations given by a nurse. As a consequence, nurses had to become adept at 'politically' manoeuvring information in order to present it in a palatable manner for the physician.

I think in Ireland as well, people still tend to look to the doctors to speak to. When I first came here I thought people didn't understand the way I spoke or something. Nobody wanted to speak to nurses. (Ireland)

Finding patients sometimes doesn't question the doctor at all. If the doctor says they need surgery they go for surgery without question. They don't explore other options or nothing ... But they don't explore what's going to happen after the

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surgery or what's going to happen if they don't go for surgery not always told, so I think it probably is the authority, you know they maybe don't feel comfortable to question that. (Ireland)

Sometimes I think the nurses are under heard if you go and you're telling the doctor, this patient is in pain, this patient is in pain ah yeah, we'll change this the patient is still in pain, sometimes they don't actually listen to what you're saying. It depends on how you say it, or who you're actually saying it to (Ireland)

One of the major factors that influence is kind of pattern of physician's decision making process that has been set for the same issue over the period of time...As we face similar and same issues, there tends to shape kind of pattern to react or resolve the issues. That's very efficient because it's like protocol. But, sometimes it also causes us to fall in mannerism and we don't really look at individual patients, but just cases. (Korea).

They're intimidated and the nurse is intimidated by the physician so she's not going to call them. I mean, she doesn't want to call him because he's going to yell. So it just trickles down. (Canada).

Discussion

Organisational climate refers to perceptions; it is often described as a psychological construct that is understood to be “the way things are” and/or “the way things ought to be” (i.e., ontologies) and may differ from one subgroup's perspective to another's. In this multination, qualitative study it seemed evident that the nurses perceived a lack of congruence between themselves, physicians, and often the patients and their families. Underlying much of the concern was empowerment. This is

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interesting given that it is a time when major changes are happening in the development of the role of the nurse within healthcare internationally.⁴⁹⁻⁵¹ All four countries involved in this study now have graduate nurses and a greater number of advanced career pathways. However, this sample of nurses understood that they had little power, despite their training and experience, and that physicians had all the power, even in cases where experience was lacking. This situation was evident in each of the focus groups from the four participating nations and was attributable to the formal and informal hierarchy of medical/nursing care.

Despite the a priori assumption based on Hofstede's data (see Table 2), the power distance between physicians and nurses appears to be rather high across each of the four disparate countries, as indicated by consistency in responses across the eight focus group sessions. For example, one would have assumed that obvious differences would have appeared between Korea and Ireland (ranked 27th and 49th, respectively of 53 countries); however, this was not the case amongst this sample of nurses. The lack of cross-cultural differences in the nurses' attitudes about their decision-making role within the health-care hierarchy demonstrates the cross-cultural pervasiveness of this hierarchy, which seems to override religious and other societal differences among the countries involved in our study. In other words, the health-care hierarchy seems to trump the socio-cultural tradition.

Our findings regarding this health-care hierarchy are consistent with two large scale surveys carried out in the United States of American in which nurse-physician relationships remained similar over a seventeen year period.⁵² In particular, the staff nurses working in hospitals (and in non specialised units such as ICU for example),

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reported dissatisfaction with their relationships with physicians and some believed that this was because physicians were seen as most powerful within the hierarchy; they furthermore believed that hierarchical institutional attitudes would be unlikely to change over time.

The nurses in our study were working in a variety contexts and represented the continuum of educational credentials (e.g., from diplomas to PhD). While some of these nurses indicated that they voiced their concern if they questioned a physician's decision, others preferred to remain silent in deference or in frustration. There is evidence that nurses experience moral distress with such frustration when they perceive that they have failed in their advocacy role or when they perceive that the physician does not respect the patient/family wishes.⁵³ Furthermore, a lack of opportunities to communicate inter-collaboratively about ethical issues can complicate the resolution of ethical dilemmas for nurses and physicians.⁵⁴

Lacking a vocabulary in ethical decision making may also contribute to the silenced voice of the nurse. The teaching of ethics in nursing and medical courses has received increased attention in the literature⁵⁵⁻⁵⁹ in response to the increasing number of ethical dilemmas faced by health-care professionals and the recognition that such professionals need to be prepared for the 'real' world of clinical practice. In the literature review by Georges and Grypdonck,⁶⁰ nurses with limited skills in ethical decision making were the ones who felt powerless.

Han and Ahn⁵⁷ argued that Korean nurses were not prepared to manage ethical decision making in practice. In a literature review undertaken by Schluter et al.,⁵³ they clearly conclude that nurses must be given 'the tools' to manage moral distress in the

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workplace. This could be achieved by way of education of students in ethical theory and its application to practice during their nurse education process.

At the root of this issue may be the basic perception of what it is to be a nurse or a physician. While it may be too simplistic to suggest the nurses care and are relationship-oriented and physicians treat/cure and are steeped in science, this may well be the crux of the problem.²⁴ Georges and Grypdonck⁶⁰ report on studies that describe the moral approaches of nurses as having a more care vs. cure orientation and highlight that nurses make decisions considering the totality of the situation rather than the medical specificities of the illness. They also report on studies which highlight that physicians take a more authoritative lead over nurses in ethical decision making. However, these roles may need to be reconsidered in the future as the boundaries between healthcare professionals are changing with more nurses taking on the roles traditionally carried out by physicians.⁴⁹

Conclusion

While there is profound overlap in the nursing and medical cultures in terms of the care for the patient, there appears to be a silence of the ethical voice of nurses and this silence appeared to run through each of the four nations we investigated. While physicians and nurses in each country were well aware of their particular realms of expertise and jurisdiction, the respective approaches to ethics and ontological perceptions are less well understood and articulated. This uncertainty can be lessened and awareness heightened through the interaction of physicians *and* nurses aimed to explore, discuss, and commit to ethical principles and decision-making processes that they share. Certainly inter-professional collaboration in ethics committees⁶¹⁻⁶⁴ to discuss case studies and to

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advise on policy developments would be one possible way to achieve this. It would be important to take into consideration the need to evaluate the effectiveness of such committees. The inter-professional sharing of principles and processes would furthermore enable/support an ethical climate where all members of the multidisciplinary team feel valued and empowered when confronted with moral distress.

This study did not reveal obvious cultural differences between nations regarding the nurse-physician relationship and ontology. It may well be, as Trevino⁶⁵ and Derry⁶⁶ identify, that organisational ethical behaviour is context driven. Trevino⁶⁵ writes

...as adults, we play highly differentiated roles. We assume that each context in which we are embedded has different behavioural expectations. We have to juggle values and behaviour depending on context....People need a way to cognitively organize their experience that limits cognitive dissonance, contradiction, and chaos. Context-specificity allows an individual to accept a behaviour as appropriate in one domain of experience and inappropriate in another without felt contradiction (p. 199)

Thus, when in the role of 'nurse' or 'physician', one generally behaves within the expected parameters. However, when one steps out of this predetermined role, socio-cultural variables may have more impact on ethical perceptions and conduct and the individual's ethical voice may gain or lose volume.

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Table 1. Demographic data

| Country of Practice | Nursing area of specialty | Educational background | Years of experience (average) | Gender |
|---------------------|---|--|-------------------------------|------------|
| Canada | Long-term care, Home care, Acute care, Emergency Care. | 2 Master's 2 Bachelor's 10 diplomas | 27.5 years | One male |
| Ireland | Long term care, Gerontology | 2 Master's, 2 Post graduate Diplomas, 9 Diplomas | 17 years | All female |
| Korea | Elderly care, social work, Psychiatric care, Dementia, Oncology | 2 PhD, 4 Master's, 3 Bachelors | 20.4 years | All female |
| Australia | Intensive care, Coronary care, Neuroscience | 3 Bachelor's 3 Diplomas | 22.9 years | All female |

Table 2. Power Distance Score Rank (Hofstede (1997, p. 26)

| Country | Score Rank |
|-------------|------------|
| Australia | 41 |
| Canada | 39 |
| Ireland | 49 |
| South Korea | 27/28 |