

**Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate
Nursing Education: An Intersectional Constructivist Grounded Theory Study**

By

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Abstract

Background: Challenges in intercultural communication (ICC) in healthcare affect culturally diverse patients, caregivers, undergraduate nursing students, and educators, often leading to adverse outcomes. Despite increasing awareness of cultural sensitivity, undergraduate nursing students and educators struggle with ICC. It was urgent to explore whether integrating empathy in ICC could address these challenges, but there was no universally accepted definition or model for empathy-based ICC (EICC) in nursing education.

Study Purpose: In this thesis, I developed a theoretical understanding of EICC for use in nursing education, drawn from the perspectives of academic/clinical nurse educators and final-year undergraduate nursing students.

Research Methodology and Methods: This study used critical constructivist grounded theory (CCGT), intersectionality theory, and a research partnership approach. Thirty participants from three Manitoba nursing schools were recruited through purposive and snowball sampling—fifteen final-year undergraduate nursing students and fifteen nurse educators whose experiences and teaching focused on communicating with multicultural populations. Data included a demographic survey, thirty semi-structured interviews, and two focus groups. All recordings were transcribed, organized in NVivo, and analyzed using intersectionality theory and Levitt's CCGT coding. Study rigor was maintained through multiple data sources, memos, and synthesized member checks.

Findings: Participants' demographics revealed intersectional influences on ICC, including gender, religious diversity, age, language, and multicultural experience. The *Relational Equitable Empathy-based ICC (REEICC) Model* was developed through theoretical analysis. The findings comprise four clusters: reflections on the intersectional maze of ICC—equality

versus equity; racism, discrimination, and marginalization in EICC interactions; navigating humanity in EICC; and partnering toward a diversified, relation-based curriculum. Participants highlighted the importance of collaboration in providing nursing students with comprehensive EICC theory and practical experience, better equipping them to care for increasingly diverse patients.

Conclusion: The research analysis yielded a new framework for understanding the psychological effects of racism and discrimination, revised the existing ICC definition, introduced a new EICC definition, outlined 16 EICC tenets, and recommended relational empathy for effective EICC. It proposed an intersectionality-based model to help nurses improve health outcomes and ensure equitable care. The research enhanced knowledge of EICC processes, nursing pedagogy, patient-centered care, and safety, impacting education, practice, policies, and research.

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Dedication

To my late father, mom, husband, and kids.

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Glossary of Key Terms and Abbreviations

AACN	American Association of Colleges of Nursing
BIPOC	Black, Indigenous, and People of Colour
CNA	Canadian Nurses Association
CEF	Clinical Education Facilitator
CRNM	College of Registered Nurses of Manitoba
CGT	Constructivist Grounded Theory
CARE	Consultation and Relational Empathy
CCGT	Critical Constructivist Grounded Theory
DOH	Determinant of Health
DAFR	Disruption of All Forms of Racism
EICC	Empathy-based Intercultural Communication
ELC	Entry Level Competencies
EDI	Equity, Diversity, and Inclusion
FNHA	First Nations Health Authority
FG	Focus Group
GT	Grounded Theory
IST	Information Services Technology
ICC	Intercultural communication
NE	Nurse Educator
NS	Nursing Student
POC	People of Colour
PTSD	Post-Traumatic Stress Disorder
PI	Principal Investigator
REEICC	Relational Equitable Empathy-based Intercultural Communication
SDOH	Social Determinants of Health
TRC	Truth and Reconciliation Commission
WHO	World Health Organization

Chapter 1: Introduction

Recent reports on challenging intercultural communication (ICC) encounters in healthcare are increasingly concerning (Brunton & Cook, 2018; Côté, 2013; Hagqvist et al., 2020; Herring et al., 2013; Pocock et al., 2020; Quine et al., 2012; Ramos-Roure et al., 2021), particularly among minority patients and caregivers, as they contribute to systemic racism, health inequities, and adverse health outcomes (Cogburn, 2019; de Moissac & Bowen, 2019; Dutta, 2016; Herring et al., 2013; Lett, 2013; Oluo, 2019). Migration and cultural diversity within Canada continue to increase; it is projected that around 48 million culturally diverse individuals will live in Canada by 2036 (Statistics Canada – The Daily, 2017). Ensuring high-quality healthcare requires engaging in high-quality ICC (Chatman & Wynn, 2021; Mosed et al., 2021; Tuohy, 2019) to provide culturally competent care to a multicultural population (O’Brien et al., 2021; Statistics Canada – The Daily, 2017).

Despite greater awareness of the importance of cultural sensitivity in healthcare, undergraduate student nurses encounter ICC challenges due to personal, relational, contextual, and structural factors (Anand & Lahiri, 2009; Armah et al., 2020; Boyer, 2017; Côté, 2013; Deardorff & Arasaratnam-Smith, 2017; Henderson et al., 2016; McKeary & Newbold, 2010; Paternotte et al., 2017; Quine et al., 2012). For example, Mikkonen et al. (2016) found that culturally and linguistically diverse students do not always have supportive clinical placements. Armah et al. (2020) also emphasized fourth-year undergraduate nursing students’ perceptions of the limited inclusion of ICC content in nursing curricula. Difficult ICC interactions can have negative effects—impacting the therapeutic relationship between healthcare providers and patients and causing misdiagnoses, which can lead to delayed health services, longer hospital stays, medical errors, and early death (Henderson et al., 2016; McKeary & Newbold, 2010;

Ramos-Roure et al., 2021). To address these ICC issues, educators are revising curricula and pedagogy (Almutairi et al., 2025a; Henderson et al., 2016; Ndiwane et al., 2014; Papadopoulos et al., 2016; San, 2015; Seckman & Diesel, 2013), and nursing regulatory bodies are promoting anti-racist ideology (Canadian Nurses Association [CNA], 2010; CNA, 2021a; O'Brien et al., 2021). Despite the development and implementation of these cultural interventions, meeting clients' holistic needs in clinical encounters remains challenging (Allan & Smylie, 2015; Armah et al., 2020; Bennett, 2013; First Nations Health Authority [FNHA], 2022; Hughes et al., 2020; Lett, 2013).

Currently, there is limited knowledge about the key components of ICC and the barriers encountered in ICC interactions. The communication literature emphasizes the importance of active listening, empathy, respect, and trust as fundamental attitudes and behaviours in effective communication (Almutairi et al., 2025a; Balzer-Riley, 2017; Tuohy, 2019). However, there is limited understanding of how these qualities are demonstrated in ICC. Identifying and addressing potential gaps in ICC interactions is essential for improving nursing care for diverse populations. Based on the analysis of existing literature (Almutairi et al., 2025a; Golubeva & Guntersdorfer, 2020; Taylan & Weber, 2022), I argue that a deficiency in empathy may be an important area for further investigation. Empathy seems to be a key factor in overcoming ICC practice challenges, as it involves understanding the other person's perspective and metaphorically stepping into their 'shoes' (Almutairi et al., 2025a; Zhu, 2011), which is vital for developing intercultural competence (Golubeva & Guntersdorfer, 2020; Taylan & Weber, 2022). Therefore, there is an urgent need to explore whether integrating empathy into ICC—referred to as 'empathy-based ICC' and, more specifically, as 'EICC'—could help address current challenges (Armah et al., 2020). Empathy is essential in caring relationships, as it fosters appreciation and recognition of

others and can build trust between individuals (Jeffery, 2016; Wiseman, 2007). Moreover, relational practice is crucial in nursing, and empathy offers notable benefits for enhancing the relational experience (Jeffery, 2016; Zou, 2016).

A clear definition or understanding of the empathy dimensions associated with EICC has not yet been established, but existing literature has identified various empathic dimensions (Main et al., 2017; van Dijke et al., 2020) that are important in ICC. Additionally, no specific model for improving EICC in undergraduate nursing education had been developed prior to this study. Therefore, it was urgent to investigate the importance of employing empathy in ICC during cultural encounters and to better understand how to foster empathy within undergraduate nursing programmes.

Study Purpose

In this doctoral thesis, I developed a theoretical understanding of EICC for use in undergraduate nursing education, focusing on the perspectives of academic/clinical nurse educators and undergraduate nursing students in Bachelor of Nursing programs. The study employed intersectional theory and critical constructivist grounded theory (CCGT) methodology (Blanchet Garneau et al., 2018; Charmaz, 2014; Collins & Bilge, 2020; Levitt, 2021) to explore what EICC entails and the social processes involved in engaging with it in undergraduate nursing education. I followed a research partnership approach (Hoekstra et al., 2018), involving the researcher, nurse educators, and final-year undergraduate nursing students as partners. Intersectionality theory enabled a critical analysis of the complex contextual influences shaping human interactions and experiences (Collins & Bilge, 2020) within the specific context of the ICC as experienced by undergraduate nurse educators and students. It explicitly considered the multiple, intersecting forms of discrimination and marginalization related to race, racism,

religion, gender, and culture. I adopted a critical framework in this study to advance social justice and health equity (Collins & Bilge, 2020). Critical constructivist grounded theory and intersectionality theory are highly relevant to intercultural relations (Lee, 2018).

The Researcher's Positionality and Motivation

The study started as my master's thesis, inspired by my experiences working with diverse cultures as a nurse in Ghana and following my relocation to Canada. Some of my immigrant and Caucasian friends, nursing colleagues, and students shared stories of difficulty communicating or forming rapport with people from different ethnic backgrounds. These challenges caused stress in nurse-patient relationships and social interactions. As a Black woman and a person of colour, I noticed that my physical differences made a strong impression during interactions with people from other cultures, which sometimes led to negative reactions. These experiences motivated me to explore other nursing students' perspectives on intercultural communication (ICC) in my master's thesis. The findings from that descriptive qualitative study highlighted the importance of involving other stakeholders in undergraduate nursing education to identify gaps in teaching ICC and to consider integrating empathy into both undergraduate nursing teaching and practice. The literature has also highlighted several gaps in intercultural nursing care and communication that can adversely affect the health and psychological well-being of culturally diverse individuals, whether patients or students (Armah et al., 2020; Cogburn, 2019; Ramos-Roure et al., 2021; Taylan & Weber, 2022). My core values—empathy, compassion, social justice, equitable care, quality relational practice, and partnership—strengthened my resilience and reflexivity in this research, which aims to understand the perspectives of nursing students and educators on EICC.

Research Objectives and Questions

Since EICC has not been extensively studied in the literature or undergraduate nursing education, there was a need to establish both a conceptual and a theoretical foundation for EICC.

The specific objectives of this study were as follows:

1. To develop a conceptual and theoretical understanding of empathy, ICC, and EICC based on the study findings.
2. To explore the social processes involved in engaging in ICC in undergraduate nursing education according to the study findings.
3. To understand the social process of integrating empathy into ICC within the undergraduate nursing education program, based on the study findings.
4. To develop a theoretical model of EICC for undergraduate nursing education, derived from the study findings.

The following research questions directed the study to achieve the objectives described above:

1. How do academic/clinical nurse educators and undergraduate student nurses view empathy? What are their perspectives on integrating empathy in teaching/learning about ICC?
2. What are the social processes of engaging in ICC in undergraduate nursing education, as understood from the perspective of nurse educators and student nurses? How is empathy integrated into those social processes? Does empathy need to be integrated into those social processes in a more explicit manner?
3. What are some of the key contextual influences on the social process of intercultural communication? How might they inform the integration of empathy into ICC encounters?

Chapter Summary

Chapter one outlined the identified gaps and challenges in ICC, as well as the reasons for conducting this study, specifically, the critical need to establish a theoretical foundation for EICC (Tihanyi, 2020) in undergraduate nursing education. The specific objectives and guiding research questions were articulated. The next chapter will present an overview of the literature on EICC and the theoretical perspective underpinning this doctoral research.

Chapter 2: Literature Review and Theoretical Framework

Literature Search

I reviewed and analyzed previous research studies on ICC, EICC, research partnership approaches, and theoretical frameworks to advance the study of EICC. Additional literature was sourced from researchers who have discussed these topics in their original text articles.

Furthermore, I reviewed the reference lists of the included peer-reviewed articles and grey literature for relevance to the study topic. Databases searched included CINAHL, MEDLINE, Scopus, ERIC, and PsycINFO. The keywords covered, but were not limited to, ‘Intercultural communication,’ ‘cultural communication,’ ‘empathy,’ ‘cognitive empathy,’ ‘emotional empathy,’ ‘behavioral empathy,’ ‘relational empathy,’ ‘empathy-based intercultural communication,’ ‘nursing students,’ ‘undergraduate nursing students,’ ‘nurse educator,’ ‘research partnership,’ ‘Crenshaw,’ ‘intersectionality,’ ‘grounded theory,’ ‘constructivist grounded theory,’ and ‘critical constructivist grounded theory.’ The search encompassed textbooks and peer-reviewed full-text articles written in the English Language from 1980 to 2026.

Empirical Evidence on EICC in Nursing

Empathy Definitions and Dimensions

Human-centred caring is a core nursing ethic that should guide clinical interactions (Bradley & Falk-Rafael, 2011). However, patients, regardless of their cultural background, frequently report a lack of empathy in their encounters with nurses (Skär & Söderberg, 2018). Empathy is defined as the ability to perceive the meaning and feelings of another person and to communicate those feelings to them (Stein-Parbury, 2005). Tan et al. (2021) defined empathy in the healthcare practice settings as ‘clinical empathy’ and described it as “a sense of connection

between the healthcare worker and the patient as a result of perspective taking arising from imaginative, affective, and cognitive processes, which are expressed through behaviours and good communication skills that convey genuine concern” (p. 4). Empathy is a multidimensional concept (Davis, 1983; Decety, 2020; Jeffery, 2016; Tan et al., 2021). The various components of empathy include cognitive or clinical empathy (Hojat, 2016), emotional – also called affective or emotive empathy (Meneses, 2011; Rettig, 2017), behavioural (Morse et al., 1992; Rettig, 2017), moral (Morse et al., 1992), and relational empathy (Fagiano, 2019; Trevisani, 2005).

Cognitive empathy is often called perspective-taking (Hoplock et al., 2021; Lobchuk et al., 2018), which involves understanding another person’s inner experience and feelings, as well as perceiving the outside world from their perspective (Brunero et al., 2010). It also includes knowing and understanding the other's experience or situation (Meneses, 2011), or imagining how the other person perceives a particular situation by putting oneself in their perspective (Rettig, 2017). Emotional, affective, or emotive empathy is the ability to generate an emotional response within oneself to another person's experience (Meneses, 2011) or to imagine what the other person is feeling in a specific situation while also being able to “feel” these emotions ourselves (Rettig, 2017). Behavioural empathy refers to the ability to act in a way that demonstrates our understanding of the other person and provides them with the sense that we care (Rettig, 2017). Finally, relational empathy involves understanding the individual's relationships and their emotional value within the culture of belonging, to comprehend who the individual connects with, whether voluntarily or involuntarily, and who can influence their professional and personal decisions (Rettig, 2017; Trevisani, 2005). Eichbaum et al. (2023) noted that “relational empathy is construed as dynamically attentive to contexts; as co-adaptively engaging with the ‘other’ in co-creation of understanding and meaning through curiosity,

sensitivity, and epistemic humility; and as democratizing power dynamics” (p. 2). See Table 1 for the definitions.

Table 1

Empathy Definitions

Empathy Type	Definition
Cognitive Empathy	Cognitive empathy is referred to as perspective taking (Hoplock et al., 2021; Lobchuk et al., 2018), the ability to understand another person’s inner experience and feelings, with an ability to view the outside world from the other person’s perspective (Brunero et al., 2010), an ability to know and understand the other's experience or situation (Meneses, 2011), or the ability to put oneself into the perspective of the other person and imagine how he or she perceives a particular situation (Rettig, 2017).
Emotional Empathy	Emotional, affective, or emotive empathy is the ability to provide an affective response within the self to the other's experience (Meneses, 2011), or to imagine what the other is feeling in a particular situation while also being able to “feel” these emotions ourselves (Rettig, 2017).
Moral Empathy	Poorly defined. Usually discussed as a product of cognitive, emotional, and behavioural empathy (Morse et al., 1992). Also discussed as morality having social and interpersonal relationships with other types of empathy, like emotional and cognitive empathy (Decety & Cowell, 2014)
Behavioural Empathy	Behavioural empathy is the ability to act in a way that shows our understanding of the other person and gives him or her the feeling that we care (Rettig, 2017).
Relational Empathy	Relational empathy is understanding the relations of the subject and its affective value in the culture of belonging to understand with whom the subject relates, whether voluntarily or compulsorily, and who can affect his/her professional and life decisions (Trevisani, 2005). Eichbaum et al. (2023) noted that “relational empathy is construed as dynamically attentive to contexts; as co-adaptively engaging with the ‘other’ in co-creation of understanding and meaning through curiosity, sensitivity, and epistemic humility; and as democratizing power dynamics” (p. 2).

There are differing views on which dimension of empathy promotes effective communication. Researchers have examined empathy in communication within the affective and cognitive domains (Hojat, 2016; Kraft-Todd et al., 2017; Main et al., 2017), only in the cognitive domain (Lobchuk et al., 2007a; Lobchuk et al., 2007b), solely in the relational domain (Fagiano, 2019), or just in the behavioural domain (Stepien & Baernstein, 2006). Hoplock et al. (2021) regard cognitive empathy as a skill that can be taught, and many empathy skills have been evaluated within the cognitive and affective domains (Ferri et al., 2017; Kiersma et al., 2013). The Consultation and Relational Empathy (CARE) Measure is a validated questionnaire used to gauge patients' perceptions of their physician's communication skills and empathy (Mercer et al., 2004). Occasionally, the CARE measure has also been employed in studies involving nurses (Bas-Sarmiento et al., 2017; Bas-Sarmiento et al., 2019; Bikker et al., 2017; Bikker et al., 2015; Lobchuk et al., 2016; Lobchuk et al., 2018; Saviato et al., 2019), but a key limitation of this scale is that it does not address intercultural contexts. The literature shows a strong interest in measuring empathy within single versus multiple domains (Hojat et al., 2017); however, empathy is multidimensional and occurs across different stages of a communication encounter (Decety, 2020; Jeffery, 2016; Walker & Alligood, 2001; Wiseman, 2007). Additionally, the focus has been on the empathizer's ability to empathize rather than on the contributing or contextual factors within the empathetic experience, or on how the various domains of empathy interact (Decety, 2020; van Dijke et al., 2020). Examining empathy within a multidimensional framework in this study may clarify the concept and give more specific guidance for undergraduate nursing education pedagogy.

Contextual/ Social Influences on Empathy

Multiple contextual factors contribute to how people demonstrate empathy – e.g., education, race, gender, culture, religion, familiarity with the patient, and interpreter-mediated consultations (Cieślak et al., 2024; Ferri et al., 2017; Jia-Ru et al., 2022; Krystallidou et al., 2018; Main et al., 2017; Matsumoto, 2007; Morse et al., 1992; Treglia, 2020; Wiseman, 2007). Main et al. (2017) argue that empathy is culturally situated and may vary across cultural backgrounds. Cieślak et al. (2024) also suggested that multicultural personality profiles can influence nursing students' attitudes towards others. Wiseman (2007) surmised that a nurse's familiarity with a patient and years of experience can enhance a nurse's self-awareness and confidence to demonstrate empathy. A correlation has also been reported between empathy and female nursing students (Ferri et al., 2017; Jia-Ru et al., 2022; Treglia, 2020).

However, there are discrepancies in reports regarding how empathy is demonstrated across the progression of undergraduate nursing education. For instance, Treglia (2020) reported that emotional empathy increases with academic year, whereas Ferri et al. (2017) reported the opposite. Ferri et al. (2017) suggested that further research is needed on the decline in empathy across academic course levels. Almutairi et al. (2025a, 2025b) proposed that empathy is best taught in the first year, when the students are more open to learning new information. There is a call for faculty development to facilitate cultural simulation (Almutairi et al., 2025, 2025b). There is also a call on nurse educators to help nursing students cultivate empathy skills (Jia-Ru et al., 2022). However, understanding relational factors that impact the empathic process and empathy development is critical to defining empathy (Main et al., 2017) in ICC and intervening as educators (Almutairi et al., 2025b). Cogburn (2019), as well as Collins and Bilge (2020), reported that racism has a pivotal role in health inequities. Therefore, such contextual or

structural factors must be critically examined to determine whether and how EICC education might help mitigate racism and persistent health inequities (Lanzoni, 2018).

Key Distinctions: Intercultural Empathy, Cultural Empathy, ICC, and EICC

Intercultural empathy (Broome et al., 2017; Zhu, 2011), cultural empathy (Van der Zee & van Oudenhoven, 2000), ICC (Bennett, 2013; Huang et al., 2012), and EICC are four distinct constructs, although they may overlap in some areas due to their components. Intercultural empathy is described as “placing oneself into the cultural background of the target language and effectively communicating his understanding of that world” (Zhu, 2011), or showing empathy during intercultural dialogues (Broome et al., 2017). Van der Zee & van Oudenhoven (2000) described cultural empathy as the ability to empathize with individuals from different cultural backgrounds, to understand their feelings, and to express interest and respect for other cultures (p. 294). The literature refers to ICC as the study and practice of communication across cultural contexts (Bennett, 2013) or the act of sociality between cultures (Huang et al., 2012). However, there is no explicit definition of EICC nor knowledge about the specific dimensions of empathy that are most important in the context of ICC. Neither have the specific empathy dimensions of ICC been explored. Nonetheless, Rettig (2017) proposed that intercultural empathy is applied across cognitive (knowledge), affective (emotional engagement), and behavioural (acting in an empathetic manner) empathy domains. There is a vital need to develop a theoretical understanding of EICC through the experiences of various stakeholders, including nurse educators, undergraduate nursing students, patients, and caregivers (Shepherd & Suddaby, 2017; Tihanyi, 2020). In this doctoral thesis, I examined the unique perspectives of educators and students in undergraduate nursing education to enhance understanding of EICC.

Why the Shift towards Empathy-based Intercultural Communication?

Intercultural communication is vital to ensuring equitable healthcare, especially given that communication among culturally diverse groups remains a global challenge (Allan & Smylie, 2015; Almutairi et al., 2025a; Armah et al., 2020; Lett, 2013). However, some concepts used to address ICC, such as intercultural competence, intercultural sensitivity, cultural humility, and cultural safety, have varying meanings and expected skills that do not explicitly include empathy (Bennett, 2013; FNHA, 2022; Hughes et al., 2020). Empathy has been positioned as a crucial element in ICC encounters (Calloway-Thomas, 2010; Chopik et al., 2017). For example, in Hagqvist et al.'s (2020) study, some clinical mentors mentioned that empathy motivates them in their ICC efforts. Therefore, it can be inferred that a deliberate attempt to teach empathy might also positively influence the development of ICC among nursing students; however, this research question has not yet been explored. Empathy is the driving force behind our understanding and appreciation of people whose values, perspectives, and behaviours differ from our own (Calloway-Thomas, 2010). While some cultural models (Deardorff & Arasaratnam-Smith, 2017; Giger & Davidhizar, 2002) and educational initiatives (Çingöl et al., 2021; Lin et al., 2016; Maar et al., 2020; San, 2015) highlight the importance of empathy and communication in cultural encounters, they do not explicitly integrate these concepts. For example, Çingöl et al. (2021) found that introducing an intercultural nursing course did not produce significant changes in students' empathic skills and cultural sensitivity levels, but it did improve their confidence in ICC. Lobchuk et al. (2016) discovered that perspective-taking (cognitive empathy) enhanced student nurses' skills in counselling carers about health risk behaviours; however, the study did not concentrate on ICC. Furthermore, Hughes et al. (2020) and Moudatsou et al. (2020) have suggested that empathy toward individuals from culturally diverse backgrounds is lacking and

challenging for healthcare workers. Consequently, it is important to determine whether integrating the constructs of empathy and ICC could assist nursing students in developing more effective ICC practices. This study aimed to address these challenges and differences by examining the concepts of empathy and ICC to develop a critical, theoretical understanding of EICC and its implications for undergraduate nursing pedagogy.

Proposed Dimensions of Empathy-based Intercultural Communication

The foundational works of Bennett (2013), Broome et al. (2017) and Zhu (2011) have illuminated the different pathways to developing EICC. However, to address the issue of potential power differentials (Eichbaum et al., 2023) and fully empathize during communication encounters, one must consider the influence of context and the network of people who are close to or influence the actions of the other person and can be best studied within the framework of relational empathy (Trevisani, 2020). For this study, I will embed relational empathy, in addition to the cognitive, affective, moral, and behavioral dimensions, to address the lens of holism in ICC. Holistic healthcare delivery encompasses not only the client but also significant contextual factors, such as culture, race, gender, ability, occupation, and language, all of which profoundly influence individual health (Hankivsky, 2012; Hankivsky, 2014). These external factors, which are intertwined with the intersectionality of life, are critical elements that must be understood to engage in meaningful empathy-based communication across cultures (Drewelow & Finney, 2018). Relational empathy, as well as the other dimensions of empathy, will be explored and analyzed using intersectional theory and a critical constructive grounded theory approach (Charmaz, 2014; Levitt, 2021).

‘Relational empathy’ in the *CARE* measure (Mercer & Reynolds, 2002; Mercer et al., 2004) has been defined as the healthcare practitioner’s ability to understand the patient’s

situation, perspective, and feelings (and their associated meanings), communicate that understanding, verify its accuracy, and act on that understanding with the patient in a therapeutic manner. However, Trevisani (2005) proposed that relational empathy in the context of ICC extends beyond patient-practitioner interactions. According to Trevisani (2005), relational empathy involves contextual and social factors that can facilitate the development of the empathic process and assist nurses in demonstrating EICC towards patients from all cultures. Additionally, Fagiano (2019) argued that the experience of empathy does not occur in isolated phases but through overlapping experiential relations, resulting in the empathizer (1) feeling into, (2) feeling with, and (3) feeling for the individual. I largely agree with Fagiano (2019) that analyzing the empathic experience without considering the relational context might produce biased and prolonged evidence and could lead to interventions that do not fully address gaps in EICC. This highlights the importance of exploring the multiple dimensions of EICC.

No study has yet investigated the proposed dimensions of empathy within the ICC context. However, this foundational research will lay the groundwork for understanding the multidimensional nature of EICC by identifying which specific empathy dimensions are significant in this context and how they can be understood. A theoretical understanding of EICC is essential for developing models and interventions to assist nursing students in their clinical interactions with culturally diverse clients, with the goal of promoting health equity and culturally safe care.

Theoretical Framework

This study is based on Crotty's (1998) scaffolding process, which defines my epistemological stance, theoretical perspective, research methodology, and methods. Using a philosophical paradigm in qualitative research is essential to maintain consistency and rigour

throughout the process (Creswell & Poth, 2018; Crotty, 1998; Mills & Birks, 2014). This section explores my epistemological approach and how it influenced my theoretical perspectives. I chose constructivism (Charmaz, 2014; Crotty, 1998) over objectivity as my epistemological foundation. My research employed an inductive, qualitative methodology to explore meaning by engaging key stakeholders in understanding ICC, thereby developing new insights from the study context (Charmaz, 2014). According to Charmaz (2014), theory is an interpretive, contextually grounded understanding that is socially constructed by both researcher and participant. Selecting the appropriate theoretical perspective helps strengthen the research methodology and methods, as well as the subsequent analysis. This perspective is vital because it shapes the concepts addressed, research questions, data collection techniques, and analysis, thereby contributing to the theoretical basis of the findings (Charmaz, 2014; Levitt, 2021).

In grounded theory methodology, opinions differ on whether to start with a ‘blank slate’ or include existing theory to guide the research (Glaser & Holton, 2004; Glaser & Strauss, 2010; Urquhart & Fernandez, 2013). Charmaz’s (2014) constructivist grounded theory (CGT) advocates engaging with relevant literature and theories; however, the researcher must be transparent about this engagement, practice reflexivity throughout, and remain grounded in the data with a high level of theoretical sensitivity (Birks & Mills, 2015). When applying a specific theory, the researcher should discuss how it influenced the development of the theoretical analysis, thereby enhancing the study's credibility, transparency, and trustworthiness (Charmaz, 2014; Streubert & Carpenter, 2011; Timonen et al., 2018). The intersectionality framework embedded in critical constructivist grounded theory is well-suited to this study, as ICC encompasses multiple realities shaped by power relations and social and historical contexts

(Charmaz, 2006, 2014; Hankivsky, 2014). Additionally, using an intersectional lens can advance equality and social justice in relational practice within the healthcare system (Hankivsky, 2014).

Critical Framework: Intersectionality Theory

This study applied intersectionality theory, which is rooted in critical and social theories (Crenshaw, 1995; Crewe, 2021; Few-Demo, 2014). There are debates about grounded theory being atheoretical in its approach to reduce bias in the data (Charmaz, 2006, 2014), but Abrams et al. (2020) suggested that intersectionality should be integrated during the conception phase to include key features that enhance recruitment, data collection, and dissemination.

Intersectionality theory emerged from the critical race theory movement (Crenshaw, 1995; Crewe, 2021; Few-Demo, 2014) and is defined as “a way of understanding and explaining complexity in the world, in people, and in human experiences” (Collins & Bilge, 2020, p. 2). It is pragmatism-oriented, allowing it to pursue critical inquiry and transform societal systems (Charmaz, 2017; Kassam et al., 2020).

The critical inquiry focus sheds light on the deep roots of marginalization at both individual and structural levels (Crenshaw, 1993), offering a comprehensive view of the context needed to understand human life and behaviour through the lived experiences and struggles of vulnerable groups (Abrams et al., 2020; Collins & Bilge, 2020). Personal forms of marginalization occur face-to-face among individuals such as those of colour or female gender, while structural marginalization results from government, political, and institutional policies and procedures that promote unequal treatment and power dynamics (Crenshaw, 1993). Originally developed as a Black feminist theoretical perspective that places gender and race in relation to the dominance of white middle-class women and Black men (Crenshaw, 1989; Crenshaw, 1991a; Crenshaw, 1991b), intersectionality examines the interconnection between power, privilege, and

social identity categories (Abrams et al., 2020; Collins, 2015) such as ethnicity (Collins, 2015), race, sexual orientation, class (Collins, 2015; Crenshaw, 2017; MacKinnon, 2013), age, gender, and ability (Collins & Bilge, 2020). These critical intersections and relationships can be key to better understanding and addressing health inequities experienced by marginalized populations (Bowleg, 2017).

Intersectionality encompasses multiple epistemological perspectives. Ontologically, each social category is distinct and cannot be understood in isolation (Collins, 2015; Van Herk et al., 2011). Kassem et al. (2020) suggested that understanding the intersection of social categories of identity and their shaping of human experience is crucial for revealing the truth about human experience and for disrupting inequalities. Scholars such as Collins (2015), Collins and Bilge (2020), Crenshaw (1989, 1991a), and Hankivsky (2012, 2014) have discussed the key frameworks of intersectionality theory and explored its application as a research paradigm or theoretical approach. Hankivsky (2014) and Kassem et al. (2020) argued that intersectionality can be situated within a constructivist epistemology, as social categories are socially constructed within specific contexts, influenced by power relations that shape actions and meaning. Nine principles are associated with intersectionality theory: intersecting categories, multi-level analysis, power, reflexivity, time and space, social justice, equity, resistance and resilience, and the diversity of knowledges (Hankivsky, 2012). Crenshaw proposed the three-dimensional analytical intersectionality framework – structural, political, and representational power relations (Crenshaw, 1989; Crenshaw, 1991a; Crenshaw, 1991b). Collins and Bilge (2020) illuminated the six core principles of intersectionality: social inequality, intersecting power relations, social context, relationality, social justice, and complexity.

The historical development of intersectionality signifies a shift from a traditional focus on discrimination towards an emphasis on power dynamics (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991). Collins (2015) and Crenshaw (1989, 1991) argue that intersectionality aims to comprehend how power influences reality and marginalization across various systems, integrating the individual's multifaceted identities and experiential knowledge of those engaged in power relations. Crenshaw (1989) advocates for moving beyond a single-axis analysis of race and gender. Numerous scholars support the understanding that marginalized populations possess multisectoral, interlocking categories that characterize them (Bowleg, 2017; Collins, 2015; Crenshaw, 1989). Given the nature of ICC and the multidimensional and relational aspects of empathy, this doctoral study applied intersectionality theory as a theoretical lens used with Levitt (2021) critical constructivist grounded theory to investigate how social processes like empathy and ICC are influenced by interconnected constructs such as power, diversity of knowledge, time and space, social inequity, and structural, political, and representational power relations, as well as social context, social justice, and relational complexity.

Relevance of the Intersectionality Theory to the Study

The research topics of empathy and ICC are rooted in power relations within both hidden and visible structures, networks, and relationships (Charmaz, 2014; Clarke, 2005) that are often overlooked in previous studies but must be examined through an intersectional lens to understand the steps needed for progress towards emancipation, health equity, and social justice. Intersectionality theory guides critical theoretical (Abrams et al., 2020) and methodological approaches (Abrams et al., 2020; Christensen & Jensen, 2012; Kassam et al., 2020) in studies addressing health inequity and disparity (Abrams et al., 2020; Bowleg, 2017; Hankivsky, 2014). It is essential to explore the intersections among specific social categories across domains of

power: structural, disciplinary, cultural, and interpersonal (Collins & Bilge, 2020), to effectively address health inequalities resulting from the complexities of human relations and behaviour (Kassam et al., 2020).

Chapter Summary

This chapter provided a literature review of the focus of this doctoral study – EICC. It discussed empirical evidence on empathy, ICC, the different dimensions of empathy, and the importance of integrating empathy into ICC, highlighting key gaps in existing research. Additionally, the complexity of managing intercultural dialogues has prompted consideration of theoretical frameworks for the socially co-development of new knowledge from a social justice perspective, aligning with Crenshaw's (1989) intersectionality theory and Levitt's (2021) critical constructivist grounded theory. These theoretical perspectives informed the research design, aligning with the study's objectives. Further details on the research methodology and methods will be included in the next chapter.

Chapter 3: Research Design, Methodology & Methods

Study Design and Methodology

The study was guided by a qualitative research design using intersectional theory (Collins & Bilge, 2020), critical constructivist grounded theory (CCGT), and a partnership research approach (Charmaz, 2014; Levitt, 2021). Although CCGT captures both constructivist and critical epistemologies, Levitt (2021) focuses on capturing the processes, functions, and contexts in the data that support the research goals. For the constructivist approach, the methodology was informed by symbolic interactionism, pragmatism, and social constructivism (Charmaz, 2014; Chen et al., 2011; Crotty, 1998; Rieger, 2018), which adopts the co-creation of knowledge through research partnerships to facilitate social transformation. The critical approach employed intersectionality theory (Collins & Bilge, 2020), which offers a critical foundation for consciousness-raising, social change, and transformation in nursing interactions (Levitt, 2021). I present a brief description of some key foundations of CCGT—social constructivism, symbolic interactionism, Kathy Charmaz's constructivist grounded theory (CGT), the CCGT guided by intersectionality theory, and the philosophical assumptions underlying the research paradigm in CCGT.

Social Constructivism

Social constructivism was established by the Russian psychologist Lev Vygotsky as a social learning theory, emphasizing that learning occurs within social and cultural contexts rather than solely within the individual (Schreiber & Valle, 2013). Charmaz's view on social constructivism in constructivist grounded theory (CGT) aligns with Lev Vygotsky and Yvonne Lincoln (Charmaz, 2006, 2014). Social constructivism is a philosophical framework that emphasizes the construction of knowledge through social interactions (Schreiber & Valle, 2013).

Social constructivists actively involve individuals in society to share their experiences and build realities through exploration, problem-solving, and critique (Lincoln et al., 2011). The philosophical foundation of CGT involves the researcher in the co-creation of reality and an iterative process of data analysis (Charmaz, 2014). Charmaz (2014) argued that social constructivism includes understanding the meanings of participants' experiences, and that the researcher actively participates in constructing and interpreting data in a co-creative manner with research participants. In social constructivism, the researcher must be reflexive, recognizing their assumptions, perspectives, and how their background influences the data analysis process (Charmaz, 2014).

Social constructivism functions as a social focus and is grounded in a relativist ontology; it aligns with pragmatist ontology and symbolic interactionist viewpoints (Charmaz, 2014). This study concentrated on an interaction among multiple stakeholders (researcher, nurse educators, and undergraduate nursing students) who collaborated as research partners to develop a theoretical understanding of EICC. The data collected and analyzed were approached as a social construction (Charmaz, 2008, 2014; Clarke, 2005; Polit & Beck, 2012), derived from shared experiences and relationships with the participants, to explore the 'how' and 'why' participants need to construct meaning and action for EICC (Charmaz, 2014, p. 239).

Symbolic Interactionism

Symbolic interactionism is informed by the work of Blumer (1969) and is defined as a dynamic theoretical perspective that views human actions as constructing self, situation, and society. It has underlying assumptions of constructed multiple realities based on individual meanings ascribed to specific concepts (Charmaz, 2014) – in this case, ICC, with language and symbols playing essential roles in forming and sharing our meanings and actions (Charmaz,

2014). Symbolic interactionism aims to understand the meaning of social phenomena through interpretivism (Andrews, 2012; Schwandt, 2003). Charmaz (2014) suggested that symbolic interactionism can raise theoretical questions about the data to facilitate deeper analysis and the discovery of new ideas.

Human interactions, language, and interpretation are vital areas of emphasis in symbolic interactionism (Charmaz, 2014), which is also critical in the multiple dimensions of empathy, primarily relational empathy. Symbolic interactionism facilitates an understanding of the reciprocal process in communication encounters, encompassing the actions of the individual being empathized with, the interpretation of those actions by the empathizer, and the responses enacted by the empathizer to the situation. In this case, Blumer (1969) asserted that the individual's actions are cognitively processed in the brain as symbolic, interpreted, and transferred to reality as an empathy-based response. Symbolic interactionism within CCGT facilitated the theoretical understanding of EICC and the specific influence of power dynamics among multiple stakeholders.

Constructivist Grounded Theory

Constructivist grounded theory was developed in 1995 by Kathy Charmaz, a sociologist and former student of Glaser and Strauss; Charmaz further refined CGT in the 21st century (Charmaz, 2006, 2008, 2014, 2017). The CGT is based on constructivist principles (Bryant & Charmaz, 2010; Charmaz, 2014, 2017), demonstrating how multiple complex realities are co-created within historical, social, and situational contexts (Charmaz, 2014, 2017). The CGT draws on pragmatism (Charmaz, 2014; Crotty, 1998; Morgan, 2020) and symbolic interactionism (Blumer, 1969; Hewitt et al., 2022) and adopts a relativist ontology and subjective epistemology (Charmaz, 2008, 2014, 2017). Charmaz (2014) highlighted the subjectivity of data and data

analysis, social processes, interpretive frameworks, iterative logic, and constant comparative analysis. To guide the research design of a CGT, the research question should be developed before beginning the study; a literature review should be conducted to deepen understanding of the phenomena under investigation and to orient the researcher; and theoretical sensitivity should be considered (Charmaz, 2014). For this study, empathy and intersectionality served as sensitizing concepts in the critical inquiry. In line with CGT, I examined the data to develop an inductive theory that is credible, original, resonant, and useful (Charmaz, 2014) by engaging in thorough interaction with the data to achieve a theoretical understanding of EICC in undergraduate nursing education.

Ontological and Epistemological Differences between Intersectional Theory and Constructivist Grounded Theory

Intersectionality provides a theoretical and ontological framework for understanding social reality and power dynamics (Collins et al., 2021). In contrast, CGT is primarily a methodological approach rooted in a constructivist ontology and epistemology, focused on creating interpretive explanations of social processes (Charmaz, 2014). The major distinctions are highlighted in

Table 2.

Table 2

Intersectionality Theory Versus Constructivist Grounded Theory: Ontological and Epistemological Distinctions

	Intersectionality Theory	Constructivist Grounded Theory
Authors	Collins (2015), Collins & Bilge (2020), Crenshaw (1989, 1991), Hankivsky (2012, 2014)	Charmaz, 2014
Ontology	Reality is constructed through the interrelation of various social systems of power and inequality.	Reality is contextual, multiple, and socially constructed.

	Intersectionality Theory	Constructivist Grounded Theory
	The social categories examined encompass gender, sexuality, race, class, colonialism, and capitalism, which are analyzed to understand structural and power dynamics (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991).	Meanings and knowledge are constructed through social interactions, partnerships, and the analysis of perspectives and contexts.
	Power relations and structural inequities are fundamental to the construction of reality, shaping social positions and structural and systemic processes (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991; Hankivsky, 2012, 2014).	Power is not the primary factor in the construction of knowledge; however, CGT recognizes that power dynamics influence the research process between the researcher and the participant. This is addressed by acknowledging the influence of researcher positionality and reflexivity.
	Relationality: Reality is constructed through an understanding of the individual's multiple, intersecting social locations (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991; Hankivsky, 2012, 2014).	Participants' meanings and experiences are contextualized within the specific social, historical, and cultural contexts of their interactions.
	Social reality is built through critical structural realism involving categories and power structures like capitalism, racism, patriarchy, sexuality, colonialism, and institutional discrimination (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991).	Relativist: Emphasizes how individuals socially construct reality and interpret meanings and processes within specific contexts, rather than relying on a singular objective truth.
	The realities of inequalities are influenced by interconnected systems and structures of power, beyond individual experiences (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991; Hankivsky, 2012, 2014).	Reality originates from interpretivism: the manner in which participants and the researcher construct meaning from experiences and processes.
Epistemology	Concentrate on emancipatory knowledge that challenges universally accepted standards of social interactions and social locations (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991).	Focus on developing emerging theory from the shared experiences of the researcher and participants.

	Intersectionality Theory	Constructivist Grounded Theory
	Knowledge is situated, structural, political, and contextual (Crenshaw, 1989, 1991)	Assumes that data and interpretations are collaboratively constructed within a partnership approach, rather than being objectively discovered.
	Data analysis centers on the interaction between social positions, locations, and structural power (Collins, 2015; Collins & Bilge, 2020; Crenshaw, 1989, 1991; Hankivsky, 2012, 2014).	Data analysis is interpretive and oriented towards a theoretically informed understanding of the social process.

Levitt (2021) Critical CGT: Guided by the Intersectionality Theory

In this study, I explored intersectionality theory within CGT as a form of critical CGT (CCGT), specifically using Levitt (2021) CCGT as my theoretical foundation. Critical CGT is a qualitative methodology grounded in critical and constructivist epistemologies (Collins & Bilge, 2020; Levitt, 2021). It combines constructivist approaches (e.g., symbolic interactionism, postmodernism) with critical perspectives (e.g., intersectionality, multiculturalism, queer theory, economic analysis) to guide the inquiry toward fulfilling the research aims (Collins & Bilge, 2020; Levitt, 2021). I chose CCGT with an intersectionality lens because it highlights context, social processes, power relations, and pragmatism (Collins & Bilge, 2020; Levitt, 2021). For instance, reality is shaped by existing structural conditions or emerging situations (Charmaz, 2014; Levitt, 2021), and the researcher's perspectives, privileges, positions, interactions, as well as the participant's life context (Charmaz, 2014; Crenshaw, 1993; Levitt, 2021), must be critically examined to fully understand the research topic.

Both intersectionality theory, CGT, and CCGT are rooted in pragmatic philosophy (Charmaz, 2017), emphasizing critical inquiry and social transformation (Charmaz, 2020; Levitt, 2021). While CCGT addresses the power dynamics present in the relationship between

researcher and participant (Levitt, 2021), intersectionality examines power relations in everyday life (Crenshaw, 1989; Crenshaw, 1991b), particularly in the practice of EICC. Pragmatism informs both CCGT and intersectionality theory, which will effectively facilitate critical inquiry into social problems and help find ways to address them within the specific realm of ICC empathy. Critical CGT employs semi-structured interviews and reflexivity of the researcher as tools for critical inquiry, aiming to identify and address issues of inequality and social injustice (Charmaz, 2014, 2017; Collins & Bilge, 2020; Levitt, 2021). This approach aligns with this study because I co-constructed an EICC theoretical understanding with the participants through our interactions during the interviews and the ongoing process of analysis, which is significant within social constructivism: considering social and historical contexts (Charmaz, 2006, 2014; Hankivsky, 2014; Levitt, 2021), to promote equity and social justice in healthcare.

I further explored, with the CCGT, how power is embedded in that construction and in the experiences of the research participants. Since this new knowledge was co-created during the inquiry, social processes and concepts of oppression and marginalization in ICC were better understood and accounted for (Collins, 2015), helping to foster an understanding of EICC that addresses power and social inequity. The use of intersectionality theory provided an opportunity to understand how social categories such as gender, race, sexual orientation, class, ability, and other markers of difference intersect to influence communication encounters in healthcare. The guiding principles outlined by Hankivsky (2014) formed the basis of this convergence. I employed intersectionality theory within the CCGT to conceptualize the study, interpret and understand stories of those who teach ICC and those who experience ICC or inequities shaped by complex, interlocking historical, social, and structural contexts.

Philosophical Assumptions of the CCGT

Ontology. The CCGT adopts a relativist and critical ontology, asserting that knowledge is socially constructed while examining the underlying pre-existing structural conditions and emergent situations, as well as the hidden power dynamics within social relationships (Charmaz, 2014; Levitt, 2021). It rejects objectivity and positivist views that regard knowledge as existing within a single objective reality to be discovered (Charmaz, 2014). However, Levitt (2021) argues that some elements of objectivity might exist within critical epistemologies. The relativist centers the experiences of individual stakeholders involved in intercultural dialogues, as these are shaped by their diverse positionalities and expectations, contributing to the social process of ICC (Charmaz, Pretorius, 2024). The critical ontology aims to identify how these intercultural dialogues are influenced by systemic, social, and structural inequalities, alongside power relations within the social environment (Crenshaw, 1989; Hankivsky, 2014; Levitt, 2021). In this doctoral study, the ontological perspective shaped the sample selection to gain in-depth experiential insights into empathy and ICC in undergraduate nursing education.

Epistemology. The CCGT employs a subjectivist, interpretive, and emancipatory epistemology, with a pragmatic approach (Charmaz, 2014; Chinn & Kramer, 2015; Levitt, 2021). It supports the co-construction of knowledge through social interactions between the researcher and key stakeholders of the concept under study, who become the participants (Levitt, 2021; Pretorius, 2024). With the CCGT, co-constructing knowledge with research participants involves keeping reflexive notes, as the research questions, interactions during data collection, and analysis can be influenced by the researcher's positionality, privileges, lived experiences, and geographical location (Braun & Clarke, 2022; Charmaz, 2014; Crenshaw, 1989).

Axiology. The CCGT embraces essential emancipatory values that identify and combat social injustices and inequalities affecting marginalized and vulnerable groups (Collins, 2015; Levitt, 2021). It creates action-oriented strategies for societal change by addressing the root causes of these issues through the developed theory (Collins, 2015). Consequently, the research process is guided from the outset by the formulation of an action-oriented theory (Collins, 2015; Levitt, 2021) and considers the researcher's influence on their positionality within the research design (Pretorius, 2024).

Methodology. The CCGT employs an inductive approach and an intersectional perspective aimed at creating new meaning through researcher-participant interactions within the social context (Charmaz, 2017, 2020; Kassam et al., 2020; Levitt, 2021). I utilized an inductive, iterative methodological approach while explicitly engaging an intersectional lens during the study's conception (Abrams et al., 2020), data collection, and analysis (Charmaz, 2014). This methodological approach guided the selection of participants, research questions, interviews, and data analysis.

Research Methods

Sample, Sampling Technique, and Setting

Guided by social constructivism and the understanding that reality is co-constructed, it is essential for multiple stakeholders to collaborate in the inquiry process to enable a multilevel analysis (Hankivsky, 2012; Hankivsky, 2014; Shepherd & Suddaby, 2017), and to develop the theoretical framework that will influence the teaching and learning of EICC in undergraduate nursing education to foster client-centred care (Tihanyi, 2020; Wensing & Grol, 2019). Schwandt (2003) argued that knowledge is built through interactions among individuals in society. Charmaz recognized the interaction between the researcher and the research participant

and was guided by the assumption that the researcher is not separate from the research, which promotes the mutual co-creation of knowledge (Charmaz, 2014; Levitt, 2021; Polit & Beck, 2012), rather than acquiring knowledge through observation or causal effect (Charmaz, 2006, 2014).

Setting

Participants were recruited from three academic institutions in western Canada, specifically in Manitoba. The institutions were the University of Manitoba, Brandon University, and the University College of the North. Manitoba in 2021 had a population of about 1.3 million, with approximately 830,000 living in Winnipeg, 54,000 in Brandon, and fewer than 30,000 in the northern areas (Statistics Canada – Government of Canada, 2025). Although all three academic institutions are located in Manitoba, they are situated in different geographic regions and serve primarily diverse populations in clinical practice, which may influence participants' ICC experiences. While the population near the University College of the North is mainly Indigenous, the population near the University of Manitoba is largely diverse due to immigrant settlement in Winnipeg. Students at Brandon University may be more exposed to a mix of Caucasian and immigrant populations. Depending on their location, nursing students complete their clinical practice at several hospitals across the province. These institutions were chosen because they offer four-year Bachelor of Nursing programs with similar academic and clinical structures and facilities. In discussions with administrative assistants at each institution, the number of final-year undergraduate nursing students per institution ranges from 60 to 120 for the academic year, supporting the feasibility of this study from a recruitment perspective. There were also diverse educators employed by the institutions to teach the nursing students both didactically and in clinical settings.

Sample

Critical partners such as academic and clinical nurse educators are encouraged to focus more on enhancing students' cultural self-efficacy and ICC skills (Armah et al., 2020; Brett et al., 2014; Hagqvist et al., 2020; Maar et al., 2020; O'Brien et al., 2021) by adopting a more pedagogically, socially, and culturally sensitive approach, as demonstrated in critical pedagogies (Blanchet Garneau et al., 2018; Lee, 2018; Maar et al., 2020). While some nurse educators say that empathy motivates them to develop ICC, there has been no explicit indication that they possess or demonstrate EICC skills (Hagqvist et al., 2020). Student nurses are recipients of shared knowledge; their perspectives should be heard on the barriers and facilitators to understanding and engaging in ICC, and on the importance of an EICC approach in nursing education. Educators must also help develop students' knowledge, resources, capabilities, and expectations regarding EICC, and identify potential challenges in teaching EICC within the undergraduate nursing program. However, the perspectives and roles of these key ICC stakeholders in undergraduate nursing education are insufficiently studied (Armah et al., 2020; Chan & Sy, 2016; Hagqvist et al., 2020; Philip et al., 2015), and there is limited literature on educators' contributions to facilitating EICC pedagogy in nursing programs. It is important to recognize that patients and family caregivers also have a crucial voice in understanding ICC needs during healthcare (Carman et al., 2013; Graham et al., 2018), but their perspectives will be explored in a future, separate study.

Thirty participants were recruited for this study. There were fifteen (n=15) fourth-year or final-year undergraduate nursing students and fifteen (n=15) nurse educators. The focus group sample was drawn from the 15 initial nurse educators. The study began with all participants identified as fourth-year undergraduate nursing students. However, one of the universities had a

program structure change from a four-year to a 28-month program, with no changes to the course requirements for completion. Therefore, qualification for inclusion as a nursing student meant being a final-year undergraduate nursing student. The final-year students were technically in their fourth year of study. Final-year undergraduate nurses were perceived to have participated in all courses and clinical programs, better preparing them to evaluate ICC teaching and practices within the learning environment and their impact on future practice.

Sampling Technique

The thirty multiple stakeholders were recruited using purposive, snowball, and theoretical sampling within Manitoba (Charmaz, 2014; Creswell, 2018; Sandelowski, 2001). Specifically, nursing students were purposefully sampled from the University of Manitoba, Brandon University, and University College of the North (Creswell, 2018). Nurse educators were recruited through purposive and snowball sampling from these same universities. Co-creating knowledge related to EICC to support undergraduate nursing education involves recruiting individual stakeholders exposed to ICC in undergraduate nursing programs who can provide rich insights about their knowledge and experiences with ICC to inform change (Charmaz, 2014; Creswell & Plano, 2011; Hankivsky, 2012; Hankivsky, 2014; Patton, 2015; Satchwell et al., 2020). Thus, fourth-year (later rephrased to final year) undergraduate nursing students and nurse educators who taught simulations or communication or culture-related courses or clinical practicums were considered to be key stakeholders. Nurse educators who did not teach these courses were excluded from the study.

Inclusion Criteria. Eligibility to participate included a) an ability to speak English, b) being 18 years or older, c) reside in Manitoba, and d) is a 4th-year or final year undergraduate nursing student or nurse educator. Nurse educators needed to teach either a simulation,

communication, or a culture-related course(s), or supervise a clinical practicum that involves culturally diverse patients and their family caregivers (Creswell, 2018).

I made every effort to recruit a heterogenous sample based on their location, education, exposure to ICC encounters, cultural backgrounds, and social status, which provided an intersectional perspective on the data; although I acknowledge there were multiple limitations related to this approach. Nonetheless, understanding these various social categories is essential. For instance, Hankivsky and Cormier (2011) observed that intersectionality conceptualizes social categories as interacting entities that co-construct realities about one another, thereby generating distinctive social positions that vary across different contexts of time and space. These intersections and their associated effects are central to intersectional analysis and collectively define the holistic individual.

Theoretical sampling was used until data saturation was reached (Charmaz, 2014, Levitt, 2021). This approach involved systematic checks during data analysis and the collection of relevant data to develop and refine the properties of categories within the emerging theory, continuing until no new theoretical properties emerged. This process resulted in saturation at the category level for theoretical integration (Baird, 2021; Birks & Mills, 2012; Charmaz, 2014; Levitt, 2021; Timonen et al., 2018). Data collection and analysis continued until the categories were fully saturated, organized into ‘clusters,’ and incorporated into the emerging theory, which Levitt (2021) refers to as the core category. According to Timonen et al. (2018), theoretical sampling begins early in data analysis and becomes more targeted, focusing on a specific category with questions progressively refined to describe that category until a saturated theory is achieved, similar to Levitt (2021).

Data saturation in CGT refers to theoretical saturation (Charmaz, 2014). Hennink et al. (2016) identified two types of data saturation: code saturation (which can be reached at nine interviews depending on data quality) and meaning saturation (which may occur between 16 and 24 interviews) in GT. According to Hennink et al. (2016), 'meaning saturation' and an adequate sample size may be achieved based on the study's purpose, the nature of the study population, the types and styles of coding, and the complexity and stability of the researcher's codes. Morse (2015) recommended using prolonged participant engagement, persistent participant observation, rich, detailed descriptions of data, inter-rater reliability, negative case analysis, peer review or debriefing, clarifying researcher bias, member checking, external audits, and triangulation to achieve saturation and ensure study rigor. According to Charmaz (2006, 2014) and Glaser (2001), researchers should not halt data collection simply because responses are repetitive; instead, they should compare the properties of categories until no new properties emerge. Charmaz (2014) maintains that categories become saturated when gathering new data no longer generates new theoretical insights or modifies the properties of core theoretical categories, thus reaching theoretical completeness (Glaser, 2001). This is consistent with Levitt (2021), in which saturation occurs when new data no longer yields additional insight into the core category.

Current critiques of data saturation include considerations of information power versus sample size (Bradshaw et al., 2017; LoBiondo-Wood & Haber, 2014; Malterud et al., 2016), conceptual and methodological nuances regarding the meaning of data saturation (Charmaz, 2006; Malterud et al., 2016; Morse, 2015; Saunders et al., 2018), and the challenge of achieving a relevant reportable finding versus capturing every detail in the data (Malterud et al., 2016). For example, Charmaz (2006) noted that there is no universally accepted definition of data saturation. Additionally, Malterud et al. (2016) acknowledged that there is no explicit

justification for sample size, which allows researchers to make reasonable estimations, suggesting that reporting of findings can occur whenever deemed appropriate or relevant based on the quality of the information collected, claiming data saturation. Thorne (2020) advocated for removing the term "saturation" from review rubrics and instead focusing on other indicators of study rigor, such as robustness, depth of analysis, and coherence. In this study, saturation was determined by each category's ability to address the research questions and by the point at which no new information added value to the categories, becoming repetitive (Charmaz, 2006, 2014; Levitt, 2021) in each cluster (Levitt, 2021). Saturation was mainly reached between the 14th and 15th interviews, when no new properties within each category were observed.

Reflexivity as a Researcher

Charmaz observed that the researcher's status—background, positions, priorities, values, and actions—should be considered through reflexivity throughout the research process, as it influences viewpoints (Charmaz, 2014, 2017, 2020). According to Charmaz (2014), prior knowledge or preconceived ideas can serve “as a tentative tool, rather than definitive concepts” (p. 31) to enhance the study, and this can be achieved through reflexive practices such as writing memos (Birks et al., 2008). It is important to note that I am a Black woman, a doctoral graduate student, a teaching assistant, and a nurse. My positionality may influence my perception of ICC from the perspectives of a student, visible minority, and clinician. I also have previous research experience studying undergraduate nursing students' perceptions of ICC. Therefore, reflexive, operational, and analytical memos were used during data collection and analysis to identify preconceived thoughts and assumptions and to document how decisions were made throughout the research process.

Ethical Considerations

This study involved human participants; therefore, it was guided by the Tri-Council Policy statement about protecting and respecting human dignity (Government of Canada, 2014, p. 6). Institutional ethics approval was obtained from all relevant academic Research Ethics Boards (REB), including REB 1 (Research Ethics Board, Fort Garry campus) at the University of Manitoba, the Brandon University Research Ethics Committee (BUREC), and the University College of the North Research Ethics Board, between 2023 and 2026. Additionally, permission was secured from the respective recruitment sites to extend study invitations to potential nursing students and nurse educators. The study was conducted on a voluntary basis, with participants provided with adequate information to give informed consent and to participate willingly. They were also able to withdraw at any time within a specified period without penalty (Polit & Beck, 2012). The study posed minimal risk; however, some participants felt uneasy about sharing some clinical experiences. This potential discomfort was described in the invitation letter (see appendices A, B, C, or D) and in the consent forms (see appendices E & F), with updated versions during the change of the supervising team. Moreover, contacts or suggestions for counselling services were provided, as needed, after the interview (see appendices A-D).

Participant information was kept anonymous and confidential during data collection and analysis. Additionally, participants confirmed or validated their statements through the synthesized member checking (Birt et al., 2016), where a draft summary of emerging categories with related quotes was sent to each participant to review, refute, or confirm if it reflected their thoughts in March - May 2025 before the final or fifth phase of Levitt's (2021) critical CGT coding process took place. The participant could include extra comments to be added to the data during the synthesized member checking process, but no additional comments were received.

Recruitment

Following ethics and site access (Appendix F) approval, an administrative assistant from each institution received an email request (Appendix A) and sent email invitations to potential students (see Appendix B) and nurse educator participants (see Appendix C). A copy of the consent form (see Appendix D-1, 2 or Appendix E-1, 2) was attached to the recruitment email. Version two of the consent forms is an updated version following the change of doctoral advisors due to a faculty retirement. Additionally, recruitment posters were posted at various institutions and departments (see Appendix G). In CCGT, theoretical sampling guides the recruitment of individuals who can provide insights into the phenomenon, thereby developing a suitable theory (Charmaz, 2014; Levitt, 2021). Therefore, some educator participants were suggested by their colleagues for contact via snowball sampling to gather rich data. Other stakeholders in education, such as Equity, Diversity, and Inclusion (EDI) experts, could have been approached to participate in a focus group or an individual interview, following the ongoing data analysis with a refined interview guide (questions were formulated after analyzing at least ten transcripts from both nurse educators' and nursing students' interviews, reviewed by the advisory team and submitted to the ethics boards). However, no EDI experts were contacted, as it was deemed unnecessary.

Interested participants contacted the researcher by email or phone to arrange a suitable time and location for the interviews. Due to difficulties recruiting participants, each administrative assistant sent at least five reminder emails to potential participants on their student and faculty lists over a 20-month period, and these reminder emails were approved by the institutional ethics committees. Informed consent was obtained either in person or by email before conducting the 45- to 60-minute semi-structured individual interviews (Charmaz, 2014;

Sandelowski, 2000) and the two focus groups. Hard copies of the signed consent forms were stored in a locked file cabinet at my home or at the Manitoba Centre for Nursing and Health Research. Each participant received a \$30 electronic Visa gift card (for both students and educators) after providing consent, and they sent an email with a gift card receipt to the principal investigator (PI) as confirmation. The PI completed the gift card reconciliation form on behalf of online participants.

Data Collection

Critical CGT was grounded in triangulated perspectives focused on social and historical inquiry, emphasizing the context and social processes of ICC and empathy, as well as the antecedents of intersectionality, such as ethnicity, gender, race, and sexual orientation (Hankivsky, 2014; Levitt, 2021). During the study's conceptualization stage, a demographic survey was created to capture the diverse social categories of research participants (Crenshaw, 1989; Crenshaw, 1991a). Data collection involved a demographic survey (see Appendix H), digitally audio-recorded semi-structured individual interviews (see Appendix I or J for interview scripts), two digitally audio-recorded follow-up focus groups (see Appendices K and L), and field notes with reflexive memos recorded immediately after data collection (Charmaz, 2014).

Demographic Survey

I began data collection by establishing rapport with the participant before they completed their demographic information, interacting with them via email. Each participant received the consent form (see Appendix D-1, 2 or Appendix E-1, 2) and the demographic survey (Appendix H) prior to the interview to allow time for reading and questions. Most research participants (22/30) completed their forms beforehand, giving them more time during the interview. I answered any related questions via email. Those who completed the forms during the interview

also received clarifications and sent their scanned, completed forms later via email. The demographic data consisted of nine main questions and took about five minutes to complete (see Appendix H). The demographic survey described participant characteristics, contributing to an intersectional understanding of the data, including gender, age, country of birth, language, disability, ethnicity, travel history, and religion.

Individual Research Interviews

Data collection took place in a quiet, pre-booked, private room at a convenient location for the participant or online via Zoom. Twenty-eight of the thirty participants (fourteen from each group) participated online. The interviews were audio-recorded with a digital device. Data was collected using semi-structured interview guides (Charmaz, 2014; Levitt, 2021). The semi-structured interview guides (Appendix I & K) were created to encourage participants to share their life stories, which is important to intersectionality theory and the CGT (Charmaz, 2006, 2014; Christensen & Jensen, 2012). Questions focused on multiple intersectional variables (Hankivsky, 2012; Hankivsky, 2014), participant identity, and their sense of belonging during ICC interactions and affiliations (Christensen & Jensen, 2012). The questions and strategies were refined to understand the EICC that is either demonstrated or anticipated (Abrams et al., 2020; Charmaz, 2006, 2014), using open-ended, semi-structured questions targeting key areas of the research. I maintained a reflective memo of each interview using the reflection guide (see Appendix M).

In constructivist interviewing, the researcher guides the interview process, including the content, relationship with the participant, and the construction of the participant's story, using open-ended semi-structured questions. However, I remained open and curious to follow the participants' lead on topics they found important to discuss related to the research, reflecting the

partnership in co-constructing new theoretical knowledge (Charmaz, 2014). Open-ended semi-structured questions focused on the emergent phenomena and aim to define their properties, eliciting participants' definitions of terms, situations, events, assumptions, implicit meanings, and tacit rules (Charmaz, 2014). Sharing life stories and participants' everyday experiences through data collection is essential to qualitative intersectionality methodology and CGT (Charmaz, 2006, 2014; Christensen & Jensen, 2012) as it boosts the utility of the findings (Levitt, 2021). As data collection and analysis progressed concurrently (Charmaz, 2014), I refined the process to better understand the phenomenon under study, ensuring that it was well captured in the data to enhance fidelity (Levitt, 2021).

Focus Group

Through the iterative process of CGT, theoretical sampling began in the interviews by reinterviewing the same participants who had completed individual interviews in focus groups for additional data or by adding extra questions to improve the ongoing analysis (Charmaz, 2014). The purpose of the focus groups was to further clarify participant responses, gain deeper insights, and explore emerging ideas during concurrent data analysis and after synthesized member checks. I determined the need for the focus groups after analyzing approximately ten transcripts from each participant category (educators and students) and following the synthesized member checks. The focus groups were originally planned for 6-8 participants each, but I had 3-4 nurse educators per focus group due to scheduling difficulties. The number of focus group was decided on based on the level of analysis, study goals, controversial topics, unexpected findings, and the amount of data sources. One focus group had three participants, and the other had four participants; the two focus groups were conducted two weeks apart. The student participants had already graduated from school at the time of the focus group and were unavailable to participate

in the interviews. Furthermore, the educators were considered suitable to confirm and clarify specific preliminary findings from this study. Participants were sent a summary of the data analysis categories, along with a note (see note in Appendix O) to guide the discussion, while the researcher used a semi-structured interview guide (Appendix K) and a concept map developed from the interview data (Appendix L). The focus groups occurred via Zoom and lasted approximately 60 minutes each. Each focus group was audio-recorded with a digital recorder and transcribed verbatim. Participants had their Zoom cameras turned off, and they were given pseudonyms beforehand to rename their devices, maintaining anonymity and confidentiality. Although there was no video, their voices were identifiable; the focus group participants signed a pledge of confidentiality (Appendix N) not to disclose any participant's identity. Each participant received a \$30 electronic gift card as an honourarium.

Data Management

Each participant's response was audio-recorded with a digital recorder during the interview. I transferred the audio data to a transcription company after they signed a confidentiality agreement (Appendix N). The digital audio recording was encrypted during data transfer from the recorder to the transcriptionist. The audio-recorded interviews were transcribed verbatim to ensure accuracy. When the transcribed data was returned to me, I verified and de-identified all the transcripts. The digital audio recorder was stored in a separate locked cabinet in my home office until I verified the transcripts' accuracy, and the data was erased from the recorder afterward. Any identifiable information disclosed during the individual interviews and focus group was de-identified before the transcript data were shared with other research team members. The interview transcripts were coded and anonymized; only participant pseudonyms were used.

A password-protected shared drive was established by the Information Services and Technology (IST) at the University of Manitoba for my use and that of my co-advisors. All code and de-identified data were uploaded to that shared drive. The printed data will be kept in my locked home office cabinet for five years (until November 2028), after which it will be destroyed as confidential waste. Any electronic files are stored on the University of Manitoba's password-protected shared drive. Emailed data were deleted immediately after printing and transferring to the University of Manitoba password-protected shared drive.

Data Analysis

Three data sources were examined in this study: semi-structured research interviews (both individual and focus group), reflexive and analytical memos, and participants' demographic data. Furthermore, synthesized data from member checks were analyzed when received from participants (Birt et al., 2016; Harvey, 2015). The demographic data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 28 for descriptive statistics. Interviews were audio-recorded with a digital recorder, transcribed verbatim (Sutton & Austin, 2015), de-identified, and imported into NVivo version 12 software, along with reflexive and analytical memos (Charmaz, 2014; Levitt, 2021).

The data analysis was guided by intersectionality (Collins & Bilge, 2020), Levitt's critical CGT coding processes (Levitt, 2021), and analytical memo writing, followed by theoretical integration using inductive-abductive logic (Charmaz, 2014), until saturation was reached (Birt et al., 2016; Charmaz, 2014; Levitt, 2021). The five-phase CCGT coding (Levitt, 2021; Rennie, 2000, 2012) differs from Charmaz's (2014) two-phase approach—initial and focused coding (see **Table 3**).

Table 3*Constructivist Grounded Theory Versus Critical Constructivist Grounded Theory Coding*

	CGT (Charmaz, 2014)	CCGT (Levitt, 2021)
Similarities	Uses a critical iterative process.	Same as Charmaz (2014)
	Employs a subjective interpretive view.	Same as Charmaz (2014)
Distinctions	Two coding phases – initial and focused	Five coding phases – unitizing, labeling meaning units, creating categories, creating a core category, and hierarchal review
	First coding phase – initial coding Second coding phase – focused coding	First three phases are congruent with Charmaz's (2014) initial coding. Last three phases are congruent with Charmaz's (2014) focused coding
	Uses inductive-abductive logic	Uses eductive-abductive-theorematic deductive- inductive logic and a critical iterative process
	Speaks explicitly to theoretical integration	Does not explicitly speak to theoretical integration
	Speaks to processes and context during coding	Specifically captures the processes, functions, and contexts – multiple social spheres; change across historical epoch, place, and time; multiple perspectives; the role of symbolic items and actions within the data
Coding Process	Initial coding - Data is studied and labelled with codes. - The researcher codes for possibilities from the data rather than ensuring complete data accuracy, resulting in a range of variation and a means to conceptualize it further or check ideas with the data. - Can be done via word-to-word or line-by-line coding to discover ideas one can build to separate data into codes and see the theorization process (p. 127) or via incident-to-incident coding. - Prompts the researcher of the needed data, areas lacking, or questions to be reframed. The researcher is open to adding social categories	1. Create units (unitizing – meaning units). - Meaning units are initial responses, drawn from the original interviews or texts, each providing a preliminary answer to the study questions. - Each meaning unit per new idea
		2. Label meaning units with words or sentences. - Be clear about varied meanings, functions, and contexts related to the study question. - Remove words that do not answer the question of the interview to keep the labels short (maximum 1.5 lines of text). - Use evocative language and metaphors, participants' quotes.
		3. Create categories. - After creating meaning units from about three to four interviews - Keep a record of how many meaning units were created from the project. - Conceptualize categories as sentences that capture the processes,

	to help understand the research question. - The constant comparison method allows the researcher to first compare data with data to seek similarities and differences and identify patterns that can form categories. - Then, the initial codes are labelled, compared, and used to generate higher-order categories with shared meanings.	functions, and contexts described in the unit titles relevant to the research question. - Engage in constant comparison of each unit label with other units. - Create subcategories or higher-level categories, being cognizant of the number of categories or clusters to report in the final draft. - Levitt's inferential process for categorization is based on Rennie's (2000, 2012) methodological hermeneutic: 1) eduction – drawing forth what seems meaningful about the piece or section, 2) abduction – formulating an approximation of the inherent meaning by considering what might efficiently explain the data - labelling, 3) theorematic deduction – deciding that continued analysis could provide useful evidence using new data source or unit to examine, and 4) induction – seeking out commonalities across the data – generating categories, which leads to data saturation and formation of a comprehensive theory (Levitt, 2021, p. 68). - Consider the following when coding – multiple social spheres; change across historical epoch, place and time; multiple perspectives; the role of symbolic items and actions within the data
	Focused coding - The researcher takes the most used and relevant codes from the initial codes and uses them to organize or theoretically code future data. - The focused codes are more conceptual, leading to abstract categories and theoretical integration. - Researchers may adopt axial codes (Strauss & Corbin, 1998) and theoretical codes (Glaser, 1978)	4. Create a core category. - Reflects common ideas across the uppermost levels of the categories. 5. Hierarchy review - Periodically review categories and clean them up by merging redundant ones, creating subcategories as needed, and refining the labels of the categories. - Results in creating fewer new categories as saturation is imminent. - Done from the initial categories upward. - Track the process of adding new sources to the hierarchy to see when saturation is reached. - Saturation: Point where the addition of new data no longer results in the creation of new categories and ideas

	if needed (Charmaz, 2014). However, Charmaz (2014) stated she does not use axial or theoretical coding because her analytical approach is emergent rather than procedural (p. 148). - Focused coding uses a conscious, interactive effort to code the initial codes, sift and use the relevant or frequent earlier codes to categorize the entire dataset clearly and completely. - Focused codes are more conceptual and advance theoretical directives of the data via the emergence of ideas. - The data is collected and analyzed until the categories become saturated, are sorted, and integrated into the emerging theory. - Saturation occurs when the data being analyzed confirms existing categories and adding new data does not generate new theoretical insight.	in the hierarchy (at least two interviews do not add anything new)
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Both Charmaz (2014) and Levitt (2021) employ similar coding methods; however, Levitt does not explicitly address theoretical integration. Charmaz (2014) focuses on inductive-abductive logic and a critical iterative process, whereas Levitt (2021) describes an educative-abductive-theorematic deductive-inductive logic based on Rennie's (2000, 2012) hermeneutic methodology. The first three steps in Levitt's (2021) coding process: unitizing, creating meaning

units, and forming categories, align with Charmaz's (2014) initial coding. The fourth and fifth steps in Levitt's (2021) data analysis process: creating core categories and hierarchical review, correspond with Charmaz's (2014) focused coding. My analysis was guided by Levitt's (2021) coding process because it explicitly captures processes, functions, and contexts—such as multiple social spheres, change across historical epochs, places, and times, multiple perspectives, and the role of symbolic items and actions within the data—that are relevant to the research questions. I adopted a subjective and interpretive stance, moving between the data to understand participants' views and actions from their perspective through an educative-abductive-theoremtic deductive-inductive logic and a critical iterative process (Levitt, 2021).

First, I began coding with the first transcript. I coded the data line-by-line to develop the codebook by creating meaning units from the initial responses, establishing patterns to answer the study questions (Levitt, 2021). This was done through paper-based analysis, and the codes were entered into NVivo. Second, I created labels and meaning units with words or sentences, paying attention to varied meanings, functions, and contexts related to the study questions. I focused on words that explicitly addressed the interview questions to keep the labels concise, limiting them to a maximum of 1.5 lines as proposed by Levitt (2021). Third, using an intersectionality lens, I queried the data after developing meaning units from about three to four interviews to identify codes of intersecting categories. I conceptualized categories as sentences that capture the processes, functions, and contexts described in the unit titles relevant to the research question. I engaged in multi-level analysis of power relations, reflexivity, time and space, social justice, equity, resistance and resilience, and diversity of knowledge (Hankivsky, 2014). For instance, I considered the race and gender of participants and the patients in their clinical encounters and examined how power relations in undergraduate nursing education and

ICC or empathy interactions influenced their actions (Abrams et al., 2020; Charmaz, 2017). I also analyzed the social processes of ICC encounters and teaching, shaped by constructs related to social inequity, structural, political, and representational power relations, social context, and relational complexity.

Levitt (2021) recommends that, when coding, multiple social spheres be considered; this includes changes across historical epochs, locations, and times; multiple perspectives; and the role of symbolic items and actions within the data. I was guided by Hankivsky's (2014) principles of intersectionality to answer the research questions and to identify relevant concepts to understand the narratives and social hierarchies that contribute to EICC in undergraduate nursing education (Charmaz, 2014; MacKinnon, 2013). I carefully considered the perspectives shared through the stories of educators who teach ICC and/or empathy, as well as the students who experience ICC and/or empathy or inequities shaped by complex, interlocking historical, social, and structural contexts. I immersed myself in the ICC experiences and stories of the participants and remained open to exploring theoretical possibilities from the meaning units and labels (Charmaz, 2014; Christensen & Jensen, 2012; Levitt, 2021). I journaled an analytical memo separately for the intersectionality analysis. As I continued coding subsequent transcripts, I used constant comparison (Charmaz, 2014; Levitt, 2021) to first compare data from transcript one with data from transcript two. I stayed close to the data to discover similarities and differences, and to identify patterns that can form categories (Charmaz, 2014; Levitt, 2021), while focusing on processes and relations in the data (Christensen & Jensen, 2012). I then created subcategories and higher-level categories, being mindful of the number of categories and clusters to report in the final draft. This study involved an extensive data set that required multiple analyses during the second and third phases of the Levitt coding process. Due to the

intensity of the intersectional analysis, I anticipated an additional step between step one and step two to thoroughly navigate the data before developing the categories and to facilitate a smoother transition between the steps.

At the fourth phase, I established a core category that captured shared ideas across the highest levels of the categories (Levitt, 2021). Finally, I conducted a hierarchy review, which involved a periodic assessment of categories from the initial level upward, and cleaning them up by merging duplicates, creating subcategories as needed, and refining category labels to reduce the number of new categories as saturation developed (Levitt, 2021). I tracked the analytical process using analytical memos. In line with Levitt (2021), I considered my core category saturated when at least two interviews did not yield any new information for the categories. See **Figure 1** for the Levitt (2021) sample for data analysis.

Figure 1

Levitt (2021) Sample of Data Analysis



Throughout the analysis, I assessed data adequacy through theoretical sampling, saturation, and sorting (Charmaz, 2014; Glaser, 2001; Glaser & Strauss, 1967) and determined whether the emerging ideas reflected the experiences of the social categories or offered recommendations for future actions (Charmaz, 2017; Levitt, 2021). I drew inferences from the data using an inductive process, considered possible theoretical explanations for the researcher's initial observations, attempted to confirm or refute these tentative ideas to identify the most plausible explanation (abductive logic), and validated them with additional data collected through theoretical sampling (Charmaz, 2014). I employed specific methodological approaches, including memo writing, reflexivity, and theoretical interpretation, to interpret the data (Bryant & Charmaz, 2010; Charmaz, 2014), to explore how EICC in nursing education can empower undergraduate nursing students to influence relational practice and promote health equity (Abrams et al., 2020; Hankivsky, 2014; Kassam et al., 2020).

I involved my co-advisors in reviewing at least one transcript per participant group to ensure we identified similar codes and categories. The co-advisors coded the anonymized transcripts and participated in five data analysis meetings to discuss the emerging categories and theoretical explanations before finalizing them for reporting. The first meeting focused on discussing codes from the initial transcript to guide the PI's subsequent initial coding. The second meeting addressed the focus codes and categories. The third to fifth meetings examined the emerging theoretical categories and understanding of EICC derived from the data, prior to the researcher drafting and finalizing the findings and discussion sections.

Memo Writing

I created various types of memos (see memo guide in Appendix M) throughout the study's stages of conception, data collection, analysis, and reporting of findings, using the

freewriting approach (Charmaz, 2014) to improve the credibility of the findings and enhance the analysis and theoretical understanding. Memo writing also aided me in mapping research activities, extracting meaning from the data, maintaining momentum, and communicating with my advisory committee (Birks et al., 2008). During the conception and data collection phases, I wrote operational memos as ideas arose (Birks et al., 2008; Glaser, 1978), along with a reflexive memo for each interview. The operational memos documented the research process steps, methodological dilemmas (Charmaz, 2014), and the reasons behind decisions and actions (Birks et al., 2008; Levitt, 2021). I also wrote analytical memos during the data collection and analysis stages. These memos described how the data were examined during coding, explained, and conceptualized (Birks et al., 2008; Levitt, 2021). The reflexive memos reflected on my positionality as a researcher, my thoughts before, during, and after interviews, and how my experiences of marginalization and privilege might have influenced or revealed important insights during data analysis (Levitt, 2021). Continuous reflexive memo writing enabled me to acknowledge limitations and address biases throughout the data analysis process.

Study Rigor

I used multiple methods to gather data from various sources and to conduct member checks to strengthen the study's rigour. The sampling techniques employed maximized the validity of the data collection (Morse & Niehaus, 2009). To improve the credibility of the data, I started the interview with an open-ended question to draw out inductive data from participants' shared stories (Christensen, 2012; Satchwell et al., 2020). The participants' responses guided the refinement of questions that provided in-depth information about EICC. I enhanced the research's fidelity by ensuring data adequacy, managing perspectives from myself and co-advisors during data collection and analysis, and achieving groundedness by including

participants' quotes for each cluster (Levitt, 2021). Data analysis began with the first interview and continued to identify commonalities and differences in participants' experiences within and across the data. I adjusted the questions when necessary (Baird, 2021; Birks & Mills, 2012; Thornberg & Charmaz, 2014). I kept a reflexive memo after each interview and during the data analysis phase (see memo guide in Appendix M). Reflexive memos included my thoughts, observations, and feelings before, during, and after each interview, serving as a space to record biases, differences, attitudes, values of the researcher, and all observations made during the interviews. Willis et al. (2016) suggested that reflexive memos enhance the transparency of analytic insights and speculations; therefore, the memos were incorporated into the data analysis documentation and played a central role in ensuring the study's rigour.

A summary of preliminary or draft findings was emailed to participants after the core categories (phase four of data analysis) were created (Levitt, 2021), between December 2024 and March 2025, to verify, substantiate, or refute the study's findings. I employed the five-step synthesized member checking process described by Birt et al. (2016) and Harvey (2015), as it aligns with the constructivist view of co-creating reality (Charmaz, 2008; Levitt, 2021). I prepared the synthesized summary from emerging theoretical categories and quotes that encapsulated the data. I then verified the participant's eligibility to receive the summary report (i.e., whether they provided consent), and sent an email with instructions on how to return it with their comments by December 2024 to March 2025. Additionally, I collected their responses and integrated them into the final analysis, with initial categories being periodically reviewed to reach the core categories, reducing the emergence of new categories awaiting saturation. The feedback obtained from the synthesized member check data also identified the need for a focus

group to seek further clarification. Once the study was completed, I provided participants with an executive summary of the findings.

Chapter Summary

In this chapter, I expanded on the research methodology – critical constructivist grounded theory – and described the settings, sample, data collection materials, and analysis process using the CCGT. The methods for maintaining study rigor were also outlined. Chapter four will outline emerging theory derived from the analysis process and based on the research interviews conducted with final-year undergraduate nursing students and nurse educators.

Chapter 4: Findings (Part A)

In this chapter, I discuss the research findings and sample, including the key clusters that emerged from the CCGT analysis. I describe the characteristics of final-year undergraduate nursing students and nursing educator participants, providing details on their gender, age, spoken languages, educational backgrounds, and intercultural experiences. Four theoretical clusters emerged from the research analysis: 1) reflections on the intersectional maze of ICC - equality versus equity, 2) racism, discrimination, and marginalization in EICC interactions, 3) navigating humanity in EICC, and 4) partnering toward a diversified and relation-based curriculum. Direct quotes and phrases were used to reflect participants' perceptions of ICC. Data from two focus groups of nurse educators further supported the theoretical clusters developed from the individual interview data. The purpose of the focus group was to offer additional clarification and insight into participant nurse educators' responses that required explanation.

Table 4

Theoretical Core Category, Clusters, and Categories Map

Core Category: Theoretical Foundations of EICC and the REEICC Theoretical Model	
Clusters	Categories
Reflections on the Intersectional Maze of ICC - Equality Versus Equity	1. Intercontextuality in EICC 2. Environmental influences on EICC 3. Equity as a foundation for EICC practices
Racism, Discrimination, and Marginalization in EICC Interactions	1. Asymmetrical power dynamics within EICC 2. The psychological functionality of racism and discrimination in EICC 3. The use of interpersonal racial conflict-resolution approaches to maintain effective EICC
Navigating Humanity in EICC	1. Humanness in EICC 2. Conceptual basis of ICC

	3. Empathy: A foundation for effective EICC 4. Emotional distress in EICC
Partnering toward a Diversified and Relation-based Curriculum	1. Structuring nursing curriculum to promote EICC 2. The call for partnership for effective EICC

Study Sample Demographics

The majority of educators (93%) were over 30 years old, while 12 (80%) of students were 21-30 years old. Of the 15 participants in each category, only two (13%) of educators and three (20%) of students were male, underscoring the predominance of females in the nursing profession. Four (27%) of the 15 educators and nine (60%) of the 15 nursing students were born outside Canada, suggesting an English-as-a-second-language link among participants. While 13 (87%) of educators had English as their first language, 8 (53%) of students had English as their second language. Similarly, 12 (80%) of educators and 6 (40%) of students were Caucasian (Whites). Participants reported only one Black and one South Asian among the educators, and four Filipino, one Black, and two South Asian nursing students. These statistics may indicate greater diversity among nursing students in Canada than among nurse educators. There was also evidence of significant religious diversity in both groups, with 10 (67%) educators selecting ‘other’ and noting additional religions not listed. Meanwhile, only 14 students reported their religion, with five (36%) identifying as Roman Catholic and five (36%) selecting ‘other.’

Almost all participants, 14 (93%) in each category, had travel history within or outside North America, including Canada and the United States of America. While educators reported a bachelor's degree as the minimum, some nursing students had a bachelor's degree as their highest level of education. For instance, 8 (53%) educators were master's-prepared, 5 (33%) held bachelor's degrees, and 2 (13%) held doctorates. Ten (67%) students held high school diplomas,

three (20%) held college diplomas, and two (13%) had bachelor's degrees. There was a link between context and participants' lived experiences across both students and educators. Three (20%) educators and one (7%) student reported a disability (See Table 5).

Table 5

Demographic Characteristics of Participants

	Nurse Educators (n=15)	Percent (%)	Final Year Nursing Students (n=15)	Percent (%)
Age (years)	n=15		n=15	
18-20 years	0	0	1	6.7
21-30 years	1	6.7	12	80
31-40 years	7	46.7	2	13.3
41-50 years	1	6.7	0	0
51-60 years	5	33.3	0	0
61+	1	6.	0	0
Prefer not to state	0	0	0	0
Gender	n=15		n=15	
Woman	13	86.7	12	80
Man	2	13.3	3	20
Non-binary/ Trans/ Gender diverse	0	0	0	0
Other	0	0	0	0
Prefer not to answer	0	0	0	0
Born in Canada	n=15		n=15	
Yes	11	73.3	6	40
No	4	26.7	9	60
English as a second or additional language	n=15		n=15	
Yes	2	13.3	8	53.3
No	13	86.7	7	46.7
Ethnicity	n=15		n=15	
White (Caucasian)	12	80	6	40
Indigenous/ Aboriginal Ancestry	0	0	0	0
Black	1	6.7	1	6.7
South Asian	1	6.7	2	13.3
Filipino	0	0	4	26.7

	Nurse Educators (n=15)	Percent (%)	Final Year Nursing Students (n=15)	Percent (%)
Chinese	0	0	0	0
Arab/ West Asian	0	0	0	0
Japanese	0	0	0	0
Other	1	6.7	2	13.3
Travel History inside or outside North America	n=15		n=15	
Yes	14	93.3	14	93.3
No	1	6.7	1	6.7
Highest Level of Education	n=15		n=15	
High School Diploma	0	0	10	66.7
College Diploma	0	0	3	20
Bachelors	5	33.3	2	13.3
Masters	8	53.3	0	0
Doctorate	2	13.3	0	0
Religion	n=15		n=14	
Roman Catholic	1	6.7	5	35.7
Pentecostal	1	6.7	0	0
Lutheran	0	0	1	7.1
Greek Orthodox	0	0	0	0
Muslim	0	0	1	7.1
Buddhist	0	0	0	0
Sikh	0	0	0	0
Hindu	1	6.7	1	7.1
Jewish	0	0	1	7.1
United Church	1	6.7	0	0
Anglican	1	6.7	0	0
Presbyterian	0	0	0	0
Baptist	0	0	0	0
Other	10	66.7	5	35.7
Presence of any form of disability	n=15		n=15	
Yes	3	20	1	6.7
No	12	80	14	93.3

Table 6*Data Analysis via Levitt (2021) CCGT Process*

	Student data	Educator Data	Combined
Core Category	1	1	1
Clusters	4	4	4
Categories	7	7	12
Subcategories	19	20	30
Meaning labels	81	87	
Meaning units	10-19	15-23	

Table 7*Participant Quotes Contributing to Clusters*

Clusters	Nursing Students (NS)	Nurse Educators (NE)	Overall number of participants
1. Reflections on the Intersectional Maze of ICC - Equality Versus Equity	Adna, Iris, Alana, Stephanie, Fola, Nana, Papa, Ellen, Breanna, Sussie, Jona, Efua, Adeola, Bisi, Vero 15/15	Rehoboth, Sunshine, Star, Elliette, Comfort, Selina, Naa, Akosua, Donna, Allan, Sky, Yaa, Angel, Moon, Pearl 15/15	30/30
2. Racism, Discrimination, and Marginalization in EICC Interactions	Iris, Alana, Stephanie, Fola, Nana, Papa, Ellen, Breanna, Sussie, Jona, Efua, Adeola, Vero 13/15	Sunshine, Elliette, Comfort, Selina, Naa, Akosua, Donna, Allan, Sky, Angel, Moon, Pearl 12/15	25/30
3. Navigating Humanity in EICC	Adna, Iris, Alana, Stephanie, Fola, Nana, Papa, Ellen, Breanna, Sussie, Jona, Efua, Adeola, Bisi, Vero 15/15	Rehoboth, Sunshine, Star, Elliette, Comfort, Selina, Naa, Akosua, Donna, Allan, Sky, Angel, Moon, Pearl 14/15	29/30
4. Partnering toward a Diversified and Relation-based Curriculum	Adna, Iris, Alana, Ellen, Stephanie, Sussie, Adeola, Papa, Breanna, Jona, Fola, Efua, Nana, Bisi, Vero 15/15	Rehoboth, Star, Elliette, Selina, Naa, Akosua, Donna, Allan, Sky, Yaa, Angel, Pearl 12/15	27/30

Table 8*Research Questions Aligning with Categories and Clusters*

Research Question	Categories	Clusters
1a. How do academic/clinical nurse educators and undergraduate student nurses view empathy?	Humanness in EICC Conceptual basis of ICC Empathy: A foundation for effective EICC Emotional distress in EICC	Navigating Humanity in EICC
	Intercontextuality in EICC Environmental influences Equity as a foundation for EICC practice	Reflections on the Intersectional Maze of ICC - Equality Versus Equity
1b. What are their perspectives on integrating empathy in teaching/learning about ICC?	Humanness in EICC Conceptual basis of ICC Empathy: A foundation for effective EICC Emotional distress in EICC	Navigating Humanity in EICC
	Structuring nursing curriculum to promote EICC The call for partnership for effective EICC	Partnering toward a Diversified and Relation-based Curriculum
	Defining EICC The Proposed tenets of EICC The Emerging Theory: Relational Equitable Empathy-based ICC (REEICC) Theoretical Model	Theoretical Foundations of EICC and the REEICC Theoretical Model (Core category)
2a. What are the social processes of engaging in ICC in undergraduate nursing education, as understood from the perspective of nurse	Intercontextuality in EICC Environmental influences Equity as a foundation for EICC practice	Reflections on the Intersectional Maze of ICC - Equality Versus Equity
	Asymmetrical power dynamics within EICC Psychological functionality of racism and discrimination in EICC	Racism, Discrimination, and Marginalization in EICC Interactions

Research Question	Categories	Clusters
educators and student nurses?	The use of interpersonal racial conflict resolution approaches to maintain effective EICC	
	Structuring nursing curriculum to promote EICC The call for partnership for effective EICC	Partnering toward a Diversified and Relation-based Curriculum
2b. How is empathy integrated into those social processes?	Structuring nursing curriculum to promote EICC The call for partnership for effective EICC	Partnering toward a Diversified and Relation-based Curriculum
	Defining EICC The Proposed tenets of EICC The Emerging Theory: Relational Equitable Empathy-based ICC (REEICC) Theoretical Model	Theoretical Foundations of EICC and the REEICC Theoretical Model
2c. Does empathy need to be integrated in those social processes in a more explicit manner?	Asymmetrical power dynamics within EICC Psychological functionality of racism and discrimination in EICC The use of interpersonal racial conflict resolution approaches to maintain effective EICC	Racism, Discrimination, and Marginalization in EICC Interactions
	Humanness in EICC Conceptual basis of ICC Empathy: A foundation for effective EICC Emotional distress in EICC	Navigating Humanity in EICC
	Structuring nursing curriculum to promote EICC The call for partnership for effective EICC	Partnering toward a Diversified and Relation-based Curriculum

Research Question	Categories	Clusters
3a. What are some of the key contextual influences on the social process of intercultural communication?	Asymmetrical power dynamics within EICC Psychological functionality of racism and discrimination in EICC The use of interpersonal racial conflict resolution approaches to maintain effective EICC	Racism, Discrimination, and Marginalization in EICC Interactions
	Intercontextuality in EICC Environmental influences Equity as a foundation for EICC practice	Reflections on the Intersectional Maze of ICC - Equality Versus Equity
3b. How might they inform the integration of empathy into ICC encounters?	Intercontextuality in EICC Environmental influences Equity as a foundation for EICC practice	Reflections on the Intersectional Maze of ICC - Equality Versus Equity

Cluster One: Reflections on the Intersectional Maze of ICC - Equality Versus Equity

This cluster addresses the social processes of engaging in intercultural communication (ICC) in undergraduate nursing education, as understood from the perspectives of nurse educators (NE) and nursing students (NS). The key contextual influences on these processes, as well as how they may inform the integration of empathy into ICC encounters, are articulated. The term ICC arises from interactions among multiple people, cultures, and perspectives. The principles of intersectionality include overlapping categories, multilevel analysis, power, reflexivity, time and space, the diversity of knowledge, social justice, equity, resistance, and resilience (Hankivsky, 2014). An educator rightly noted: “I think we also need to look at intersectionality, the ways that people's experiences kind of overlap to create positions of power, or less power, and racism, and all of those other things” (NE, Elliette). Therefore, intersectionality cannot be understood from a single context or factor. The analysis revealed

various perspectives on contextual factors influencing ICC among nursing students, staff, nurse educators, and their patients. Recognizing these factors collectively is essential for engaging in quality empathy-based intercultural communication (EICC). The findings highlight the impact of each factor on facilitating communication and the potential barriers faced by nursing students and educators. To understand the theoretical foundations of EICC, the data was mapped to identify variable social and personal intersections contributing to the process. This complex web involves 1) navigating intercontextual factors in EICC, 2) highlighting environmental influences on EICC encounters, and 3) applying equity perspectives to foster EICC and reduce bias in patient interactions.

Intercontextuality in EICC

Intercontextuality is the dynamic interaction among multiple contexts that influences the social processes of EICC. Social processes have intersectional elements. In this analysis, clinical scenarios, settings, and the lived experiences of culturally diverse individuals were central to the intersectional nature of communication encounters. Within this first theoretical cluster, I highlight key intercontextual factors influencing the social process of EICC encounters: language, religion (diversity of beliefs), gender, culture, and time. I draw on multiple realities from individual participants' data to demonstrate how the social processes of EICC unfold within these interacting contexts. Most significantly, I acknowledge that all participants bring multiple experiences and contexts to each EICC encounter. As one educator noted:

When you come to the hospital, you're still a person, and you're still who you are, you're still that person from that country. You're still that person with those cultural backgrounds and beliefs; you're still that person with those religious beliefs. So, sometimes we think about medicine, and we think of it apart from culture and religion

and things like that, but they all integrate, and sometimes people don't understand that (NE, Angel).

These aspects must be approached holistically to meet the needs of culturally diverse patients. Understanding intercontextual factors in EICC promotes understanding of the patient's perspective, recognizes their experiences and struggles, and creates space for safe communication. Participants from both categories frequently noted the importance of reflecting on their experiences and how those experiences impacted their engagement in EICC practices:

I can relate a lot to empathy and ICC because I'm a newcomer myself. So, I can relate to the challenges for people who have come here without family... And for a lot of these newcomers as well, they might not even speak English as good as others... that can be a huge factor... empathy for me is huge because I've experienced it myself, and that carries over to the way that I communicate as well with others in different cultures (NS, Breanna).

Nursing students felt they interacted, connected, and empathized more effectively with those who had similar cultural experiences.

The five categories that framed key elements of the EICC encounters: language, religion (diversity of beliefs), gender, culture, and time, are discussed in the following section. I highlight how participants addressed each element and demonstrated the complex intersectional nature of each category.

Intercontextuality of Language in EICC. Within the study data, many participants faced language barriers that hindered EICC. Most culturally diverse individuals who were not physically identifiable by their complexion or accent were identified through these language barriers. A student noted:

At first, I thought she was just really quiet...then one day, I overheard her on the phone with her family, and I realized that she was not speaking English. And so, then I asked her...“Is English your primary language?” because I hadn’t detected any language barrier, and then she said, “No.” She primarily spoke Ojibwe. And I said, “When the staff are speaking to you about your care, do you understand what they’re saying?” And she said, “Not really,” and she had been there about a month by that point (NS, Bisi).

While some culturally diverse patients faced challenges speaking English or expressing themselves, some culturally diverse nursing students were scrutinized by patients and educators because their accents were perceived as hindering understanding and effective communication. A student shared her observation: “But she had a patient who was so angry and rude to her because she didn’t speak English. She spoke English well, but with an accent, and they were finding it hard to understand her and kept getting flustered” (NS, Stephanie).

Language barriers increased miscommunication, misunderstanding, agitation, loneliness, mistrust, poor nursing care, and strained rapport between the nurse and patient, ultimately affecting health outcomes. These situations hindered nursing students’ ability to demonstrate empathy. A student shared a heartfelt experience related to this:

There was a patient who spoke Slovenian; no one in the hospital spoke it, so that was a big deal because we couldn’t communicate with her. She couldn’t communicate with us. Nobody knew what was going on. She would cry out loud all the time, and the son hardly ever came, so that was a big cultural issue we were having (NS, Nana).

The data highlighted challenges in securing interpreters and translators due to structural limitations within health agencies. Translation services also posed unforeseen difficulties. An educator noted, “In my own practice and with students, that’s something that I’ve struggled with,

is we always look to the interpreter and we're forgetting about the patient. That's just an idea that I have" (NE, Rehoboth). Often, the lack of translators' forces student nurses to rely on Google Translate or whiteboards, which creates additional challenges depending on the level of technological familiarity among the culturally diverse patient, student, educator, or staff member. A student shared:

I had used Google Translate for a Russian patient a while ago. So that was a bit more complicated because she had no caregiver, we had no translator ... And she wasn't quite getting the hang of Google Translate. She was a bit older (NS, Stephanie).

These findings suggest that age, technology, and race intersect in some ICC situations. The patient's ability to use technology to overcome language barriers must be evaluated to prevent issues. Other sources for interpretation identified included family caregivers, nursing students, staff, and clinical education facilitators (CEF). An educator noted that staff combined questions when family members were present to help: "... But I think that's basically how the staff were treating the patient, was when the husband was available, they would basically consolidate all the questions...which is not ideal, right, she was there" (FG2, NE, Moon). This finding raises concerns about individualized and quality care, as the patient's needs went unaddressed until a spouse was available to translate, thereby placing an additional burden on family members and introducing an additional layer of interpretation. Unfortunately, students were not always able to translate, so staff had to wait for family caregivers. The limited information and lack of consent arising from language barriers were major issues that students sought to navigate and avoid. The students expressed their desire to keep patients and their families informed with the necessary details, despite language barriers.

Language also influenced how nurses were positioned in EICC encounters. For example, clinical nurse educators reported that student nurses may not be assigned to patients with language barriers to save time or avoid challenging situations. This limited students' opportunities to interact with culturally diverse patients and develop EICC skills. It may also have worked against student nurses who could offer EICC practices to patients, particularly when they shared a language with them. Both students and educators emphasized the importance of discussions and education about how to address language barriers in relational practice to improve the quality of nurse-patient communication and relational care.

Intercontextual Influences of Religion (Diversity of Beliefs) in EICC. The analysis indicated a strong influence of religious or spiritual diversity on EICC, particularly in contexts where factors such as gender, race, power, cultural values, and migration history were present. An educator noted: "My race, my gender, my belief system, impacts how I'm going to respond, and I have to know what that is and see how it fits within what their beliefs are" (NE, Sky). This suggests that, before engaging in an ICC dialogue, individuals process information through their prior knowledge of race, gender, and beliefs. For example, a student shared:

I was at [Local Hospital], and they play mass or like a little prayer over the speakers every day at 8 o'clock or something. A patient was super agitated or unhappy in the morning. ... the mass wasn't her religion. It was her first night there, and she felt a bit offended that they were playing that over the speakers and all patients' rooms. And there's crosses like there's crucifixes hanging up in every patient room (NS, Stephanie).

Diversity in religious beliefs affects how people process information, give feedback, and experience emotions in response to what they see or hear, which can lead to offence, tension, and discrimination. Discriminatory actions were evident in Adeola's interview:

There was a patient who was a Catholic and was not willing to be provided care by a Black person. Yes, so that is where I think maybe religion can fall in. Like communication is going to be very hard in the sense that a Catholic is expecting only a white person to provide care (NS, Adeola).

These findings illustrate the connection between religion and race in ICC and how religious or racial discrimination makes meaningful conversations or empathy difficult.

Diversity in beliefs also led student nurses to face conflicts in decision-making during care encounters. A student shared:

I even had a patient from a different culture where they do not want any blood products given to them. And if their heart were to stop, it doesn't matter what age they are; it is just appropriate for them to pass away. And that came as a big shock to me because in my culture, you just keep trying, right? You want to save as many people as you can, but that's not the case for everyone and their belief system (NS, Jona).

Some ICC encounters were reported to be marked by nervousness stemming from differences in beliefs, values, and cultural preferences, which affected nursing students' ability to empathize and provide appropriate care.

Migration of students and patients was noted to intersect with religion, as some countries are dominated by specific religions. Transitioning into the healthcare system as an immigrant nursing student meant learning about the new religion to adequately support your patients. An educator shared a reflection from her immigrant student who cared for a patient from another religion: "He felt that he wasn't supporting the patient because he didn't really know the Christian religion that well. And coming from a different country" (NE, Donna). This reflection highlights the influence of 'unknowing' and the importance of finding common ground –

acceptance without criticism – which connects nurses and patients from diverse religious and racial backgrounds during ICC interactions. For example, an educator shared, “For myself, I guess, with religion and power, it’s always that there is no one right belief or one right way to live life. And it’s always finding that common connection” (NE, Naa). This demonstrates that when an individual concludes that their choice or preference takes precedence over another, a power imbalance begins to manifest in their thoughts; hence, the need to diffuse this power relation by accepting the other’s religion to foster adjustment and adaptation towards effective EICC.

Findings also suggest that religious diversity may lead to specific expectations, such as room allocation. An educator shared, “I have seen where patients have said, ‘I can’t be put in a room with a man,’ because of religious beliefs and cultural beliefs and all the things” (NE, Sky). This diversity in religious preference could even affect how some male patients or students perceive nursing, which is predominantly female, and how people view female nurses. One educator observed, “I think that certain religions have views on women’s roles” (NE, Sunshine). These religious and cultural expectations can influence how someone perceives a nurse’s role and affect a patient’s lived experiences within a healthcare setting.

Intercontextuality of Gender in EICC. There was a clear connection between gender and cultural preference in the findings. Some culturally diverse patients requested nurses of a specific gender based on their cultural values and preferences. An educator shared that, “with the different cultures sometimes it’s because of the fact that I’m a guy, too. Some people do not want a guy taking care of them, which is fine too. So, you find a female to go in” (NE, Allan). It was clear that some culturally diverse patients preferred being cared for by someone of the same sex,

especially when privacy was needed. Educators must be culturally aware of such preferences to support their students.

Additionally, biological differences between males and females were found to influence human psychology, affecting communication patterns, emotions, and behaviours. Students observed that some female patients or educators are more emotional than their male counterparts, making them more comfortable expressing empathy toward certain genders. A student shared: “For gender, I think that men have a different way of thinking than women; I think their brains are wired a bit differently. And women, they are more emotional, I guess, than men” (NS, Ellen), suggesting that some women may respond emotionally and exhibit empathetic reactions during ICC, whereas their male counterparts tend to respond with less emotion. While emotional empathy contributes to effective EICC, this analysis also suggests multiple intersections of gender across social norms, the identities of males and females, beliefs, stereotypes, and the nature of acceptance, all of which are shaped by lived experiences.

EICC also relies on situational context, which interacts with gender, language, patriarchy, the culture of those participating in the dialogue, and an individual's flexibility in demonstrating empathy in those situations. Many participants shared instances in which they had to communicate with other family caregivers, especially men, to reach the patient. An educator shared,

I have noticed that with some Middle Eastern cultures, with women. And so, there's a person who's always communicating for them. And I'll be asking them about symptoms or how they're feeling. And I won't actually be hearing it from the patient themselves but from their family member, and to kind of respect that, that's how they're going to communicate (NE, Naa).

These reported situations highlight the importance of understanding the patient's language barriers and patriarchal cultural norms in communication: "In some instances, the man of the family might be expected to make the decision even if it was on behalf of the female. And of course, that's different than my cultural beliefs" (NE, Pearl). This impacts EICC because the nurse might be unsure whether the interpreter or the decision-maker accurately conveys the patient's wishes.

Intercontextual Influence of Culture in EICC. Participants observed that age influences culture and communication in areas of respect and knowledge. A student shared,

I think age influences me in a way where if I see someone who is older than me, I would be more resolved in the way I would be talking to them, and maybe more respectful and respect what they're saying. Maybe I would even take their views more and not put my own thoughts in front of them (NS, Adna).

The participants linked their cultural values of showing respect for the elderly and respecting older individuals' autonomy in decision-making, which might influence students' perceptions and actions during ICC encounters.

Additionally, age was used to assess a nurse's knowledge in some cultures. A student shared: "because I'm young, I feel like sometimes people would see, you know, – they don't feel I know everything" (NS, Sussie). The findings indicate that patients are less likely to trust or accept what a nurse says or offers because of the nurse's age. Additionally, in the social process of ICC, age is intertwined with power and experience. An educator shared:

And that might be a power thing, whereas the nurse, I might be saying, hey, we've got to do this. And I think because I'm older and I have been around the block a few times, I've dealt with this quite a lot. I think I would tend to slow down and say OK, what's

important to you? Where a newer person, a newer nurse in that role might be still just very highly focused on we got to do X, Y and Z to make sure that we save your life, and I don't care if you're happy or not, this is just how it has to be (NE, Pearl).

Older individuals are perceived as experienced in handling ICC and as demonstrating authority in healthcare settings, compared with younger nurses who are still navigating the ICC process. Similarly, a report indicated that younger female nurses might not be taken seriously in ICC encounters: “that they don’t maybe take me as seriously because I’m a woman, because I’m younger” (NE, Sunshine). Culture shapes perceptions based on age and gender, with women appearing to be the most negatively affected during ICC.

The findings also confirmed that clinical settings in Manitoba serve multicultural populations, and that communication encounters are influenced by factors such as travel history, time, worldviews, cultural values and preferences, patriarchy, and religion, all of which impact ICC. Most Black, Indigenous, and People of Colour (BIPOC) nursing students reported experiencing cultural shock when working with Caucasian patients. Participants highlighted the need for cultural sensitivity: “And when it comes to culture, you need to be sensitive to the culture of the patients you’re treating, like eye contact, there are some cultures that are not comfortable with you talking to them and looking in their eyes” (NS, Bisi). There appear to be distinct behaviours across cultures that nurses need to be aware of to help them navigate ICC and build their confidence. For example, they need to be aware of the appropriate use of touch when a patient is upset. Nurses need to investigate which non-verbal gestures are acceptable during ICC encounters, which requires open-mindedness to adapt to different cultures.

The nurse educator data also confirmed that some patients prefer care from certain racial groups, which affects relational practice in ICC encounters. One educator shared:

I've unfortunately seen a lot of racism in nursing, where they only want certain – you know, what they deem to be their culture, care for them, or avoid certain other cultures, so that it directly impacts relationship-building between nurses and patients (NE, Sunshine).

Some patients were noted to prefer Caucasian health care professionals. These imbalances in patient allocation were often rooted in systemic racism, patriarchy, classism, and language proficiency. A preference for specific populations can create tension between nurses and their patients, limiting the ability to demonstrate empathy. Furthermore, the varied positionalities of individual patients, nurse educators and students engaged in the ICC encounter can hinder understanding, delay rapport development, and prolong interactions.

Time as a Social Process for EICC. Time was regarded as a vital part of the social process within EICC. A student noted: “Because we're spending more time with the patients, they're more comfortable with us, telling us more details, or at least part of their personal story that could be beneficial” (NS, Papa). Findings indicate that nursing students generally have more time to engage in meaningful relational practice. Extra time helps patients feel more comfortable and builds trust, making it an ideal opportunity to develop ICC skills during undergraduate nursing studies. The findings also suggest that time constraints can significantly hinder effective ICC, because EICC requires patience and goes beyond words. An educator shared, “And normally, as a clinical instructor, you think, oh, they're slow; they're not doing their job. They were taking their time because they knew they had to take their time to explain things” (NE, Akosua). People who demonstrate empathy spend quality time understanding their patients and addressing their questions, thereby fostering a therapeutic environment for EICC. Nonetheless, educators expect students to complete tasks within specific time frames. An educator

shared, “my student is pushing IV medication for their second or third time in their life. And so, it takes their whole mental capacity almost to make sure they’re pushing that medication correctly” (NE, Naa). Students have limited multitasking skills, which affect their ability to effectively engage in EICC. Nurse educators are challenged to create environments that center on safe patient care, while also creating the time and space to grow students’ skills in empathetic communication amid institutional time constraints.

Time was also affected by language barriers in ICC encounters. Participants reported the associated frustration: “Maybe feel a little bit frustrated because it would take so much more time to try to communicate something that maybe was fairly straightforward and simple” (NE, Pearl). The language barrier required extra effort to convey intentions, which could be overwhelming for students. This limits the opportunity to spend sufficient time with the patient to understand the patient's context or to show empathy in ICC.

Understanding the intersections of EICC improves the ability to engage with, comprehend, and provide high-quality, culture-specific care to culturally diverse patients. The complexity of the network of contextual influences on the social processes of EICC requires an in-depth analysis of environmental factors and strategies to address the identified barriers within these intersections.

Environmental Influences on EICC

Environmental influences were described as internal and external experiences and factors that shaped the development of EICC knowledge, skills, and the relational behaviours of nursing students, educators, nursing staff, and patients during ICC interactions. These influences included physical, structural, socio-cultural and psychological environments.

Physical Environment. The physical environment encompasses spaces in academic and clinical settings that can either support or hinder ICC exposure. Insufficient hospital space can

limit clinical placements and nursing students' exposure to culturally diverse patients. A student remarked, "The current surgery rotation, they're having six extra weeks of simulation and six fewer weeks of clinical because they don't have the hospital space" (NS, Stephanie). The limited physical space restricts clinical placements, leading to a restructuring of the academic curriculum to substitute clinical experience with simulation, which provides minimal or no ICC scenarios depending on the institution. Moreover, students reported varied experiences across clinical environments, noting that they are most likely to encounter ICC during palliative care, labour and delivery, or acute care rotations. The care environment greatly influences patients' health; however, it does not always fully meet the needs of the diverse patient populations we serve. Another student shared: "If they are Muslim and must lay a mat and pray on the floor, they should be able to. Housekeeping can work a bit more diligently on the floor in that area, if that's what they have to do" (NS, Ellen). An accessible and culturally competent environment and workforce were reported as necessary to facilitate EICC.

Socio-cultural Environment. Nursing students who had experienced diverse geographical environments through travel and multiple residences in different countries were more confident in their ICC encounters. The educators also shared that students' immigration backgrounds seemed to support the ICC process through their exposure to multicultural settings. An educator noted that "I don't know if I've just lucked out, but I've just had great students that have been very multicultural, and they understand the cultures in which they work" (NE, Akosua). Having multicultural experiences from diverse residences enabled students to develop a better understanding of working with culturally diverse populations and to demonstrate good ICC. Most educators indicated that immigrant students were more proficient in handling ICC encounters. Participants reported that experiences such as travelling for enjoyment or learning, or

engaging in dialogues with multicultural staff, helped shape nursing students' and educators' ability to collaborate with other ethnicities and translators, thereby improving relational practice. A lack of travel and multicultural experience was perceived to limit worldviews. An educator shared: “Through my life I’ve always been in different places. I worked in [Province 3] too, which was very multicultural. Lots of Asian people were there, actually, at that time... I’ve had lots of influence from other people” (NE, Donna). Nurse educators noted the importance of sharing this knowledge and experience with students so they can also explore travel and, where possible, develop ICC skills, since not all learning occurs at the bedside.

Structural Environment. Educators and students noted that workload, size of clinical groups, time allotments, limited cultural resources, student status, and patient assignments influence EICC development, some of which have already been discussed. For instance, assigning a student to culturally diverse patients may be affected by a patient’s preference for registered nurses over students. An educator noted, “I’ve had students before who have patients turn them away. And that sometimes it’s because they’re students – they don’t want a student” (NE, Sunshine). Patients turn students away because of perceived age and lack of experience. Such barriers limit students’ exposure to other cultures and hinder the development of confidence in ICC skills.

Psychological Environment. The psychological environment was another critical influence on the development of EICC skills. The preferences of culturally diverse patients during ICC and the comfort levels of students and CEFs in enacting EICC were important factors to consider. We must accommodate the needs of culturally diverse patients, students, and others by respecting their preferences and enhancing their comfort during ICC. For example, a student asked for more contextual information to better understand and plan care with her patient:

I asked what her preferences were and if she had any concerns going back. And also does anyone else have other important information, such as the sister or any other family members that may live in her community up North (NS, Fola).

Participants observed that patients often arrive at the hospital in vulnerable states and need support and accommodation of their preferences. A student noted: “So, to me, is that if they’ve got preferences, you’ve got to respect those, whether it be for religious purposes or for just personal preferences” (NS, Breanna). When these expectations are met, patients feel more comfortable accessing healthcare. When nurses understand the patient’s context and preferences during the ICC interaction, it reassures culturally diverse patients that their concerns are heard, understood, and accepted. Likewise, when the nurse or student is uncomfortable with ICC, they may label the patient as difficult. An educator shared: “And then also the influences, specifically environmental influences I see a lot, in report in the morning, “Oh well, that patient just is difficult and just ignore if they’re whatever.”” (FG2, NE, Moon). This focus group submission endorsed the psychological influence of the work environment on ICC.

Equity as a Foundation for EICC Practices

These research findings highlight a critical distinction between equality and equity in the context of ICC. Equality in ICC involves providing the same resources, treatments, and strategies to everyone during communication, regardless of cultural background or needs. In contrast, equity in ICC entails applying cultural awareness, recognizing the diversity of people’s backgrounds and needs, and introducing specific resources and strategies to overcome communication barriers. Equity promotes justice and fairness by attending to individualized, relational, and contextualized care, facilitating interactions that lead to better health outcomes.

Empathy-based ICC entails understanding what constitutes social justice and adopting an equity perspective. A student described it as “I think it’s just kind of going the extra mile and just treating people fairly” (NS, Sussie). The key concepts in this statement are fairness and ‘going the extra mile,’ which foster an equitable perspective. Going beyond basic procedures in an ICC encounter might include arranging interpreters for patients who do not speak English or assigning female staff to patients with cultural preferences for female care. Another student discussed fairness in the context of forming impressions of others, as shown in ICC interactions: “I think treat them all fairly, no matter your initial viewing of them, if that makes sense, impression” (NS, Alana). This analysis underscores the importance of pursuing equity without stigmatization or judgment. Some patients may appear vulnerable, unkempt, uneducated, or of colour, but that should not define the care they receive. People come from different backgrounds, and those backgrounds sometimes influence how we interact. The analysis reflects a need for nurses to be mindful of their personal biases and ready to adjust their care to suit patients, providing individualized care in a culturally safe and equitable way.

A certain level of cultural awareness was identified as a means of improving equity-focused interactions with culturally diverse patients. A student noted: “Just understanding where they’re coming from, not treating them super differently, but also treating them differently. I want to give a quick, like equity. Equity, just making sure that everyone has the resources they need” (NS, Vero). Using an equity lens enables targeted resource allocation to support culturally diverse patients.

Nonetheless, some participants regarded all their patients and colleagues as equals, a perspective that warrants further exploration because everyone has a different background that influences their interactions. For example, a student shared: “When I go into work, I guess it’s

just me, though. I just see everyone as equal” (NS, Ellen). The lack of cultural awareness, or reflection on the positionalities and intersecting identities individuals hold, can impede equity-based practice. Another student also noted that “You don’t have to like them, you don’t have to agree with them, but you have to support them, and you have to treat them the same as you treat anybody else” (NS, Sussie). This statement is concerning because no two people are exactly the same. People are individuals, and nurses must consider this. While all nurses are present at clinical settings to provide care, nursing care should be tailored to meet each person’s unique needs. Individuals face both direct and indirect barriers that can impede meaningful ICC. These barriers may stem from a lack of understanding, limited cultural awareness, and structural barriers within political and organizational systems. For example, a student shared: “Because I feel that I can’t completely understand what people from other cultures are going through, depending on their social determinants of health, because there is an obvious, like, difference” (NS, Alana). Another participant made a contradictory statement, saying, “And I think my most important takeaway is that it’s like those barriers, they just want to get the same care as everyone else” (NS, Fola). Patients seek personalized care that addresses their unique needs rather than receiving the same treatment as everyone else.

These participant quotes emphasize the importance of distinguishing between cultural awareness and treating everyone equally. Similarly, a student stated that he never considered his patients' backgrounds during communication encounters, which is concerning: “I think for my patients, I didn't know their background or their social status level, so it wasn't much of a factor” (NS, Papa). Knowing a patient’s background is the first step in addressing their cultural and ICC needs. Cultural awareness is vital for recognizing the unique communication needs of others; without it, efforts may focus on equality rather than equity. Understanding the patient's context

influences the nurse's positionality and responsibility to provide more equitable care. However, participants may be confused about the difference between equality and equity. For example, one student shared that they gathered information about patients to be culturally aware, yet they did not treat the patient any differently from others:

And again, it wasn't so much that I've got to treat this person any differently than all my other patients; they were all treated equally. But in a sense, it was very rewarding, I guess, to be able to be like OK, I have to be aware of this, and then it translated into them thanking me in a very unique way (NS, Breanna).

EICC should promote equitable treatment rather than equal treatment. Some participants sought to distinguish between equity and equality, emphasizing the importance of equity. One student shared, "I feel like in healthcare you should just cater to people based on their needs and treat people with kindness equally. Not like equally, but like equity, based on one patient's need might be more than another" (NS, Bisi). However, most participants used the term 'equally,' reflecting a misunderstanding of the distinction between 'equity' and 'equality,' a crucial step toward achieving social justice, as illustrated in this participant's response: "It's difficult because I just think everyone should be treated the same, right? With kindness and respect. I don't think I, myself, would ever treat someone differently for their belief system, culture, or the way that they look. I just – I don't know" (NS, Jona). This statement implies that some student nurses equate equality with being kind and respectful.

Having contextual information about patients, or using it stereotypically, is not enough; it must be applied relationally and integrated empathetically. For example, a student suggested that when information is gathered from an Indigenous patient, do "not just focus .as an Indigenous patient. Like, not to label them, but just to use that information to guide your care" (NS, Fola).

An awareness of an individual's cultural background should be used constructively to enhance care pathways and outcomes. For example, translators are recognized as vital assets for fostering social justice and equity within ICC contexts. A student stated:

This was a very normal situation, but there might be in case of emergency or something, and you don't know their language, and maybe you want to give them something, a medication or whatever; it's better to have someone like a translator to help you in those situations (NS, Adna).

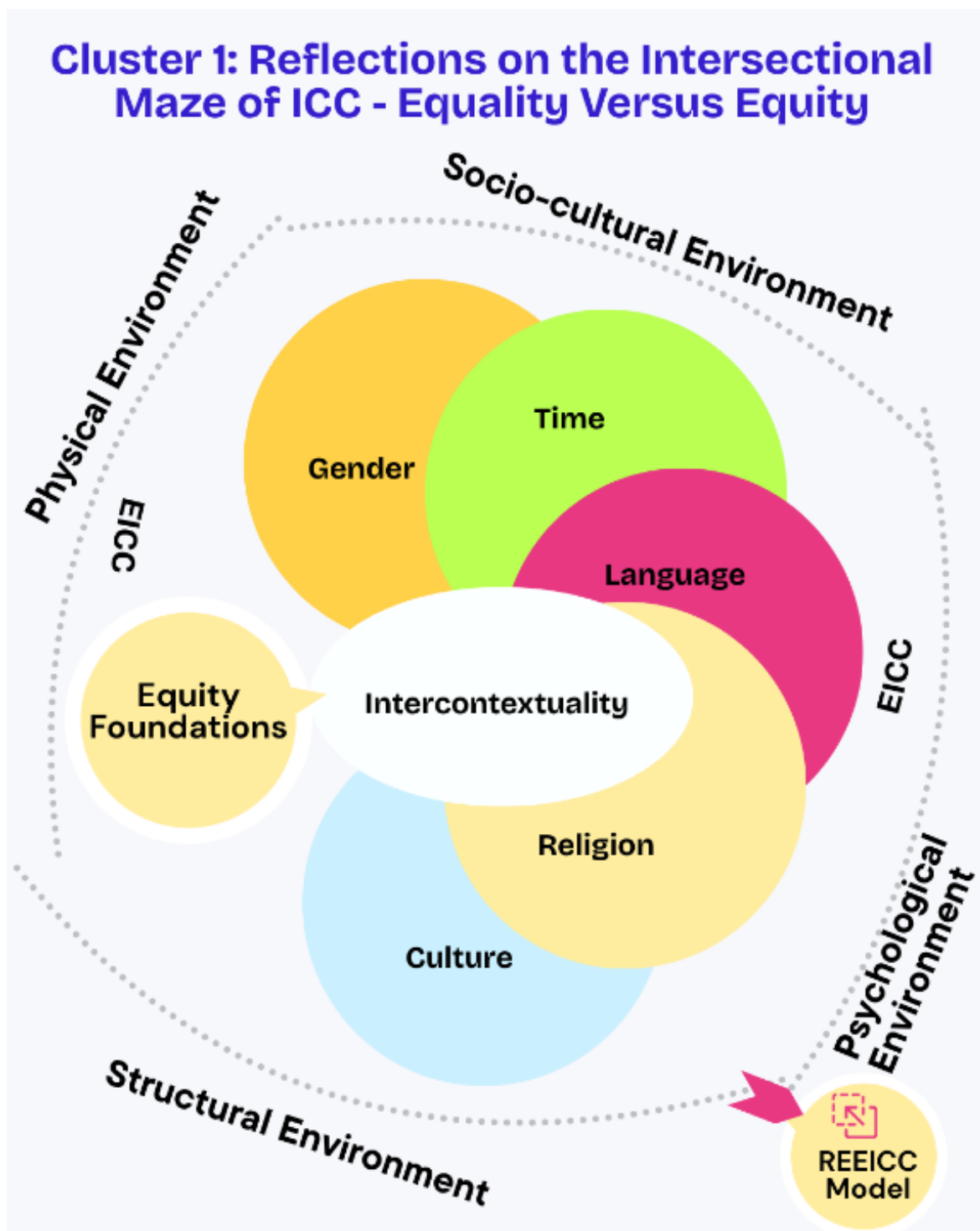
Having an equity lens within ICC was regarded as an urgent necessity to address the barriers and consequences associated with EICC.

Summary: Reflections on the Intersectional Maze of ICC – Equity versus Equality

Within the “Reflections on the intersectional maze of ICC” cluster, I have described participants' reflections on the intersectional maze of ICC as encompassing five intercontextuality factors, four environmental influences, and the infusion of equity foundations (See **Figure 2**). Engaging in effective EICC requires understanding intercontextuality and being aware of the various environmental categories that can promote or inhibit its enactment. The section leaned towards equitable healthcare rather than equality in healthcare. Having an equity lens was noted as foundational to EICC and can also help prevent racism and discrimination during ICC. Educators play a role in empowering nursing students with key concepts of equity and helping them translate these concepts into ICC and intercultural care.

Figure 2

Visual Representation of Equity Foundations in the ICC Maze



Cluster Two: Racism, Discrimination and Marginalization in EICC Interactions

This cluster examines how social processes and contextual influences related to ICC are affected by racism, discrimination, and marginalization. The analysis confirmed that racism, discrimination, and marginalization shape ICC encounters among nursing students, nurse educators, nursing staff, and patients, affecting their ability to demonstrate empathy. The findings show that asymmetrical power dynamics, as reflected in institutional structures and hierarchies, shape how individuals perceive and respond to systemic racism, discrimination, and marginalization in ICC encounters. Three subcategories were identified in the analysis, each informing how racism, discrimination, and marginalization affect the social processes of EICC: 1) understanding asymmetrical power dynamics within EICC, 2) the psychological functionality of racism and discrimination in EICC, and 3) the use of interpersonal racial conflict-resolution approaches to maintain effective EICC.

Asymmetrical Power Dynamics within EICC

Power structures and imbalances within the social processes of ICC contributed to racist and marginalizing behaviours. According to both nursing students and educators, asymmetrical power relations are influenced by factors such as socio-economic status, race, gender, culture, patriarchy, positionality, and colonialism (including whiteness) within institutional structures, affects decision-making, empathy-based relational practice, and resource allocation. In cases of power imbalance during ICC encounters, those in positions of power—such as educators, nursing staff, or management—exert greater control over students and patients, contributing to negative outcomes such as racial and discriminatory conflicts. A student noted, “... whenever you have a bit of an extra layer of low socioeconomic status or a minority, especially if you're Indigenous, or if you're gender diverse, then immediately that power imbalance kind of feels

bigger” (NS, Stephanie). Lower socioeconomic status, race, and gender were intersecting identities that posed racial and discriminatory challenges for EICC in healthcare institutions.

Power imbalances adversely affected individuals with less authority or privilege, undermining students' confidence and shaping the lived experiences of culturally diverse patients. In interactions with culturally diverse patients, doctors are perceived as holding higher status than nurses, a perception linked to patriarchal and cultural norms. A student shared that,

I know that in a lot of cultures, nurses are viewed as someone you should trust and that have knowledge that you should listen to. In other backgrounds, it's the doctor who holds that power, and the nurses are there to wipe your bum essentially (NS, Jona).

Communicating with respect between individuals holding different levels of power and privilege is challenging. Sensitivity to and awareness of power imbalances lead patients and even staff to look down on one another, creating tension and limiting decision-making during ICC. Some students also noted that patients communicate more effectively with student nurses than with staff because of reduced power dynamics.

Power imbalances can adversely affect EICC when authority is exercised hierarchically among educators and students during ICC interactions. Abuse of power by educators can traumatize culturally diverse students and negatively affect their future practice. When a racial or discriminatory conflict arises between an instructor and a culturally diverse nursing student, the findings suggest that the current conflict-resolution process leaves the student feeling intimidated. One student shared: “I also felt like the course leader should have an individual meeting with the student, as opposed to the clinical instructor and the course leader with the student, because we are scared of the course instructor” (NS, Ellen). Educators are authority figures, and culturally diverse students, given cultural assumptions about who is superior or

holds final authority, may not feel confident enough to advocate for themselves, as illustrated by Ellen's (NS, Ellen) experience.

Worldviews or positionality reflect the diversity of knowledge (Hankivsky, 2014) and are shaped by students' and educators' experiences and backgrounds, which, in turn, affect how they communicate or exert control. The influence of power imbalances on ICC encounters is more complex in contexts with diverse cultural experiences and/or where there has been limited exposure to immigration. About 60% of the students and 27% of the educators were themselves immigrants. A focus group participant said, "We're coming in [into nursing] with our experiences as well: our experiences from home, our experiences from previous careers, our experiences from day-to-day living. So, as an immigrant, I'm coming in with all those experiences that I'm bringing in" (FG1, NE, Angel). The lens, worldview, or background from which a nurse comes influences how they perceive a patient in context and how they interact with them. One educator observed,

And when we're discussing the case, one of the main starting points is that we perceive our world, our ontological perspective, how we see the world and an epistemological perspective, how the knowledge is created, depends on our upbringing about our gender, religion, and relationship with other people (NE, Star).

Major factors influencing perception were identified as one's upbringing, friendships, and cultural experiences, which shape how we perceive and understand people's contexts and actions. The analysis also identified that some nurses and educators with biased perspectives on other cultures stereotype them. For example, students noted that Indigenous patients were often perceived by nurses as wasting resources and as drug seeking in healthcare, leading them to

“think they are of the very lower authority and get scared to ask for the best care they deserve” (NS, Adeola).

Limited exposure to or experience with cultural diversity can pose challenges during ICC encounters, particularly among White nurses and nursing students. Whiteness can activate power dynamics, thereby acting as a barrier to effective ICC when caring for patients from diverse ethnic backgrounds. Some students and nurse educators who identified as Caucasian reported feeling underprepared and uncomfortable when engaging with culturally diverse patients, citing their background, lack of cultural awareness, and education as contributing factors. A student shared, “Definitely, because I’m a white person, I don’t understand how prevalent even little microaggressions and racism are” (NS, Stephanie). Without lived experience, it is difficult to imagine what others are going through when they describe their experiences in ICC encounters. The focus group participants confirmed this finding: Caucasians may have difficulties in their ICC encounters due to limited exposure or experience with diversity.

And oftentimes, I really think that students don’t necessarily get it until they’re in that position. So, for students who are people of colour, I feel like they already are coming off – standing at a very different level because they have experienced difficulty because of either their culture or the colour of their skin, their religion or whatever. Versus people who are of the, you know, global north majority, who think this is the way things are. So, they have a harder, higher and steeper learning curve to get that level (FG1, NE, Sky).

Culturally diverse lived experiences can foster greater empathy, as often observed among immigrant or BIPOC populations, whereas Caucasians are typically more challenged in relating to diverse cultural experiences. However, education was noted to enhance ICC encounters and foster empathy. A student noted: “I think that I felt more empathy for my Indigenous patient

because I had previous education about residential schools, intergenerational trauma and stuff like that” (NS, Iris). Education about other cultures increased awareness and empathy.

Participants in both categories also highlighted the lack of diversity among faculty and staff, which negatively affects the delivery of culture-related curriculum. A student noted:

My school instructors, my sim instructors, they've all been White. ... I think that will also help because a white prof speaking to cultural competency, I mean, they can do a good job, but it's not necessarily as... powerful as someone who's maybe had lived experiences and can recognize it a bit better and place more of an importance on it (NS, Stephanie).

More equitable cultural representation among faculty and students is critical to preparing nursing students for ICC practice in real-world clinical settings, where patients and families have complex, intersecting identities and diverse cultural experiences.

Psychological Functionality of Racism and Discrimination in EICC

Racism and discrimination operate in various ways, especially psychologically among previous victims, shaping attitudes and limiting empathy during ICC encounters. For example, some clinical instructors were reported by nursing students to label BIPOC nursing students as unprofessional, timid, or accentuated, which affected their confidence, patient interactions, clinical performance, and grades. The psychological functionality of racism and discrimination in EICC was evident in a transition through six phases: perception framing, recognition and acceptance, internalization, transferability, expressivity, and role adaptability.

Perception Framing. Racial and discriminatory assumptions influenced student nurses’ interpretations and perceptions of their ICC interactions with patients, students, or staff, particularly when they had experienced prior racial and discriminatory encounters. They reported that racial interpretations from educators and patients also negatively affect patient assignments

and rapport, as some BIPOC nursing students were failed in their clinical course due to racism by educators. A student said: “It was perceived by the CEF that other nurses or patients could not understand my friend because of his accent” (NS, Papa). Racial assumptions and perceptions were found to have a negative emotional impact on students and patients. However, the main issue with the perception framing phase was a lack of full understanding of what racism truly involves. An educator noted:

So, part of it is really understanding when we say that there’s racism that exists, well, what does it actually mean, and what does it look like, and what are those examples?

Because if we can understand what it is, we can stop doing it (NE, Naa).

There is a need for students and educators to better understand racism, discrimination, and marginalization, to foster awareness and actively reconstruct preconceived biases that some student nurses and educators hold about other ethnicities.

Another aspect of perception framing concerns how information is constructed in nursing students' minds. For instance, a nurse educator recalled a student being drawn into a racist conversation because she was the same colour as the nursing staff: “The student was likely brought into that very racist world because the nurse assumed we look alike, we think alike. And the student was appalled. She probably wouldn’t have done that if the student were a person of colour” (NE Sky). Educators must intervene when students experience racism in the clinical context. Encounters with staff, patients, and instructors all influence student's ability to learn and develop EICC in practice.

Recognition and Acceptance. Perception framing leads to recognition of racism and discrimination. The development of EICC is characterized by an understanding of how perceptual framing creates experiences of racism. It is critical to recognize racism and

marginalization when they occur and to accept that such behaviour is wrong. Acceptance was evident in owning up to racial and discriminatory injustice rather than denying it, analyzing its impact, and learning to foster an inclusive environment for all. Recognizing the wrongdoings, problematic word choice related to specific ethnicities, and contextual factors—race, religion, gender, and culture—that shape racial conflict, is a step toward demonstrating empathy and challenging racism and discrimination. A student shared: “When I’ve spoken to a dear friend who is Muslim and she’s Black, she said, “I can never hide.” And she’s like, “I’ve never, ever, ever had an issue with a patient. I have issues with other staff” (NS, Ama). Clothing and skin colour that reflect a person's religion and race lead to racist and discriminatory behaviour, such as name-calling and labelling by nursing staff and patients, undermining nursing students’ comfort and their ability to open up and build empathy. A student mentioned, “But when I walked into his room, he said – the first thing he said, he said he wants a white nurse. And I said, OK, fine. We’ll get you a white nurse” (NS, Papa). It was evident in the data that people of colour (POC) faced more systemic racism from Caucasian patients, nursing staff, and instructors. From all indications, darker skin colour limits participation in ICC encounters and hampers the ability to engage with or build rapport with White patients, making it difficult to get to know them and empathize with their experiences. Interestingly, an educator noted, “So, I think that was probably nursing school, and nursing was the first time that I really came in contact with people who didn’t want care from me because of my skin colour” (NE, Akosua). Given the years between the educators’ training and the students’ submissions, such racist behaviours have persisted for decades and require strategic communication approaches.

To facilitate acceptance, educators emphasized the need to recognize their own racist behaviours, admit their mistakes, and learn from those experiences. An educator shared, “And I

think that's one of the big challenges right now is that everyone's so dismissive and in denial, and racism is an other than I problem because I'm not racist" (NE, Naa). Recognizing racist behaviours is a crucial step in the healing process, learning from past mistakes, and improving the nurse-patient relationship through a lens of cultural awareness and empathy. Awareness of cultural diversity fosters acceptance and respect for the patient's preferences and perspectives. According to students, one tip is: "understanding their point of view as well. Understanding why it is that this person was sort of refusing care. Is there a specific reason behind it?" (NS, Papa). The concept of racism and discrimination during ICC encounters highlights the need to see everyone as humans with unique backgrounds, to understand their needs through active listening, and to foster deeper empathy that informs the care plan. One student noted, "At least you're trying, and then you're also not going in blind. You know where they're going to be coming from, so I think it's important for people to take the initiative and do some research" (NS, Nana). Taking an extra step to gather information or understand our patients' context enhances empathy. Recognition and acceptance are important for creating an enabling environment for EICC and for fostering stronger, trusting relationships.

Internalization. After recognizing and accepting that there has been an experience of racism and discrimination within an ICC and racial encounters, internalization occurs as the cognitive impact that shapes how the individual would react to themselves and to others afterwards. When nursing students face racism and discrimination from patients or educators, it has psychological, emotional, and physical effects, diminishing their passion for serving members of these racist populations. A student shared how uncomfortable such acts made him: "I get really uncomfortable and offended when people say things like that around me" (NS, Nana). Such encounters also led to fear, stress, anxiety, trauma, embarrassment, alienation, and a

decrease in students' confidence, stemming from these discomforts. Racism affects decision-making and raises questions about belonging. An educator noted, “Clearly any incident that's traumatizing can lead to some maladaptive strategies going forward, like shutting down and feeling shy, and less forthcoming in the future if you have a negative experience” (NE, Comfort). BIPOC students were sometimes perceived as lacking confidence when caring for people from different cultures, but they were being cautious because of internalized fears of racism or marginalization.

Negative racial incidents towards culturally diverse patients and students from staff and educators also triggered emotional outbursts, which affected how they demonstrated empathy. There were two types of reactions to empathy: either fostering empathy among nursing students towards their peers and patients, or diminishing their empathy towards racist populations. In instances where it fostered empathy, a student shared: “If I ever saw any patients getting treated like that, it kind of makes my heart hurt, to be honest. And it makes me want to go into the patient’s room and just show them kindness” (NS, Ellen). This suggests that observing racist actions encourages students to demonstrate greater empathy. On the flip side, the educators offered different perspectives on students having repeated past encounters with populations they now perceive as perpetuating racial and discriminatory behaviour:

When they see the same population as a patient, they might be nervous in interacting with that person because they think the same thing would happen, so that might shape them in a negative way, right? It might make them nervous; it might make them not interact more properly or more on a personal level with the patient (NE, Angel).

Fear exhibited during ICC encounters, stemming from past racial encounters, can harm nursing students' communication and diminish empathy for others. Students pay close attention during

clinical placements and learn from their experiences, which powerfully shape their attitudes and behaviours towards patients. These negative racist encounters seem to open students' eyes and raise awareness of systemic racism, even within academic institutions, and this racial awareness carries through their lives.

Transferability. Past experiences of racism and discrimination were seen to create an internalized memory with negative effects that spilled over into all areas of the victim's life and were transmitted to their patients, students, colleagues, and others. Similarly, perpetrators of racism and discrimination within the healthcare team pass these experiences on to nursing students, influencing how they perceive and engage with different cultures. For example, a student observed, “I hear the nurse and the doctor talk about patients behind their backs, not to their faces, in a way that, to me, is inappropriate. And people of colour, different cultures, and it can get political, and it’s uncomfortable” (NS, Nana). Racism and discriminatory behaviour by preceptors or staff in the presence of students created a negative work environment, as students tended to copy what their preceptors did:

It certainly rubs off on preceptors and staff nurses as well when they have student nurses ... I think it’s fairly powerful because students look up to these nurses and students look up to them like their preceptors, and so if they think that’s normal, then they will likely carry it forward as well (NS, Breanna).

These racial acts can affect their attitudes towards culturally diverse patients, now or in the future, as seen in one student's hesitation to work with a specific population: “She didn't even want to work with those patients. She would rather go to different populations than treat them at all” (NS, Iris). This attitude stemmed from past racist or discriminatory experiences that had a negative impact, making it difficult for the student to empathize with certain patient groups.

Expressivity. Transferability leads to expressivity, evident in speech and in adjustments to care following racial or discriminatory encounters. Racism and discriminatory acts affected not only the victims but also their friends, families, and their educational journeys. Most of the racist actions students experienced were verbal. These findings also highlight that many patients are stereotyped even before they receive care, and that some assumptions can lead to stereotypical behaviour, which might influence how nurses demonstrate empathy:

And one of the staff said to me something to the effect of, “Of course, the family came up so that they can milk the system, and actually, they're just staying here to support their family, but they're really just going to go out and party and get wasted and ...” Yes, so you would see things like that more frequently than I care to admit, which is hard, right? So, just very blunt racism (NE, Sunshine).

Almost all students discussed the negative impact of racist and discriminatory behaviours during clinicals, regardless of their cultural background. A student noted: “And during that time, he was just super stressed, very, I would say even depressed, because of the situation, because the CEF told him that his best option would be to VW the course. Like, he’s going to fail” (NS, Papa). Some CEFs demonstrated a lack of empathy in their word choices and interactions with culturally diverse students. Another student described post-traumatic stress disorder (PTSD) following racial interactions with a CEF, which appeared to involve power dynamics.

The analysis also highlighted the power of using one’s voice in advocacy, which can demonstrate empathy. One student noted the potential to change racial narratives by speaking up. Empathy is shown here through listening, choosing to act, showing concern, and making an effort to create change. Another educator shared that they have mastered demonstrating empathy through advocacy, a skill developed over time.

Honestly, there were times, and especially as a younger nurse, where I went Yes, you're probably right. But as I have come along through my career, I'm more likely to say, 'Wait a minute, is that really true? Is it just their race?' (NE, Pearl).

Students who had been victims of racism also found ways to cope and suppress their emotions to fit into the healthcare system amid the racial climate. Participants described the difficulty they experienced reconnecting with perpetrators after a negative encounter. A student noted, "And it's hard to connect with someone when they're calling you names and treating you terribly" (NS, Iris). The lack of connection could impede information flow and reduce motivation to seek assistance. The findings highlight how racism can impede communication and access to healthcare, which contributes to poor health outcomes.

Role Adaptability. Following expressivity, the student or nurse begins to develop role adaptability, associated with cognitive flexibility, resilience, and mediation skills. The student or nurse develops psychological flexibility and begins to demonstrate empathy by remaining neutral and providing the necessary care during ICC encounters with patients who are racist: "They might be racist and nasty, but you offer them the care they're supposed to. And if they refuse it because of your skin colour, then I know there's usually an intervention from another nurse, the charge nurse" (NS, Bisi). Nursing supervisors and charge nurses play a role in addressing racism and discrimination by showing empathy and managing the patient reassignment. Student participants observed that students who experience racism from patients are reassigned to other patients. One student noted, "But she definitely experienced that, and that was really hard. But then my CEF have made sure not to give her that patient anymore. They just transitioned to another patient" (NS, Stephanie). In situations with limited staff, the opposite occurred: "And I've also seen other cases where the charge nurse tells the patient that, 'Look, this is the person

that is going to care for you, and we don't have enough staff, so you either take it or leave it" (NS, Bisi). When patient reassignment was difficult, nurses were encouraged to adjust their care to best suit the patient, a process that required expressivity and role adaptability. Some participants from both categories who experienced racism and discrimination developed resilience and cognitive flexibility, choosing to focus on positive learning and treating others more kindly as a result: "I think the more you see that's wrong, the more you want to not do wrong" (NS, Sussie). Negative encounters with racism motivated student victims to undertake proactive measures to safeguard others from similar adverse experiences.

Nurse educators who had developed racial conflict mediation skills assumed roles as mediators and advocates to resolve racial conflicts among CEFs, patients, and students. An educator who witnessed a staff member's racism toward a student in the staff room pulled the student aside and noted: "So, I apologized on that nurse's behalf to the student and then just went to go and get the jacket anyway because I'm not going to allow my students to be talked to like that by someone else" (NE, Akosua). Mediation plays a crucial role in addressing racism, but it can be daunting without proper training or skills. An educator remarked: "... I have no training on this, I don't know. I've never even thought about it, that's a really good question. ... if this incident happens, a proper debrief in the post-conference time would be my first step" (NE, Comfort). Many educators expressed discomfort with such conversations, which often led to moral distress.

The Use of Interpersonal Racial Conflict-Resolution Approaches to Maintain Effective EICC

Interpersonal racial conflicts among nurses, students, patients, and instructors from diverse ethnicities can undermine the demonstration of empathy in EICC. Therefore, racial conflicts that arise during ICC interactions must be addressed. The process of conflict resolution

involves recognition and reflection, acknowledgment of diverse perspectives, and a firm decision to end the problematic behaviour. In the following paragraphs, conflict resolution is highlighted within two relationships: nursing student-patient and nursing student-educator-educator.

Student Nurse – Patient Racial Conflict Resolution. Reports from participants in both categories indicate that during ICC encounters with patients, student nurses face internal and external conflicts that can hinder empathetic responses. A student shared: “it’s OK to step back if you think it’s not appropriate for you or you think it’s against your own culture because there can be a cultural conflict like that” (NS, Adeola). Suggestions included recognizing and accepting people's unique cultures and acknowledging the racial behaviours exhibited during ICC encounters. An educator noted that bias in ICC conflicts can hinder the empathetic process. “And we can’t be bringing those biases into our care. And so how do we learn to get better than that is by acknowledging that this did happen, and these things do and are happening, and we need to stop it” (NE, Naa). This suggests that individuals need to reflect on their biases and take steps to address them. A student shared, “And accepting that not everyone is the same way that I am thinking” (NS, Adeola). There is a diversity of perspectives within the ICC encounter that must be acknowledged and accepted to prevent racial conflicts. Responding to racism, discrimination, and marginalization requires structured conflict-resolution skills to achieve realistic outcomes rather than avoiding the conflict. For example, a student shared,

I don't know if that's the best way to go about it, because in the real world, you're not going to be able to swap patients all the time. I think it's more or less a manager or the instructor having to go in and talk to the patient about how that's not OK (NS, Jona).

These findings highlight the need for a mediator to manage the clinical situation and for a long-term structure or guideline, since racism, discrimination, and marginalization are deeply embedded, systemic issues.

The current racial conflict resolution approaches are not standardized or sufficient; therefore, educators agreed on the importance of having a better educational approach in addressing racism. An educator noted,

And if they come across that, you basically apologize and be like, don't worry about it, let's focus on what we're doing now. I would like to debrief a bit more on that, but I don't think that it is my job to go into that, or I don't really know how to tackle that more. I just really apologize on their behalf, say let's forget about it and let's move on (NE, Akosua).

Although there was a push towards debriefing about racism, educators tend to apologize, empathize, and move on with clinical tasks rather than find real solutions to support their students or patients. Some educators were uncertain about how to manage the conflict and therefore chose to avoid the discussion to avoid discomfort.

Student – Educator – Educator Racial Conflict Resolution. Some participants recounted incidents of racism and discrimination exhibited by instructors toward students, emphasizing that students are in a vulnerable position during conflict resolution; they often cannot speak up or advocate effectively for themselves. One student shared this about her friend, “She can't really talk back, and it's really hard to stand up for yourself. Who do you think the course leader is going to believe? Of course, the other faculty member” (NS, Ellen). Educators are seen as part of hierarchical power structures, with students in the lowest position, making them vulnerable. Occasionally, minority CEFs also feel powerless, especially when they are

BIPOC, as they are often marginalized by white patients and colleagues. It is important to identify the vulnerable group in racial conflicts and to arrange for a mediator during disputes between students and educators or among educators, to review the case and advocate for the minority student or BIPOC educator if needed, ensuring fairness.

Reports have indicated that students experienced targeting throughout their undergraduate nursing education when they reported an instructor during incidents of racial conflict. One student stated:

Sometimes, maybe I guess some instructors – if it's not kept confidential, some instructors might come back with a grudge or they might not change in the sense that they will just come back and think that these are the students who reported this instructor, they think what of themselves and stuff like that (NS, Adeola).

There were worries that the instructors involved in the conflict might hold grudges against the student victims who reported them. As a result, some conflicts remain anonymous, making it difficult to address the situation effectively.

Interestingly, one educator remarked that nothing could be done about racism, which was concerning. She noted, “But I have seen that happen so many times, and I don't think there's anything we can really do about it. I don't think there's anything the college could do about that” (NE, Akosua). If educators and academic authorities lack a structured approach to addressing racism, discrimination, and marginalization in clinical and academic settings, the effectiveness of EICC would be compromised. The findings challenge educators to engage in mediation and meet with victims to hear their perspectives. For instance, one educator shared, “Because sometimes I find we have conversations about people without ever bringing them into the conversation” (NE, Naa). In the mediation process, both parties to the conflict must be allowed to present their

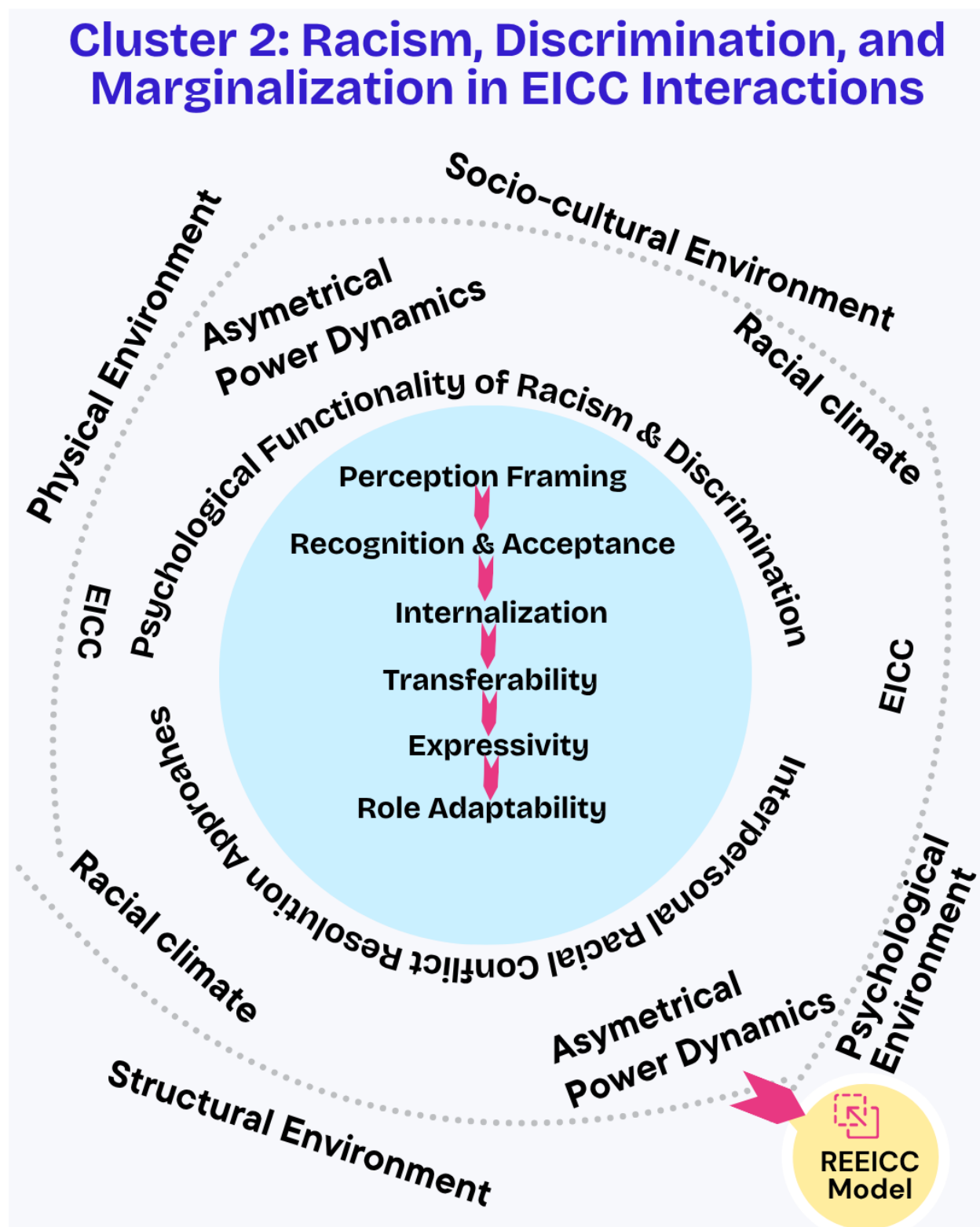
respective sides of the story. There was a suggestion to hold separate meetings to hear each side before bringing them together. A student shared, “I also felt like the course leader should have an individual meeting with the student, as opposed to the clinical instructor and the course leader with the student, because we are scared of the course instructor” (NS, Ellen). Fear of those in positions of authority hinders the conflict-resolution process. A mediator may be needed when a third party is essential to resolving the conflict.

Summary: Racism, Discrimination and Marginalization in EICC Interactions

In ‘Racism, discrimination and marginalization in EICC Interactions,’ I explored power dynamics from intersecting factors that foster racism and discrimination, and their psychological effects on racialized patients, nursing students or educators (See **Figure 3**). I highlighted recognizing interracial conflict, effective advocacy, and mediation, stressing that racial conflict can occur anytime during ICC but must be resolved. Establishing professional boundaries and seeking support are crucial, with conflict resolution guided by social justice principles. The next cluster will discuss navigating humanity in EICC.

Figure 3

Power and Psychological Functionality of Racism and Discrimination in EICC Interactions



Cluster Three: Navigating Humanity in EICC

This cluster explores the importance of humanness in EICC interactions. The first discussion examines humanity, the qualities of humanness in EICC, the impact of bias on EICC, and the essence of self-reflection in humanity from a social justice perspective for effective EICC. The second discussion identifies the conceptual basis of ICC and examines the data to determine the meaning, interrelated concepts, antecedents, consequences, barriers, and facilitators of equitable EICC. The third discussion focuses on empathy and its role in effective EICC. The data reveal different types of empathy, with a shift toward relational empathy highlighted. The final discussion focuses on the emotional distress that can result from EICC encounters.

Humanness in EICC

Humanness was portrayed as a distinct aspect of the EICC experience, highlighting the recognition of others and their cultures through qualities such as humility, empathy, connection, and kindness. An educator noted that nurses need to “be more humanistic” (NE, Rehoboth) in their behaviour and actions. It was emphasized that being human helps to understand the other person’s context and their current illness journey. Therefore, EICC requires a person-centred approach that meets patients where they are. Most participants emphasized the importance of human connections: “It’s really putting human connection and care back into what can become such a sterilized environment of policy, procedure, touching things, germs, et cetera” (NE, Naa). This was a call to shift from task-focused, robotic, or procedural nursing care toward a relationship-centred approach, in which the individual's cultural characteristics are accepted and acknowledged within the EICC process.

Understanding humanity within EICC begins with acknowledging cultural differences and potential communication challenges. A student shared:

Just being able to take a step back, recognize that this is a human being, and that there are some cultural differences and barriers that might be causing nurses to react like that. ... and go in with an open mind (NS, Iris).

There was a need to reflect on the cultural differences that exist and could pose barriers to care decisions, judgments, and actions. Humanity does not endorse bias or favouritism. Additionally, participants suggested that the decision to engage in effective ICC should not be based on skin colour, as everyone deserves respectful treatment. However, this ideology promotes equality rather than equity. For example, one student noted, “It’s just communication and treating each other like humans, no matter what the colour of the skin is or no matter what they practice at home” (NS, Ellen). Moreover, skin colour can be argued to be a source of one’s positionality or worldview, reflecting one’s experiences, connections with others, and perceptions of humanity. Participants said that being human involves helping patients trust the student or nurse and feel supported, heard, understood, respected, and safe. A student added that,

I think they should feel heard. They shouldn't feel like they're being stigmatized just because they are from a different culture. And they should feel like the nurse understands them and what they want, what they need in terms of care (NS, Iris).

It is important to ensure that people feel safe during ICC encounters and are free from stigma or discrimination. Intercultural communication also needs to support open communication and a genuine interest in culturally diverse patients as individuals with unique life contexts. A student noted, “... trying to show them that I’m interested in them as a human, as a person, rather than them as my patient. But really trying to understand them and their journey, and how they got into

where they are” (NS, Vero). However, this approach appears challenging for nursing students. A few educators noted that academic perceptions limit humanity. One educator stated, “So that’s something that I think is hard for some students to transition into because they don’t realize that this isn’t really a course that you just pass and fail; you actually have to have some humanity to you” (NE, Naa). It is not enough to learn about ICC; it also requires adapting the practice of being human throughout the process. The academic hat must be worn with a social justice and empathy lens to demonstrate humanity in EICC.

Focus group participants reaffirmed the importance of recognizing and maintaining our humanity in every ICC interaction. An educator shared, “Establishing that connection, ‘I’m not just a diagnosis, I’m not just, there’s so much more to me, look at me as a person.’ Treating patients from other backgrounds as humans improves the flow of care” (FG2, NE, Star). It was suggested that recognizing personhood and being human lead to better care, improving the hospital experience for culturally diverse patients without stress, anxiety, or uncertainty. Therefore, every interaction during care matters, as does EICC with the patient. An educator noted: “So, it’s not how many days or weeks you had that patient, but what kind of difference did you make in a minute, in a shift, in that interaction you had? Because truly, every interaction matters” (FG2, NE, Star).

Being human presents challenges such as workload and burnout. Participants expressed concern that when a nurse has limited time, patients may be treated as a checklist. A student noted: “We learned a lot about nursing burnout in class and how that can result in nurses not viewing the patients as an ‘actual human being with all these holistic needs’ but as ‘a task to check off their list’” (NS, Alana). Organizational and system-level structural constraints on EICC, such as increased workloads and work environments, were found to influence how

individuals demonstrate empathy in patient care. Humanity goes beyond being task-focused.

There was a call to focus more on the qualitative effectiveness of EICC – more on the relationship than on the number of patients seen. A student shared,

I've seen a lot of people in my cohort as well, and the way that they do things is very task-focused. They can handle a lot more patients than I can. They can finish their tasks a lot quicker than I can. But I think what makes a difference with me is that I can communicate better with my patients. I can get a better understanding of my patients, not just their illness, but also who they are as a person. What's the best way to approach my care with them? Yeah. So, I feel I am a lot more human than some of my classmates are. I feel I'm a lot more human than a lot of doctors (NS, Vero).

Being able to relate to and understand a patient as a person rather than merely as a disease was considered more beneficial, supporting better relational therapeutic practice.

Self-reflection in Humanness. Self-reflection in humanness, as reflected in the data, is rooted in the call to examine one's biases and take responsibility for them during ICC encounters, thereby enabling effective participation in EICC and emphasizing a positive social justice perspective. Nursing students and educators emphasized the importance of checking for cultural, racial, and gender biases, among others. To demonstrate humanity in ICC, individuals needed to be aware of their cultural biases and how those biases could affect the nurse-patient relationship and patient care. An educator shared,

And doing that self-assessment piece too, kind of being in check with our own emotions before we even go in the room, and thinking about how our non-verbal or even our verbals may be offensive to the patients that we're working with. You know, our volume or even our stand-in (NE, Rehoboth).

Nurses need to engage in self-reflection on their assumptions, emotions, and actions to ensure that decisions and assessments are not based on personal biases. With the numerous intersecting factors involved in ICC, a student shared that “I think I need to stay self-reflective of that and not only be grateful for what I’m blessed with, with my social determinants of health, but be open and understanding of other cultures” (NS, Alana). It was observed that nurses often develop bias when another culture is involved and become more cautious. A student noted, “I think the cultural background kind of made me cautious to go in” (NS, Iris). However, with empathy, nurses can better understand, take responsibility for, and challenge preconceived negative judgments toward other races. There were several instances in which student nurses made incorrect assumptions based on cultural values or gestures:

I can sometimes label them as just being grumpy or unfriendly. But that's not it. There was a Polish nurse on my unit. And Polish people are quite direct. I thought she was so rude, but she was really nice. She just had a way harsher tone than I'm used to. And I feel it's so much easier to get jaded or judgy or biased when you don't understand the history behind it. And I never even thought of that (NS, Stephanie).

Such mistaken judgments require educators to guide students as they encounter increasingly culturally diverse patients, while maintaining a focus on the human foundations of the ICC encounter.

The analysis suggests that biases may have historical roots in a person's upbringing, experiences, positionality, worldviews, and structural exposures. For example, a student noted: “Sometimes you find yourself going back to your background, that's OK. But then you also have to remember that your patient also deserves proper care and the care that they want or that is appropriate for their belief system” (NS, Jona). A nurse's or student's culture, religion, or belief

system can influence their values and perceptions of acceptability, potentially affecting how they perceive patients' needs. Some of these biases are rooted in dominant patterns established within society and institutional structures. One educator shared:

How I can care for them well is by knowing who they are. And to do that, you really have to be very honest with who you are, your perceptions, your biases, and again, really trying to let go of this idea that there's one dominant way. Back in the day, the one dominant way would have been colonial Christian. And that's the messaging that nursing would have spread, and that's kind of the normative value (NE, Naa).

Historical foundations must be incorporated into education, given the rise of new religions and practices in society, to better prepare student nurses for what they will encounter when caring for diverse populations. Some students reported applying approaches that had worked for previous patients with similar cultural backgrounds. However, as an educator noted, "You can't assume that what worked with one person will work with another person" (NE, Elliette). This analysis highlights the importance of nurses remaining open-minded. and curious, focusing care on the patient's cultures and beliefs rather than on those of the clinicians. Some participants also noted that their background created gaps in their understanding of other cultures. One educator noted, "Because I'm aware of the difference between me as a white person and then interacting with people from cultural minorities, I guess" (NE, Selina). Therefore, recognizing differences and being aware of the potential bias that can stem from a person's race can help prevent negative biases. Nurses must stop viewing their personal and cultural beliefs and values as superior to those of patients. Approaching the patient's room with an open, curious perspective sets the stage for demonstrating empathy, fostering trust, and building stronger relationships during the ICC encounter.

Assumptions and biases can also stem from superficial observations. For example, patterns within the data indicate skin colour and race may be misleading indicators of a patient's language, beliefs, and culture, as these may not be immediately apparent. An educator shared that "... one of my colleagues is from an [Asia 2] background, and to be mindful that, just because someone looks like a certain culture, doesn't mean they practice those cultural values, right?" (NE, Sunshine). Some culturally diverse individuals have second- or third-generation ethnic backgrounds and may speak English fluently or hold Canadian values, having been born or raised in Canada. Therefore, their appearance may be misleading regarding their beliefs. There was a call to learn how to ask appropriate questions and build trust with patients, so they feel comfortable sharing more about themselves, which can inform our history, assessment data, and care decisions. A student shared,

Don't assume things about your patients just because they're not obvious. Her language barrier was not obvious until I explicitly brought it up, and then she decided to trust me. And I thought cultural difference came in in the sense that I was just assuming that that's their way of living and that's their way of life the whole day, and I don't know how to go and talk to someone like that, so yes (NS, Adeola).

Students expressed fear of asking appropriate questions or speaking with culturally diverse patients to clarify misconceptions. Educators confirmed this finding. One educator noted, "I think a lot of people are afraid to ask questions because they think that might come across as being discriminatory or racist" (NE, Akosua). It is essential to understand why students hesitate to ask questions during ICC encounters and how to support them effectively.

Conceptual Basis of ICC

Defining Characteristics. Intercultural communication was seen as a crucial aspect of relational practice. A student noted: “And I think it’s very important for nurses and student nurses, because especially in our environment, where there are just people from all sorts of backgrounds. And Canada is also a very multicultural country, and that's also very important.” (NS, Fola). However, the understanding of the term ICC was limited, and some participants in both categories initially struggled to explain it. Most asked the researcher for an explanation of what ICC is. A student shared, “It’s like it’s a basic term, but it’s very hard to explain” (NS, Adeola). An educator described it as “being able to give information or find out what’s going on with each individual” (NE, Allan), which does not address the key elements of ICC. This highlights the need for in-depth work to develop theoretical knowledge that empowers educators and enhances students' understanding of ICC. Some participants described culture and communication separately before combining them for a clearer understanding. One student shared:

I know that culture is the way of living, different ways of living life. So, communication will be knowing how that person’s culture works around or how they live their daily lives and how another person lives, and that’s conversing and bringing it all together (NS, Adeola).

Participants described ICC in various ways. For example, a student described ICC as:

Interacting with...patients from different cultural backgrounds; so that means they have different values, beliefs, perceptions of their life, different interpretations of their experiences. And based on all of that, you know, with communication — intercultural

communication you need to be open to how different they might be apart from myself.

(NS, Alana).

ICC goes beyond merely talking with someone and involves psychosocial awareness of differences among people and their distinct cultural experiences, as well as openness to adapting to and learning from patients who are different from us.

Related Concepts in ICC. Another dimension recognized by participants was the relational process or emotional connection within ICC encounters. A student shared, "... it's like a relationship process rather than like – like someone is like the subject of your observations. And so, I think ideally in an intercultural, communicative relationship context, there is like an authentic connection happening" (NS, Ama). These connections would exist between the individuals involved in the ICC encounter. For example, an educator described ICC as "It's two people, three people, whoever, you're in a conversation with a diverse group of people that are not from your same culture" (NE, Yaa). The individuals involved in the dialogue come from diverse cultural backgrounds. As a result, participants stressed the importance of integrating cultural sensitivity and respect into ICC encounters. Some comments indicated that white individuals primarily developed the nursing communication approach, which tends to favour Caucasians. However, a few participants also emphasized the importance of recognizing diversity within the Caucasian population. A student noted: "communication among different cultures, so even among white people. White is such an umbrella, there are different, obviously, different kinds of white, and they have different cultural practices" (NS, Ellen). The situational analysis of stories shared by participants revealed varied distinctions among Caucasians, even though they may all appear white. An educator shared:

I have seen patients who are elderly who speak a different language, and they may have the appearance of the dominant culture, so they're white appearing, but they speak Italian or something that is not well understood by most of us nurses, healthcare providers. And sometimes these clients can become very frustrated and angry, and why aren't you understanding me? I'm looking right at you. I'm talking a mile a minute in my language, and why aren't you understanding me? So, helping nursing students to have empathy for the frustration or the anger that the client is experiencing is also important (NE, Pearl).

This analysis indicates that nurses must establish rapport with their patients to gain an understanding of their individual needs. Assumptions regarding a person's skin colour may be inaccurate, potentially resulting in biased ICC encounters.

Antecedents of ICC. The descriptions above highlight that ICC must involve showing empathy, respecting others and their different perspectives, understanding cultural differences, checking personal biases, being open to other cultures and learning, and demonstrating cultural sensitivity. For instance, a student noted that, “I think intercultural communication involves empathy and being able to understand the client more. ... Being more gentle, more polite, more respectful” (NS, Adna). This analysis suggests that bias should not influence the conversational pattern when a student or educator is open-minded and willing to learn. Intercultural communication can therefore be defined as a relational process involving interactions between individuals from different cultural backgrounds, with an intentional effort to respect, understand, and accept one another's differences in dialogue. There was a call from nursing students and educators for a guideline addressing cultural diversity that could serve as a resource for nurses to improve cultural awareness, understanding, and adaptation. A student shared that,

“There might be some merit to guidelines, for example, where it might be beneficial to be aware of certain practices. To be aware of certain languages that you should be – or words that you should be avoiding and stuff like that” (NS, Breanna).

Intentional integration of ICC was not recognized as an integrated concept in academic and healthcare settings. However, this analysis highlights the importance of courses that integrate ICC and the need for students to appreciate, accept, and be open to learning from cultures different from their own.

Many participants shared their perspective on how effective ICC should feel in intercultural settings: non-discriminatory, trusting, and comfortable. A student shared that: “I feel like the patient should be able to trust you and feel comfortable divulging information. So, on your part, you have to work towards building trust with the patients here” (NS, Bisi). Many patients share relevant histories to guide their care when they trust the nurse. An educator shared that people are likely to share their personal stories during ICC: “For me, I think the best times have been when everyone’s feeling relaxed and open” (NE, Akosua). Building trust and rapport was essential for effective ICC. Another participant mentioned that: “And I think, yeah, there is definitely room for improvement there because so much is focused on like clinical competencies. Like your assessment is going to be useless if your patient doesn’t trust you enough, to be honest” (NS, Ama). Some participants with limited experience reported that ICC can be awkward for both the nurse and the patient as they try to understand each other, underscoring the complexity of approaching it from a relational perspective.

Empathy: A Foundation for Effective EICC

Participants frequently emphasized empathy as a vital component that enhances ICC, underscoring the need for EICC and supporting the conclusion that empathy should be

incorporated into ICC for effective EICC. For instance, a student noted, “But also, not just communicate, because anyone can really communicate, but being able to understand, and being able to empathize, and being able to really, on a deeper level, build that relationship with another person” (NS, Vero). Empathy made a difference in the ICC process by moving beyond formal conversations to focus on individualized, more patient-centred relational practice, where a nurse holds their biases responsibly and is open to challenging them through reflection and learning from those with whom they work. Another student noted:

I think without empathy, it's easier for someone to seem really different from different cultures, or different languages or different customs. But if you're able to at least try to understand what it would be like to be in a hospital and have all of these nurses who aren't in your culture, or be in a hospital with all of those who don't speak your home language, if you can try to think about what that would be like for them (NS, Stephanie).

There was a call to imagine and view situations from the perspective of culturally diverse patients during their vulnerable period of illness, as a means of expressing emotional empathy. However, this could be achieved through the ICC and a contextual understanding of the patient's background, thereby expediting understanding and facilitating empathy in intercultural settings. A student shared that, “Really getting to know and understand where they're coming from, just because maybe it's different than what you think, and you think maybe, oh, herbs don't work. You need medicine. Whereas their beliefs are, we do this natural way” (NS, Nana).

Empathy was identified as a crucial element that connects people across backgrounds, beliefs, values, race, and colour, and helps build trust in the healthcare system. Therefore, participants agreed that, amid the complexities, barriers, and systemic racism, teaching empathy thoroughly in undergraduate nursing education can make students more empathetic and better

advocates in their interactions with culturally diverse patients. An educator shared: “And students will really appreciate that because it created that human connection between the patient and us and lowered those barriers that exist” (NE, Star), which improves rapport and care.

All participants expressed varied understandings of empathy and its importance to their practice. They used phrases such as “listening,” “feeling,” “understanding,” “being in their shoes,” “advocacy,” “kindness,” and “authenticity” to describe empathy. One student shared that “empathy to me is kind of being able to feel what other people are feeling, I guess” (NS, Iris). This assertion may be impossible, as one cannot precisely feel what another person is feeling. Another student rightly observed:

And of course, we will not be able to feel the way they feel, but showing them that we can – we are there to listen to them, to help them if they need, and we are genuinely showing them concern, like in terms of empathy, showing them that you care for them (NS, Adna).

According to participants, empathy helps nurses understand patients' contexts and appreciate their cultures. One student also said, “empathy is actually like understanding their experience and, I think, like being in their shoes” (NS, Alana). This means being genuine in patient interactions to foster trust and get to know them better. An educator shared that:

Empathy is understanding who that person in front of you truly and utterly is and how they're doing. It is knowing them, and to do that, you have to build trust. And part of the way that you're building that trust is being authentic in who you are as a professional. So sometimes that's me sharing something about myself. Sometimes it is me really engaging with that person and sitting down and talking to them. It's me getting to know them and who they are (NE, Naa).

Some participants used the terms empathy, compassion, and sympathy interchangeably and also found it challenging to define empathy. A student described it as:

When I think of the word empathy, I often compare it with sympathy rather than compassion. So, how I think of it is, sympathy is kind of a feeling bad for the person, and, yes, just feeling bad, I guess. And empathy would be like holding their hand throughout the issue and really understanding where they're coming from and trying to understand why the issue makes them feel that way. And then maybe, yes, helping them through that. And then I think of compassion as being gentle. So, I believe that both of those are really important in nursing (NS, Ellen).

There is a critical need for deeper reflection on these terms within nursing curricula and addressing these gaps in ICC. Nursing students noted that their curricula lacked sufficient content on empathy, which constrained their understanding of and ability to apply it. A student shared: "I think there were maybe one or two sessions that we just talked about empathy. And the main thing was saying, "OK, I understand your point of view" (NS, Papa). To broaden their limited understanding of empathy, participants requested greater exposure to clinical scenarios related to the phenomenon. A student shared:

So, to me, empathy is very personal, but also a lot of it can also be – I wouldn't say taught, but we can be exposed to a lot of it, using again just the different discussions and even courses around the different backgrounds. Because once you are a little bit more aware of their cultures and what people experience over in their countries, for example, you get the feel of what it is like (NS, Breanna).

Exposure to empathy requires both internal and external stimulation. A student said: "I do think that some people are born very empathetic in a way. I do think it's genetically related. But I also

think that there is a big environmental component in the way that we're raised" (NS, Iris). These findings suggest that empathy may be genetically heritable and that upbringing and the people around you also influence how empathetic someone can be, indicating that the environment can shape behaviours. The analysis revealed that empathy among nursing students can be developed through education and regular exposure. One student shared:

But my instructor was able to tell me that, "You need to go beyond your head-to-toe. You just cannot be charting your head-to-toe all the time. That's not what you are also here for. You need to understand what your patient is doing, what your patient is feeling. Is the patient wanting to go home? So, you have to indulge empathy." So yes, my instructor did teach me, and I'm so happy for that (NS, Adeola).

This scenario suggests that regular exposure to ICC, with adequate guidance and instruction in academic and clinical settings, can shape nursing students' empathy skills.

Empathy Types. With the introduction of various types of empathy, participants shared what was effective and most relevant for empowering EICC encounters. Discussions with study participants focused on five types of empathy identified in the literature—cognitive, emotional, moral, behavioural, and relational (see **Table 1** for definitions). Some participants expressed shock at these empathy categories and noted they had never been taught or heard of them before. A student stated: "That's a good question because I'll be honest, I don't think I know of the types of empathy" (NS, Breanna). They said empathy is generally taught as putting oneself in another's shoes. The educators echoed this idea. One educator shared,

I don't know specifically the different types of empathy, and if they're included in the curriculum. But when I talk about it for students, I suppose – I guess I thought kind of –

putting yourself in the other person's shoes, I guess, is, I think, the most common maybe definition of empathy (NE, Moon).

A student also noted: "The way you broke it down, I don't think it has been introduced like that. I think we just talked about empathy as a whole" (NS, Bisi). Some participants believed that all types of empathy are interconnected and evident during interactions.

There were debates about certain types of empathy, especially emotional empathy. While some participants believed that emotional empathy is simply a natural reaction of the person experiencing it and cannot be taught, many argued that it is impossible to truly put oneself in another person's shoes. For example, a student remarked: "Trying to be in someone's shoes is very hard because – unless you've not experienced it, you won't understand it" (NS, Ama). Moreover, it is impossible to fully comprehend everything your patient has endured. One can only imagine those lived experiences. Another participant shared:

I think that sometimes, like putting them in my shoes or putting someone in their shoes, isn't the most accurate reflection, because there are some cultures where things like eye contact are different. So, making, like, really strong eye contact isn't something they do. And I might take that as disrespectful, but it might not be disrespectful, where some cultures value modesty a lot more (NS, Stephanie).

These arguments reinforce the earlier claim about the validity of the emotional empathy definition and advocate a review of some accepted definitions. There was a call to move beyond simply putting oneself in another's shoes. Similarly, there was a warning about how behavioural empathy is demonstrated. An educator stated:

The behavioural one, I think you have to be careful with, because just recently I just witnessed a student, it was just in a simulation. It wasn't a real client. But the student kept

responding to the client by saying ‘don't worry, you'll be OK’ and doing kind of a touch.

It's OK, there, there. I feel that is a behavioural one and it's very unhelpful. I think that actually can come across as a very condescending thing (NE, Pearl).

Educators have a role in teaching nursing students to demonstrate behavioural empathy beyond merely providing patients with false verbal or gestural reassurance.

The Shift towards Relational Empathy. There was a call to move beyond the traditionally emphasized cognitive and emotional empathy and to explore other dimensions of empathy, such as relational empathy, that affect communication. Many participants noted that educators usually focus on cognitive, behavioural, or emotional empathy. A student remarked, “For me, I feel the relational empathy is the most important. But I think in school, they focus a lot on cognitive or behavioural, I’d say” (NS, Vero). An educator shared a similar view, “Yes. Relational empathy is more important” (NE, Moon).

Participants discussed how EICC, or relational empathy, improves therapeutic relationships. An educator shared:

I think that basically leads to the difference between just intercultural communication and EICC. I think it all kind of is placed on the therapeutic relationship that is initiated. And I feel like relational empathy helps support that therapeutic relationship faster and more efficiently (FG2, NE, Moon).

Most nursing students identified relational empathy as more suitable for effective EICC. They viewed it as a remedy for the gaps found across various types of empathy. For example, a student shared:

The combination one [relational empathy]. I think because you also recognize the other person’s emotions and thoughts and share the emotions with them. I think that just

widens your perception and helps you better understand the person in the situation (NS, Fola).

Participants stated that relational empathy promotes self-reflection and that nurses should receive education on it, as it can help them better understand culturally diverse patients.

Participants reaffirmed this view: “I think that would be really important to learn more about relational empathy. I just think that if you know where your patient is coming from, then you can understand where they are now, right? And how to help them” (NS, Jona). Relational empathy was observed to foster a sense of connection through shared stories, helping people better understand others. Although this form of empathy was considered necessary, participants noted that it was absent from nursing curricula. A student stated: “Like understanding how all these things influence a person’s life. And certain profs will kind of like – or instructors, I guess – some talk more about intersectionality, which I think relates well to that. Yeah, again, like not a ton is taught on that” (NS, Ama). Relational empathy, intersectionality, and humanness have one thing in common – proactive steps to understanding the other’s context and the intersecting variables that influence their actions or situation, to guide the student’s reflection and EICC practice. Notwithstanding, some educators believed it would be easier to begin teaching either cognitive or emotional empathy and gradually develop it into relational empathy. An educator noted:

I do think relational empathy is the most important since it sounds like it’s a mix of all the rest. But I feel like when you’re teaching, it’s hard to start at that point. For me, I really hit on the emotional empathy with students because that’s kind of the easiest for them to grasp ... So, in order to get to that, you know, relational empathy, I think it’s more of a stepping stone (NE, Akosua).

It was evident that emotional and cognitive empathy have become the standard for evaluating or expressing empathy, making this approach more flexible and straightforward. Some participants from both categories noted that employing multiple forms of empathy could improve care. For example, a student shared, “I think in order to provide the optimal care, I think those three would be the main ones. The cognitive, relational, and emotional. I think those would be very beneficial.” (NS, Papa). Participants considered relational empathy an umbrella term encompassing all other types. When relational aspects are understood, nursing students will be better equipped to practice relational empathy in ICC.

Emotional Distress in EICC

Educators confirmed that student nurses experience fear, nervousness, apprehension, and anxiety when engaging in EICC with culturally diverse patients or nursing staff. Focus group participants noted that students' fear may stem from limited exposure to ICC interactions. One educator shared, “You were talking about how students felt that they needed more exposure to this type of thing, which I interpret as a lack of confidence or fear... Maybe they’re feeling apprehensive, or maybe they’re feeling nervous as well.” (FG2, NE, Sunshine). Limited exposure reduces students' confidence when they encounter culturally diverse patients, leading to feelings of intimidation and nervousness. Fear was also evident in interactions between culturally diverse staff and students. An educator shared:

Fear always is one thing. So, some of our students have long, beautiful braids that they have tied back. And I remember this one student, her hair was beautiful, everyone thought it was beautiful, but everyone wanted to touch her hair. And I remember someone who was a member of the healthcare team just coming and touching her hair

and not asking for her permission. And they kind of pulled back, the student did, but they never said, “Don’t touch my hair.” (NE, Rehoboth).

In this case, although the educator was unhappy about the situation, the educator failed to speak up or advocate for the nursing student to inform the healthcare team member that such acts are unacceptable. Students were observed to be fearful when expressing themselves in hierarchical or power-dynamic ICC situations, as they did not want to get into trouble. This means educators must support them empathetically to build their confidence to speak up.

Educators also reported that students feel like ‘deer in the headlights’ during ICC interactions, unsure how to manage them or fearful of the unknown. Students are skeptical about saying or doing the right thing to demonstrate appropriate behaviour during ICC, especially when the patient’s English is a second language. A focus group participant shared: “Oftentimes, students would be a little bit apprehensive, “How do I engage in that?” Yes, we talk about it, “How should we operationalize that?”” (FG2, NE, Star). The main concern is how to navigate interactions with culturally diverse patients without fear. This fear was observed not only at the bedside but also in simulations. An educator shared:

Students do say, “Even though it’s sims, we do still feel nervous.” So, like you're saying, yes, and then you go, and you walk into a patient room, and there’s ten family members there, and half of them don’t speak English, and you're a student already, so you're nervous about your competency in general, and now you add that additional layer (NE, Sunshine).

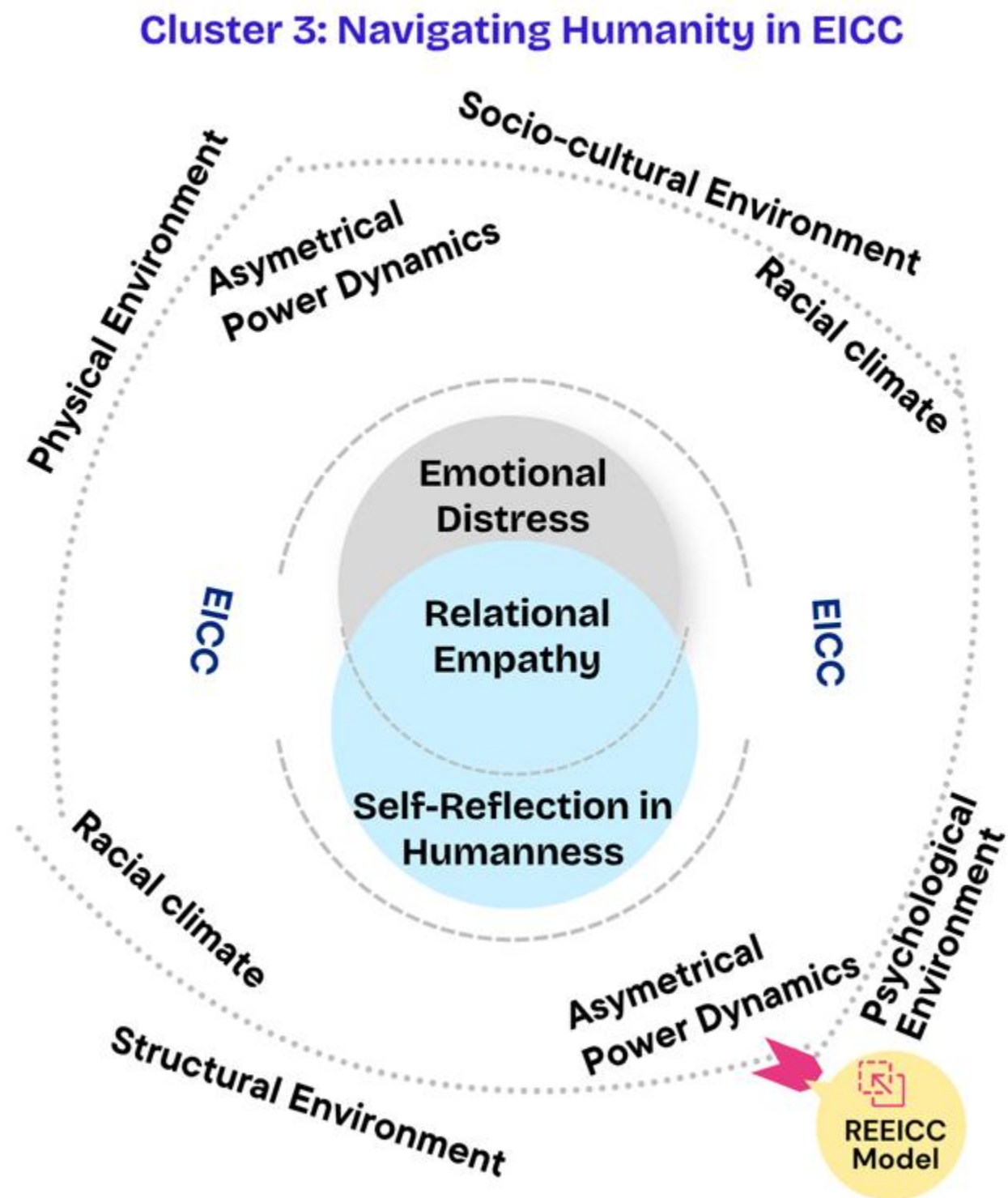
These fears and anxieties lead students to repeatedly review patients' charts or even hide in hallways and bathrooms to avoid unpleasant ICC dialogues. The state of nervousness in both

simulated and real-life encounters must be studied and addressed to better support nursing students in developing competent EICC skills.

Summary: Navigating Humanity in EICC

The section described humanity as a critical aspect of EICC, encompassing qualities such as humility, empathy, connection, and kindness. It called for awareness of one's biases, understanding their historical foundations, and working to dispel them in ICC interactions. Both nursing students and educators play a role in achieving this goal. This cluster also outlined the conceptual foundations of ICC, including its defining characteristics, related concepts, and antecedents, to clarify what ICC is and how it should feel in the presence of empathy, respect, and understanding. Five types of empathy – cognitive, moral, behavioural, emotional, and relational – were explored based on previous literature (Brunero et al., 2010; Decety & Cowell, 2014; Eichbaum et al., 2023; Hoplock et al., 2021; Jeffery, 2016; Lobchuk et al., 2018; Meneses, 2011; Morse et al., 1992; Rettig, 2017; Trevisani, 2005). However, participants leaned towards relational empathy as a better fit for advancing EICC in undergraduate nursing education. The section also highlighted the fear and emotional distress that can result from unpreparedness, lack of confidence, and fear of not approaching culturally diverse patients appropriately. Refer to **Figure 4** below for a visual illustration of the key features of this cluster. The next cluster will focus on the gaps identified in teaching EICC and the need to build partnerships to address them.

Figure 4

Visual Representation of Navigating Humanity in EICC

Cluster Four: Partnering toward a Diversified and Relation-based Curriculum

The cluster investigates the root cause of the EICC theory-practice gap, the structuring of the nursing curriculum to foster EICC, and the need for partnerships to enhance effective EICC. Structuring the nursing curriculum to promote EICC highlights the integration of culturally diverse resources, the importance of timing in advancing EICC, the promotion of nurse educators' ICC competencies and comfort, and a definition of the relation-based curriculum. Lastly, the call for partnerships to promote effective EICC explores avenues to understand the Clinical Education Facilitator as a reflection of the current system, the significance of patient and family partnerships in developing EICC, and the opportunity to reconsider the role of academic partnerships in advancing EICC.

Structuring Nursing Curriculum to Promote EICC

The study identified variable EICC gaps in teaching and practice across the nursing curriculum. The EICC theory-practice gap was identified as a disconnection between what is taught, either didactically or through simulations, in nursing schools and what is practiced in clinical settings, both of which together enable students to build competencies in interacting with culturally diverse patients. The EICC's theory gaps pertained to curriculum structure and a lack of culturally diverse resources, while its clinical gaps were evident in its institutional structures, patient assignments, and evaluation. The current nursing curricula at the three participating institutions are structured, with designated time and duration for teaching theory, technical and communication courses. Educators emphasized the limited amount of culture- and empathy-related content in these curricula. There is a need for specific, communication-focused scenarios with cultural elements to address and evaluate nursing students' EICC needs and competencies. An educator noted, “But if I could recall being a student or even within the simulations that I

teach. I teach virtual reality simulations. I don't think there are any cultural aspects in it, even someone who is of a different culture" (NE, Akosua). This finding reveals that cultural content is missing from simulation and classroom teaching, a historical omission, as evidenced by the educator's witnessing it during her time in nursing school and, many years later, in her role as a simulation educator.

Another aspect of the reported curriculum design is the introduction of cultural competency without clearly defining its concepts. One student noted, "There's, like, a strong emphasis in nursing about cultural competence and being aware of cultural perspectives. Although they don't go into certain detail about what those perspectives are" (NS, Fola). Multiple educators and students repeatedly referred to a course on human diversity, intended to address cultural elements within the nursing program. However, reports indicate that this course did not meet the intended vision, as it primarily focuses on Indigenous concepts and features Indigenous guest speakers. For instance, a student shared, "We have human diversity, I think in your first year. And I did not find that class helpful in terms of increasing my ability to be culturally competent in my practice" (NS, Stephanie). Analysis of responses from more than 60% of students indicates that the learning activities in this course did not facilitate engagement with culturally diverse patients. Additionally, students reported being taught content on cultural safety and racism towards Indigenous people within healthcare. However, racism faced by other cultures was not addressed. There is a need to periodically evaluate courses to ensure they meet the growing needs of the diverse population being served and the program's objectives.

Some students and educators noted that cultural knowledge in their nursing curricula was typically focused on the dominant population in their communities. However, when they transition to work in other locations, they experience cultural shock when serving diverse

cultural populations. For instance, an educator noted, “I grew up in rural Manitoba in a small farming community, so when I moved to [Region 1] I felt like I knew nothing about caring for people that were of different cultural backgrounds than myself” (NE, Rehoboth). Ideally, the knowledge gained from these courses and simulations must be transferable to other settings in which nurses work. There is a need to review the nursing curriculum and the approach to teaching cultural concepts to support effective teaching and knowledge uptake. It is prudent to examine the EICC theory, clinical or practice gaps, and the disconnect between knowledge and skill uptake to adequately address the concerns. Proposed strategies to address the EICC theory-practice gap include incorporating culturally diverse resources, levelling EICC into the nursing curriculum, and promoting nurse educators’ ICC competencies and comfort levels.

Incorporation of Culturally Diverse Resources. To address these curriculum gaps, suggestions included adding intercultural courses and research projects that explore major cultures, beliefs, systemic racism in healthcare, the history of colonization, and ICC. Other educational initiatives could involve cultural journals, revising clinical routines to encourage more active cultural encounters during clinical practice and debriefs, cultural projects and presentations, or cultural drama and skit theatre. A student remarked, “There should probably be a cultural course that inculcates most of the dominant cultures in Canada based on diversity... I feel they should inculcate more intercultural communication into our curriculum” (NS, Bisi). Such teachings can help students identify and challenge their biases about other races and learn how to better support diverse groups. Another student cited examples of the required teachings: “Like immigrants or refugees, because I think of how different their experiences are, and I think that will help students to know what kind of supports to refer to them on discharge for the continuity of care” (NS, Alana). Refugees and immigrants have specific needs that fall

outside the usual scope of patient care and also require empathy. That's why students need to engage with them through clinical or simulation exercises to develop cultural awareness and build competency with EICC.

Furthermore, to address limited nursing resources, suggestions included diversifying standardized patients and case characteristics to reflect diverse cultures and beliefs, adopting textbooks with a global health perspective, showing model videos demonstrating EICC, and inviting guest speakers from various backgrounds. A student remarked: "I think they should put on more simulations with culturally different clients, like newcomers, immigrants. Because they do have some Indigenous patients, but it would be nice to have other population groups as well" (NS, Fola). Using a diverse patient population can expose students to the intercontextual factors that influence ICC interactions and encourage them to incorporate empathy into those interactions. Another student remarked, "Sometimes having also intercultural fairs" (NS, Adeola). The intercultural fair was suggested as an event for nursing students to showcase diverse cultures. Participating in intercultural fairs will trigger nursing students' reflection on the experience. Another proposed resource was a curriculum-based intercultural travel experience to prepare students for EICC. An educator shared an experiential service-learning activity involving travel.

I mean, for me as a practitioner, I did take students to [S. America] one year, as part of a service-learning experience. And so, we were in one of the [capital of S. America], and we did not speak Spanish, and their group did not speak English, and so there was a lot of work with translators. (NE, Selina).

Intercultural service learning was regarded as a way to introduce nursing students to different cultures and strategies to consider when caring for patients with English as a second language. In

situations where travel was difficult, students believed that EICC videos could serve as an alternative: “I wish that there were videos available that demonstrated culturally appropriate communication, because it's one thing to talk about it, but it's another to see it represented in another way” (NE, Elliette). There was a call to invest in educational resources that expose students to cultural diversity and enable them to develop and showcase EICC. Some of the recommended materials included coloured mannequins, culturally appropriate textbooks, and investing in educator training, along with culturally diverse guest speakers. One key point raised was that resources used for course content and teaching should reflect the diverse cultures of the patient population to promote awareness, foster a realistic understanding of the course, and enhance cultural practices within the healthcare environment.

The suggested resources could help address the shortage of teaching materials reported by educators to support these EICC conversations and lectures. One educator noted, “Sometimes you'll find at the end of a chapter that there's like a little blurb about cultural differences, or sometimes it's maybe one chapter in the textbook, but it's never really thorough enough to actually prepare students in my opinion” (NE, Elliette). Other educators also mentioned they could not find culturally appropriate textbooks, videos, and resources to explain cultural differences and effective communication strategies. For instance, another educator said, “We don't have that in textbooks; we only have Caucasian skin types. ... Canada is diverse, yes, you see it is diverse, but the educational system is not diverse enough” (NE, Angel). The increasing ethnic diversity means that textbooks, videos, and simulation mannequins must reflect colour diversity to empower nursing students as they conduct health assessments and care for such populations in clinical settings. A simulation educator shared, “In our simulation lab, we have one mannequin who's Black and the rest are White, but then people think like, “Oh, we have one

Black mannequin, yay for us” (NE, Elliette). It is not enough to have representation; equitable representation of culturally diverse resources is essential. This highlights the urgent need for adequate representation of physical and human resources that reflect diversity and for educators to understand the purpose those coloured mannequins serve in simulation education. Hence, the call for more culturally relevant resources.

The Need for ICC Exposure for Nursing Students. All students expressed the need for sufficient exposure to different ethnic groups to build confidence in interacting with people from diverse backgrounds, recognizing that Canada is a multicultural country. One student remarked, “I personally think that I did not get enough cultural experiences with patients from different backgrounds” (NS, Alana). It was also noted that simulations rarely reflect patient diversity; as a simulation educator shared: “Gender doesn’t matter, ethnicity doesn’t matter. It’s still the chest pain, let’s put on some leads, let’s look at the monitor, which is not a good thing” (NE, Selina). Gender, culture, and ethnicity are crucial elements that improve holistic care but are often not a focus in most nursing curricula. As a result, some students only encountered patients from different cultures during clinical practice, underlining the need for additional opportunities to strengthen ICC skills and knowledge. Another student said, “It’s a very important tool for us to have, to enhance the care that we give and make sure that we can provide patient-centred care, and that the patient feels comfortable and well taken care of” (NS, Fola). The ICC was seen as a vital tool for promoting patient-centred care.

It was also observed that there was a lack of clinical or simulated experiences to help students develop empathy skills in clinical settings. Most students reported limited exposure to ICC situations where they could apply their empathy skills, as the whiteness of their real or standardized patients mainly reflected a biomedical focus rather than a cultural or

communicative one. Students indicated that their personal lived experiences and backgrounds were more significant sources of empathy during ICC encounters. One student remarked, “My lived experiences taught me a lot more about empathy and helped me develop more as a person than my nursing program” (NS, Vero). Undergraduate nursing education was seen mainly as a way to gain theoretical knowledge and prepare students for clinical competence, rather than as a means to foster a humanistic approach to care. As a result, students from multicultural backgrounds had an advantage in ICC. A Caucasian student noted, “I think they just experience it, or they just get it more, and they understand how to relate more and empathize and sympathize” (NS, Nana). It was observed that coming from a culturally diverse background made it easier to engage in ICC, as such students regularly participate in culturally diverse interactions in their daily lives, which improves their interactions with culturally diverse patients and colleagues. Consequently, most Caucasian participants recognized the gap caused by their backgrounds and the lack of formal cultural education. Therefore, there is an urgent need to expose students to patients from different cultural backgrounds to gain sufficient ICC experience.

But I think as nursing students, you’re in this awesome, unique position of just being able to learn. You’re not on your own; you’ve got a preceptor, CEF, and you’ve got a buddy nurse. So, it’s the perfect time to do those uncomfortable situations and conversations, rather than after your one-week orientation, and just being the nurse and being the only resource that the patient has (NS, Stephanie).

Being a student was viewed as the ideal time to develop ICC skills through mentorship and the CEF’s ample resources, including buddy nurses. This also requires educators to identify real-life,

culturally diverse patients to assign to nursing students, better preparing them for EICC.

Knowing the definitions is not enough; applying the knowledge in practice is equally essential.

Timing Matters - Levelling EICC in Nursing Curriculum. Structuring the curriculum involves designing the timing and methods for delivering EICC education, incorporating both didactic instruction and practical application, and identifying the resources required to sustain EICC learning within the nursing program. While EICC is fundamental to ensuring quality nurse-patient communication, it could not be acquired instantaneously and necessitated ongoing learning, experience, reflection, and evaluation. The timing of instruction must be responsive to the periods when nursing students need this knowledge and practice most, particularly since EICC is an essential component of nurses' interactions with culturally diverse patients. An educator noted:

Third years are definitely more accepting of all of their responsibilities. They're able to multitask a bit more. Whereas in the first years, I think that they're just so focused on actually getting into nursing, understanding what nursing is, learning how to do the foundational tasks of nursing, that it's really hard to even think of teaching them empathy. I'm sure that it is introduced, but maybe it's not something they could grasp right away (NE, Akosua).

There were arguments that relational concepts are difficult to grasp and should be introduced later in the program after the students have developed their technical skills. However, the complexity of relational skills warrants deliberate scaffolding throughout the curriculum to promote ongoing knowledge uptake. Relational concepts like EICC are foundational for the nurse-patient interaction during the development of the technical skills and cannot be sidelined for later. Nursing students typically commence clinical practice in their first or second year, depending on the institution's

program structure; therefore, to enable them to engage effectively with culturally diverse patients from the outset, it is essential to introduce EICC early in the program. A student confirmed that: “I think if they could introduce it as early as possible, that would be great, because I think we specifically started learning about it in the third year. I believe it was the second term” (NS, Papa). Furthermore, there is a need to shift the emphasis from focusing solely on technical skills to including relational competencies from the outset. This introduction should be complemented by continuous reflection and the gradual development of related concepts, such as cultural influences, power dynamics, racism, equity, and inclusion, throughout their relational experiences in both simulation and real-world clinical settings. Introducing communication scenarios early helps build a strong base, but educators clarified that these scenarios mainly involved general therapeutic communication without cultural elements.

Relational concepts such as EICC require time and practice to develop individual nursing students' competencies, particularly when some students commence the program with limited cultural awareness, while others have been shaped by experiences of immigration and frequent intercultural interactions, as discussed previously. Consequently, evaluating these EICC competencies using standardized outcome criteria can be challenging, as clinical experiences are individualized and EICC is cultivated through continuous exposure. The frequent reports of students lacking exposure to ICC encounters may further complicate assessment efforts. Educators bear the responsibility to introduce the concept and relevant experiences to students at the earliest opportunity, as well as to implement evaluative measures to monitor the progression of EICC in students over time. The analysis suggests that the current evaluation of relational practice is primarily focused on either general therapeutic communication or on cultural safety with Indigenous patients.

Incorporating EICC into the nursing curriculum signifies a prioritization of ICC as a fundamental concept for developing relational understanding. However, there were concerns that the current nursing curriculum is biomedically dominated, has limited cultural content, and focuses mostly on the cognitive domain. A simulation educator shared: “I don't think we’ve intentionally addressed any other types of empathy” (NE, Selina). Educators shared that, particularly in simulations, they place greater emphasis on medical content and rarely address types of empathy beyond cognitive empathy. Most students also reported limited exposure to empathy and ICC in their courses, despite its significance. It is evident that efforts to teach empathy and cultural concepts are superficial; however, students would benefit from greater exposure to these concepts. Cultural relational content can be integrated alongside other subjects, provided that educators consciously strive to enhance nursing students' ability to engage empathetically with culturally diverse patients and their families.

Promoting Nurse Educator ICC Competencies and Comfort Levels. It is described as follows: understanding the learning needs of nurse educators to promote EICC practices; patient assignment for nursing students and the advancement of EICC; and promoting EICC in evaluative strategies.

Understanding the Learning Needs of Nurse Educators to Promote EICC Practices.

The academic faculty and clinical education facilitators (CEFs) are recognized for their pivotal role in equipping nursing students with essential knowledge and skills to develop communication competence. Nonetheless, numerous students and educators have expressed concerns regarding the educators’ proficiency with EICC. Consequently, a gap exists in EICC, pertaining to how educators’ lack of competence influences the transfer of ICC knowledge and the availability of environmental or structural support. According to participants, “There are so many factors

impacting; if the CEF even cares about that cultural experience” (NS, Alana). Some nursing students also perceived that certain CEFs lack the competence to support them effectively in ICC, which results in their not being assigned to individuals from diverse cultural backgrounds. The CEFs' failure to support culturally diverse nursing students significantly reflects their mentoring capabilities in preparing students to provide culturally competent care.

Some educators expressed discomfort in guiding, engaging, or instructing nursing students about ICC. An educator remarked, “Generally, I feel underprepared and sometimes nervous, because I am Caucasian” (NE, Elliette). Most Caucasian educators reported a lack of intercultural background, experience, knowledge, or skills, which adversely affected their teaching and confidence. A few educators recounted situations they encountered that they did not feel comfortable addressing or even assigning to students. For example, some CEFs are unable to multitask in evaluating or modelling ICC during clinical supervision and consequently tend to concentrate on psychomotor tasks. An educator shared:

I think you have to be a strong CEF to do that, because while I was having that conversation with the patient from [region 4] about the polar bears, I was also piggybacking my brain to make sure that the student was doing their IV push medication properly (NE, Naa).

There appeared to be a diversity of contexts, and the educators were hesitant to disclose their challenges with ICC. Some CEFs assign students exclusively to patients with whom they feel comfortable supervising. One educator also added, “I agree with that. I’ve never looked – it’s always the learning needs of the student” (FG1, NE, Allan). Interestingly, none of the educators identified ICC as a student learning need, which is concerning. The reference to the students’ learning needs was ambiguous and warranted further investigation. Nursing students recognized

a requirement for increased empathy, ICC content, and practical opportunities with culturally diverse patients to enhance confidence, awareness, and skills in navigating ICC dialogues with empathy and expression. There was a call for educators to be equipped with knowledge of ICC and empathy.

Patient Assignment for Nursing Students and the Advancement of EICC. Participants highlighted the need for patient assignments that merge EICC experience with clinical skills. Reports indicated that patient assignments mainly focused on developing clinical or psychomotor skills rather than communication. One student shared: “They’re not really thinking about race or culture, and how students can learn and have a good experience from that, to just as like physical needs. I think that could improve, actually” (NS, Alana). Nursing students want improvements in patient assignments to address the issue of focusing only on psychomotor skills and to include learning how to establish rapport and build trust with culturally diverse patients. A student said, “Like your assessment is going to be useless if your patient doesn’t trust you enough, to be honest” (NS, Ama). Nursing students need a solid foundation to communicate effectively with patients from different cultural backgrounds. Nurse educators confirmed these findings, with one saying, “In all honesty, I do also assign students based on skills, but more so because for me it’s about time management of skills. So, it’s more of a test to see if they can handle many skills with many different patients” (NE, Akosua). There seems to be a link among clinical skills, time management, and competency assessment in patient assignments, with no mention of patient communication.

Language also seems to influence patient selection for nursing student assignments. It was observed that some CEFs may not assign students to patients with language barriers. A student shared, “I know some CEFs won't give you patients if they know there's a huge language

barrier. So, I think that adds a level of complexity to it” (NS, Stephanie). In response to this concern, some CEFs mentioned that they assign students to patients from the same cultural background to help students feel more comfortable communicating. Despite the challenges of caring for a patient with a different language, giving students this experience offers a valuable learning opportunity that prepares them for future difficult ICC encounters and deserves further exploration in clinical settings. Participants propose establishing a collaborative partnership between students and educators to discuss students' needs and to efficiently assign them to patients from diverse backgrounds in order to develop their EICC skills.

Promoting EICC in Evaluative Strategies. Most of the clinical educators interviewed expressed uncertainty regarding whether the evaluation criteria incorporated an ICC component. According to these educators, nursing students are assessed using outcome indicators established by academic institutions that align with the entry-to-practice competencies (ELC) mandated by the regulatory body. One educator stated, “I honestly cannot remember, ... that’s if there are actual cultural competencies when it comes to final evaluations of students in clinical. Or if that’s something that’s really overlooked and something that we don’t really focus on” (NE, Akosua). The inability of educators, who assess students each term, to recall the presence of ICC components suggests that such elements were likely not evaluated. Nevertheless, only two of the fifteen educators mentioned a potential cultural element in the assessment of nursing students' clinical competencies, although skills and time management were rated as the highest evaluative criteria.

Nursing students reported that educators provided minimal supervision of their communication with all patients, making it challenging to assess, evaluate, or give feedback on ICC-related issues. One student shared, “It was me and the patient mostly, yes” (NS, Papa). An

activity that is not observed cannot be evaluated, and these situations compromise the effectiveness of clinical assessments of nursing students. A student mentioned,

They didn't sit in on any of the conversations – when the patient had wife and daughter and son present, and when I sat and talked with them about where they're from – yes, I just felt like it was a really typical response. And I wanted more depth with a patient like that. But how can she provide more depth if she didn't see it all? (NS, Ellen).

Clinical educators were reported to give general feedback when they did not observe their students' communication encounters. Therefore, the absence or limited presence of CEFs during nursing students' ICC encounters reduces the feedback they receive, limiting support for improving their ICC knowledge and skills, as guidance is either absent or limited.

Defining a Relation-Based Curriculum. The analysis indicates that undergraduate nursing education and care cannot be delivered in isolation; they necessitate interaction among patients, nurses, and other healthcare professionals. Nursing students also collaborate with educators and patients to acquire knowledge in academic and clinical environments, with the aim of developing skills for their future practice. Consequently, the curriculum should be designed to emphasize relationship-building and foster interaction among nursing students, educators, and their culturally diverse patients in teaching, learning, and practical applications. As communication involves relationship development, students endeavor to establish trust with their diverse patients and educators. An educator noted: “And you know also trying to make sure that we have a bit of a trust between the two so that, I may not be from your culture, but I want to learn what I need to do to help us meet the goal together” (FG1, NE, Sky). Attaining this requires collaboration among all parties to co-create knowledge through dialogue, trust, and respect, thereby establishing a secure learning environment where individuals can express themselves –

whether to receive safe care (patients) or to be assessed and provided with feedback on their EICC efforts (students).

The nature of EICC relies on the interconnected relationships among culturally diverse individuals engaged in dialogue. Students view educators as mentors; educators facilitate learning while also acting as co-learners; and patients are both the consumers of knowledge and co-constructors through shared experiences with students. An educator shared:

“I had the students kind of evaluate what’s important to them, and looking at their own values and beliefs, having them write it down, and then we had a discussion about how I can support them in their learning, and how I can support them on the unit. And that was very positive” (NE, Rehoboth).

Facilitating learning as an educator within a relation-based curriculum involves listening to your students and guiding them according to their needs (Berg & Lepp, 2023; Rege Colet, 2017). A relation-based curriculum is not just about content; it also offers opportunities for reflection to understand contextual information, personal perspectives and positionalities, and power dynamics. It promotes learning through ongoing relationships while embodying humanistic qualities. An educator shared: “You need to engage in that ongoing process of introspection, in order to make sure that you're communicating in a way that meets that person's needs rather than your own personal needs for thoughts and beliefs” (NE, Elliette). Self-reflection creates opportunities for growth and better relationships. This relation-based curriculum is rooted in principles of diversity, equity, inclusion, and social justice, encouraging collaboration to achieve these goals. These foundational elements promote social inclusion, meaningful relationship building, a safe teaching and learning environment, and a collaborative process that fosters the holistic development of nursing students for future EICC practices.

A relation-based curriculum in EICC practice can therefore be defined as an educational framework in which learning concepts are clustered around relational practice and relationship-building between academic actors in nursing and their clinical partners within an intercultural environment.

The Call for Partnership for Effective EICC

All participants acknowledged that effective EICC is fostered through collective efforts to co-create knowledge and develop skills among nursing students and educators via equitable relational partnerships. Collaboration in education is essential for meeting curriculum objectives. An educator remarked,

Term to term, you get different things. You get different people. It isn't threaded through... There are people who are motivated to do that, but it's not a joint conversation. We still have people using their very colonizer language to try to fit into that space. And it's still a us-and-them, "we will do this for you" kind of conversation, as opposed to how to do it collaboratively. So, I would agree with the students; it's very, very poorly done (FG1, NE, Sky).

The partnership was seen as a way to promote dialogue, change unhelpful patterns in academic and clinical settings, dismantle colonial voices, and create structures that support effective EICC in nursing student education. The aim of the EICC partnership was considered achievable through CEFs, reflecting the current system, recognizing the importance of patient and family collaborations in developing EICC, and rethinking the role of academic partnerships in advancing EICC.

Clinical Education Facilitators as a Reflection of the Current System. Clinical education facilitators occupy a critical role at the intersection of healthcare systems and

academic expectations. They tend to emphasize practices predominant within their respective systems and integrate these methodologies into their teaching. These facilitators manage escalating workloads, staff shortages, constrained patient resources, the necessity of providing high-quality nursing care, and limited time for clinical supervision and professional development, all while ensuring the education of future healthcare professionals. For example, time limitations resulting from increased workloads affect patient assignment responsibilities for nursing students. As one educator remarked, “when they go into practice, they’ll have more than four patients, for sure. So, to me, that becomes completely time management based because I just want to make sure that they could handle having four patients” (NE, Akosua). The educators emphasized that, due to time-management considerations, they prefer that students be assigned to care for patients who require less time; however, this expectation does not align with the realities nursing students face when transitioning to registered nurse roles. Nursing students must adapt to caring for patients with diverse needs, including cultural differences. This situation shows that the challenge goes beyond simply training CEFs in EICC; it also involves how to effectively navigate the system to promote EICC among nursing students. Educators have asked for support both in academic and clinical settings. One of them mentioned,

That means educational institutions and clinical programs need to be aware of where we are sending our students and what we can provide in that intercultural space so they feel more comfortable and prepared. That might be self-reading, that might be pushing a faculty member, searching resources online, I’m sure there are a lot of resources. So, there are no surprises once they set foot in the clinical environment (FG2, NE, Star).

Several educators highlighted how power hierarchies influence their interactions with colleagues and students at clinical sites. They underscored the significance of engaging in critical dialogue

about power structures and of academic institutions empowering proactive action. An educator remarked,

I think that there has to be more conversation and less of 'Oh, I don't really know, and I don't want to say anything.' I think we must be much more activist in our approach to these conversations and be intentional (FG1, NE, Sky).

There is an imperative for educators who willingly transcend their comfort zones, deliberately participate in discussions regarding diversity and power imbalances, and identify strategies to integrate these topics into policies and curricula. Furthermore, they should support nursing students in developing EICC knowledge and skills while effectively managing their nursing programs. Educational institutions must empower their educators to address inequities and to implement culturally inclusive policies and strategies for resolving racial conflicts. As another educator observed,

I could totally see that happening because there are some cultures where you might need to know a bit more, maybe, when it comes to patient care. But the only way I or other CEFs would know this is if we had some sort of meeting or, like, something where all CEFs can get together, like a symposium we do, in which we actually talk about strategies and ways to tackle that (NE, Akosua).

Some educators mentioned that they lacked formal education on the ICC and relied on experiential learning to determine what was effective and what did not help support their students. Educators need support through orientations, symposia, and workshops to equip them with the necessary knowledge and skills to address EICC concerns. According to the educators, interactions among educators will help identify knowledge gaps, highlight areas of overlap or difference, and guide the most effective resolution within the learning environment to support

nursing students. The learning environment for the nursing students discussed here includes the classroom, simulation, and clinical settings. Another educator said, “As with the other areas, there has to be collaboration, because we use the skills lab with Skills 4. If we change something, sometimes we need to collaborate – it has to be conducive to whatever Skills 4 is doing” (NE, Yaa). The analysis suggests that educators could benefit from collaborating to integrate ICC content, as well as from improvements to physical space and resources, such as sufficient room and equipment for simulation-based teaching, because the use of shared simulation space was observed to influence the selection of practice scenarios.

There was also a call for nurse educators to collaborate with nursing students to understand their ICC needs and determine what would be relevant to them, considering that they are learning and aware of their gaps. Educator partnerships were needed for patient assignments, evaluating student-patient interactions, mentorship, information sharing, guiding students to potential resources for effective EICC, and debriefing. For example, some CEFs who spoke the same patient languages were found to be helpful in working with patients to give students a culturally diverse experience. A student noted, “I had a [Asia 4] CEF. And I had a [Asia 4] patient who was not on board with having students. She didn’t like it at all. My CEF came in and just spoke to her in her home language, what it is, and made jokes and put her at ease, and then she was much more receptive to me” (NS, Stephanie). The lack of such partnerships might have discouraged the student from communicating their difficulties to the educator, potentially leading to the student being assigned to an easier, more accommodating patient. Students tend to perform better and exhibit greater empathy during ICC encounters when they collaborate effectively with their instructors. As one student noted, “So my number one go-to person was my instructor, and so we worked together. We went up to the CRN, we phoned everyone and everyone we could

phone, we still couldn't get anyone" (NS, Breanna). Students value engagement and learning from the challenges and procedures involved in establishing an effective EICC. Such collaborations are characterized not by power disparities but by equitable efforts aimed at achieving successful EICC interactions.

Some CEFs were also considered racist or unsupportive during ICC encounters. For example, a student stated, "I faced nothing but resistance in getting her a translator, though. I had to go behind my CEF's back to even put in the consult" (NS, Ama). The student was compelled to override the instructor's directive, which was not ideal and diminished empathy in challenging ICC situations. Students expressed disappointment when their CEFs did not act in culturally appropriate manners. To address these issues of resistance, another educator proposed, "I think that it might be helpful to work with nursing students to understand the patient's perspective" (NE, Pearl). Educators must recognize when students require assistance, as well as identify their communication strengths and deficiencies, in order to better support and guide them in enhancing their interactions with patients.

To support educators, it was noted that incorporating additional jurisprudence modules focused on cultural care, as well as institution-based workshops on communication and conflict management, could significantly enhance their professional development and furnish strategies to address structural and systemic challenges impacting EICC. Certain institutions have established platforms enabling students to share their perspectives and experiences with faculty, which have proven to be valuable learning opportunities and should be continued. An educator comments: "It seems so obvious that we would learn so much from our students, but I don't know why we didn't start doing that years ago. It feels terrible to say it out loud, but so that's been really great" (NE, Rehoboth). Furthermore, it was noted that CEFs could also benefit from

participation in cultural modules offered as part of the regulatory body's annual jurisprudence exercises. This underscores the necessity for organizations such as nursing regulators and the Canadian Association of Schools of Nursing (CASN) to incorporate EICC content into jurisprudence or communication modules, thereby preparing all nurses who may assume educator roles in the future.

Interprofessional collaboration was also viewed as a means of supporting nurse educators in empowering their students to develop EICC skills. As part of the educator partnerships, there was a call for collaboration with other health-profession educators to discuss strategies for integrating intercultural perspectives into their curricula and pedagogy. One educator noted,

And that IPC course might be a great time to bring in intercultural communication, intercultural perspectives, and related topics, because they're also partnering with other professionals, right? ... everybody needs to learn about the intercultural aspects of healthcare. So that would be a great way to bring intercultural perspectives to students. They can talk more with people from other faculties and maybe get into groups. Do an assignment (FG1, NE, Angel).

The proposed interprofessional collaboration will create a course to promote greater understanding and support for EICC, fostering a positive environment for EICC in healthcare settings.

Understanding the Importance of Patient and Family Partnerships for the Development of EICC. The effective implementation of EICC was observed to involve not only the students and patients but also family caregivers. Partnerships among students, patients, and family caregivers were identified to facilitate the EICC relationship and enhance patient and family engagement in care, thereby improving health outcomes. One student remarked, "And I was just, like, trying to make sure that everyone in his family was informed of the situation, and was able

to understand” (NS, Fola). Collaborating with family caregivers promoted active participation in understanding and supporting the patient within the ICC context. Gaining insight into their circumstances allows for access to the most suitable support resources. A student shared,

We ended up contacting the husband, then a friend who was available that day, for a few hours to interpret. And I know it wasn’t the most ideal situation to have a friend with stuff like that, but they were all open to it and agreed to the situation (NS, Breanna).

A partnership requires a collective effort to support the patient through volunteering and other forms of assistance. Family collaboration creates a supportive environment for nursing students to understand their context, the patient’s care process, assist the patient, demonstrate nursing skills, and observe and replicate them alongside family caregivers. For example, a student stated,

The patient’s mouth was dry, so I helped them clean out his mouth. And I also showed them that, “OK, you can also do this too. Just make sure you’re not giving him water to drink, but you’re just cleaning out.” And they watched me clean his mouth, and they’re like, “OK, we can do this too. Thank you for showing us (NS, Bisi).

The social process of partnership with the patient and their family involved connecting them to appropriate resources and respecting their preferences, which requires empathy within that ICC context. Furthermore, it encompassed asking questions without assumptions about family roles and actively engaging the family in the patient's care.

Furthermore, educators outlined several approaches for collaborating with patients to promote effective EICC among nursing students. Some of the identified strategies include engaging patients and their families as guest panelists for specific topics and establishing a community-of-practice team with them to inform course development. An educator remarked,

And, just while we were having this conversation, it's just spurring some ideas of how I can add things to my classes. And one of the ideas that I thought of just now is maybe having a panel of patients who could come and speak to a group of students. And patients who are from – well, different cultures, and they can talk about their experiences as a patient and maybe answer questions that the students might have (FG1, NE, Pearl).

Previous discussions underscored that guest speakers for certain culture-related courses tended to be monocultural and lacked diversity. Likewise, some courses seemed to be developed primarily by White-dominated faculty, who may not possess multicultural perspectives. Nurse educators advocated for collaboration with culturally diverse patients to develop pertinent lesson content, case scenarios for simulations and lectures, and assignments that offer students practical, real-world experience. All focus group participants concurred with this assessment. One educator stated, “I think it would be helpful to have a bit of – like a council of leaders from a variety of cultural places to come and help inform some of the information that we teach” (FG1, NE, Sky). The involvement of individuals from diverse cultural backgrounds in establishing a community of practice to explore the integration of EICC into nursing curricula offers numerous benefits.

Rethinking the Role of Academic Partnerships in Advancing EICC. Academic collaborations are recognized as fundamental to advancing the EICC within undergraduate nursing education. This includes engaging with key stakeholders to co-create knowledge from a multidimensional epistemic perspective, the meaningful application of the EICC in nursing practice settings, the creation of a safe and supportive learning environment, and the dismantling of hierarchical educational models and monocultural frameworks regarding cultural competence. It entails constructing relational and context-specific collaborative networks to meet the EICC needs of students across academic and clinical settings, while remaining aware of potential

power and cultural dynamics that may hinder the process and developing strategies to address these challenges.

Academic partnerships should be considered a means of crafting a significant EICC experience for students, ensuring alignment with the expectations of nursing regulatory authorities. It is imperative for educators to evaluate the entry-level competencies (ELC) that inform curriculum development and student assessment, while also establishing channels for meaningful dialogue with regulatory bodies to incorporate essential cultural elements, including EICC and culturally competent care. Students conveyed their insights regarding empathy and ICC in relation to the ELC for undergraduate nursing students, as specified by the College of Registered Nurses of Manitoba (CRNM). Most students were uncertain whether EICC constitutes a requirement of the CRNM. Only one of the fifteen students remarked, “I actually remember this quite clearly. I had an Indigenous patient, and advocacy is one of the categories for entry-level competencies on the CRNM website” (NS, Ellen). Although there may be an Indigenous component, no specific considerations for other cultures were identified. There were calls for academics to collaborate with the CRNM to update the ELC and evaluation criteria and indicators for students, ensuring adequate ICC education and reducing a monocultural curriculum that is primarily focused on Indigenous studies. Educators also confirmed that regulatory bodies can facilitate the advancement of EICC knowledge through the annual CRNM jurisprudence modules. One educator shared:

I think it might benefit to have possibly some type of ICC included in the competencies for our licensing renewals. So, we do jurisprudence modules every year, and it might be valuable to have something integrated into that. And I say that only because then we’ll be

sort of universally hearing the same things, learning the same things, and then we can obviously build from that sort of foundation (FG2, NE, Sunshine).

Since the jurisprudence module was accessed annually by all registered nurses prior to license renewal, it was regarded as a method of imparting foundational knowledge universally, thereby equipping them with EICC knowledge for effective future EICC encounters.

Additionally, academic partnerships were proposed to enhance understanding of the cultural and social contexts in which ICC transpires, thereby positioning educational frameworks to account for relational equity. Educators emphasized the necessity of collaboration to mitigate structural and systemic barriers, such as racism, health disparities, time constraints, and resource limitations that influence clinical and academic experiences, thereby promoting equitable care and enabling nursing students to effectively apply EICC knowledge. A student remarked, “I just went directly to the unit clerk who helped me. It was a long wait – that’s why I’m fired up about this topic, because of that rotation in particular, where I witnessed a lack of empathy” (NS, Ama). Prolonged wait times in addressing patient concerns can be exhausting for nursing students navigating the healthcare system and available resources, potentially impeding their capacity to demonstrate effective EICC. Similarly, nursing students were anticipated to participate in post-conference or debriefing sessions after extensive clinical practice. However, many students reported that, due to time constraints, they either had never received debriefing or had limited opportunities to discuss their patient experiences with CEFs to enhance their ICC knowledge. An educator stated, “I think leadership, perhaps including nursing unions, the CRNM, or the Canadian Nursing Association (CNA), as well as higher-level nursing authorities, need to work toward safeguarding time, ensuring that nurses have dedicated time for meaningful communication” (NE, Pearl). No single nursing institution can implement changes in workload

and staffing policies without a collaborative effort and a unified voice to ensure nurses have adequate time for quality ICC, where necessary. The partnership process provides greater advocacy benefits by alleviating workload and creating additional time for empathetic care and high-quality communication.

Another area to reconsider in academic partnerships for promoting EICC is the establishment of a secure environment that fosters the teaching and learning of EICC. This environment should encourage students to be attentive to patients' contextual needs and to implement EICC in order to deliver competent care. This entails developing effective policies for social inclusion and racial conflict resolution that endorse diversity and relational practice. An educator observed,

I think that is something I try to be open about, so people feel safe discussing their experiences and to try to address some of the experiences students have reported. We've created a committee, like an EDI committee, where students can kind of anonymously report what has taken place (NE, Naa).

Students should feel secure in discussing their challenges when engaging with culturally diverse patients, families, or educators to seek guidance. It also involves viewing students as partners in co-creating and co-learning from the EICC experience and knowledge, recognizing that knowledge is generated through shared experiences and interactions. This approach challenges the traditional transactional model of education (Eksteen & Slabbert, 2001; Mackintosh-Franklin, 2016; Rege Colet, 2017; Schaefer & Zygmunt, 2003; Stanley & Dougherty, 2010) and promotes a relational model aligned with the relation-based curriculum (Aspelin & Eklöf, 2022; Berg & Lepp, 2023; Healy & Mulcahy, 2021; Hickey & Riddle, 2022, 2024). The relational educational framework, according to the analysis, posits that educators should not concentrate solely on

psychomotor skills but also show genuine interest in their learners' communication abilities, supporting them through relational partnerships with culturally diverse faculty, patients, regulatory bodies, and other communities of practice that can enhance their EICC knowledge and integration, as previously discussed. These relational actions serve to dismantle power dynamics and foster a secure learning environment for EICC.

Another area for reconsideration in academic partnerships pertains to the organization of the nursing program in terms of spatial arrangements, duration, and logistical considerations to accommodate its expanding requirements through a responsive relational framework, periodic evaluation, reflection, and negotiation. Educators identified several additional barriers, including program duration, large class sizes, organizational structure and resources, and substantial course content loads. One educator remarked, “I think that the push to just put students through the program quickly makes it very difficult for people to spend that time... I wonder, in this current structure, how much time or energy can be put towards that” (FG1, NE, Sky). The existing curriculum is cumbersome, condensed, and overly loaded, leaving minimal opportunity to incorporate content that reflects the increasing diversity of the patient population the nursing students serve. Educators must engage in critical dialogue with administrators to implement strategic measures that provide students with a conducive physical environment to excel in their EICC experiences. There is a need to restructure the curriculum to include essential nursing concepts, establish adequate simulation and practice facilities, and redistribute class sizes to ensure equivalent resources.

Summary: Partnering toward a Diversified and Relation-based Curriculum

This cluster's main theme was partnership. It examined concerns about theory-practice gaps related to EICC and suggested restructuring curricula to include diverse cultural resources

and EICC, exposing nursing students to EICC scenarios in academics and clinicals. It also addressed the need for educators to gain confidence and competence. The cluster defined a relation-based curriculum and emphasized forming strategic partnerships with stakeholders to promote the EICC agenda by understanding systems, patient and caregiver roles, and reimagining academic collaboration. Addressing EICC gaps through partnerships can improve its use in daily nursing communication, fostering culturally safe, personalized, and relationship-focused care. Refer to **Figure 5** below for a visual overview of the key highlights of this cluster.

Figure 5

The Partnership Call for Effective EICC in Undergraduate Nursing Education



Chapter Summary:

The critical perspective on this equity-oriented social process of EICC depends on the complex understandings of the fluidity of intercontextuality, asymmetrical power dynamics, and environmental influences within ICC dialogues. The environment is seen as a protective layer through which all ICC dialogues among culturally diverse people begin. Inherent in this environment are individual relational structures, power structures, and imbalances that influence the flow of ICC, empathy integration, and decision-making. The racial climate is influenced by asymmetrical power, which gives rise to racial and discriminatory acts that inhibit EICC. Within these asymmetrical power dynamics, interconnected contextual factors and worldviews must be addressed to advance the agenda of empathy in ICC dialogues for better health outcomes. However, this agenda can be realized through partnership when students are empowered with equity knowledge and when culturally diverse populations are engaged from an equity perspective. An effective partnership among key EICC stakeholders can contribute to the relation-based curriculum. When these elements are navigated effectively, they create a collaborative environment that explicitly addresses power imbalances and provides a pathway to practicing EICC in culturally congruent nursing, leading to better health outcomes. The next chapter will describe the proposed REEICC theoretical model and the theoretical basis of EICC.

Chapter 5: Findings (Part B)

This chapter expands on the findings from Chapter Four by outlining the theoretical foundation of EICC, which was developed from earlier analyses of transcripts and reflective journals of students and educators. The chapter presents a proposed definition of the ICC and EICC, along with key tenets that encourage EICC in ICC interactions. Direct quotes and phrases were used to illustrate participants' perceptions of ICC. Data from two focus groups of nurse educators further supported these clusters, categories, and quotes. Finally, the chapter explored the proposed Relational Equitable Empathy-based ICC (REEICC) theoretical model.

Core Category: Theoretical Foundations of EICC and the REEICC Theoretical Model

Defining EICC

Participants in both the individual interviews and focus groups hesitated to define ICC and EICC, which aligns with existing research showing that people still find it difficult to define ICC and empathy-based ICC. This highlights the need to establish a clear definition for these concepts in this study. The conceptual basis of the ICC was outlined in cluster three of Chapter Four.

Table 9

Participant Definitions for ICC

	ICC	Emerging Tenets
1	“Sort of communicating with someone with the understanding or the option of understanding that we may have different ways that we communicate as our primary communication method. ... And sort of coming into any interaction with that knowledge , and with the readiness to sort of approach and appreciate what I’m seeing in front of me. And adapting my communication styles when possible or necessary.” (FG2, NE, Sunshine)	Cultural curiosity, cultural awareness and sensitivity, humility, respect, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment, advocacy,

	ICC	Emerging Tenets
		time commitment, and intercultural allyship and empowerment.
2	“So, in these forms of communication, I think that there’s a sort of recognition that can be taken from both sides when you sort of are open about , “You know what, this is maybe the first time I’ve had to communicate with somebody who doesn’t speak the same language or whose cultural practices are quite different surrounding different kinds of communication” and sort of navigating that together.” (FG2, NE, Sunshine)	Cultural curiosity, humility, openness to lifelong cultural learning and adjustment
3	The interaction between individuals or groups of people with different cultures , and that can include verbal and/or non-verbal exchanges. It involves understanding or gathering the understanding of the different types of communication, social norms, and whatever characterizes different cultures. ” (FG2, NE, Moon)	Active listening, cultural curiosity, cultural awareness, humility, understanding of intersectional realities and context
4	“Just kind of the ability to communicate, or, yeah, to communicate with someone of a different culture ” (NS, Vero)	Cultural awareness and sensitivity
5	“ interacting with like patients from different cultural backgrounds ; so that means they have different values, beliefs, perceptions of their life, different interpretations of their experiences. And based on all of that, you know, with communication — intercultural communication you need to be open to how different they might be apart from myself. ” (NS, Alana)	Cultural curiosity, cultural awareness, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment
6	“It means communicating with or engaging with an individual with a different culture ” (NS, Stephanie)	Cultural awareness and sensitivity
7	“I know that culture is the way of living, different ways of living life. So, communication will be knowing how that person’s culture works around or how they live their	Cultural curiosity, cultural awareness and sensitivity, understanding of intersectional realities and

	ICC	Emerging Tenets
	daily lives and how another person lives, and that's conversing and bringing it all together" (NS, Adeola)	context, openness to lifelong cultural learning and adjustment
8	"I would say it's just engaging with others of different cultures " (NS, Fola)	Cultural awareness and sensitivity
9	"I think it's just a communication of two people between two different cultures, and learning to understand the differences of each other's culture, and just respecting them " (NS, Sussie)	Humility, cultural curiosity, respect, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment
10	"I would say intercultural communication means how you communicate with other cultures when you're not from the same culture as them. And being sensitive to their cultural norms, and being respectful of their culture " (NS, Bisi)	Cultural awareness and sensitivity, humility, respect, understanding of intersectional realities and context.
11	"I think it means doing your very best to understand that individual and who they are. It's being grateful to be able to learn from them as well." (NE, Naa)	Humility, cultural curiosity, openness to lifelong cultural learning, and time commitment.
12	So, to me, intercultural communication means either being aware or being open to learning about different cultures and the way in which they may be perceived, or how they communicate." (NE, Akosua)	Cultural curiosity, cultural awareness and sensitivity, humility, openness to lifelong cultural learning and adjustment, and time commitment
13	"It's two people, three people, whoever, you're in a conversation with a diverse group of people that are not from your same culture. " (NE, Yaa)	Cultural awareness and sensitivity

Table 10*Participant Definitions for EICC*

	EICC	Emerging Tenets
1	“... my interpretation of the definition of empathy-based ICC would be the ability of a nurse or a healthcare provider, or a person in general, to look at the patient in the bed or in front of you and think, “If I were to switch situations, and I were the patient in the bed, and my nurse was of a different cultural background than myself. What would I want them to know about me? What would I want them to know about how I like to communicate and be communicated with?” And then ask questions of my patient to get the answers to those particular things that would be important to me. And then ask them further if there’s something more that I need to know to give them the best care?” Another layer to the definition was the process of engaging in that conversation and the action of asking the right questions and resources needed to support the interaction. (FG2, NE, Sunshine)	Active listening, cultural curiosity, trust, cultural awareness and sensitivity, humility, respect, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment, advocacy, kindness, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, intercultural allyship and empowerment, intercultural conflict resolution, and relational empathy
2	“I think it involves the understanding and responding to the needs of the patient. So, that includes basically putting yourself in their shoes and what you would need, like (FG2, NE, Sunshine) said. Going deeper than surface-level communication, and really making a meaningful interaction where you’re comprehending their thoughts and feelings.” (FG2, NE, Moon)	Active listening, cultural curiosity, trust, cultural awareness and sensitivity, humility, respect, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, and intercultural allyship and empowerment, and relational empathy

	EICC	Emerging Tenets
3	Just being open to different points of view, different cultures , and just being as open as you possibly can so that you can have the best possible outcomes for your patient , because that's what you want ultimately. And the way to get there is through empathetic and kind communication , because you can't get anywhere if you can't communicate properly. But just kind of to understand how they're feeling . And sometimes it's like you almost feel it yourself , which as nurses, I feel like can be hard because then we kind of absorb all of their suffering if you are a very empathetic person (NS, Iris).	Active listening, cultural curiosity, trust, cultural awareness and sensitivity, humility, respect, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, and intercultural allyship and empowerment, and relational empathy
4	You need to be empathetic ; you need to understand how the person is feeling . If you do understand how they are feeling, that's when you'll be able to prioritize your care or prioritize your tasks for the day or prioritize your assessments and skills for what one patient needs . And if you do feel or you do understand how they're feeling, you'll be able to also advocate for them. (NS, Adeola)	Active listening, cultural curiosity, trust, cultural awareness and sensitivity, humility, respect, understanding of intersectional realities and context, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, and intercultural allyship and empowerment, and relational empathy

Only a few students could explain EICC; similarly, only a few nurse educators attempted to do so. However, the varying descriptions of ICC and EICC (by nurse educators) in **Tables 9 and 10** above show that those involved in ICC interactions must recognize that there are different ways of communicating across cultures, either verbally or non-verbally, and be willing to explore and adjust their perceptions and conversational routines to foster effective relational practice. EICC requires a level of self-reflection within the ICC encounter, imagining ‘what if

you were the other person.’ An educator shared about “the process of engaging in that conversation ...” (FG2, NE, Sunshine). It is essential to engage in ICC interaction, knowing which questions to ask and how to demonstrate empathy by soliciting resources to support culture-specific needs. Additionally, focus group participants agreed that EICC can foster a trusting therapeutic relationship between nurses and culturally diverse patients. An educator noted,

“I think that having an empathy-based ICC is going to help further that therapeutic communication, in order for the other person to feel comfortable and trusting, to share about their culture. I think that if you go into intercultural communication, maybe not empathy-based, you’re not going to gather the same results.” (FG2, NE, Moon)

Empathy-based ICC was seen as a tool to make culturally diverse encounters trusting and comfortable, enabling the nurse to glean more information to offer patient-centred care.

A proposed definition of ICC, based on the participants' descriptions, is: Intercultural communication is defined as a social, relational, culture-dominated interactive process in which culturally diverse individuals from two or more cultures interact and co-create meaning amid cultural variances, power dynamics, and worldviews, and it fosters respect, appreciation, and openness to cultural adaptations that enable one to interact with and care for others.

A proposed definition for EICC that could serve as a foundation for future dialogue and research arising from this analysis is: Empathy-based ICC is defined as a deep, social, relational, and context-dependent interactive process in which culturally diverse individuals engage, co-create meaning through ongoing perspective-taking and emotional connection, demonstrate a willingness to understand others’ contexts amid cultural differences, power dynamics, and worldviews, and foster respect, appreciation, and openness to cultural adaptations for unbiased

interactions and holistic care. The EICC definition encompasses relational, social, and critical perspectives that are essential to unveiling inherent power relations and biases, which result in personal and structural limitations to EICC, as well as issues such as racism, discrimination, and marginalization, thereby promoting advocacy, equitable relational interactions, and social justice perspectives. It specifically emphasizes the importance of context dependence and the empathy process, both of which were absent from the ICC definition.

Proposed Tenets of EICC

The analysis identified 16 core principles that could strengthen EICC (see **Tables 9 & 10**), including active listening, cultural curiosity, cultural awareness and sensitivity, humility, respect, trust, understanding of intersectional realities and context, kindness, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, intercultural allyship and empowerment, intercultural conflict resolution, and relational empathy.

Tenet 1: Active Listening. There was a strong emphasis on nursing students demonstrating empathy through active listening and an open mind. Students were expected to demonstrate engagement by observing the patient's body language and attentively listening to their narratives to understand their needs and foster autonomy in decision-making. Additionally, an educator remarked, "... sometimes they need something different, so active listening. Seeing what we can do to help meet their needs." (FG1, NE, Allan). A genuine understanding of the patient's experience necessitates active listening to their narratives and validating their experiences and perspectives. Patients from diverse cultural backgrounds may have needs that diverge from standard routines and must be appropriately accommodated.

Tenet 2: Cultural Curiosity. Cultural curiosity was exemplified by a keen sensitivity to diverse cultures and an eagerness to explore and acquire knowledge about them, rather than forming assumptions, judgments, or biases. This EICC principle was reaffirmed during the focus group discussion. An educator remarked that she had deliberated on this idea with her colleagues.

I was actually talking with some of my coworkers prior to coming to this, just to get their take, maybe something I could bring to the focus group. And one of the big things is, they always tell their students to be curious, so curious about it if you're not sure about other cultures, obviously, in a respectful way. But if you're not sure, find out. (FG2, NE, Moon)

It is evident that both participants and non-participants endorse cultural curiosity as a pragmatic approach to overcoming communication barriers and fostering understanding and empathy in ICC. Cultural curiosity is also linked to the capacity for personal growth and the development of effective communication skills. An educator stated, "If you approach from that aspect of curiosity, you're sensitive. And I think there's a place for growth and continuous improvement" (FG2, NE, Star). Cultural curiosity is regarded as a means to enhance awareness of other cultures, facilitate the understanding of diverse perspectives and preferences, and support students in adapting to the cultural routines of various patients and their family caregivers. This visibility bolsters their confidence and competence as effective communicators. An educator participant noted, "By coming from that position of curiosity, I think you help build a relationship with a person ... you also start to learn that person's perspective, which I think helps build empathy" (NE, Elliette). Cultural curiosity cultivates a bond between the nurse and the

patient as stories are shared, thereby promoting relationship-building and facilitating greater empathy.

Tenet 3: Cultural Awareness and Sensitivity. Cultural awareness was defined as the recognition of diverse cultures, each with distinct values and traditions, that may affect communication and caregiving. Cultural sensitivity was regarded as respectful acceptance and acknowledgment of cultural differences, along with their integration into the care process, devoid of prejudice or judgment. Participants indicated that acquiring knowledge about other cultures by inquiring from patients about culture-specific information enhances their cultural awareness and empathetic capacity during ICC. An educator remarked,

I think that – we’ve moved beyond just recognizing white-only skin. But I don’t know if that’s talking about how we recognize people’s culture. How do we listen to – if a patient is celebrating Ramadan and they’re diabetic and we need them to eat, how do we incorporate the beliefs during Ramadan and fasting and getting them to eat? (FG1, NE, Sky).

A more in-depth exploration of the patient’s cultural background assists nurses in identifying particular barriers and strengths, addressing their needs, and formulating culturally oriented objectives to guide care and enhance health outcomes. There was an encouragement for nurses to acknowledge their cultural ignorance with honesty and humility, recognizing the patient’s context and how to deliver suitable cultural care. A student shared: “I think just being upfront with them and your patients and just understanding what it is that they need from you and how you can be more culturally sensitive” (NS, Jona).

Most instances of cultural sensitivity discussed during the interviews predominantly centered on Indigenous populations rather than encompassing other cultural groups. While

exhibiting sensitivity towards various cultures is commendable, the particular emphasis on Indigenous communities warrants inquiry into why students' attention may not be equally drawn to other cultures. An essential aspect of cultural sensitivity identified was patience. Participants expressed that patience is a crucial element that empowers nurses to allocate sufficient time to inquire without prejudice, understand patients' cultural backgrounds, demonstrate empathy, and effectively communicate nursing procedures to patients for whom English is a second language.

Tenet 4: Humility. Another fundamental principle, humility, was reaffirmed. Humility was characterized as a process of self-reflection regarding the nurse-patient or nurse-student relationship, emphasizing strategies to minimize biases, encourage curiosity for learning, and cultivate respectful, trusting relationships throughout the ICC encounter. An educator remarked, “When you come from the place of humility and kindness, you want to be empathetic and sympathetic to what they’re going through, it opens up that human connection ... you treat somebody how you would like to be treated” (FG2, NE, Star). Humility during ICC involves managing vulnerability, building trust, empathizing with the patient, and showing respect. Educators bear the responsibility of preparing students to engage humbly with culturally diverse patients, helping them avoid ethnocentrism and instead promote understanding of patients' cultural backgrounds. An educator shared:

That would be the cultural empathy piece in trying to get them to understand it. To recognize that you know they have a whole world of how they’ve always done it, and we’re trying to fit them into our box, so maybe having that conversation. (FG1, NE, Sky)

Tenet 5: Respect. Respect was seen as being attentive, allowing the patient or family space to express their values, prioritizing the patient’s perspectives or preferences, and clearly explaining procedures. Participants highlighted the importance of understanding family dynamics during the

ICC encounter. For example, a student shared, “I feel educating yourself is definitely an important thing and being respectful of the dynamics between the patients and the family as well, also comes into play” (NS, Bisi). It was observed that culturally diverse patients and families behave differently depending on the occasion or their health state, and the nurse must be aware of the environment to provide the appropriate space and cultural support to ensure the patient's comfort. Furthermore, respect was identified as a crucial element for effective ICC. A student stated that,

There's always that one common denominator where everyone, no matter your culture or belief or language, the common denominator is that we respect each other. So, if we can all go down to that basic common denominator, I feel like that barrier could be decreased (NS, Breanna).

Respect was seen as an essential tool for reducing cultural barriers in nurse-patient and student-educator relationships.

Tenet 6: Trust. Trust was another core value that was confirmed and used interchangeably with ‘connection.’ Building trust is a process that starts with asking questions to understand the culturally diverse individual and their experiences. An educator shared:

When you're asking these types of questions, people are often very – I think in some cases, happy or sometimes even surprised that you're taking these extra steps. It's always been very positive types of experiences. And I think by doing so, you're building a relationship, or you're building a connection with that person (NE, Elliette).

The authenticity of an individual's interest and effort in understanding and supporting a culturally diverse person fosters a positive experience of trust and a professional, therapeutic, or academic relationship, depending on the parties involved. A few educator participants reported learning simple terms from patients' languages, which helped them connect and communicate. They also

helped narrow down questions to better understand their background, context, and needs, and to relate to or support them. A student noted that, “I think building that relationship, that so-called trust, that temporary trust for the stay of the patient in the hospital. I think that was the most important thing” (NS, Papa). Quality health service delivery is built on trust, even if it is temporary, as it helps culturally diverse patients express themselves in their vulnerable state. Trust was noted as fundamental to effectively advancing the EICC agenda in cultural interactions and to meeting the needs of the patient or student. Trust enables the patient to share their vulnerability and history with the nurse, helping them navigate resources that can better support them.

Trust was also found to strengthen patient-provider relationships, fostering a sense of belonging and fulfillment. One student shared, “He was like, ‘You’re one of us now,’ is what he said, and I felt pretty good about that... because I’ve never heard anything or anyone tell me like you’re one of us now in that sense” (NS, Breanna). The patient can relate to the nurse on a casual level, enabling open sharing. Another student noted, “That was like the beginning of a really strong patient/provider relationship because I think I was able to demonstrate to her that I was in her corner” (NS, Ama). Trust also gave patients confidence that the nurse believed in them and would advocate for their needs. However, trust requires time to develop, especially with people in positions of authority or those with a history of trauma. An educator shared that, “I know sometimes people who have more of a traumatic background, and maybe that’s related to culture, not always, they are so non-trusting of people in positions of power or positions of authority or people with more education” (NE, Pearl). Participants noted that in non-trusting, power-dominated environments, EICC cannot take place because fear and anxiety dominate the ICC dialogue.

Tenet 7: Understanding of Intersectional Realities and Context. From the EICC descriptions, it is clear that understanding the patient's or student's context is essential; that's where intersectionality plays a role, especially in developing social processes of human connection for engaging in EICC. An educator shared, "I think it involves the understanding and responding to the needs of the patient. Going deeper than surface-level communication, and really making a meaningful interaction where you're comprehending their thoughts and feelings" (FG2, NE, Moon). One cannot fully understand the patient's feelings and thoughts, or empathize with them, without grasping the underlying context of those needs. There is a need to consider the patient's background, our own worldview and practices, and how they all interact. An educator shared:

There is a layer of where are you coming from? How do you understand our healthcare system? It's different from what you're exposed to. And this cultural layer of the other needs to be understood to facilitate an effective EICC (FG1, NE, Angel).

We cannot practice EICC without understanding or being aligned with the relationships among the elements within the backgrounds of the patients or students we work with. Participants confirmed that an additional layer, specifically the patient's culture, family relations, and patriarchal systems in decision-making during communication, also influences EICC. To understand the intersections of culture, beliefs, and gender among culturally diverse patients, nurses must be open to thinking outside the box and beyond their Western knowledge and personal worldviews.

Tenet 8: Kindness. Another core principle supporting the EICC social processes is kindness and an openness to learning. Kindness is demonstrated through two approaches: being helpful or asking for help during ICC interactions. A student remarked, "I think I approach every patient interaction with just kindness and openness and willingness to learn. So, I think that's

helped my cultural competency” (NS, Stephanie). Kindness begins with a readiness to understand the other person’s needs, to empathize, and to take steps to support them. Acts of kindness help culturally diverse patients feel comfortable during ICC conversations and promote a positive image of the nursing profession.

Regarding the student-educator relationship, many culturally diverse students expressed the need to be shown kindness, but they found it difficult to ask for help. A student who had ICC-related struggles shared that, “I think I should have asked the CEF if she had any recommendations for what else I should be asking about” (NS, Fola). Many students reported entering ICC interactions naively and needing more guidance. Their CEFs could be kind by offering them support during these struggles. A student observed, “Just having someone to help you in these kinds of situations is also helpful” (NS, Adna). To facilitate effective EICC, all individuals involved in the ICC dialogue must understand that it is acceptable to ask for help and to be kind when helping others.

Tenet 9: Openness to Lifelong Cultural Learning and Adjustment. This principle emphasizes the importance of continually being open to reflecting on one's limitations in cultural knowledge and worldviews. It also highlights the need to learn and adapt communication and care practices. An educator shared,

People come from different cultural backgrounds and different beliefs. ... It's OK sometimes to be uncomfortable and be sensitive and empathetic, but learning, and in that learning, in that discomfort, is a place to grow. And then we have students that realize, yes, this is something different, yes, the assessment is different yet, but you need to know what is appropriate, and in that process of discomfort, that's where the learning can occur (FG2, NE, Star).

Continuous cultural learning and adaptation can be uncomfortable, but they lead to greater understanding and acceptance of any culturally diverse patient in our care. It is a process of learning that “Things that might be OK for me might not be another person's preference” (NE, Elliette). Openness to learning about cultural dynamics requires epistemic humility to unlearn societal expectations and historical structures. For instance, societal expectations for communication favour direct, one-on-one interactions; however, some patriarchal cultures imply the opposite, as seen in the interplay between culture and language. The clinician must unlearn and adjust care through self-reflection on their biases and positionality to demonstrate empathy during such ICC encounters.

I guess my lifelong journey is like how to be anti-racist, tied to like the whole colonial history in all of that. I don't identify with any religion, so for myself, it's just like to be committed to curious learning. Being willing to be corrected (NS, Ama).

The pathway to unlearning historical bias and systemic racism requires a long-term commitment and aspiration. There is a need for education on antiracism and anticolonialism, cultural curiosity, and corrigibility to support cultural adaptation.

Tenet 10: Advocacy. Empathy-based ICC demands more than just accepting the norm that sustains inequalities among culturally diverse and marginalized patients and students. Nurses have a role in ensuring that patients' and students' cultural backgrounds are understood, accepted, and supported in service delivery through advocacy. A student shared,

I think in order for people to feel OK in themselves about being only able to do the bare minimum, they write a narrative about why it's OK, right? They justify it, and so they kind of start telling themselves, “Well, that's just what we do here.” Or you know, “We

can't do this for everyone," or whatever, and they find ways to justify it, and then it just perpetuates (NS, Ama).

Advocacy in EICC involves shifting the narrative through strategic actions and speaking out to challenge existing practices, rejecting the bare minimums.

Advocacy fosters a sense of connection and empathy during ICC dialogues. A student noted, "That you're there for them, I think, is how I show empathy when I'm taking care of patients. Just knowing that there is someone there to advocate for them, listen to their concerns, but also listening to their family" (NS, Nana). Advocacy involves listening to the needs of culturally diverse patients and students, raising awareness of barriers to culturally appropriate care, engaging support people who reflect patients' cultural diversity, incorporating their cultural values into care, and promoting changes in social policies that influence health service delivery.

Tenet 11: Time Commitment. This EICC tenet highlights the time needed to build rapport, trust, and confidence with EICC. An educator shared: "Someone who is from a different culture, who maybe has encountered trauma, it might take a lot of time just to build trust with that person so that communication could occur effectively" (NE, Pearl). The duration varies depending on the situation at the time of contact and the experiences of the culturally diverse patient or nurse. Participants reported that it can take from days up to four weeks to establish a proper, trusting relationship with their culturally diverse patients or students. A student noted, "It takes a while to develop a bond, right, ... it took me a while to adapt, but by the end of like three to four weeks, I knew what I was expecting from her as my patient" (NS, Adeola).

Nurses' communication skills were often overlooked due to increased patient load and time constraints. Participants emphasized the importance of spending quality time with patients to build emotional connections and address concerns. A student shared an experience where her

patient was angry because of unfamiliar religious surroundings: “She was really snappy at me. And I was offended initially because no one likes to be snapped at. But I had lots of time. So, I was able to go back in the afternoon, and she apologized” (NS, Stephanie). The analysis consistently showed that student nurses have more flexibility with their time compared to registered nurses. Limited time during care can leave emotions unaddressed, resulting in confusion, mistrust, and a lack of empathy.

Time commitment is essential for developing EICC skills. An educator observed, “And likewise, I think it goes to the student as well, how that story with the Black student. It wasn’t necessarily that he had attitude problems; it was more that he needed to build his comfort and his confidence” (NE, Naa). Building comfort and confidence with EICC requires time and consistent practice. Without experience, students who lack skills may be labelled as poor communicators and may face academic challenges, as was the case with the Black student.

Tenet 12: Self-reflection on Power and Positionality. The social process of EICC revealed the influences of one’s positionality, racism, colourism, class, and institutional structures. Consequently, to establish effective EICC, the analysis recommends engaging in self-reflection regarding the power dynamics inherent in the systems within academia, healthcare, or society that influence the attitudes of nurses, educators, or patients in intercultural dialogue. An educator shared:

Being a nurse is being in a position of power; being an educator is being in a position of power. But power is, and that goes back to my being a white person and having the power of a nurse over a patient, or an educator over a student (NE, Comfort).

Critical to this self-reflection is also considering the impact of skin colour in the discussion, and whether the Whiteness of a nurse or educator, or an institutional policy, or the BIPOC nature of

the nursing student or patient, introduces another layer of power differentials that affects the intercultural dialogue process. The analysis indicates that students and patients did not see themselves as being in a position of power. However, institutional structures have created hierarchical power dynamics that favour educators and nurses over those in top-down positions when addressing patients, especially those of ethnically diverse origins, mirroring policies on time allocation, resources for culturally diverse clients, and other structural issues. A student shared:

So, my professor last week was talking about what happened to her and a student. So, we were talking about power imbalances, and my professor had said, “The clinical instructor said that the student was not performing well. And I was the course leader, so the three of us all sat down, and I listened to what the clinical instructor felt that the student was not doing well, and the student did not stand up for herself, because how can she when it’s two figures of authority talking about her wrongs” (NS, Ellen).

This analysis posits that power exists within a context, influenced by an individual's professional identity and institutional policies, such as conflict mediation approaches. A person wielding influence must therefore engage in self-reflection regarding the presence of this influence and adopt strategies to mitigate its effects in relational practices, for example, by diminishing power structures that hinder the student's ability to advocate for themselves in interactions with educators. A student shared:

When I have a patient who is probably more likely to get steamrolled or given less autonomy, I take more time to make sure that they understand that they can say no, and that they deserve to ask questions and receive comprehensive answers. Because I think

it's true that that power dynamic is intentionally played into, like nurse knows best or doctor knows best, depending on who is in the room at the time (NS, Ama).

The example above illustrates a nurse who has engaged in self-reflection regarding their positionality and authority, dedicating additional time to empower a culturally diverse patient to assert themselves and assume autonomy over their care. Consequently, self-reflection on one's own power and positionality in relation to other racial groups can inform a more empathetic approach to ICC.

Tenet 13: Intersectional, Equity, and Social Justice Lens. The analysis posits that both visible and invisible power structures, such as policies, standardized work culture, cultural biases and assumptions, and decision-making processes, within the environment and racial climate impact equitable ICC relational practice and care delivery, and warrant an intersectional lens. For instance, a student noted: “We can't just look at one piece of the puzzle; we have to look at how all of these things intersect and combine for that person's experience. Yeah, you can't just look at one piece, you have to kind of look more holistically” (NE, Elliette). The ethnically diverse patient or student nurse experience in the clinical environment is shaped by several multisectoral factors that must be explored in the ICC encounter with empathy to address their concerns effectively. However, a student shared that “Some people just have the mindset that people are less than them because they aren't White, which is terrible” (NS, Jona). This biased mindset toward other races affects how nurses see intersectional identities and how to be more culturally responsive to the needs of the ethnically diverse patient or student. A Caucasian educator shared: “But you still treat everyone the same and go through it. I don't think your culture should be a blockage to a relationship between a nurse and a patient. You're setting up your therapeutic relationships; you get things done” (NE, Donna). EICC goes beyond building a therapeutic

relationship by considering an equity lens in the relationship. However, a BIPOC educator with multicultural experience had a different opinion. She noted, “Intercultural communication is not communicating with everybody the same way, right? It’s communicating with people based on them” (NE, Angel). This implies that an intersectional, equity-oriented, social justice lens in EICC requires talking to and treating others based on who they are, their unique intersectional identities, and cultural needs. The EICC encounter must be centred on equitable care, not equal or less treatment.

Tenet 14: Intercultural Allyship and Empowerment. To facilitate effective EICC, participants emphasized the importance of demonstrating a willingness to reduce cultural assumptions and biases, and to engage with and provide support to racially marginalized patients and students as a means of challenging racism and marginalization. An educator shared:

Now, if you can’t learn from the mistake and keep making that same mistake over and over again, and you keep denying that you have a problem, then we’re into a concern. I think that’s something that we have to really think about and work on. And know that collaboratively and collectively, we have the good intention of wanting to care for all people in a good way (NE, Naa).

The capacity to participate in EICC, demonstrating empathy, commences with a willingness to engage, consciously choosing to communicate and care for all individuals regardless of their race, in an appropriate manner. Additionally, another student articulated that, during the process of EICC, “They should not feel like an outsider or just the patient. We want to empower them to make their own, to help make the decisions, make the choices. So, it’s welcoming, belonging, and a sense of empowerment” (NS, Vero). Empathy-based ICC necessitates the utilization of one’s knowledge and resources to establish an inclusive environment and atmosphere free of

racism or discrimination, thereby enabling culturally diverse patients or students to engage meaningfully, thrive, and feel heard and secure.

Tenet 15: Intercultural Conflict Resolution. It was observed in cluster two of chapter four that educators frequently apologize to students or patients during instances of racist or discriminatory encounters. Additionally, the majority of nurses and educators lack the requisite skills to appropriately address intercultural conflicts when they occur. An effective EICC emphasizes the necessity for individuals engaging in intercultural contexts to develop skills that enable them to recognize intercultural conflicts and apply culturally appropriate relational ethics to mediate and resolve them. An educator shared:

I had a patient who was forced to undergo surgery to attempt to save their life when it was highly unlikely to be successful. Family members were of a different race from the surgeon and from me. Family were like no, we don't want this surgery; we want this person to be able to peacefully pass away. But the surgeon steamrolled right over it, and he said no, got to try to fix them. And the person did die two days later, after an excruciatingly painful surgery and to me, that was just one of the biggest ethical dilemmas of my career, being a part of that. Even though I was against forcing the surgery to happen, the surgeon overruled the family and me, and the patient was unable to speak for themselves. And they were an Aboriginal family. And I don't know if that played a role in the surgeons not taking them as seriously (NE, Pearl).

This shared life story shows that healthcare clinicians may sometimes hold biases that impede patient and family autonomy during ICC, leading to adverse effects. Nurses must be able to mediate and advocate for vulnerable, culturally diverse patients and students.

Effective EICC requires knowing the appropriate channels for addressing intercultural conflict, seeking help, and managing interracial conflict fairly. An educator shared:

I actually knew the primary nurse personally. But I just felt it was not my place – I'm there for the student and the patient they're looking after; I'm not a colleague at that time of the primary nurse, so that's why I got the charge nurse involved, because that was not my place. (NE, Moon)

Instead of addressing conflicts to favor colleagues and peers, it is prudent to adopt a fair and just stance to work with the appropriate sources to ensure conflicts are resolved in a just manner.

This principle is critical to effective EICC in advancing equitable relational practice.

Tenet 16: Relational Empathy. Significant emphasis was placed on nursing students demonstrating relational empathy through the effective understanding of the contextual influences affecting culturally diverse patients or students. Relational empathy was regarded as a comprehensive dimension of empathy that encompasses cognitive, emotional, behavioural, and moral aspects. Furthermore, an educator observed, “We’d encourage that for everybody, but sometimes, culturally based, there are beliefs that may not be of mainstream culture, and so I think part of that empathy piece is to understand where they’re coming from.” (FG1, NE, Sky). Gaining insight into the multisectoral contexts of culturally diverse patients or students provides a clearer understanding of their interconnectedness and intersectionality, enhances empathetic responses, and informs how support can be optimally offered. Demonstrating relational empathy as a nurse or educator can help reduce power imbalances and inequities, foster effective EICC relationships, and address the culturally specific needs of students and patients.

The Emerging Theory: Relational Equitable Empathy-based ICC (REEICC) Theoretical Model

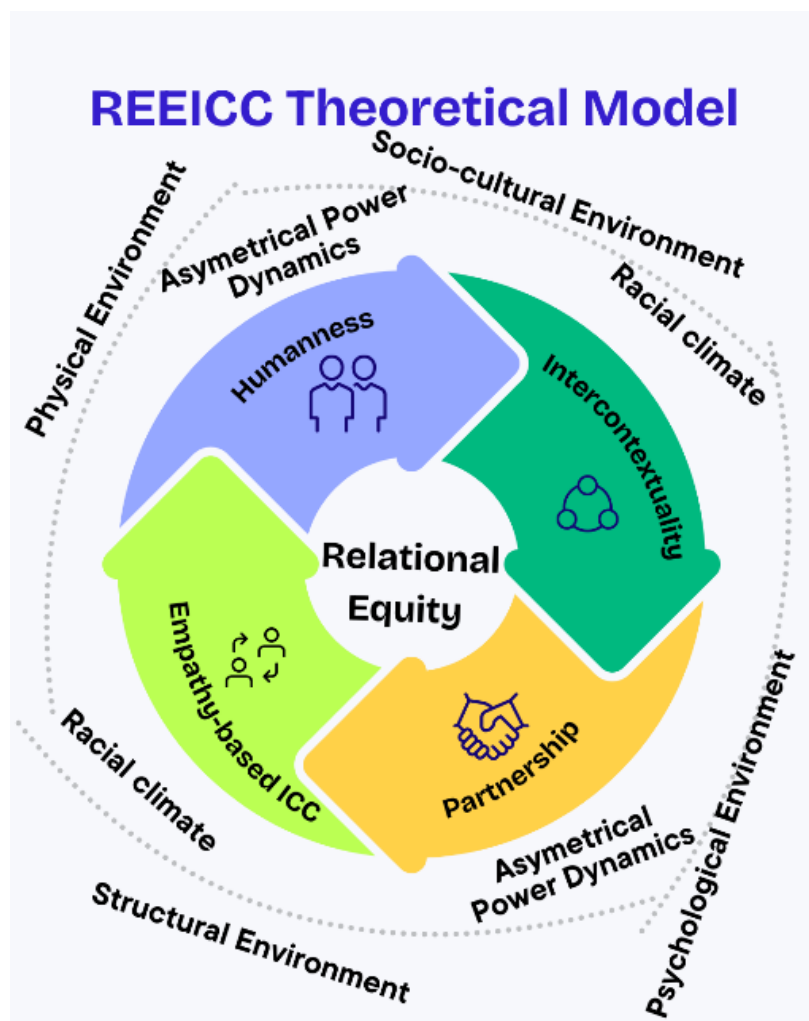
The findings discussed under the four clusters in Chapter Four led to the proposed EICC theoretical model, called the *Relational Equitable Empathy-based ICC* (REEICC), presented in **Figure 6** below. This model synthesizes **Figures 2-5**, highlighting the need to adopt a relational equity lens in intercultural communication to better serve culturally diverse patients, students, and populations. The shift towards relational empathy, coupled with the equity lens derived from clusters three and one, respectively, emerged as the central focus of this theoretical model. These significant elements come amid significant EICC theory-practice gaps, racism and discrimination, and limited theoretical foundations of EICC.

At the heart of **Figure 6** lies relational equity, which interconnects the four essential strategies for effective EICC. The social process underlying EICC necessitates a shift towards relational empathy to comprehend the patient's contextual influences, a transformation that is vital within intersectional theory. Correspondingly, participants observed that acts of humanity within ICC emanate from an equity perspective. Consequently, the concept that encapsulates both phenomena is relational equity, signifying that EICC is fundamentally rooted in the quality of human relational practice and equity. By centering relational equity, the model questions the notion of exclusively equal or unequal communication practices and emphasizes that effective EICC arises from and fosters personalized therapeutic communication adapted to the particular contextual needs of the culturally diverse individuals involved in the ICC encounter – be they patients, students, or healthcare professionals.

Figure 6

The Proposed Relational Equitable Empathy-based Intercultural Communication (REEICC)

Theoretical Model



Source: Author (2026)

Encircling the core of the theoretical model is an interconnected, continuous cycle comprising four strategies for effective EICC – humanness, understanding intercontextuality, partnership, and EICC itself — which then repeats. This ongoing cycle promotes interdependence, functioning as a dynamic system in which each element supports and relies on others to enhance relational empathy and ICC interactions. A disruption in one element can affect

the entire relational structure. It also offers opportunities to collaborate with conversation partners and stakeholders in academia and clinical settings, and to reflect on action strategies to improve knowledge transfer and nursing practice.

A void or space exists after the continuous cycle involving interdependent elements. Encasing this cycle is a manifestation of power dynamics and the racial climate, molded by various structural and institutional hierarchies and cultural expectations that influence perceptions of language, actions, and intentions of individuals from diverse cultural backgrounds. Within this layer are components that either restrict or facilitate the interdependent factors, contingent upon environmental conditions. This layer is delineated from the external circle, which is governed by the environment, with broken lines symbolizing permeability and the ongoing influence of the external world.

The outermost circle of the model delineates four environmental domains – physical, structural, socio-cultural, and psychological – that constitute the contextual framework within which relational practice occurs. In the field of nursing, this environment exerts influence over and shapes the curriculum, as well as the knowledge, skills, and competencies of students and educators. The positioning of the environment within the outermost layer indicates that the ICC is multidimensional and interrelates among the individuals engaged in ICC interactions. The physical environment pertains to academic and clinical settings. Without this physical environment, students are unable to interact with culturally diverse patients or educators to enact EICC. The structural environment encompasses factors such as time, policies, leadership, and available resources within physical spaces. The socio-cultural environment encompasses aspects such as culture, travel, immigration, and multicultural dialogue across diverse settings. The psychological environment reflects neurological activity, influencing individuals' comfort levels

and preferences, which in turn affect ICC encounters. The broken lines between the environment and the racial or power space symbolize fluidity and adaptability, permitting ongoing interactions in which elements continuously influence one another and exhibit interdependence. All stakeholders bear responsibility for ensuring that this continuous cycle functions effectively to advance the EICC.

Model Strength. The REEICC model visually demonstrates the interconnectedness of relational, contextual, and social justice perspectives and aligns with CCGT and intersectionality theory (Crenshaw, 1989; 1991a; 1991b, 2017; Levitt, 2021). It presents a process that encapsulates the complexity of real-world circumstances, where structural and institutional barriers — including power dynamics, systemic racism, organizational policies and structures, time constraints, conflicts, and others — can impede the flow of EICC. It underscores that qualities such as humanness, partnership, understanding intercontextuality, and EICC practice may be restricted if external influences are not adequately managed or mitigated. The model offers a valuable theoretical framework for comprehending EICC as a relational, equity-focused and ethically grounded practice, rather than merely a psychomotor task. The interdependent domains are shaped by personal and social factors, rendering them an essential framework for intersectional analysis and critical reflection within academic and professional contexts.

Model Limitations. Despite the aforementioned strengths, further empirical research is needed to examine how the domains interact in practice and education, as well as their implications for nursing, education, and policy development.

Chapter Summary

This chapter addressed a critical aspect of the study by proposing definitions of the ICC and the EICC, developing a theoretical foundation for the EICC, and outlining principles to

enhance the EICC's effectiveness. Additionally, the chapter elaborated on the proposed REEICC theoretical model, which was derived from the analysis. The subsequent discussion chapter will contextualize the key findings from the analysis within the existing literature, further elucidate the practice, policy, and research implications, and examine considerations for implementing the proposed REEICC model.

Chapter 6: Discussion and Conclusion

This doctoral study examined EICC's role in nursing education and practice from the perspectives of nurse educators and undergraduate nursing students. This chapter synthesizes the study's findings within the context of the existing literature and through an intersectional lens, and discusses implications for future research, practice, and policy. The first part will address four main areas of the study findings: 1) demographic variations and their intercontextual correlations, as discussed in Chapter Four; 2) EICC advancement as a key step toward relational, culturally responsive, and equitably structured care; 3) variations in pedagogical approaches to advancing EICC in nursing education; and 4) the REEICC theoretical model, developed from the research analysis. The final part will discuss: the implications of the findings and recommendations for nursing education, practice, policy, and future research; the study's significance, strengths, and limitations; and the knowledge translation plan.

Demographic Variations and Intercontextuality Foundations in EICC

This section of the discussion will review the demographic variations in EICC and offer a critical reflection on intercontextuality in EICC that stood out in the data, compared with the literature.

Demographic Variations in the EICC Study

Key areas highlighted in the demographic data include gender, culture and language, travel and immigration history, religion, education, and the educational institution's geographical location.

Gender. The literature indicates that the nursing profession is predominantly female (Cottingham et al., 2016; Liaw et al., 2016; Teresa-Morales et al., 2022; World Health Organization (WHO), 2019), due to biological factors related to reproductive functions and

traditional caregiving roles. Some scholars question the validity and competencies of male nurses (Cottingham et al., 2016; Cottingham et al., 2018; Kane et al., 2020; Kim et al., 2016; Saleh et al., 2020; Teresa-Morales et al., 2022). These gender-related dynamics within nursing have significant research implications, as demographic data show that males account for 20% or less of both student and nursing educator populations. The study also suggests that males and females process information and respond differently during ICC interactions. This discussion concentrates solely on binary gender, as the demographic and interview data did not document any outcomes pertaining to gender diversity. Gur and Gur (2017) and Li et al. (2020) found that females excel in memory and social-cognitive skills for interpreting emotional and social cues, while males excel in spatial processing and motor speed related to physical and objective navigation. Participants observed females respond emotionally with greater empathy, whereas males were more practical. This matches findings from Ferri et al. (2017), Gümüşsoy et al. (2021), Jia-Ru et al. (2022), Korkmaz Doğdu et al. (2022), and Treglia (2020). Furthermore, Gümüşsoy et al. (2021) posit that women tend to be more empathetic due to social roles as mothers and wives, aiding emotional understanding.

Culture and Language. The study sample reflected less diversity among faculty than nursing students, consistent with prior research (American Association of Colleges of Nursing [AACN], 2017; Bell, 2021; Hamzavi & Brown, 2023; Hudson et al., 2023; Jefferies et al., 2019; Premji & Etowa, 2014; Wiapo et al., 2024). Student responses indicated limited cultural representation among faculty, a pattern previously noted to affect instruction, simulation, and anti-racism efforts (Bell, 2021; Jefferies et al., 2018; Jefferies et al., 2019). The increasing diversity among nursing students shows most are non-native English speakers, aligning with findings that accents, tonal variations, and language barriers affect assignments, evaluations by

CEFs, and interactions with patients and CEFs (Beagan et al., 2023; Juntunen et al., 2024; Luhanga et al., 2023). Juntunen et al. (2024) suggest educators should encourage students with language difficulties to build social relationships, join community support groups, and practice communication in different settings to improve their ICC. Challenges in educator-student relationships have led to conflicts, student withdrawals, failing grades, and perceptions of unfair conflict resolution, which can foster distrust and endanger student safety (Luhanga et al., 2023). Conversely, a positive racial climate in which faculty trust students improves students' clinical and academic performance (Torregosa et al., 2016).

The study found that patients from diverse cultural backgrounds speaking English as a second language need interpreters for effective nurse-patient communication. Lack of interpreters increases time and costs, as noted by Seremetkoska et al. (2025) and Shamsi et al. (2020). Nursing students often used Google Translate, whiteboards, or help from colleagues, family, and friends (Chang et al., 2021), which sometimes caused misinterpretation and tech issues, especially among older and migrant patients unfamiliar with technology. Shamsi et al. (2020) suggest that online tools such as Google Translate and MediBabble could improve interpretation, but our study highlights the challenge of patients' and families' ability to use such technology effectively.

Numerous debates have been conducted regarding the conceptualization of racism as a cultural variable (Ali, 2022; Braveman et al., 2022; Lei & Guo, 2022; Pon, 2009). Ali (2022) and Lei and Guo (2022) argued that systemic inequalities are obscured when culture is employed as a substitute for race. However, it is imperative to recognize that, within the parameters of the ICC, understanding the social processes involved in cross-cultural interactions is crucial; perceptions and worldviews regarding race and racism significantly influence EICC, as does culture (Lei &

Guo, 2022). Thus, for this doctoral study, racism was not solely subsumed into culture but served as a foundational platform to examine the racial climate and to analyze its contribution to systemic inequalities and social injustices in ICC encounters. This research supports a paradigm shift towards relational, equitable, and empathy-driven ICC, complemented by structural policy measures, rather than reliance on frameworks focused on racism and cultural competence within nursing education and practice. This perspective aligns with the views of Ali (2022), Bintley and George (2020), Çingöl et al. (2021), and Pon (2009).

Travel and Immigration History. The history of immigration significantly influences engagement in EICC experiences—students with immigration backgrounds outperform their Caucasian peers in ICC interactions. Educators without immigration backgrounds often feel incapacitated when teaching ICC content, which affects patient assignments, as CEFs lack adequate training or confidence in supporting culturally diverse patients (Bell, 2021; Harvey et al., 2019). The literature shows empathy is culturally dependent (Main et al., 2017), and multicultural traits shape attitudes (Cieślak et al., 2024; Ramos-Roure et al., 2024). Travel experiences enhance multicultural understanding and awareness of SDOH (Newberry et al., 2023). Understanding SDOH (WHO, 2020) is essential in EICC to foster empathetic, socially just ICC (Nemetchek, 2019).

Religion. Some immigrant nursing students struggle to adapt to patients' diverse religious views, affecting ICC interactions. Qualitative findings show religion intersects with factors like gender and race. These support Murgia et al. (2022), highlighting that unclear distinctions between spirituality and religion hinder nurses' understanding of spiritual needs, requiring more education. Janzen et al. (2019), Murgia et al. (2022), and Reimer-Kirkham et al. (2019) found that spiritual care depends on nurses' beliefs, patients' religion, policies, and

environment. Since religion and spirituality are not seen as nursing skills, they are often overlooked in relational care, potentially harming EICC, as noted by Murgia et al. (2022).

Education. The study showed that prior education with cultural content boosts confidence in engaging with diverse patients, aligning with previous findings (Arruzza & Chau, 2021; Osmancevic, Großschädl, & Lohrmann, 2023; Osmancevic, Steiner, et al., 2025). Students with higher education, including trauma-informed care, were better prepared to empathize with Indigenous people. However, there was no evidence that this holds for other culturally diverse groups. Gümüşsoy et al. (2021) found that intercultural awareness and empathy correlate with higher educational levels.

Geographical Location of the Institution. In this study, students across three regions of Manitoba showed similar responses, including challenges in defining ICC and EICC, limited understanding of empathy, systemic obstacles, gaps in nursing education on EICC, and strategies for integrating EICC into curricula. The study showed some minor variations in patient populations and the titles of cultural courses. For instance, students from one institution predominantly served Indigenous patients, another served Caucasian patients, and the third served a mix of diverse patients, offering insights into their clinical experiences and the cultural focus of their courses.

Critical Reflections on Intercontextuality in EICC

Crenshaw's three-dimensional intersectionality framework shows ICC is rooted in systemic power relations (Crenshaw, 1989; 1991a; 1991b), which aligns with Hankivsky's (2012) nine intersectionality principles. This study provided evidence that intersecting categories like culture, religion, time, gender, and language require multilevel analysis and reflexivity to understand the culturally diverse individuals. Researchers such as Collins et al. (2021),

Crenshaw (2017), and Misra et al. (2021) argue that overlapping marginalized identities shape experiences through interlocking systems of oppression and privileges within the relational cycle. In this study, the social process of EICC articulated how time and space affected social justice and equity, as well as how students and nurses can engage empathetically in ICC dialogues despite challenges (Hankivsky, 2012; Nemetchek, 2019). Understanding the contexts of culturally diverse patients and/or students helps nurses and educators navigate their SDOH, disparities, power dynamics, racism, and discrimination, and ensures respectful treatment, all of which influence health and academic outcomes (Juntunen et al., 2024; Nemetchek, 2019; Newberry et al., 2023; Ramos-Roure et al., 2024). This doctoral study indicates nurses can show empathy by recognizing these contextual factors and advocating for equity-focused initiatives. Key trends include neoliberalism and managerialism of time (Al-Chami, 2025; Dalal, 2017) in EICC; positionality and lived experience of nursing students as EICC determinants; and navigating power, race and belonging: disrupting racism and marginalization in nursing to advance EICC, supporting Shahzad et al. (2022).

Neoliberalism and Managerialism of Time in EICC. Adopting Crenshaw's (1989, 1991a, 1991b) structural intersectionality analysis reveals the structural challenges nurses face in ICC, such as increased workloads, time constraints, and institutional policies. Individual barriers, such as limited cultural awareness, can prolong EICC encounters, and greater awareness can boost empathy (Gümüşsoy et al., 2021). This study found that heavy patient workloads hamper the adoption of humanistic approaches, especially among students who have difficulty multitasking, whereas experienced nurses manage their time better due to their expertise in multitasking. Policies on interpreter services can also restrict ICC time (Chang et al., 2021; Seremetkoska et al., 2025; Shamsi et al., 2020). This study shows that institutional and structural

time constraints cause physical and emotional stress for nurses and students, which limits their capacity to enact EICC and to build relationships with culturally diverse individuals. Despite heavy workloads, nurses must provide timely care (Chang et al., 2021), similar to nursing students who must complete assigned procedures within set timeframes regardless of patients' cultural backgrounds. This emotional burden may lead to burnout and affect patient safety and the quality of care (Garcia et al., 2019). Time constraints also limit CEFs' opportunities for evaluation due to clinical assessment standards and brief debriefings during placements. It is essential to create structures supporting students and nurses in EICC discussions.

Positionality and Lived Experiences of Nursing Students as EICC Determinants.

Lived experiences influence the positionality, perspectives, and actions of nursing students (Ličen & Prosen, 2023; Osmancevic et al., 2023) by shaping the context and lens through which they understand the health concerns of ethnically diverse patients (Mojini et al., 2024). Nurses' lived experiences can introduce assumptions, biases, and worldviews that differ from others, thereby affecting their information processing and actions during EICC encounters (Ličen & Prosen, 2023; Osmancevic et al., 2023). This is exemplified by immigrant students, who related and empathized more deeply with other culturally diverse individuals in this study.

Navigating Power, Race and Belonging: Disrupting Racism and Marginalization in Nursing to Advance EICC. The study reveals that inherent power relations in intercultural dialogues significantly affect nurse-patient or educator-student relationships, leadership decision-making, policies, racism and marginalization of all forms, and the demonstration of EICC. These powers are embedded in organizational policies, structures, accreditation standards, and work ethics, which shape organizational cultures and transform individuals' relational and equity practices (Hudson et al., 2022; Watson & Collins, 2023). In this doctoral study, these internal

power structures were evident in curriculum restrictions on teaching EICC-related content, the timing of such instruction, and educators' relationships with culturally diverse students.

Additionally, the study revealed pressure on nurses due to increased workloads, even when caring for ethnically diverse patients with greater time and resource needs, stemming from organizational structures. Hudson et al. (2023) propose adopting an intersectional antiracist advocacy framework within organizations to disrupt the cycle of power and racist characteristics.

Racism, discrimination, and marginalization were present in one of the study's clusters in chapter four, with marginalized BIPOCs students and educators sharing key insights. Bell (2021), Thomas-Hawkins et al. (2022), and Van Bower et al. (2026) noted that reports of racism and discrimination were common among non-White, racialized students, especially those of African descent and those who were facing financial insecurity (Van Bower et al., 2026). This study confirms that lower socioeconomic status patients often face labelling and marginalization in healthcare. Racism appeared in patient assignments, workplace culture, and interactions among patients, students, educators, and staff during ICC, aligning with Beagan et al. (2023). As a result, the CNA identified anti-Indigenous (CNA, 2021b) and anti-Black racism (CNA, 2020, 2021c) as public health emergencies in Canada. These findings necessitate maintaining an anti-racist praxis across all organizations to ensure ongoing review and critical reflection on anti-racist and anti-discriminatory measures (Wiapo et al., 2024), an approach that will directly influence EICC education and practices.

This study highlighted racism and marginalization at interpersonal (micro), institutional (meso), and structural (macro) levels, as described by Nazroo et al. (2020). Interpersonal racism occurred in interactions among staff, patients, and educators, who commented on or targeted culturally diverse students, often using derogatory language (Dhari et al., 2025; Prendergast et

al., 2024). For example, some Caucasian patients were reluctant to receive care from Black nursing students, citing accents and stereotypes about religion and attire, such as Muslim headgear, confirming previous findings by Beagan et al. (2022), Korhonen et al. (2019), and Luhanga et al. (2023). Institutional racism appears in nursing environments, including work culture, teaching practices, curricula, and expectations rooted in a predominantly white, Eurocentric perspective. This impacts clinical placements, educators' attitudes toward BIPOC students, evaluations, and college policies on anti-racism and conflict resolution (Beagan et al., 2023; Hamzavi & Brown, 2023; Korhonen et al., 2019). Structural racism and marginalization are embedded in unjust healthcare practices influenced by workload, limited diversity resources, and high standards that may see BIPOC individuals as incapable, coupled with clinical ethics (Beagan et al., 2023; Van Bower et al., 2026). Racism manifests across micro, meso, and macro levels when responses are inadequate. Racialized individuals often have marginalized identities, with hierarchies reflecting intersections of gender, race, social status, migration, and skin color, consistent with Van Bower et al. (2026).

To address racism and social injustices, scholars suggest strategies like helping students identify and articulate relevant terminology (Bhandal et al., 2023), self-reflection, awareness and sensitivity training, ongoing professional development, and anti-racism pedagogies (Iheduru-Anderson et al., 2021). Additionally, anti-Black training for healthcare professionals and educators (Prendergast et al., 2024), cultural humility education (Lekas et al., 2020), and improving communication skills (Ramos-Roure et al., 2024) have been called for. This study has delineated the cycle of psychological impacts from racism and discrimination, including perception framing, recognition and acceptance, internalization, transferability, expressivity, and role adaptability. Oluo (2019) argued that racism has psychological, physical, and social impacts.

Thomas-Hawkins et al. (2022) found that workplace racism causes emotional distress among non-White nurses, potentially leading to resignation. Similarly, Truitt and Snyder (2020) found that some racialized nurses cope through silence, isolation (internalization), or engaging with family (expressivity), due to lacking friends from their racialized communities at work. Byers et al. (2021) noted that racialized victims often show low psychological resilience (role adaptability), ruminate over racist experiences, and worry about recurrence (internalization). Recognizing this cycle is key to supporting racialized individuals and breaking racism and discrimination.

Remaining silent about racist actions, whether as a victim or perpetrator, can perpetuate ongoing racism (DiAngelo, 2018; Iheduru-Anderson et al., 2021) and cause emotional distress (Luhanga et al., 2023). A stress cycle begins in the brain, affecting the cognitive and behavioral functions of racialized victims, but no research has analyzed this psychologically. This study adds to the literature on racism's psychological effects and urges proactive measures to break the cycle. There is a rising call for critical allyship (Nixon, 2019), anti-racist policies (Truitt & Snyder, 2020), and a multistakeholder approach involving academic, professional, regulatory, and healthcare sectors to combat racism (Iheduru-Anderson et al., 2021; Kechi et al., 2024).

EICC Advancement: A Key Step Toward Relational, Culturally Responsive, Equitably Structured Care

The study underscored the potential of EICC to promote a relational, culturally responsive, and equitable care framework, which shall be discussed in the following sections: the transitioning from ICC to EICC; humanness, relational empathy, relational equity, and equitable care; and nursing as an art: pursuing relationality within diversity.

Transitioning from ICC to EICC

The study confirmed ICC encounters are challenging due to lack of empathy, as noted by Almutairi et al. (2025a, 2025b) and Golubeva and Guntersdorfer (2020). Most participants in this study (educators, students), had limited or no knowledge of empathy or how to demonstrate it. Ramos-Roure et al. (2024) found that some healthcare professionals lack empathy, impacting patients' understanding and trust during ICC. Empathy was identified as essential for effective EICC, supporting Armah et al. (2020) and Golubeva and Guntersdorfer (2020). The study also confirmed that teaching empathy motivates the development of EICC. Hagqvist et al. (2020) observed that empathy motivates educators during ICC but did not explore its transfer to students. Much of the educational focus has been on cultural competency courses rather than on fostering empathy, aiming to turn cultural awareness into ICC skills. However, there is evidence that this approach is ineffective (Çingöl et al., 2021). Advancing ICC is required to improve EICC practices and patient engagement.

Humanness, Relational Empathy, Relational Equity, and Equitable Care

This study demonstrated that humanness is manifested through actions that exemplify connection, curiosity, empathy, humility, kindness, and respect towards patients and students from culturally diverse backgrounds. These innate human qualities were attributed to humanness in Graebe's (2024) study. Humanness is essential in the nurse-patient relationship, enhancing care without reducing nurses to mere automatons (Chen & Locsin, 2022). Human connection and empathy are vital for a safe environment and effective communication, especially with vulnerable groups (Chen & Locsin, 2022; van Dijke et al., 2020). Humanness promotes holistic care and better relational practice, requiring self-reflection, awareness of contextual influences,

and acceptance of cultural diversity to overcome biases and foster empathetic, respectful interactions in intercultural care (van Dijke et al., 2020).

This study shows that empathy is multidimensional and suggests a shift towards relational empathy, which encompasses cognitive, emotional, behavioural, and moral aspects, all of which are crucial for EICC engagement. Furthermore, the study indicated that healthcare professionals could demonstrate relational empathy through context-specific questioning or perspective-taking and responding appropriately to culturally diverse needs. These findings corroborate the views of Chalmers (2025), Eichbaum et al. (2023), and Rettig (2017). Similarly, these findings about the multidimensionality of empathy and the nature of perspective taking address Decety (2020), Jeffery (2016), and van Dijke et al. (2020)'s concerns about the limited focus on contextual factors and interactions among empathy domains in communication.

In demonstrating equitable relational care, behavioral empathy suffices. The study found students and educators often interchange empathy, behavioral empathy, compassion, and sympathy. Jeffery (2016) contends that empathy differs from sympathy and compassion in their cognitive prerequisites, with empathy being influenced by reflection from an objective stance, whereas the latter are derived from a self-centred perspective. Behavioral empathy, a subset of empathy, involves emotional and physical responses (Byrne et al., 2024). While both behavioral empathy and compassionate care involve emotional responses, behavioral empathy demonstrates understanding through actions like listening, mindfulness, validation, and support (Jeffery, 2016). In contrast, compassionate care, driven by love, focuses on acts of kindness toward the sufferer (Byrne et al., 2024; Jeffery, 2016; Sinclair et al., 2017). Sympathy is a general emotional response (Jeffery, 2016) or a pity-based reaction (Sinclair et al., 2017) to another person's distress. Sinclair et al. (2017) argue compassion is preferred over empathy or sympathy;

however, this study suggests a strong foundation in relational empathy within ICC could be more effective than compassion alone. Furthermore, Sinclair et al. (2017) concentrated on a general analysis of empathy, without paying particular attention to the specific details of the individual empathy dimensions. This study indicates that such extensive generalizations may overlook certain aspects of empathy in analysis and pedagogy, consistent with Jeffery (2016). This study provides evidence that practicing relational empathy leads to equity in ICC contexts (Chalmers, 2025). Although compassion has been proposed as an initial response that fosters the therapeutic relationship and positive health outcomes, there is no explicit evidence that it leads to equitable relational practice in health (Babaei et al., 2020; Malliarou, 2022; Sinclair et al., 2017, 2018).

Relational equity considers contextual factors (Chalmers, 2025; Ko et al., 2025). This study indicates that relational engagement among culturally diverse individuals facilitates the co-creation of EICC meaning through interaction, thereby promoting learning about such individuals via an empathetic cycle informed by their contexts. This supports the social constructivist view that reality is co-constructed (Charmaz, 2014; Schreiber & Valle, 2013). However, this study shows that nursing students struggled to differentiate between equity and equality, hindering their engagement with the EICC. I argue that equity involves more than equality: some individuals, like those with English as an additional language, need translators, extra time, and support (Ko et al., 2025; Juntunen et al., 2024). To apply an equity lens in EICC, fairness, nonjudgmental attitudes, and cultural awareness are crucial.

This doctoral study identified 16 EICC tenets that were not explicitly linked to the EICC literature. However, certain prior studies have examined actions that facilitate communication to enhance cultural competency (Mojini et al., 2024; Osmancevic et al., 2023; Ramos-Roure et al., 2024). The EICC principles emphasize relational aspects like cultural curiosity, cultural

awareness, sensitivity, humility, and understanding intersectional realities, including self-reflection on power and positionality, aligning with Eichubbaum et al.'s (2023) view of relational empathy. The study also found ten additional principles—active listening, trust, respect, kindness, openness to lifelong cultural learning and adjustment, advocacy, good time management, intersectional, equity, and social justice lens, intercultural allyship and empowerment, and intercultural conflict resolution—not explicitly covered in ICC or EICC literature. Mojini et al. (2024) highlight that trust, respect, active listening, sensitivity, and understanding are essential for effective communication with culturally diverse clients. Osmanovic et al. (2023) emphasize the importance of maintaining an open attitude and respect for cultural differences. Ramos-Roure et al. (2024) note that some nurses struggle with listening and communication, perpetuating power imbalances and paternalism, making active listening crucial in ICC to reduce risks. Delivering a relationally equitable EICC involves intersectionality (Chalmers, 2025; Simola, 2021), which requires nurses and students to navigate social inequities, power dynamics, patients' social contexts, and intercultural conflicts to promote social justice. The findings also show that relational empathy, intersectionality, and humanness involve understanding an individual's context, nurse's own positionality and the intersecting factors affecting patients, guiding reflection and EICC practice. The differences among these concepts are in **Table 11**. Additionally, the uniqueness of the 16 tenets compared with other studies is captured in **Table 12**.

Table 11*Comparing Humanness, Relational Empathy, and Intersectionality in EICC*

Humanness	Relational Empathy	Intersectionality
Chen & Locsin (2022), van Dijke et al. (2020)	Trevisani (2020), Eichbaum et al. (2023)	Kimberley Crenshaw (Crenshaw, 1989, 1991a; Crenshaw, 1991b, 2017)
Connection	Connection and context-based – social, cultural, emotional, physical, etc.	Based on context and structural complexities
Dignified, empathetic, and respectful care, irrespective of background	Ability to understand and respond to the needs of others	Experiences of power, oppression, privilege, systemic inequities, and complexities that shape human experiences
Human experience	Human relationships and interactions	Multiple social identities (gender, race, class, ethnicity/ culture)
Universal dimension	Relational dimension	Structural dimension
Humanistic and ethical frameworks	Relational and care ethics framework	Critical and social justice framework

Table 12*Comparison of the Proposed EICC Tenet with Selected Studies*

EICC Tenets	Eichbaum et al.'s (2023)	Mojini et al. (2024)	Xu et al. (2025)	Current Study (2026)
Active listening		√		√
Cultural curiosity	√		√	√
Cultural awareness and sensitivity		√	√	√
Humility	√ (cultural humility)			√
Respect	√	√		√

EICC Tenets	Eichubbaum et al.'s (2023)	Mojini et al. (2024)	Xu et al. (2025)	Current Study (2026)
Trust		√		√
Understanding of intersectional realities and context	√		√ (perspective shifts based on context)	√
Kindness				√
Openness to lifelong cultural learning and adjustment	√ (epistemic humility)		√ (cultural adaptations)	√
Advocacy				√
Time commitment				√
Self-reflection on power and positionality	√ (democratizing power dynamics)		√ (reflexivity, power sensitive communication)	√
Intersectional, equity, and social justice lens				√
Intercultural allyship and empowerment				√
Intercultural conflict resolution				√
Relational empathy	√		√ (empathy)	√

Nursing as an Art: Pursuing Relationality within Diversity

Humanistic Perspectives in EICC. Humanity is best demonstrated through a profound comprehension of the multiple, intersecting identities of culturally diverse individuals (Chen & Locsin, 2022; van Dijke et al., 2020). A key aspect of intersectionality is colourism and classism in the ICC dialogue (Crenshaw, 1989, 2019; Hollis, 2022; Iheduru-Anderson & Waite, 2022). However, some educators advocate treating all individuals equally, regardless of skin colour, also known as 'color blindness.' A person's view of skin colour reflects their worldview, with Casillas-Martínez et al. (2023) stating it signals power differences, fueling systemic racism and bias. These biases are deeply rooted at individual and institutional levels, influencing perceptions and interactions. Incorporating EICC into nursing education can reduce biases and promote

appreciation of diverse identities. Jamal-Eddine and Abboud (2025) suggest healthcare equity is achievable by embedding humanness in care and involving students in transformative learning. Intersectionality provides an essential framework for understanding how systems interact with the realities of culturally heterogeneous patients or students (Crenshaw, 1989).

Participants said EICC promotes humanistic qualities that foster positive intercultural relationships. It involves self-reflection, understanding, and emotion during intercultural encounters, creating a safe space to practice empathy (van Dijke et al., 2020). Effective EICC requires customizing communication strategies to empathetically address the needs of individuals from diverse cultural backgrounds. For example, encouraging individuals to use their strengths (Juntunen et al., 2024) during illness or in nursing tasks as students. Patients want to feel acknowledged and safe when expressing themselves without judgment, which aligns with van Dijke et al. (2020). Also, people may communicate differently, including language, tone, accent, gestures, and preferences. Challenges such as language barriers and a lack of resources, such as translators, hinder effective communication.

Interracial Conflict Management Strategies to Strengthen EICC. Individuals from different cultures express themselves through verbal and nonverbal cues during ICC, which can sometimes lead to conflicts. To promote effective EICC, it is vital to address these conflicts to prevent negative impacts on health or academic learning. Some culturally diverse students reported that interracial conflicts impacted their clinical grades and educational participation. Research also shows intercultural conflicts lead to longer hospital stays and poorer relational practices. Additionally, the findings highlight that some students hesitate to speak up out of fear, which supports Beagan et al.'s (2023) findings.

Effective intercultural conflict resolution hinges on a comprehensive understanding of intersectional identities and the contextual factors of culturally diverse patients or students involved in the ICC dialogue (Al Kabbani & Dalati, 2025; Chand et al., 2014; Olekalns & Adair, 2013). Furthermore, it is imperative to consider the impact of racism (Oluo, 2019) when developing an interpersonal, person-centered, and trust-based relationship to facilitate conflict resolution (Crump, 2015; Thakore, 2013). This research indicates that nursing students who have experienced racism and discrimination tend to be reluctant to voice their concerns during racial conflicts. Nonetheless, the capacity to trust mediators involved in conflict resolution is crucial (Allinson & Chaar, 2016; Birkhäuser et al., 2017), as it enables individuals to speak freely within a safe environment and ensures that their voices are acknowledged. Moreover, it is essential to consider how the individual's self-perception, emotions, power dynamics, and social status influence negotiation processes (Fisher et al., 2011), while remaining aware of the diverse values and multisectoral realities that participants bring to intercultural conflict negotiations.

Accordingly, Al Kabbani and Dalati (2025) advocate for collaboration and accommodation to promote effective intercultural conflict resolution, thereby addressing the specific cultural and situational requirements of individuals from diverse backgrounds. Such collaborative efforts foster open communication, empathy, and mutual understanding, contributing to the preservation of relationships (Oba et al., 2026) and thereby supporting effective EICC. Rothman (2014) proposes a conflict typology and engagement strategy for the effective management of conflicts. According to Rothman, identifying the origin of the conflict—whether resource-based, objective-based, or identity-based—facilitates diagnosis and guides the resolution approach (Rothman, 2012, 2014).

Discussing conflict mediation policies across institutions is vital for integrating social justice. For instance, in 2020, the University of Manitoba's Rady Faculty of Health Sciences introduced the 'Disruption of All Forms of Racism (DAFR)' policy, Canada's first anti-racism policy in a faculty or post-secondary institution (University of Manitoba – Rady Faculty of Health Sciences, 2026). It officially recognizes racial harassment, discrimination, vilification, and racism, with a DAFR pathway for reporting racial misconduct. The DAFR process starts with establishing a 'safe door' reporting system and deciding if informal or formal complaint procedures are suitable, each of which is linked to specific pathways. Outcomes include mediated discussions, educational initiatives, or investigations that could lead to discipline, restorative actions, or mediation for DAFR violations. However, the mediator's identity and role are unclear within the policy. Despite existing conflict management policies and pathways, this study shows that culturally diverse students hesitate to voice concerns or seek help through safe doors due to concerns about the mediation process and potential repercussions from course instructors following investigations (Luhanga et al., 2023; Truitt & Snyder, 2020).

The study highlights the importance of effective mediation for culturally diverse individuals to express concerns and achieve fairness in clinical and/or academic settings (Luhanga et al., 2023). It is crucial to clearly define the roles of mediators who advocate for students, helping them assess their trustworthiness and safety. Many mediators are also educators or course leaders, creating hierarchical power dynamics that may disadvantage culturally diverse students and lead to unjust outcomes. Policies on racism and discrimination should be reexamined in conflicts involving students and patients, students and educators, or among educators themselves. Chinn (2013, 2016) suggests investing in conflict transformation to foster peaceful collaboration and decision-making.

Variations in Pedagogical Approaches for EICC Advancement in Nursing Education

The study emphasizes advancing key pedagogical strategies to embed empathy in ICC dialogues, aiming to enhance EICC among nursing students and its clinical application. Findings suggest a shift to a relation-based curriculum capable of fostering relational and reflective skills among students and educators. Strategies to enhance equity-driven EICC will be detailed below.

Disrupting Colonial Influences on Nursing Education and Practice

The study found that nursing practice and education are deeply rooted in white biomedical paradigms of communication, care, and learning, with professional relationships in faculty and leadership centred on whiteness through power structures, hierarchy, and practice standards (Hamzavi & Brown, 2023). Many students voiced concerns about predominantly white faculty, clinical settings, Eurocentric resources, and a lack of an intersectional lens on nursing education and the analysis of program outcomes (Bell, 2021; Hamzavi & Brown, 2023). These issues often lead BIPOC students to face racist behaviors from patients and educators, who may see them as unprofessional due to accents or tone. Findings align with reports by Beagan et al. (2023), Hamzavi & Brown (2023), Korhonen et al. (2019), Luhanga et al. (2023), and Van Bower et al. (2026). Luhanga et al. (2023) noted BIPOC nursing students face stereotypes and racist comments from educators. This study further demonstrated that hierarchical power structures within nursing curricula may adversely affect marginalized groups, particularly during clinical rotations. Certain educators tend to overstep their boundaries by scrutinizing and highlighting issues that do not impede students' learning. For example, some students pass English competency examinations yet are subjected to racialized and discriminatory scrutiny rooted in Eurocentric perspectives.

Findings show current courses in the institutions studied mainly include diversity or Indigenous content explored through the lens of cultural competence and safety. Canadian nursing education programs have prioritized the Truth and Reconciliation Commission (TRC) calls to action by integrating specific courses focused on the history of Indigenous Peoples of Canada in their undergraduate programs (Blackstock, 2017; Braithwaite et al., 2022; Cameron & Mitchell, 2022; Mojini et al., 2024; TRC, 2015). It is important that these separate courses exist, while also creating space for courses to prepare healthcare professionals to communicate effectively with diverse cultural groups. This promotes skills for understanding the intersectional realities that are foundational to relational ethics and empathetic nursing practice (Ko et al., 2025; Li et al., 2023).

Furthermore, course resources, including textbooks, mannequins, training modules, and guest speakers, were mainly created by individuals of Caucasian background with Eurocentric perspectives (Bell, 2021; Hamzavi & Brown, 2023). The findings suggest that investing in materials that introduce students to intersectionality, cultural diversity, and relational equity will assist them in developing and demonstrating EICC. Resources should reflect the cultures being taught and the patient populations they serve to promote awareness, foster realistic connections, and improve cultural practices in healthcare.

Building upon ICC and Intercultural Frameworks in Nursing Curriculum

Traditional cultural educational frameworks focus on developing cultural knowledge, competencies (Lekas et al., 2020; Li et al., 2023), and sensitivity (Chang et al., 2017; Ličen & Prosen, 2023) for diverse populations. Many frameworks exist in the nursing literature but exhibit gaps, particularly in intercultural competence (Allan & Smylie, 2015; Armah et al., 2020; Bennett, 2013; FNHA, 2022; Hughes et al., 2020; Lett, 2013). They often lack emphasis on

communication and empathy (Bennett, 2013; FNHA, 2022; Hughes et al., 2020). Critics question the philosophical basis of the cultural competency paradigm, especially its focus on awareness, sensitivity, safety, and behavioral skills, which may not meet the diverse needs of ethnic populations (Foronda, 2020; Fraser et al., 2018). Ramos-Roure et al. (2024) noted that immigrant patients feel fewer interventions are tailored to their needs. Additionally, the widespread use of cultural competency frameworks has resulted in a lack of systematic instruction in how to apply these competencies in teaching practice (Çingöl et al., 2021; George et al., 2019). For example, Çingöl et al. (2021) found their curriculum lacked a dedicated cultural competency course. This underscores the need for strategies to enhance understanding of holistic, culturally sensitive care (Bintley & George, 2020).

This study highlights empathy as key in EICC (Armah et al., 2020; Çingöl et al., 2021; Chopik et al., 2017). It shows that teaching empathy during ICC boosts students' confidence with diverse patients and their needs. The study also supports Çingöl et al.'s (2021) view that intercultural nursing courses may improve ICC, but their intervention did not increase students' empathy. Various critiques target cultural competence interventions. Critiques of Çingöl et al. (2021) include timing (spring of the fourth year), duration (14 weeks), being an elective, two contact hours per week, student-led activities, readings, group PowerPoint presentations, and movie screenings, with a focus on transcultural nursing topics but excluding empathy. Chang et al. (2017) used Facebook for web-based activities on cultural awareness, self-efficacy, and skills during the final undergraduate year, predicting success but not linking to empathy. Ličen and Prosen (2023) noted that less than five hours over three years are dedicated to transcultural nursing, which is insufficient to prepare students for intercultural care or EICC. The study's findings provide evidence that intercultural courses may be ineffective at developing cultural

competence. This study found that most culture-specific courses in Canada focus on a monocultural or Indigenous perspective. Hence, there was a call to include migrant cultures to help students understand patients' realities and prepare for diverse patient interactions (Gümüşsoy et al., 2021).

Timing for EICC Education in Nursing Curriculum

The study recommends integrating EICC content across all nursing courses using a scaffolded approach, while acknowledging differing perspectives on whether empathy and intercultural learning should be introduced early or later in the curriculum. The literature offers many recommendations for introducing empathy (Almutairi et al., 2025a, 2025b; Ferri et al., 2017; Treglia, 2020), including cultural courses/ICC (Chang et al., 2017; Çingöl et al., 2021), cultural simulation (Almutairi et al., 2025b), intercultural sensitivity, and culture-specific care practices (Chang et al., 2017; Çingöl et al., 2021; Gümüşsoy et al., 2021). Matshaka (2023) found no difference in caring empathy between third- and fourth-year nursing students, while Korkmaz Doğdu et al. (2022) reported higher empathy among fourth-years compared to second-years. Most students in the study were exposed to empathy and cultural courses in their final third- or fourth-year term, which may be too late to make a significant impact. Notably, one fourth-year student reported only one ICC experience, and most did not feel confident demonstrating empathy or practicing EICC. Previous studies, such as Chang et al. (2017) and Çingöl et al. (2021), show that intercultural courses must explicitly include empathy. These courses should start early and be integrated throughout the program, not just for a single term, to effectively develop EICC skills. Korkmaz Doğdu et al. (2022) supported a scaffolding process for embedding EICC into the nursing curriculum, gradually building knowledge and skills at each academic level.

This study showed that EICC was not prioritized over technical skills in patient assignment, which is concerning, as Korkmaz Doğdu et al. (2022) found that clinical exposure improves students' empathy skills. Çingöl et al. (2021) noted that education and exposure to the concept are essential for developing intercultural sensitivity and EICC. Previous research shows empathy can be cultivated through empathy educational models (Levett-Jones et al., 2017, 2019; Lobchuk et al., 2016; Lu et al., 2018; Ozcan et al., 2018; Yang et al., 2020). Yang et al.'s (2020) study involved a two-week, 12-hour empathy training program in final year, focusing on perspective-taking, compassionate care, and understanding patient experiences, using lectures, videos, role-play, and problem-based learning. Lu et al. (2018) used a game-based simulation to promote empathy, incorporating storytelling, real-time interaction, immediate feedback, competition, and peer learning with active involvement from educators and students. Most curricula focus on cognitive, emotional, and behavioural empathy, but this study shows that empathy is broader when nurses build meaningful, holistic connections with patients, including sensitivity to context and equity. All types of empathy should be included from the start of nursing education.

Partnership Model as a Valuable Educational Strategy for a Diversified Relation-Based Curriculum

To build a strong foundation for a relational-based curriculum, there was a call to partner with academic and healthcare stakeholders to integrate content on intercultural relational practice and EICC. This includes topics such as empathy, racism, prejudice, conflict, language barriers, health equity, social justice, and settler colonialism, while recognizing that both institutional and individual factors can hinder progress in these areas. Such collaborations can also ease the stress of implementing intersectional decolonizing pedagogies in nursing education (Bhandal et al.,

2023; Watson & Collins, 2023). Partnership is vital for critically examining gaps in nursing curricula related to EICC, educators' skills, and student needs, and for engaging stakeholders, including diverse patients, content experts, nurse regulators, and administrators, to improve curricula and teaching (Andrews & Boyle, 2019). Juntunen et al. (2024) highlight that a partnership between clinical practice and academic institutions supports efforts to address gaps, clarify roles, and help students retain EICC competence, especially as resources increase to promote an equitable environment. Similarly, Li et al. (2023) recommend co-creating curricula with stakeholders involved in different aspects of student development to ensure personal, communal, and interprofessional connections. Educators and administrators must collaborate to integrate EICC content across disciplines and to scaffold intercultural nursing concepts (Ličen & Prosen, 2023).

A relation-based curriculum is built on principles like intersubjectivity, relationality, recognition, mutuality, support, informality, and relational ethics to foster creative inquiry and co-construct knowledge (Aspelin & Eklöf, 2022; Healy & Mulcahy, 2021; Hickey & Riddle, 2022, 2024). Educational design approaches co-created by educators in collaboration with students and peers enable learners to see themselves as active collaborators who influence learning rather than passively receive knowledge. Including cultural experts enhances content development and knowledge transfer, proven effective (Lu et al., 2018). Collaborating with course instructors, CEFs, and clinical preceptors helps establish assessment strategies and address students' cultural learning needs (Korhonen et al., 2019). Engaging nursing students to understand their challenges improves EICC practices (Shahzad et al., 2022). Furthermore, Foronda (2020) emphasized the need to minimize power disparities to achieve effective stakeholder engagement and change. A relation-based curriculum rooted in strong partnership

fosters diversity, inclusion, and equity, making education more relevant and creating a secure environment for culturally diverse patients and learners.

Storytelling of Lived Experiences as a Catalyst for Learning EICC.

When individuals with lived experiences of EICC share their stories, learning occurs through active reflection, interpretation, and taking practical actions based on new knowledge (Barrow, 2018; Greenwood, 2019; Hobson et al., 2020; Osteen et al., 2016; Pringle & Smith, 2022; Sandars, 2009; Senehi et al., 2009). This study showed that nursing students with limited intercultural dialogue experience prefer that educators share their ICC challenges. The goal is to learn from educators' reflections to develop strategies for EICC. This aligns with Karlowicz (2023), Létourneau et al. (2022), and Sanders (2009), who say storytelling informs learning and reflection. Barrow (2018) demonstrated that storytelling influences practice behaviours by promoting a caring nursing culture through the sharing of experiential knowledge. It can also enhance nursing students' understanding of complex concepts (Pringle & Smith, 2022).

Researchers emphasize art-based pedagogical methods such as storytelling, spoken-word poetry, and expressive arts to address critical concepts and foster social change (Barrow, 2018; Jamal-Eddine & Abboud, 2025; Létourneau et al., 2022; Petty, 2016; Rieger et al., 2016; Sandars, 2009).

The concept of storytelling goes beyond being just a resource for nurse educators; it involves inviting individuals from diverse backgrounds to share their experiences in communication, cultural, or simulation courses. In this study, nursing students report that stories shared by Indigenous guest speakers inspire them to provide more empathetic care to Indigenous populations. Expanding storytelling to include various cultures may help bridge gaps within EICC. Létourneau et al. (2022) suggested that nursing students gain valuable insights when

patients share their narratives during communication classes. Karlowicz (2023) noted that stories from patients, families, and healthcare providers help students relate real-world experiences to their coursework, fostering a safe clinical environment.

Diverse Experiential and Simulation-Based Learning Approaches

This study found that students rarely worked with culturally diverse patients during clinical rotations. Simulation equipment also lacks diversity in skin tone and gender, supporting previous research by Ansari et al. (2025), Foronda et al. (2017), and Wofford et al. (2023, 2026). These scholars argue that nursing programs should diversify faculty and simulation resources to provide realistic examples and develop relational empathy before working with diverse patients. Foronda et al. (2017) noted that only 6% of mannequin components had Black skin, with the rest mostly pink. Levett-Jones et al. (2019) suggested immersive simulation helps empathy for vulnerable groups. Matshaka (2023) suggests educators create bedside teaching moments to foster empathy. When bedside exposure is limited, diversified simulation, like role-plays, mannequins, virtual reality, 3D e-simulation, and point-of-view modes, can enhance empathy and EICC skills (Ansari et al., 2025; Levett-Jones et al., 2019). Lobchuk et al. (2016) proposed using interactive video software with empathy feedback. These approaches, rooted in cultural practices, help students address patients' cultural and relational needs. Lee et al. (2018) found that situated Objective Structured Clinical Exams (OSCE) teaching improves empathy assessment, while Levett-Jones et al. (2017) used point-of-view simulations to teach empathy.

Reflective Practice as a Tool for Personal Growth with EICC

The study emphasizes self-reflection as key to developing humanness and advancing EICC. Sandars (2009) states that reflection-on-action supports professional growth, as reflecting on experiences can improve practice. Research suggests that assessment scales may improve

reflection among healthcare professionals, but those that include relational empathy, such as the CARE measure (Bas-Sarmiento et al., 2017; Bas-Sarmiento et al., 2019; Bikker et al., 2015, 2017; Lobchuk et al., 2016, 2018; Saviato et al., 2019), often neglect intercultural aspects. The findings highlight the importance of reflecting on different facets of empathy within relational empathy, as supported by Decety (2020), in contrast to the focus on a single empathy domain by Hojat et al. (2017). Reflection aims to guide future actions (Sandars, 2009), encouraging nursing students to develop a reflective mindset to identify learning needs and improve EICC skills. Self-reflection involves recognizing strengths and weaknesses related to ICC, understanding cultural needs, and engaging in critical thinking, all supported by epistemic and cultural humility. These practices are essential for addressing the needs of culturally diverse patients or students, reinforcing the importance of understanding intersectional realities and contexts, and fostering lifelong cultural learning and adjustments.

CEF Empowerment as a Catalyst for Effective EICC

Almutairi et al. (2025b) advocate that educators actively promote empathy through teaching initiatives. However, their findings indicate that nurse educators may still have gaps in their competence and confidence in teaching empathy and ICC across clinical, simulation facilitation, and didactic teaching, and may require additional training. Juntunen et al. (2024) identified that supporting students from culturally and linguistically diverse backgrounds presents substantial challenges for educators. Conversely, Korhonen et al. (2019) contend that nursing students tend to perform more effectively when guided by mentors who exhibit competence and relatability. It is imperative that educators base their practice on fundamental nursing principles, such as intercultural competence and EICC, to improve patient assignments and assessments during clinical or simulation exercises (Harvey et al., 2019).

Nursing students prefer educators who demonstrate EICC through role modelling, bedside guidance, or debriefing. However, these methods are frequently absent due to educators' lack of understanding or exposure to EICC as a concept, discomfort with EICC, or structural barriers in the educational environment that limit opportunities for EICC engagement.

Létourneau et al. (2022) observed that some clinical preceptors act as dehumanizing counterexamples, failing to exhibit appropriate caring behaviours or explain their significance.

Bell (2021) contends that White nursing faculty often lack the capacity to teach or effectively address racism. Juntunen et al. (2024) propose that nurse educators' ability to guide and evaluate students depends on their self-reflection on ICC skills and on their capacity to accept students and support diverse learning needs, which in turn necessitates versatile assessment strategies.

The Relational Equitable Empathy-based Intercultural Communication (REEICC)

Theoretical Model

The REEICC model aims to integrate EICC across organizations and prepare nursing students to deliver equitable relational EICC (see Figure 6). It shows that EICC is influenced by environmental factors (Ko et al., 2025), racial climate (Thomas-Hawkins et al., 2022; Ko et al., 2025), asymmetrical power dynamics, intercontextuality, humanness (Chen & Locsin, 2022), EICC itself, and partnership (Shahzad et al., 2022), all contributing to achieving relational equity in ICC contexts.

According to this study, humanistic perspectives are influenced by internal and external stimuli. Van Dijke et al. (2020) suggested that empathy develops in environments that foster care practices. Internal stimuli include genetics, neurological functions, and psychological insights into relationships. The study provides evidence that guided exposure to ICC can enhance nursing students' empathy and the practice of effective EICC (Korkmaz Doğdu et al., 2022). In this

study, students showed increased empathy during clinical rotations in palliative care, acute care, and labour units, which require empathic engagement. Assigning students to culturally diverse patients and focusing on EICC can improve empathy. The physical environment, such as simulation labs, helps develop skills but can reinforce cultural bias if it is not diverse (Ansari et al., 2025). External stimuli include power dynamics, hierarchical relationships, upbringing, and EICC teaching.

The racial climate in academic and healthcare institutions are characterized by racial differences and various forms of systemic racism and discrimination (Nazroo et al., 2020), which adversely affect intercultural dialogues and promote the perception that one individual's culture is superior to another (Melino et al., 2025). This contributes to patriarchal power structures (Eichbaum et al., 2023). These asymmetrical dynamics hinder relationships between culturally diverse patients and students, including nursing students and educators, who often face classism or expectations based on Whiteness (Luhanga et al., 2023; Melino et al., 2025). These dynamics reinforce stereotypes rooted in privilege and oppression (Collins et al., 2021; Crenshaw, 2017; Misra et al., 2021), highlighting the need for an intersectional perspective to critically examine the colonial and Eurocentric views embedded in academic and healthcare institutions. Recognizing others as fellow humans deserving empathy is vital. Adopting a social justice and equity approach promotes relational exchanges within the EICC framework by encouraging the unlearning of cultural biases and fostering acceptance, both of which are essential in education (Nixon, 2019).

Humanness impacts intercontextuality within the model (Chen & Locsin, 2022), thereby driving the desire to understand the multiple realities that shape human connections (van Dijke et al., 2020), including gender, time, language, culture, and religion. Crenshaw states these realities

inform human experience and must be navigated through an intersectional lens to understand culturally diverse individuals (Crenshaw, 1989; 1991a; 1991b). Humanness promotes curiosity, learning, and openness, fostering qualities like kindness, respect, trust, and empathy (Graebe, 2024). These qualities shift relationships from transactional to genuine efforts to understand and meet others' needs (Chen & Locsin, 2022).

The current state of ICC highlights the need for ongoing strategic partnerships with stakeholders, including educators, culturally diverse nurses, students, and patients, throughout the care process. As patients' cultural backgrounds evolve amid increasing diversity, ICC becomes dynamic and influenced by intercontextual factors. Eichbaum et al. (2023) recommend shifting from an ego-logical (individual-based) to an eco-logical (context-based and distributed) model of relational practice, emphasizing relational empathy and humanistic qualities to understand the intersecting identities and realities of patients and students. This study stresses the importance of openness and empathy in assessing contexts and delivering equitable care within these relationships.

Effective EICC occurs through a continuous cycle that follows 16 tenet principles established by the findings in chapter five, to achieve relational equity. This goes beyond equal care, including social and critical adaptations within the ICC context that foster relational transformation and ensure patient safety. The model shows that EICC is complex and context-dependent, influenced by factors at multiple levels. Effective implementation requires balancing power, racial, and environmental considerations through humility, personalized care, and culturally safe practices to ensure equitable healthcare. While many institutions focus on technical skills early in nursing education, nursing is inherently relational and requires preparing students for empathy-driven, intercultural communication (Korkmaz Doğdu et al., 2022).

The REEICC model addresses the limitations of cultural competency models and ICC frameworks. The uniqueness of the REEICC model from some existing ICC models is captured in **Table 13** below.

Table 13

Comparison of the Proposed REEICC Model with Selected Existing ICC Models

Existing ICC Models	REEICC Model
Focus on intercultural communication competence. No model was found specific to EICC	Focus on empathy-based intercultural communication
Model of Intercultural Communication Competence (Arasaratnam, 2009; Arasaratnam & Doerfel, 2005) Competent intercultural communicators (from the other's point of view) shared five qualities: empathy, intercultural experience/training, motivation, a global attitude, and the ability to listen well in conversation. The measurement instrument for this model included the following elements: attitude towards other cultures, ethnocentrism, motivation, interaction involvement, and intercultural communication competence. The model focused on the cognitive, affective, and behavioural components of ICC competence.	Competent intercultural communicators possess 16 qualities: active listening, cultural curiosity, cultural awareness and sensitivity, humility, respect, trust, understanding of intersectional realities and context, kindness, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, intercultural allyship and empowerment, intercultural conflict resolution, and relational empathy. The REEICC model is more holistic than Arasaratnam (2009) and Arasaratnam & Doerfel (2005). The REEICC addresses the influence of structural and psychological environment, racial climate, asymmetrical powers, and the influence of partnership, intercontextuality, relational empathy, and humanness. The early authors did not address intersectional realities, humility, respect, trust, time commitment, self-reflection on power, positionality, equity, social justice, allyship, and conflict resolution, nor did they specify the type of empathy needed for EICC.

Existing ICC Models	REEICC Model
Byram's (1997, 2008, 2020) model of intercultural communication competence Factors associated with effective intercultural communication: 1. Savoir (knowledge of self and other, of interaction) 2. Savoir être (relativising self, valuing other) 3. Savoir comprendre (skills of interpreting and relating): touches on empathy 4. Savoir apprendre/faire (skills of discovering and/or interacting) 5. Savoir s'engager (political education, critical cultural awareness): addressed power differentials, time constraints	While Byram (1997, 2008, 2020) addresses some critical and structural concerns of ICC, the REEICC model explicitly emphasizes intersectionality, relational empathy, conflict resolution, environmental considerations, racial climate, partnerships, equity, and specific humanistic characteristics that are absent in their work.
Xu et al. (2025) Hybrid ICC Model Synthesized theoretical contributions from Byram's (2008) competency-based framework, Kramsch's (2006) third space theory, and Welsch's (1999) transcultural competence. Built on three interrelated components: 1. Dynamic Cultural Awareness: cultural identities and experience, reflexivity, empathy, perspective shifts based on context 2. Power-Sensitive Communication: Impact of power dynamics, voice, agency, and representation. 3. Contextual Adaptability: adjusting communication strategies effectively in response to platform, language, or audience using multimodal texts, asynchronous interactions, and hybrid communication spaces. Proposes that ICC education must evolve by thoroughly integrating:	The REEICC model proposes all the interconnected concepts and implications delineated by Xu et al. (2025). Furthermore, it considers diverse intercontextualities, including time, language, gender, religion, and culture, as well as environmental influences and the impact of the racial climate. The model explicitly endorses relational empathy and humanistic qualities. The principles of EICC, as part of its ongoing cycle, specify attributes such as equity, social justice, trust, respect, and intersectionality, which collectively contribute to the formation of EICC in nursing education.

Existing ICC Models	REEICC Model
1. Critical digital literacy 2. Practical multilingualism 3. Nuanced sociocultural awareness.	

Study Implication and Recommendations

This research bears considerable significance for nursing education, practice, policy, and future research, thereby enriching the understanding of the EICC and its applicability across various settings. The implications will be thoroughly examined in key areas essential for maintaining and expanding its global translation: nursing education, nursing practice, policy development, future research directions, and communication studies.

Nursing Education

This research study will be influential for nurse educators, curriculum committees, academic nursing leaders, and policymakers, encouraging reflection on nursing education standards in Canada and globally. It fills gaps in the existing literature (Bhandal et al., 2023; Hughes et al., 2020; Moudatsou et al., 2020), explores empathy and ICC, develops a theoretical framework for EICC, and articulates how relational equity can unfold in undergraduate nursing education. The study offers refined definitions of ICC and EICC, advocates incorporating relational empathy into nursing curricula, and provides a framework for integrating empathy into nursing education.

The study highlights the need to shift from Eurocentric biomedical models to an anti-racist, diversity-focused, equity-oriented framework that inclusively addresses intersectional realities in nursing education (Bell, 2021; Hamzavi & Brown, 2023; Ramos-Roure et al., 2024). Hamzavi and Brown (2023) advocated for institutional self-assessment of whiteness and white supremacy. This involves developing a diversified, relation-based curriculum and critical

pedagogies (Jamal-Eddine & Abboud, 2025) that are student-centred, experiential, interdisciplinary, and competency-based. Educators should select student-centred, versatile, culturally appropriate, anti-racist teaching resources that promote group distinctions amid microaggressions and racism, all of which are supported by previous research (Han et al., 2020; Juntunen et al., 2024; Torregosa et al., 2016). Since students have diverse learning styles, videos on empathy in ICC, along with activities such as case studies, role-playing, and reflective journals that consider cultural and social health, can enhance learning (Chalmers, 2025; Shahzad et al., 2022).

Empathy education should address all dimensions to enhance the understanding of ICC. Jamal-Eddine and Abboud (2025) suggested that relational skills such as empathy, advocacy, critical thinking, and active listening can be developed through critical, arts-based pedagogies. Rieger et al. (2016) found that arts-based approaches can increase empathy, attitudes, reflection, and ethics maturity—key for ICC. Critical pedagogies promote emancipation, dialogue, and multicultural identity (Jamal-Eddine & Abboud, 2025). Addressing relational empathy, which involves perspective-taking across diverse contexts, is vital, and simulation methods like EICC videos, role-plays, and debriefings are recommended. Nurse educators and students should debrief and self-reflect on their intrapersonal skills and beliefs to better support marginalized students and patients, approaching learning and unlearning openly to promote EICC through social justice (Juntunen et al., 2024; Li et al., 2023; Shahzad et al., 2022). Students must be equipped to access contextual information to provide equitable care for diverse patients and families.

This study recommends establishing guidelines for cultural practices, languages, and perspectives to guide nursing students during ICC encounters. However, discussions are ongoing

about whether to standardize ICC guidelines (Majda et al., 2021). Majda et al. (2021) suggest that culturally congruent care is achieved through respect, honesty, composure, sensitivity, a positive attitude, curiosity, tolerance, and insight, not just memorizing cultural practices.

Participants have emphasized how these guidelines promote cultural awareness and guide the scaffolding process towards EICC. Gümüşsoy et al. (2021) concur that familiarity with migrant cultures improves empathy and communication.

This study recommends that educators adopt a collaborative approach to curriculum development, including diverse case scenarios, understanding and ensuring a safe environment, logistical choices, and the use of standardized actors and guest speakers to showcase diversity. Simulation provides an authentic alternative for students with limited real patient practice, fostering empathy and EICC skills such as cultural awareness and sensitivity, active listening, cultural humility, and understanding intersectional realities (Ansari et al., 2025; Foronda et al., 2017). Expanding scenarios to include community settings, coloured mannequins, and culturally diverse actors helps recognize differences in health assessment. It is essential to include various skin tones, religions, practices, and names (Ansari et al., 2025; Foronda et al., 2017). Combining experiential learning with self-reflection enhances these skills (Ansari et al., 2025). Developing culturally authentic cases and relation-focused EICC assignments, such as vignettes and social justice themes, promotes reflection and critical thinking (Chalmers, 2025). This study highlights limited empathy among health professionals when engaging with diverse patients (Hughes et al., 2020; Moudatsou et al., 2020) and calls for targeted interventions to foster empathy and ICC learning. Regular practice boosts confidence and interactions with diverse patients and caregivers. Feedback and diverse faculty roles in simulation are essential for effective training (Ansari et al., 2025).

This study highlights the need for a clear pathway to implement a clinical placement model for EICC in nursing education, emphasizing collaboration, preceptorship, patient assignment, and relational skills. Such a model needs to empower nurse educators, including simulation facilitators and CEFs, who are crucial to providing students with real-world experiences through effective training and empowerment (Korhonen et al., 2019). Nurse educators need support to build confidence in EICC to guide students during clinical rotations. The process involves assessing CEF self-efficacy for EICC, discussing challenges, and providing workshops and training to enhance skills and prepare students for culturally safe, relational care. International service-learning can also broaden understanding of SDOH, fostering advocacy, collaboration, and relational practice with diverse patients through an equity lens (Mihu et al., 2024; Newberry et al., 2023; Nemetchek, 2019; Shahzad et al., 2022).

With increasing numbers of immigrants and refugees in Canada and worldwide, there is a call to include EICC content and cultural materials in nursing textbooks to support effective EICC. Omitting this content misses opportunities to teach and hampers students' ability to learn effective EICC. The study suggests creating model videos to teach empathetic, culturally appropriate communication.

Nursing students should attentively address culturally diverse patients and seek relevant resources, focusing on EICC principles like cultural curiosity to understand patients' and families' perspectives. They must inquire about culture-specific factors and offer appropriate support. This study indicates that exploring the patient's context: culture, work, residence, support system, and travel history, is effective in initiating dialogue. Participants proposed questions to guide EICC's efforts and to reduce ICC barriers (see **Table 14**).

Table 14*Proposed Guiding Questions to Advance the EICC Process*

Proposed Guiding Questions for EICC
How do you normally do this? What works for you? I recognize that this may be how you do things, or is there other support we can put in place?
What are the things that you do in your culture that have been successful in supporting your health?
What is your cultural understanding and belief? Can you please help me understand what the expectations of your own culture are?
Can we arrange a translator for you? Or is there a family member that you trust?
Where are you coming from? How do you understand our healthcare system? It's different from what you're exposed to, and how do you understand that? How do we make sure you're comfortable?
What else is it that's helping you? What's hurting you? What's confusing you?
Can you tell me, based on your beliefs and values, what you would like me to know to help myself and the team to provide the best care we can?
Can you tell me, in terms of your hygiene practices, dietary practices, boarding, and everything else, what you would like me to know to help myself and the team provide the best care we can?
If I were in that position, what would I want the nurse to know, and how would I communicate that? And ask my questions based on the things I want.

Nursing students are expected to engage in self-reflective practice (Shahzad et al., 2022) and to cultivate patience and emotional regulation when interacting with diverse patients and educators, in accordance with the recommendations of Ramos-Roure et al. (2024).

Nursing Practice

EICC is vital in nursing due to patient diversity. This study shows educators must expose and prepare nurses to interact with culturally diverse patients. Chang et al. (2021) found that nurses improve their cultural awareness through experience and adjusting communication for multicultural patients. Consistent assignment of student nurses to diverse patients enhances EICC development and provides guidance to build confidence, encourage reflection, and strengthen skills in preparation for practice (Juntunen et al., 2024; Korkmaz Doğdu et al., 2022).

Constructive feedback helps students recognize areas for improvement in EICC (Juntunen et al., 2024). To ensure culturally appropriate and non-Eurocentric assessments, educators should understand their diverse students' backgrounds to accurately recognize behaviors and provide support (Juntunen et al., 2024). Evaluations from a white-settler view may wrongly see these students as incompetent or having communication issues when their expressions are culturally normal. Effective EICC aligns with the 16 EICC tenets discussed earlier in Chapter Five: active listening, cultural curiosity, cultural awareness and sensitivity, humility, respect, trust, understanding of intersectional realities and context, kindness, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity, and social justice lens, intercultural allyship and empowerment, and intercultural conflict resolution, and relational empathy.

Intercultural allyship and empowerment can help deconstruct white fragility and color blindness by challenging biased comments during handoffs and improving relationships with diverse individuals. Developing an EICC support community for students who are less proficient, from culturally diverse backgrounds, and facing racism is vital (Luhanga et al., 2023). Harvey et al. (2019) promote collaboration among nurse educators to identify intercultural

support for students. However, these actions could be realized through systemic partnerships to empower educators towards relational equity (Chin, 2013, 2016; Watson & Collins, 2023).

EICC is multidimensional, needing resources, cultural and linguistic support, interprofessional collaboration, and leadership aligned with relational principles. Prioritizing access to interpreters aids nurses in communicating with diverse patients (Chang et al., 2021; Shamsi et al., 2020). Recruiting and training unit translators is recommended. Allocating more time for nurses caring for culturally and linguistically diverse patients is crucial for safety and rapport (Chang et al., 2021; Seremetkoska et al., 2025). Nursing must go beyond technical skills, as task-focused approaches hinder effective EICC. Leaders should review workload and policies affecting EICC. Effective communication improves caring behaviors (Korkmaz Doğdu et al., 2022), and organizations must support ICC and nurses' well-being to reduce moral distress.

This study advocates for and predicts a shift from cultural competency to a relation-based model of diverse healthcare. While current literature endorses cultural competency (Arruzza & Chau, 2021; Lekas et al., 2020; Osmancevic et al., 2025), achieving this requires high-quality EICC. Lekas et al. (2020) observed a move towards cultural humility, emphasizing self-reflexivity, recognizing patients' lay expertise, shared power, and ongoing learning. However, this does not fully resolve intercultural nursing care challenges. Cultural humility is vital for EICC, which depends on effective communication, empathy, and understanding patients' backgrounds through relational empathy. Nurses need training in SDOH, power dynamics, and intersecting realities (Nemetchek, 2019; Newberry et al., 2023). Overreliance on cultural competency risks stigmatization, stereotyping, othering, and racism (Lekas et al., 2020).

The findings influence ELC revisions for Registered Nurses in Canada (Chiu et al., 2025; Moghabghab et al., 2018), EICC evaluations, patient assignment, mentorship, and racial

interactions. They show EICC is not currently recognized as a core competency in nursing regulations or curricula. Elements like relational empathy, ICC, and intersectionality should be integrated into educational modules, regulations, workshops, and policy development (Gümüşsoy et al., 2021). Professional development must include empathy, ICC, intercultural sensitivity (Gümüşsoy et al., 2021; Ramos-Roure et al., 2024), and awareness of racism (Truitt & Snyder, 2020). Educators should learn to identify racism and microaggressions and take proactive steps. Courses should be designed to prepare educators to teach culturally congruent care to diverse nursing students (Harvey et al., 2019). This aims to raise awareness, promote self-reflection, foster equity, and support EICC practice (Shahzad et al., 2022). Korhonen et al. (2019) highlight that effective mentoring creates a secure clinical environment. When recruiting CEFs, qualities such as dynamism, cultural diversity, social justice, equity, and nonjudgmental attitudes should be prioritized.

Policy Development

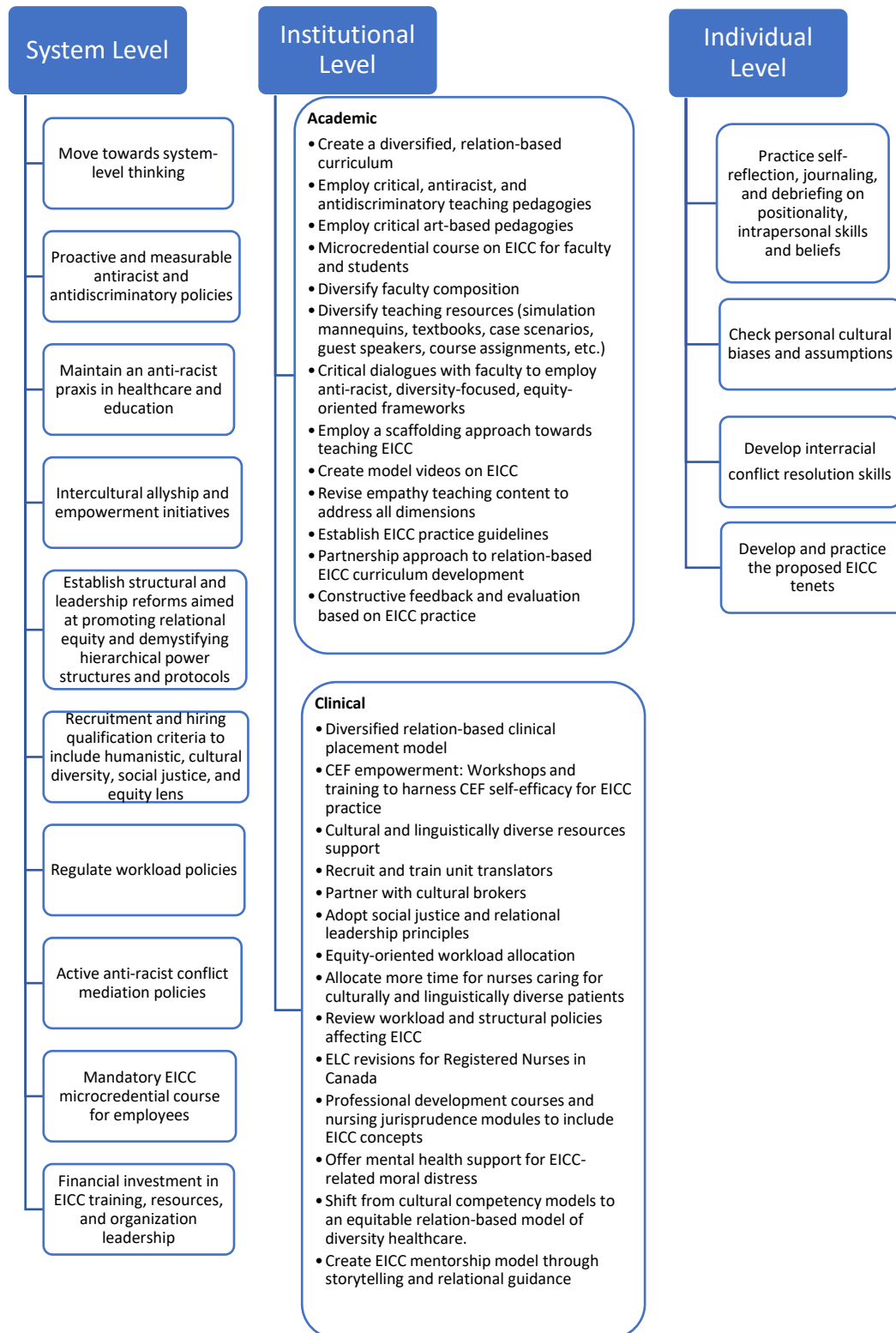
Integrating EICC necessitates a system-level approach to inform decision-making, regulation, partnerships, content, and resource allocation, all of which are directed by policy considerations (Watson & Collins, 2023). The EICC influences policy at all levels in academic and clinical settings regarding workload in patient assignment and workload in CEF: nursing student ratios, racism, EDI, hiring practices, and safety protocols. Recruitment efforts should emphasize diversity, with particular attention to race and multilingual abilities, to promote cultural representation and facilitate intercultural learning (Hudson et al., 2023; Luhanga et al., 2023; Seremetkoska et al., 2025; Torregosa et al., 2016). Hamzavi and Brown (2023), along with Luhanga et al. (2023), advocated for greater diversity in nursing faculty by including BIPOCs and for implementing retention strategies. Policies for new hires should integrate intercultural

principles, racial equity, social justice (Hudson et al., 2023), cultural humility, intercultural conflict-resolution skills, and go beyond mere acceptance of diversity.

The emotional distress associated with the failure to ensure EICC underscores the necessity of addressing workload concerns, which impact rapport-building with culturally diverse patients and the effective implementation of EICC. Policies should regulate caseloads to prevent burnout and ensure equitable treatment. Policies related to interpreters, bilingual nurses, and translators are essential in linguistically diverse regions (Chang et al., 2021; Shamsi et al., 2020). They should endeavor to eliminate systemic barriers and promote inclusivity within the ICC encounters by implementing financial policies that allocate resources towards hiring culturally diverse personnel, EICC training and critical partnerships, thereby supporting racially diverse patients and students (Hudson et al., 2023). Furthermore, conflict mediation and anti-racism policies are critical for fostering a safe and inclusive environment free of racial conflict, discrimination, and racism, including provisions for reporting and for impartial mediators representing diverse student populations (Luhanga et al., 2023; Torregosa et al., 2016; Truitt & Snyder, 2020). The establishment of policies that address racism in clinical and academic settings, including procedures for student withdrawal when racism occurs, a safe avenue for students to express racist concerns without jeopardizing their academic standing, and debriefing sessions with educators or nurses regarding culturally insensitive practices, is a critical need.

The policy implications of EICC call for regulation and measures to make it an institutional, competency, and professional standard for nurses providing equitable services. Implementation can include accountability measures, reporting of racist actions, and providing training and workshops (Hudson et al., 2023). It also involves revising curricula, developing educational modules, and establishing EICC guidelines and assessment tools. EICC can also be

integrated into policy frameworks as a requirement for practice, such as accreditation standards, pre-licensing requirements like ELCs, ongoing licence renewal requirements like jurisprudence modules, and adherence to nurses' ethics and conduct codes. These EICC policy implications guide actions to address healthcare inequities for marginalized groups. Integrating EICC into academic and healthcare policies, with measurable outcomes, can enhance its impact on relational and equity-focused practices. See **Figure 7** for some selected recommendations from this study.

Figure 7*Selected Actionable Recommendations from the Current Study*

Future Research Directions

This research expands upon ICC and empathy by establishing a theoretical foundation for EICC and proposing its integration into undergraduate nursing curricula, drawing on insights from nurse educators and final-year students. Nonetheless, due to persistent knowledge gaps, further qualitative and empirical research is required to deepen understanding and explore prospective applications of EICC. A study involving patients and caregivers to collect their perspectives on EICC in clinical practice could augment these findings. Similarly, insights from interpreters and cultural mediators could provide valuable contextual information regarding the experiences of diverse patients. Additionally, a concept analysis and a systematic review of the literature on pedagogical implications of the EICC and the REEICC model are needed.

Conducting a pilot test of the REEICC model within nursing institutions will be instrumental in facilitating academic and clinical discourse and in implementing the articulated theoretical process. This endeavour will necessitate a comprehensive review of the existing literature on integrating this innovative model into curricula and educational environments. Additionally, further qualitative research across diverse contexts is essential to assess transferability (Ramos-Roure et al., 2024). The third phase should entail piloting the model in other professional institutions to verify transferability across various healthcare settings, thereby advancing relational EICC practice. The fourth phase needs to involve developing educational modules and assessment tools to evaluate students' proficiency with EICC, gather insights into their experiences, and inform pedagogical enhancements.

Further research is needed to determine if alternative methods or theories yield similar results when assessing EICC in relational practice. An area for improvement in EICC is technological equity, given that many migrant patients and families may lack technological skills

and face language barriers, often relying on tools like Google Translate. A qualitative study should identify the best ways to assist this group. Additionally, some international students faced comparable challenges that affected their academic performance, highlighting an additional focus for future research.

Study Significance

This research provided novel insights into EICC that have the potential to enhance health/education outcomes and promote health equity within the Canadian healthcare system. It proposed a definition of EICC and outlined a cycle illustrating the psychological impact of racism and discrimination in EICC contexts, elements that were previously absent from scholarly discourse prior to this doctoral study. The study contributed to a more profound understanding of EICC processes, cultural nursing pedagogies, and the development of an EICC model informed by intersectionality theory (Collins & Bilge, 2020)—the REEICC theoretical model—aimed at fostering relational practice that has an equity focus, patient-centred care, and culturally safe practices. It makes a significant theoretical contribution to the ongoing efforts of other researchers to advance EICC. Moreover, the findings have relevant implications as discussed above. Refer to **Table 15** for a summary of the study’s contributions.

Table 15

Comparison of the EICC Findings with the Current Literature

Current Literature	EICC Study Findings
Non-existent cycle of psychological function of racism and discrimination	Proposed cycle of the psychological impact of racism and discrimination: perception framing, recognition and acceptance, internalization, transferability, expressivity, and role adaptability

Current Literature	EICC Study Findings
Measuring empathy as a single-domain framework (Hojat et al., 2017) Empathy as a multidimensional framework (Decety, 2020)	Measuring empathy as a multidimensional framework
Empathy focuses on the empathizer (Decety, 2020; van Dijke et al., 2020)	Empathy focuses on contextual factors and how the multiple domains interact in EICC
The existing relational empathy assessment scale does not address the intercultural context (Bas-Sarmiento et al., 2017; Bas-Sarmiento et al., 2019; Bikker et al., 2017; Bikker et al., 2015; Lobchuk et al., 2016; Lobchuk et al., 2018; Saviato et al., 2019)	Proposed the development of an EICC measuring or assessment scale with an intercontextual focus
Traditional curriculum, Teacher-centered , transactional curriculum (Eksteen & Slabbert, 2001; Mackintosh-Franklin, 2016; Rege Colet, 2017; Schaefer & Zygmunt, 2003; Stanley & Dougherty, 2010)	Proposed a relation-based curriculum in EICC with a definition: A relation-based curriculum is an educational framework in which learning concepts are clustered around relational practice and relationship-building between academic actors in nursing and their clinical partners within an intercultural environment.
Some existing ICC definitions: The study and practice of communication across cultural contexts (Bennett, 2013) The act of sociality between cultures (Huang et al., 2012)	Proposed ICC definition: Intercultural communication is defined as a social, relational, culture-dominated interactive process in which culturally diverse individuals from two or more cultures interact and co-create meaning amid cultural variances, power dynamics, and worldviews, and it fosters respect, appreciation, and openness to cultural adaptations that enable one to interact with and care for others.
No EICC definition	Proposed EICC definition: Empathy-based ICC is defined as a deep, social, relational, and context-dependent interactive process in which culturally diverse individuals engage, co-create meaning through ongoing

Current Literature	EICC Study Findings
	perspective-taking and emotional connection, demonstrate a willingness to understand others' contexts amid cultural differences, power dynamics, and worldviews, and foster respect, appreciation, and openness to cultural adaptations for unbiased interactions and holistic care.
No note of specific dimension to EICC	Identified a specific empathy dimension for EICC: Relational Empathy
Empathy has the potential to help the advancement of ICC (Armah et al., 2020; Golubeva & Guntersdorfer, 2020)	Confirmed teaching empathy as a driving force that influences the development of EICC.
No EICC theoretical model; Previous work focused on cultural competence or intercultural communication competence frameworks (Arasaratnam, 2009; Arasaratnam & Doerfel, 2005; Byram, 1997, 2008, 2020; Xu et al., 2025)	Proposed a REEICC theoretical model with a critical framework
No specific EICC tenets; however, a few similar micro-tenets were embedded in the cultural competency and ICC literature, as discussed above.	Proposed 16 EICC tenets: active listening, cultural curiosity, cultural awareness and sensitivity, humility, respect, trust, understanding of intersectional realities and context, kindness, openness to lifelong cultural learning and adjustment, advocacy, time commitment, self-reflection on power and positionality, intersectional, equity and social justice lens, intercultural allyship and empowerment, intercultural conflict resolution, and relational empathy
Minimal or no focus on the intersectional lens and partnership approaches in communication	Strong focus on intersectional perspectives, partnership, relational practice, and system-level thinking

Strengths and Limitations of the Study

Strength of the Thesis

This study is the first critical constructivist grounded theory study of EICC, exploring complex intersectional contexts of human relations among culturally diverse groups in healthcare and education. Using a CCGT methodology (Levitt, 2021), it offers new insights into ICC and EICC, fills research gaps and creates a REEICC model to incorporate EICC, equity, and social justice into nursing education and practice. It challenges reductionist views of traditional cultural competency frameworks by proposing a relational, equity-focused, dynamic approach. The study includes the experiences of final-year nursing students and educators, with the researcher reflexively co-creating innovative, relation-based knowledge that benefits intercultural nursing (Berger, 2015; Charmaz, 2014; Creswell & Poth, 2018).

The thorough responses of students and educators led to data reaching theoretical saturation. Findings include detailed descriptions and participants' quotations that show their valuable perspectives (Creswell & Poth, 2018). Participants validated the results through synthesized member checking, thereby enhancing validity and trustworthiness (Birt et al., 2016; Harvey, 2015). Some educators were interviewed twice—via individual interviews and focus groups—to clarify and confirm responses. The researcher kept reflexive memos about their positionality and influences throughout the study (Berger, 2015).

The research was conducted across three nursing institutions within a Canadian province, yielding consistent and comprehensive results across various academic and healthcare policy frameworks and geographical locations. This indicates that the findings may be contextually relevant and transferable to other settings within Canada and globally (Creswell & Poth, 2018). Although most participants were White, similar observations regarding gaps in nursing related to

EICC were reported by all participants. The study addressed critical contextual and influential factors such as gender, culture, power, time, language, racism, and relational empathy, which impact the EICC process with practical implications.

In accordance with CGT (Charmaz, 2014), this study collaboratively developed EICC knowledge that was relatable to all study participants, the researcher, and the public. The findings were presented in the participants' voices, with interpretations grounded in the specific context to connect to their experiences and diverse settings. Each participant provided genuine accounts that challenged the researcher's insights and the previous literature. EICC knowledge development is critically important in both academic and clinical environments to advance relational, equity-focused nursing practice.

Study Limitations

The study found that fewer men than women participated, with none identifying as gender-diverse, which may have affected the results due to gender–empathy links (Korkmaz Doğdu et al., 2022). Most participants were White, particularly within the nurse educator group (Hamzavi & Brown, 2023). It lacked patient input, except for one educator's account as a family caregiver. Future research should examine the perceptions of additional stakeholders, including patients, family caregivers, interpreters, and cultural mediators, concerning EICC to further advance the development of the REEICC theoretical framework. In the future, a nationwide, multicenter, longitudinal study is needed to assess nursing students' EICC knowledge, test the REEICC theoretical model, and develop a REEICC scale. Furthermore, there was an absence of data relating to remote or virtual nursing and its influence on EICC. Consequently, it is advisable to explore EICC within technological contexts, including remote nursing practices. Data collection also spanned twenty months due to recruitment challenges that caused delays.

Therefore, future research should implement strategies to effectively address and reduce such recruitment challenges.

Knowledge Integration Plan

I plan to incorporate the findings into policy briefs, simulation scenarios, and peer-reviewed publications, and also plan to develop a follow-up knowledge translation study. The approved dissertation will be uploaded to the University of Manitoba MSpace. Interested participants received an executive lay summary via email (Appendix P). I will create a scientific poster and research briefs highlighting results to be posted in the Colleges of Nursing, and I will share findings with students and faculty through lecture presentations and faculty workshops. I will organize meetings with nursing faculty to discuss findings and strategies to promote the adoption of EICC education. The study's results will be published in scientific nursing, communication, or methodology journals and presented at conferences and stakeholder meetings. A future follow-up study will use arts-based storytelling pedagogy (Greenwood, 2019; Hobson et al., 2020; Osteen et al., 2016; Senehi et al., 2009) to translate knowledge into healthcare settings and among stakeholders. Within my future research program, I also plan to develop EICC simulation videos, EICC guides, and instruments to pilot-test the new REEICC model developed in this research.

Conclusion

This chapter emphasizes the principal findings of this EICC critical constructivist grounded theory study, highlighting the influence of structural, political, and representational power relations (Crenshaw, 1989; Crenshaw, 1991a; Crenshaw, 1991b), as well as the contextual, environmental, and racial climate factors that impact the social process of integrating empathy into EICC. Additionally, it delineates the vital role of EICC in fostering empathy-based,

inclusive, relational, and equity-oriented care on a global scale. EICC should develop into a fundamental competence in relational practice, promoting an intersectional, culturally sensitive, equity, and justice-focused perspective when engaging with diverse individuals. EICC advocates for a humanistic approach to care, viewing nursing as an art guided by human relationships to ensure relationally equitable healthcare (Chalmers, 2025).

The study established the theoretical foundations of EICC, including the definition, tenet, and the REEICC model, with the objective of enhancing its integration into nursing education. However, considering the unique influence of power dynamics, structural environment, and racial climate within the system, effective implementation of EICC in nursing education and practice necessitates system-level thinking, proactive conflict resolution measures, strong partnerships and support from academic and clinical institutions, diversified relation-based curricula, policy backing, and ongoing healthcare research. Educators are tasked with preparing nurses to communicate effectively and confidently with all populations, advancing beyond traditional cultural competency frameworks towards an empathy-based approach that promotes relational practice, patient-centered care, and intercultural care centered on equity. Overall, EICC represents a timely, comprehensive, and transformative framework essential for nursing education and practice, addressing interpersonal, cultural, and structural dimensions to meet the needs of diverse patients and students.

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Appendix A

Email Invitation Request – Institutional Administrator

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study

Subject: Recruitment Request: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study

Dear [Administrator's name],

I recently received approval from your institution for my doctoral dissertation research entitled, 'Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study.'

The eligibility for final year undergraduate nursing students from your institution to participate in the study include:

- (a) An ability to speak English
- (b) Must be 18 years of age or older
- (c) Must reside in Manitoba
- (d) Must be a final year undergraduate nursing student
- (e) Must provide consent to be recorded during the interview(s)

The eligibility for nurse educators from your institution to participate include:

- (a) An ability to speak English
- (b) Must be 18 years of age or older
- (c) Must reside in Manitoba
- (d) Must teach either a simulation, communication or a culture-related course(s) or supervise clinical practicums involving culturally diverse patients and their family caregivers.
- (e) Must provide consent to be recorded during the interview(s)

Please find attached the recruitment email to potential participants for the study. I have also attached the consent forms to be included in the email. Reminder recruitment emails can be sent via the Nursing Department's Administrative Assistants as scheduled – six reminders after the first week of sending out the initial recruitment email, each reminder should be one week apart.

Interested participants would need to contact the Principal Investigator, Naomi Armah ([Redacted]), via email by October 30, 2024, to follow up with the necessary arrangements for the data collection.

Please let me know if you have any questions.

Thank you.

Kind Regards,

Naomi Armah, RN, MN, PhD Candidate
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba
Phone: [Redacted]

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Research Supervisors:

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Appendix B

A Letter of Invitation to Nursing Students (via Blind Carbon Copy Email, University of Manitoba, Brandon University, University College of the North)

Subject: Recruitment for an Intercultural Communication Study

This email is being sent on behalf of Naomi Armah – RN, MN, Ph.D. Candidate

University of Manitoba – College of Nursing
89 Curry Place, Winnipeg, Manitoba, R3T 2N2
Tel: [Redacted]
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Research Supervisors: Marnie Kramer, RN, PhD, Assistant Professor

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University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study

As part of my doctoral dissertation, I will explore the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. Knowing the views of student nurses on the subject matter, their experiences, and suggestions will enable faculty to develop effective ways to teach empathy-based ICC (empathy, ICC, human diversity, etc., practicing empathy when communicating with culturally diverse populations).

You are eligible to participate if you speak English, are 18 years or older, reside in Manitoba, are a final year undergraduate nursing student, and provide consent to be recorded during the interview(s).

This study is voluntary, and you may choose to withdraw at any time before December 30, 2024, at which time I will have completed the data analysis. Your role in this study will involve sharing what you know about empathy and ICC, as well as your perspectives on teaching strategies on empathy and ICC. You will also be invited to describe your personal encounters with culturally diverse clients and offer recommendations for future educational strategies. The one-on-one interview and the focus group interview (to be contacted at a later date after data analysis to seek clarification and explore new ideas that emerge from the one-to-one interviews) are estimated to

last between 45 to 60 minutes each and will be audio recorded for accuracy. You would also complete a five-minute demographic survey before the one-on-one interview. Each participant will receive a \$30 electronic Amazon gift card after consenting to the interview, and an additional \$30 electronic Amazon gift card if contacted and provides consent for the focus group.

This research has been approved by the Research Ethics Board, Fort Garry campus (REB 1) at the University of Manitoba, the Brandon University Research Ethics Committee, the University College of the North Research Ethics Board, and the College/ Faculty of Nursing Leadership Team in your institution. If you have any concerns about this project, contact the Human Ethics Officer at 204-474-7122 or by email: humanethics@umanitoba.ca or Naomi Armah at [\[Redacted\]](#)

Attached is the consent form for your review. Interested participants are invited to contact me.

Kind Regards,

Naomi Armah, RN, MN, PhD Candidate
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba
Phone: [\[Redacted\]](#)
Email: [\[Redacted\]](#)



University of Manitoba | Rady Faculty of Health Sciences

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T: [Redacted]
E: [Redacted]

Appendix C

A letter of Invitation to Nurse Educators (via Blind Carbon Copy Email, University of Manitoba, Brandon University, University College of the North)

Subject: Recruitment for an Intercultural Communication Study

This email is being sent on behalf of Naomi Armah – RN, MN, Ph.D. Candidate

University of Manitoba – College of Nursing
89 Curry Place, Winnipeg, Manitoba, R3T 2N2
Tel: [Redacted]
Email: [\[Redacted\]](#)

Research Supervisors: Marnie Kramer, RN, PhD, Assistant Professor

University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Adjunct Professor

University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study

As part of my doctoral dissertation, I will explore the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. Knowing the views of nurse educators on the subject matter, their experiences, and suggestion will enable faculty to develop effective ways to teach empathy-based ICC (empathy, ICC, human diversity, etc., practicing empathy when communicating with culturally diverse populations).

You are eligible to participate if you speak English, are 18 years or older, reside in Manitoba, are a nurse educator who teaches a simulation, communication, or culture-related course, or supervise clinical practicum that involves culturally diverse patients and their family caregivers, and provide consent to be recorded during the interview(s).

This study is voluntary, and you may choose to withdraw at any time before December 30, 2024, at which time I will have completed the data analysis. Your role in this study will involve sharing what you know about empathy and ICC, as well as what empathy-based ICC means to you. You will also be invited to describe how you teach empathy in your communication, simulation, or culture-related course, how empathy-based ICC could be taught, and the available resources to support teaching empathy-based ICC. I am also interested in your recommendations for future strategies to teach empathy-based ICC. The one-on-one interview and focus group (to be contacted later after data analysis to seek clarification and explore new ideas springing up) is estimated to last between 45 to 60 minutes each. The interview and focus group will be audio recorded for accuracy. You would also complete a five-minute demographic survey before the one-on-one interview. Each participant will receive a \$30 electronic Amazon gift card after consenting to the interview, and an additional \$30 electronic Amazon gift card if contacted and provides consent for the focus group.

This research has been approved by the Research Ethics Board, Fort Garry campus (REB 1) at the University of Manitoba, the Brandon University Research Ethics Committee, the University College of the North Research Ethics Board, and the College/ Faculty of Nursing Leadership Team in your institution. If you have any concerns about this project, contact the Human Ethics Officer at 204-474-7122 or by email: humanethics@umanitoba.ca or Naomi Armah at [Redacted]

Attached is the consent form for your review. Interested participants are invited to contact me.

Kind Regards,

Naomi Armah, RN, MN, PhD Candidate
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba
Phone: [Redacted]
Email: [\[Redacted\]](#)



University of Manitoba | Rady Faculty of Health Sciences

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E: [\[Redacted\]](#)

Appendix D -1

Letter of Information for Consent to Participate in Research (Nursing Student)

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing: An Intersectional Constructivist Grounded Theory Study

Principal Investigator: Naomi Armah, Ph.D. Candidate

University of Manitoba – College of Nursing
89 Curry Place, Winnipeg, Manitoba, R3T 2N2
Tel: [Redacted]
Email: [\[Redacted\]](#)

Research Supervisors: Michelle Lobchuk, RN, PhD, Associate Professor

University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Associate Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Marnie Kramer, RN, PhD, Assistant Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Jessica Senehi, PhD, Associate Professor
University of Manitoba – Arthur V. Mauro Institute for Peace and Justice
Email: [\[Redacted\]](#)

Sponsor: Canadian Institutes of Health Research (CIHR)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the

research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The study

This research is a Ph.D. thesis where I (Naomi Armah, PhD student) will explore the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. There is limited understanding of empathy-based ICC (empathy, ICC, human diversity, etc.; practicing empathy when communicating with culturally diverse populations) in nursing and healthcare delivery as a potential factor that enhances relational practice in healthcare. Your viewpoint about empathy-based ICC will enable educators to create and use more engaging student-centred teaching approaches that facilitate optimal relational practice. Findings from the study will contribute to evidence-based literature to guide future practices in empathy-based ICC.

Eligibility criteria

You are eligible to participate if you can speak English, are 18 years or older, reside in Manitoba, and are a 4th-year undergraduate nursing student.

What will my participation in this study require?

This study is voluntary, and you may choose to withdraw at any time before May 31, 2024, at which time I will have completed the data analysis. Your role in this study will involve sharing your perspectives on empathy-based ICC; for example, what you know about empathy, ICC and teaching strategies, personal encounters with culturally diverse clients, and recommendations for future educational strategies. The one-on-one interview and focus group (to be contacted later after data analysis to seek clarification and explore new ideas springing up) are estimated to last between 45 to 60 minutes each and will be audio recorded with a digital recorder and transcribed verbatim for accuracy. The interview may be held in-person or virtually via zoom at a time that is convenient for you. If you feel uncomfortable being audio-recorded during a portion of the interview, you may request to have the digital recorder paused. You would also complete a 9-item demographic survey (e.g., age, gender, educational background, religion, etc.) before the interview. Each participant will receive a \$30 electronic visa gift card after consenting to the interview. I will email you a summary of the findings by June 2024, so you can verify or substantiate or ask questions about the study's findings. Upon completion of the study, I will provide you with a final summary of the study's findings via email in December 2024. Please note that not all participants who consent to a follow-up focus group will be contacted. Only those who are required to provide additional information will be invited for the focus group and will be provided an honorarium of \$30 for the extra time after the focus group.

Possible risks and discomfort

There are minimal risks or discomfort to this intersectional constructivist grounded theory study which may be in the form of emotional discomfort during reflection. If you share a difficult clinical or teaching experience where you were challenged in ICC, you may experience some discomfort. If this occurs, you will be given the choice to take a break from the interview, meet at a different time to complete the interview, or withdraw from participating in the study. However, contacts or suggestions for counselling services post-interview, if needed, include

Student counselling services in the various academic institutions, Mobile Crisis Service (204-940-1781), Klinik Crisis Line (204-786-8686), Manitoba Suicide Prevention and Support Line (1-877-435-7170), and First Nations and Inuit Hope for Wellness Services (1-855-242-3310).

Benefits for participating

By participating in this study, you may:

1. reflect on empathy-based ICC education in your nursing program or ICC encounters while providing or receiving health care.
2. garner a deeper understanding of what empathy-based ICC is in nursing education.
3. help identify teaching strategies to enhance empathy-based ICC in undergraduate nursing education programs.

This information will inform nurse educators about student nurses' empathy-based ICC educational needs to provide care for culturally diverse patients and family caregivers with varied cultural backgrounds, support resources that are available and those needed, and curricula revisions.

Cost for participation

There will not be an additional cost for participating. Instead, each participant will be eligible to receive a \$30 electronic visa gift card after consenting to the interview to thank them for their time and contributions to study.

Confidentiality

I will maintain your confidentiality as a research participant by removing all identifiable cues about you from the data and assigning codes to the transcripts. Only I (as the researcher) will know who has participated in the study. While the information collected in the interview and/or focus group will not be shared, it will be stored on a password-protected shared drive set up by IST at the University of Manitoba. The electronic, de-identified data will be kept in that password-protected shared drive for a period of five years following the completion of the study. The database will have firewalls to secure all information and allow access by authorized, password-protected user accounts only, i.e., the researcher and co-advisors. This action will ensure that all study participant information remains confidential and safe. Any electronic copies of the de-identified data will be destroyed by December 2029 using the electronic deletions procedures of the University of Manitoba. Any hard copies of the signed consent forms will be kept in a locked filing cabinet in my home or at the Manitoba Centre for Nursing and Health Research unit for seven years and subsequently disposed of as confidential waste by December 2029. Note that efforts will be made to keep your personal information confidential; however, absolute confidentiality cannot be guaranteed.

Sharing the findings from this study

I will share the findings from this research with you and the nursing faculty such as undergraduate course instructors, students, and faculty leadership at the University of Manitoba, Brandon University, and the University College of the North. You will receive a summary of the initial findings by June 2024 and the final report by email by December 2024. In addition, the results will be presented at nursing, education, or communication conferences and published in a

peer-reviewed scientific journal (e.g., Nurse Education Today, the International Journal of Qualitative Methods, Nursing Inquiry, and BMC Nursing).

Questions

If you have any questions regarding this study or your rights as a research participant, please get in touch with the following: Naomi Armah (Phone number - [Redacted], [Redacted]), Dr. Michelle Lobchuk ([Redacted]) or Dr. Christina West ([Redacted]).

Voluntary participation/withdrawal from the study

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time before May 31, 2024, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Research Ethics Board, Fort Garry campus (REB 1) may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board, Fort Garry campus (REB 1), at the University of Manitoba. If you have any concerns or complaints about this project, you may contact the persons named above or the Human Ethics Coordinator (HEC) at 204-474-7122 or by email: humanethics@umanitoba.ca. A copy of this consent form has been given to you via email for your records and reference.

Participant signature _____ Date _____

Researcher/or Delegate's signature _____ Date _____

Email address to receive summary findings, final summary, and gift card honorarium:

Consent to be contacted for follow-up focus group: Yes _____ No _____

Contact information (e.g., telephone number or email address) _____



University of Manitoba | Rady Faculty of Health Sciences

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E: [Redacted]

Appendix D - 2

Letter of Information for Consent to Participate in Research (Nursing Students) - Updated

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study

Principal Investigator: Naomi Armah, RN, MN, Ph.D. Candidate

University of Manitoba – College of Nursing
89 Curry Place, Winnipeg, Manitoba, R3T 2N2
Tel: [Redacted]
Email: [\[Redacted\]](#)

Research Supervisors: Marnie Kramer, RN, PhD, Assistant Professor

University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Adjunct Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Sponsor: Canadian Institutes of Health Research (CIHR) and College of Nursing Endowment Fund, University of Manitoba

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The study

This research is a Ph.D. dissertation where I (Naomi Armah, Ph.D. candidate) will explore the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. There is limited understanding of empathy-based ICC (empathy, ICC, human diversity, etc.);

practicing empathy when communicating with culturally diverse populations) in nursing and healthcare delivery as a potential factor that enhances relational practice in healthcare. Your viewpoint about empathy-based ICC will enable educators to create and use more engaging student-centred teaching approaches that facilitate optimal relational practice. Findings from the study will contribute to evidence-based literature to guide future practices in empathy-based ICC.

Eligibility criteria

You are eligible to participate if you can speak English, are 18 years or older, reside in Manitoba, are a final year undergraduate nursing student, and provide consent to be recorded during the interview(s).

What will my participation in this study require?

This study is voluntary, and you may choose to withdraw at any time before December 30, 2024, at which time I will have completed the data analysis. Your role in this study will involve sharing your perspectives on empathy-based ICC; for example, what you know about empathy, ICC and teaching strategies, personal encounters with culturally diverse clients, and recommendations for future educational strategies. The one-on-one interview and focus group (to be contacted later after data analysis to seek clarification and explore new ideas springing up) are estimated to last between 45 to 60 minutes each and will be audio recorded with a hand-held digital recorder and transcribed verbatim manually by a transcription agency for accuracy. The interview may be held in-person or virtually via University of Manitoba zoom at a time that is convenient for you. If you feel uncomfortable being audio-recorded during a portion of the interview, you may request to have the digital recorder paused. You would also complete a 9-item demographic survey (e.g., age, gender, educational background, religion, etc.) before the interview. Each participant will receive a \$30 electronic amazon gift card after consenting to the interview. I will email you a summary of the findings by December 2024, so you can verify or substantiate or ask questions about the study's findings. Upon completion of the study, I will provide you with a final summary of the study's findings via email in February 2025. Please note that not all participants who consent to a follow-up focus group will be contacted. Only those who are required to provide additional information will be invited for the focus group and will be provided an honorarium of \$30 for the extra time after the focus group.

Possible risks and discomfort

There are minimal risks or discomfort to this intersectional constructivist grounded theory study which may be in the form of emotional discomfort during reflection. If you share a difficult clinical or teaching experience where you were challenged in ICC, you may experience some discomfort. If this occurs, you will be given the choice to take a break from the interview, meet at a different time to complete the interview, or withdraw from participating in the study. However, contacts or suggestions for counselling services post-interview, if needed, include Student counselling services in the various academic institutions, Mobile Crisis Service (204-940-1781), Clinic Crisis Line (204-786-8686), Manitoba Suicide Prevention and Support Line (1-877-435-7170), and First Nations and Inuit Hope for Wellness Services (1-855-242-3310).

Benefits for participating

By participating in this study, you may:

1. reflect on empathy-based ICC education in your nursing program or ICC encounters while providing or receiving health care.
2. garner a deeper understanding of what empathy-based ICC is in nursing education.
3. help identify teaching strategies to enhance empathy-based ICC in undergraduate nursing education programs.

This information will inform nurse educators about student nurses' empathy-based ICC educational needs to provide care for culturally diverse patients and family caregivers with varied cultural backgrounds, support resources that are available and those needed, and curricula revisions.

Cost for participation

There will not be an additional cost for participating. Instead, each participant will be eligible to receive a \$30 electronic Amazon gift card after consenting to the interview to thank them for their time and contributions to study. Only those who are required to provide additional information will be invited for the focus group and honorarium will be another \$30 electronic Amazon gift card.

Confidentiality

I will maintain your confidentiality as a research participant by removing all identifiable cues about you from the data and assigning pseudonyms, like 'Abena' instead of your original name or use general descriptors like 'a female nursing student,' in the transcripts to enhance confidentiality. Any health information you share will be treated as confidential in accordance with the Personal Health Information Act of Manitoba. Only I (as the researcher) and my research supervisors (Dr. Christina West and Dr. Marnie Kramer) will know who has participated in the study. While the information collected in the interview and/or focus group will not be shared, it will be stored on a password-protected shared drive set up by IST at the University of Manitoba. The electronic, de-identified data will be kept in that password-protected shared drive for a period of five years following the completion of the study. The database will have firewalls to secure all information and allow access by authorized, password-protected user accounts only, i.e., the researcher and co-advisors. This action will ensure that all study participant information remains confidential and safe. Any electronic copies of the de-identified data will be destroyed by November 2028 using the electronic deletions procedures of the University of Manitoba. Any hard copies of the signed consent forms will be kept in a locked filing cabinet in my home for five years and subsequently disposed of as confidential waste by November 2028. Note that efforts will be made to keep your personal information confidential; however, absolute confidentiality cannot be guaranteed.

Sharing the findings from this study

I will share the findings from this research with you, MSpace as dissemination of thesis, and the nursing faculty such as undergraduate course instructors, students, and faculty leadership at the University of Manitoba, Brandon University, and the University College of the North. You will receive a summary of the initial findings by December 2024 and the final report by email by February 2025. The first summary is for member checking to know if this summary reflects your thoughts and the experiences you shared during the interview. If we do not hear back from you by January 15th, we would assume you have no additional comments, and the summary reflects your thoughts and shared experiences. In addition, the results will be presented at nursing, education, or communication conferences and published in a peer-reviewed scientific journal

(e.g., Nurse Education Today, the International Journal of Qualitative Methods, Nursing Inquiry, and BMC Nursing).

Questions

If you have any questions regarding this study or your rights as a research participant, please get in touch with the following: Naomi Armah (Phone number - [Redacted], [Redacted]), Dr. Christina West ([Redacted]) or Dr. Marnie Kramer ([Redacted]).

Voluntary participation/withdrawal from the study

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time before December 30, 2024, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. For the focus group, your individual response will be retracted from the data if the PI receives the notice before data analysis by December 30, 2024. However, if data analysis has taken place already, the content cannot be retracted. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you want to withdraw from the study, please get in touch with the researcher, Naomi Armah, via email, [Redacted]. As a student, your participation or discontinuation in this study will not constitute an element of your academic performance nor will it be part of your academic record.

The University of Manitoba Research may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus, the Brandon University Research Ethics Committee, the University College of the North Research Ethics Board, and the Faculty of Nursing Leadership Team in your institution. If you have any concerns or complaints about this project, you may contact the above-named persons or the Human Ethics Officer at 204-474-7122 or humanethics@umanitoba.ca. A copy of this consent form has been given to you via email for your records and reference.

Participant signature _____ Date _____

Researcher/or Delegate's signature _____ Date _____

Email address to receive summary findings, final summary, and gift card honorarium:

Consent to be contacted for follow-up focus group: Yes _____ No _____

Contact information (e.g., telephone number or email address) _____



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E: [\[Redacted\]](#)

Appendix E -1

Letter of Information for Consent to Participate in Research (Nurse Educators)

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing: An Intersectional Constructivist Grounded Theory Study

Principal Investigator: Naomi Armah, Ph.D. Candidate

University of Manitoba – College of Nursing
89 Curry Place, Winnipeg, Manitoba, R3T 2N2
Tel: [Redacted]
Email: [\[Redacted\]](#)

Research Supervisors: Michelle Lobchuk, RN, PhD, Associate Professor

University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Associate Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Marnie Kramer, RN, PhD, Assistant Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Jessica Senehi, PhD, Associate Professor
University of Manitoba – Arthur V. Mauro Institute for Peace and Justice
Email: [\[Redacted\]](#)

Sponsor: Canadian Institutes of Health Research (CIHR)

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to

ask. Please take the time to read this carefully and to understand any accompanying information.

The study

This research is a Ph.D. thesis exploring the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. There currently exists a gap in comprehending empathy-based ICC (empathy, ICC, human diversity, etc., practicing empathy when communicating with culturally diverse populations) in nursing and healthcare delivery. More specific, more studies are needed that contribute knowledge on how to enhance relational practice in healthcare. Knowing the views of key stakeholders like you based on your knowledge, roles, and experiences will enable faculty to use more engaging student-centred approaches to teach relational practice. Findings from the study will contribute to evidence-based literature to guide future practices in empathy-related ICC.

Eligibility criteria

You are eligible to participate if you can speak English, are 18 years or older, reside in Manitoba, and are a nurse educator who teaches either a simulation, communication, or culture-related course, or supervise clinical practicum that involves culturally diverse patients and their family caregivers.

What will my participation in this study require?

This study is voluntary, and you may choose to withdraw at any time before May 31, 2024, at which time I will have completed the data analysis. Your role in this study will involve sharing your perspectives on empathy and ICC; for example, what empathy, ICC, and empathy-based ICC means to you, how you teach communication courses, how empathy-based ICC could be taught, available resources to support teaching the concept and recommendations for future educational strategies. The one-on-one interview and focus group (to be contacted later after data analysis to seek clarification and explore new ideas springing up) are estimated to last between 45 to 60 minutes each and will be audio recorded with a digital recorder and transcribed verbatim for accuracy. The interview may be held in-person or virtually via zoom at a time that is convenient for you. If you feel uncomfortable being audio-recorded during a portion of the interview, you may request to have the digital recorder paused. You would also complete a 9-item demographic survey (e.g., age, gender, educational background, religion, etc.) before the interview. Each participant will receive a \$30 electronic visa gift card after consenting to the interview. I will email you a summary of the findings by June 2024, so you can verify or substantiate or ask questions about the study's findings. Upon completion of the study, I will provide you with a final summary of the study's findings via email in December 2024. Please note that not all participants who consent to a follow-up focus group will be contacted. Only those who are required to provide additional information will be invited for the focus group and will be provided an honorarium of \$30 for the extra time after the focus group.

Possible risks and discomfort

There are minimal risks or discomfort to this intersectional constructivist grounded theory study which may be in the form of emotional discomfort during reflection. If you share a difficult clinical or teaching experience where you were challenged in ICC, you may experience some discomfort. If this occurs, you will be given the choice to take a break from the interview, meet at a different time to complete the interview, or withdraw from participating in the study.

However, contacts or suggestions for counselling services post-interview, if needed, include Student counselling services in the various academic institutions, Mobile Crisis Service (204-940-1781), Clinic Crisis Line (204-786-8686), Manitoba Suicide Prevention and Support Line (1-877-435-7170), and First Nations and Inuit Hope for Wellness Services (1-855-242-3310).

Benefits

By participating in this study, you may:

1. reflect on empathy-based ICC education in your nursing program, practice, or ICC encounters while providing or receiving health care.
2. garner a deeper understanding of what empathy-based ICC is in nursing education.
3. recommend strategies to enhance empathy-based ICC in undergraduate nursing education programs.

This information will assist faculty in determining student nurses' empathy-based ICC education needs, communication expectations of culturally patient/ family caregivers, support resources available/ needed, and support curricula revisions.

Cost for participation

There will not be an additional cost for participating. Instead, each participant will be eligible to receive a \$30 electronic visa gift card after consenting to the interview to thank them for their time and contributions to study.

Confidentiality

I will maintain your confidentiality as a research participant by removing all identifiable cues about you from the data and assigning codes to the transcripts. Only I (as the researcher) will know who has participated in the study. While the information collected in the interview and/or focus group will not be shared, it will be stored on a password-protected shared drive set up by IST at the University of Manitoba. The electronic, de-identified data will be kept in that password-protected shared drive for a period of five years following the completion of the study. The database will have firewalls to secure all information and allow access by authorized, password-protected user accounts only, i.e., the researcher and co-advisors. This action will ensure that all study participant information remains confidential and safe. Any electronic copies of the de-identified data will be destroyed by December 2029 using the electronic deletions procedures of the University of Manitoba. Any hard copies of the signed consent forms will be kept in a locked filing cabinet in my home or at the Manitoba Centre for Nursing and Health Research unit for seven years and subsequently disposed of as confidential waste by December 2029. Note that efforts will be made to keep your personal information confidential; however, absolute confidentiality cannot be guaranteed.

Sharing the findings from this study

I will share the findings from this research with you and the nursing faculty such as undergraduate course instructors, students, and faculty leadership at the University of Manitoba, Brandon University, and the University College of the North. You will receive a summary of the initial findings by June 2024 and the final report by email by December 2024. In addition, the results will be presented at nursing, education, or communication conferences and published in a peer-reviewed scientific journal (e.g., Nurse Education Today, the International Journal of Qualitative Methods, Nursing Inquiry, and BMC Nursing).

Questions

If you have any questions regarding this study or your rights as a research participant, please get in touch with the following: Naomi Armah (Phone number - [Redacted], [Redacted]), Dr. Michelle Lobchuk ([Redacted]) or Dr. Christina West ([Redacted]).

Voluntary participation/withdrawal from the study

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time before May 31, 2024, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba Research Ethics Board, Fort Garry campus (REB 1) may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board, Fort Garry campus (REB 1), at the University of Manitoba. If you have any concerns or complaints about this project, you may contact the persons named above or the Human Ethics Coordinator (HEC) at 204-474-7122 or by email: humanethics@umanitoba.ca. A copy of this consent form has been given to you via email for your records and reference.

Participant signature _____ Date _____

Researcher/or Delegate's signature _____ Date _____

Email address to receive summary findings, final summary, and gift card honorarium:

Consent to be contacted for follow-up focus group: Yes _____ No _____

Contact information (e.g., telephone number or email address) _____



**University
of Manitoba** | Rady Faculty of
Health Sciences

College of Nursing
University of Manitoba
89 Curry Place
Winnipeg, Manitoba
Canada R3T 2N2
T: [Redacted]
E: [\[Redacted\]](#)

Appendix E - 2

Letter of Information for Consent to Participate in Research (Nurse Educators) - Updated

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study

Principal Investigator: Naomi Armah, RN, MN, Ph.D. Candidate

University of Manitoba – College of Nursing
89 Curry Place, Winnipeg, Manitoba, R3T 2N2
Tel: [Redacted]
Email: [\[Redacted\]](#)

Research Supervisors: Marnie Kramer, RN, PhD, Assistant Professor

University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Adjunct Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Sponsor: Canadian Institutes of Health Research (CIHR) and College of Nursing Endowment Fund, University of Manitoba

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The study

This research is a Ph.D. dissertation where I (Naomi Armah, Ph.D. candidate) will explore the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. There currently exists a gap in comprehending empathy-based ICC (empathy, ICC, human

diversity, etc., practicing empathy when communicating with culturally diverse populations) in nursing and healthcare delivery. More specific, more studies are needed that contribute knowledge on how to enhance relational practice in healthcare. Knowing the views of key stakeholders like you based on your knowledge, roles, and experiences will enable faculty to use more engaging student-centred approaches to teach relational practice. Findings from the study will contribute to evidence-based literature to guide future practices in empathy-related ICC.

Eligibility criteria

You are eligible to participate if you can speak English, are 18 years or older, reside in Manitoba, are a nurse educator who teaches either a simulation, communication, or culture-related course, or supervise clinical practicum that involves culturally diverse patients and their family caregivers, and provide consent to be recorded during the interview(s).

What will my participation in this study require?

This study is voluntary, and you may choose to withdraw at any time before December 30, 2024, at which time I will have completed the data analysis. Your role in this study will involve sharing your perspectives on empathy and ICC; for example, what empathy, ICC, and empathy-based ICC means to you, how you teach communication courses, how empathy-based ICC could be taught, available resources to support teaching the concept and recommendations for future educational strategies. The one-on-one interview and focus group (to be contacted later after data analysis to seek clarification and explore new ideas springing up) are estimated to last between 45 to 60 minutes each and will be audio recorded with a handheld digital recorder and transcribed verbatim manually by a transcription agency for accuracy. The interview may be held in-person or virtually via University of Manitoba zoom at a time that is convenient for you. If you feel uncomfortable being audio-recorded during a portion of the interview, you may request to have the digital recorder paused. You would also complete a 9-item demographic survey (e.g., age, gender, educational background, religion, etc.) before the interview. Each participant will receive a \$30 electronic amazon gift card after consenting to the interview. I will email you a summary of the findings by December 2024, so you can verify or substantiate or ask questions about the study's findings. Upon completion of the study, I will provide you with a final summary of the study's findings via email in February 2025. Please note that not all participants who consent to a follow-up focus group will be contacted. Only those who are required to provide additional information will be invited for the focus group and will be provided an honorarium of \$30 for the extra time after the focus group.

Possible risks and discomfort

There are minimal risks or discomfort to this intersectional constructivist grounded theory study which may be in the form of emotional discomfort during reflection. If you share a difficult clinical or teaching experience where you were challenged in ICC, you may experience some discomfort. If this occurs, you will be given the choice to take a break from the interview, meet at a different time to complete the interview, or withdraw from participating in the study. However, contacts or suggestions for counselling services post-interview, if needed, include Faculty counselling services in the various academic institutions, Mobile Crisis Service (204-940-1781), Klinik Crisis Line (204-786-8686), Manitoba Suicide Prevention and Support Line (1-877-435-7170), and First Nations and Inuit Hope for Wellness Services (1-855-242-3310).

Benefits

By participating in this study, you may:

1. reflect on empathy-based ICC education in your nursing program, practice, or ICC encounters while providing or receiving health care.
2. garner a deeper understanding of what empathy-based ICC is in nursing education.
3. recommend strategies to enhance empathy-based ICC in undergraduate nursing education programs.

This information will assist faculty in determining student nurses' empathy-based ICC education needs, communication expectations of culturally patient/ family caregivers, support resources available/ needed, and support curricula revisions.

Cost for participation

There will not be an additional cost for participating. Instead, each participant will be eligible to receive a \$30 electronic Amazon gift card after consenting to the interview to thank them for their time and contributions to study. Only those who are required to provide additional information will be invited for the focus group and honorarium will be another \$30 electronic Amazon gift card.

Confidentiality

I will maintain your confidentiality as a research participant by removing all identifiable cues about you from the data and assigning pseudonyms, like 'Abena' instead of your original name or use general descriptors like 'a female nurse educator,' in the transcripts to enhance confidentiality. Any health information you share will be treated as confidential in accordance with the Personal Health Information Act of Manitoba. Only I (as the researcher) and my research supervisors (Dr. Christina West and Dr. Marnie Kramer) will know who has participated in the study. While the information collected in the interview and/or focus group will not be shared, it will be stored on a password-protected shared drive set up by IST at the University of Manitoba. The electronic, de-identified data will be kept in that password-protected shared drive for a period of five years following the completion of the study. The database will have firewalls to secure all information and allow access by authorized, password-protected user accounts only, i.e., the researcher and co-advisors. This action will ensure that all study participant information remains confidential and safe. Any electronic copies of the de-identified data will be destroyed by November 2028 using the electronic deletions procedures of the University of Manitoba. Any hard copies of the signed consent forms will be kept in a locked filing cabinet in my home for five years and subsequently disposed of as confidential waste by November 2028. Note that efforts will be made to keep your personal information confidential; however, absolute confidentiality cannot be guaranteed.

Sharing the findings from this study

I will share the findings from this research with you, MSpace as dissemination of thesis, and the nursing faculty such as undergraduate course instructors, students, and faculty leadership at the University of Manitoba, Brandon University, and the University College of the North. You will receive a summary of the initial findings by December 2024 and the final report by email by February 2025. The first summary is for member checking to know if this summary reflects your thoughts and the experiences you shared during the interview. If we do not hear back from you by January 15, 2025, we would assume you have no additional comments, and the summary reflects your thoughts and shared experiences. In addition, the results will be presented at nursing, education, or communication conferences and published in a peer-reviewed scientific journal (e.g., Nurse Education Today, the International Journal of Qualitative Methods, Nursing Inquiry, and BMC Nursing).

Questions

If you have any questions regarding this study or your rights as a research participant, please get in touch with the following: Naomi Armah (Phone number - [Redacted], [Redacted]), Dr. Christina West ([Redacted]) or Dr. Marnie Kramer ([Redacted]).

Voluntary participation/withdrawal from the study

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time before December 30, 2024, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. For the focus group, your individual response will be retracted from the data if the PI receives the notice before data analysis by December 30, 2024. However, if data analysis has taken place already, the content cannot be retracted. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you want to withdraw from the study, please get in touch with the researcher, Naomi Armah, via email, [Redacted]. As an employee, your participation or discontinuance in the study will not constitute an element of your job performance or evaluation nor will it be part of your personnel record at any of these Institutions.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus, the Brandon University Research Ethics Committee, the University College of the North Research Ethics Board, and the Faculty of Nursing Leadership Team in your institution. If you have any concerns or complaints about this project, you may contact the above-named persons or the Human Ethics Officer at 204-474-7122 or humanethics@umanitoba.ca. A copy of this consent form has been given to you via email for your records and reference.

Participant signature _____ Date _____

Researcher/or Delegate's signature _____ Date _____

Email address to receive summary findings, final summary, and gift card honorarium:

Consent to be contacted for follow-up focus group: Yes _____ No _____

Contact information (e.g., telephone number or email address) _____



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Appendix F

Access Approval Request

Subject: Request for Student Nurses and Nurse Educator Access to Participate in a Research Study

Dear College of Nursing/ Faculty of Health (Nursing),

I write to seek access to potential participants in your institution and department for a research study entitled, **‘Partnering to shape empathy-based intercultural communication in undergraduate nursing education: An intersectional constructivist grounded theory study.’** The study has been approved by the research ethics board in this institution. I have attached the ethics approval letter.

As part of my doctoral dissertation, I will explore the perspectives and roles of nurse educators and student nurses involved with empathy-based intercultural communication (ICC) in undergraduate nursing education and healthcare delivery. Knowing the views of nurse educators on the subject matter, their experiences, and suggestion will enable faculty to develop effective ways to teach empathy-based ICC (empathy, ICC, human diversity, etc., practicing empathy when communicating with culturally diverse populations).

Eligibility to participate includes speaking English, being 18 years or older, residing in Manitoba, being a final year undergraduate nursing student or being a nurse educator who teaches a simulation, communication, or culture-related course, or supervise clinical practicum that involves culturally diverse patients and their family caregivers.

Data collection will commence in June 2023 with an anticipated research study completion in December 2024.

I look forward to your kind consideration and permit.

Thank you.

Kind Regards,

Naomi Armah, PhD Candidate
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba
Phone: [Redacted]
Email: [\[Redacted\]](#)

Appendix G – Recruitment Poster (Nurse Educators & Nursing Students)

INTERCULTURAL COMMUNICATION STUDY





CALL OUT TO NURSE EDUCATORS & 4TH-YEAR UNDERGRADUATE NURSING STUDENTS

STUDY OF EMPATHY-BASED INTERCULTURAL COMMUNICATION IN NURSING EDUCATION

I want to know your views about empathy-based intercultural communication in nursing education and practice, your experiences with culturally diverse clients, and suggestions for future educational strategies.

TO PARTICIPATE OR ASK ANY QUESTIONS KINDLY CONTACT:

Naomi Armah, RN, MN, Ph.D. Candidate
 [Redacted]
 Call/ text: [Redacted]

Research Supervisors:
 Marnie Kramer, RN, Ph.D., Assistant Professor
 University of Manitoba – College of Nursing
 [Redacted]

Christina West, RN, Ph.D., Adjunct Professor
 University of Manitoba – College of Nursing
 [Redacted]

WHO CAN PARTICIPATE?

- Ability to speak English
- 18 years or older
- Resides in Manitoba
- final year undergraduate nursing students or nurse educators teaching either a simulation, communication, or culture-related course or supervising clinical practicum that involves culturally diverse patients and their family caregivers.
- Provides consent to be recorded during the interview(s)



UM | Rady Faculty of Health Sciences

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus, and the College/ Faculty of Nursing Leadership in your institution



DATA COLLECTION

Individual Interview Duration: 45 to 60 minutes (Includes a five-minute demographic survey)

Focus Group Duration: 45 to 60 minutes (Only few participants will be contacted if needed, based on findings)

Honorarium: Amazon gift card

- Nursing students - \$30
- Nurse educators - \$30
- Participation in a focus group will earn an additional \$30 honorarium

Appendix H

Data Collection Instrument - Demographic Survey

Before we proceed to talk about empathy-based ICC when we meet for our interview, I would like to gather some demographic information about yourself. Please leave any questions you are not comfortable answering blank.

1. Age (years): 18 to 20 _____ 21-30 _____ 31-40 _____ 41-50 _____ 51-60 _____ 61 + _____

Prefer not to state: _____

2. Gender: Woman _____ Man _____ Non-binary/Trans/Gender Diverse: _____
Other: _____ (please specify) Prefer not to answer: _____

3a. Were you born in Canada?

Yes: _____ No: _____

3b. If 'No,' where were you born?

4. Is English your second/additional language?

Yes: _____ No: _____

5. Ethnicity: White (Caucasian): _____ Indigenous/ Aboriginal ancestry: _____ Black: _____
South Asian: _____ Filipino: _____ Chinese: _____ Arab/ West Asian: _____
Japanese: _____ Other: _____

5b. If Indigenous, do you self-identify as First Nations, Métis, or Inuit?

6a. Do you have any travel history inside/outside of North America?

Yes: _____ No: _____

6b. If yes, can you expand more on that?

7. Highest level of education received today: High School Diploma: _____

College Diploma: _____ Bachelors: _____ Masters: _____ Doctorate: _____

8. Religion: Roman Catholic: _____ Pentecostal: _____ Lutheran: _____ Greek
Orthodox: _____ Muslim: _____ Buddhist: _____ Sikh: _____ Hindu: _____
Jewish: _____ United Church: _____ Anglican: _____ Presbyterian: _____
Baptist: _____ Other: _____

9a. Do you have any form of disability?

Yes: _____ No: _____

9b. If yes, can you expand more on that? _____

Appendix I

Data Collection Instrument – Semi-structured Interview Guide (Nursing Students)

Introduction to the Interview: Thank you for agreeing to participate in this study. The study aims to understand your views about intercultural communication (ICC) and the potential role of empathy in ICC in your nursing education program and practice. The questions will focus on what you recall about empathy, ICC and communication teaching strategies, personal encounters with culturally diverse patients, and recommendations for future educational strategies.

Note: Prompts will be used when necessary to elicit further discussion.

Grand Tour Question: Could you tell me about a time when you cared for a patient or interacted with a family caregiver from a different culture during clinical practicum, or in simulation?

Grand Tour Question Prompts (not all to be used, but based on the interview conversation some selected prompts may be used):

1. What did you do/say during this care encounter? What was the patient/ caregiver's response? What went well? What did not go well? How did you feel? What did you find yourself thinking during and after the interaction? What influenced how you chose to respond towards that person? Can you tell me more about that experience? What was the most important thing you did to understand that patient? What did you learn from this experience?
2. What factors have influenced your interaction with culturally diverse patients? [age, gender, color, race/culture, position as a student nurse] What are your views on how gender, social status, race, religion, power might affect your ability to understand diverse patients when communicating with people from diverse backgrounds?
3. When you reflect on our conversation about your experiences with ICC, what would you say ICC means to you? What do you think it should feel like to you? What do you think it should feel like to the patient?
4. What is most important for student nurses to learn about in relation to ICC?

Mini Tour Question: Tell me about an experience where your instructor supported you in an ICC interaction with a patient or family caregiver.

Prompts:

5. What did they do/say? What did you find yourself thinking? How did you feel when your instructor showed they understood you and respected your viewpoint? What do you think students most need for instructors when they are learning about ICC?

Mini Tour Question: Tell me about an experience where you experienced or are aware of other individuals' (e.g., peers) experiences with racism, marginalization or discrimination in your education or practice?

Prompts:

6. How did it make you feel? What did you find yourself thinking? How might these experiences impact students/instructors' experiences of providing ICC in their practice?
7. Tell me about a practice experience you might have had working with a patient who had experienced racism, marginalization, or discrimination in healthcare. How did it make you feel? What did you find yourself thinking?

8. How did that patient's experience with racism, marginalization and/or discrimination impact your practice of ICC and the patient/family caregiver's response to you?

Mini Tour Question: Can you tell me how your nursing education has influenced your interaction with culturally diverse patients?

Prompts:

9. What are your thoughts on what your instructors and the College of Nursing might do differently to help you develop ICC knowledge and skills for practice? What is missing in your education? What needs to be included to improve ICC in nursing education and practice?

Conclusion:

10. Was there anything that surprised you in our conversation today?

11. Is there anything else you would like to tell me about your experiences with ICC in education or practice?

Other Prompts: These questions will be asked if the participant does not address empathy in the responses to the questions above.

1. What do you consider to be most important about empathy in your practice with culturally diverse patients and family caregivers? Why?

Appendix J

Data Collection Instrument – Semi-structured Interview Guide (Nurse Educator)

Introduction to the Interview: Thank you for agreeing to participate in this study. The study aims to understand your views about intercultural communication (ICC) and the potential role of empathy in ICC in your nursing education program and practice. The questions will focus on what you recall about empathy, ICC and communication teaching strategies, personal encounters with culturally diverse patients, and recommendations for future educational strategies.

Note: Prompts will be used when necessary to elicit further discussion.

Grand Tour Question: Could you tell me about a time when you worked with a student caring for a patient or who interacted with a family caregiver from a different culture during clinical practicum, or in simulation? Alternatively, you might want to talk about an experience you had teaching about ICC in one of your courses.

Grand Tour Question Prompts (not all to be used, but based on the interview conversation some selected prompts may be used):

1. What did you/they do/say? What was the patient/ caregiver's response? What went well? What did not go well? What were your thoughts and feelings about/ during the interaction? Can you tell me more about that experience? What role did you play in that interaction? What influenced your decision/ directive of how the student facilitated understanding the patient or family caregiver in the moment with that person?
2. What factors have influenced your interaction with culturally diverse patients? [age, gender, color, race/culture, position as a nurse or clinical or academic nursing instructor, etc.] / What do you view as important when teaching about understanding the viewpoints of patients from other cultures?/ What are your views on how gender, social status, race, religion, power, etc. might affect your ability to communicate and understand patients from diverse backgrounds?
3. When you reflect on our conversation about your experiences with ICC in your teaching practice, what would you say ICC means to you? How does it feel?/ How do you want it to feel?/ What do you think it should feel?

Mini Tour Question: Tell me about an experience you had with racism, marginalization, or discrimination in your teaching or clinical practice?

Prompts:

4. How did it make you feel? How did that experience with racism, marginalization and/or discrimination impact your teaching ICC?
5. I am interested in knowing about your experiences working with patients or students who experienced racism, marginalization, or discrimination? Tell me more about your thoughts on how experiences of racism, marginalization and/or discrimination might impact the student's practice of ICC? How did it make you feel? How did that experience with racism, marginalization and/or discrimination impact your teaching ICC?

Mini Tour Question: Can you tell me how your nursing knowledge or experience has influenced your interaction with or teaching about culturally diverse patients?

Prompts:

6. What are your thoughts on what instructors, or the College of Nursing might do differently to help nursing students develop ICC knowledge and skills for practice? What is missing in their education? What needs to be included to improve ICC in nursing education and practice?

Conclusion

7. Was there anything that surprised you in our conversation today?

8. Is there anything else you would like to tell me about your experiences with ICC in education or practice?

Other Prompts: These questions will be asked if the participant does not address empathy in the responses to the questions above.

1. What do you consider to be most important about empathy in the context of teaching and practicing ICC? Why?

Appendix K

Data Collection Instrument – Semi-Structured Focus Group Guide (Nurse Educator)

Introduction to the Interview: Thank you for agreeing to participate in this focus group. The study seeks to understand your perspectives on intercultural communication (ICC) and the potential role of empathy in ICC within your nursing education program and practice. The focus group questions will aim to clarify and expand upon ideas gathered from the individual interviews concerning your recollections of empathy, ICC, communication teaching strategies, personal experiences with culturally diverse patients, and recommendations for future educational approaches.

Note: Prompts will be used when necessary to elicit further discussion.

1. When assigning students to culturally diverse patients, what strategies do you use to guide your decision-making?
2. How would you distinguish ICC from empathy-based ICC? How do you think nurses can display empathy during an intercultural communication encounter?
3. My preliminary findings indicate that the themes that are central to developing empathy-based ICC include restructuring curriculum content and activities, recapitalizing internal and external influences on intercultural encounters, recognizing humans and being human, and partnership (see a map of these themes attached. Each theme will be explained to focus group participants based on the preliminary findings). What are your thoughts on these themes, and do any of them require more clarity in their description?
4. What supports are needed to enhance nurse educator's ICC competency level?
5. My preliminary findings emphasized the importance of nurse educators' collaborating with nursing students, culturally diverse patients, and other nurse educators.

How should educators approach partnerships with nursing students to develop empathy-based ICC? How should educators teaching theory courses approach partnerships with clinical/ simulation educators to develop empathy-based ICC? How should educators approach partnerships with culturally diverse patients to develop empathy-based ICC?

Appendix L

Concept Map for Empathy-based Intercultural Communication Focus Group Discussion

Developing empathy-based ICC Skills and Knowledge	Restructuring curricula content and activities	Teaching empathy and ICC basics
		Employing active teaching and learning strategies
		Diversifying teaching resources
	Recognizing humans and being human	Understanding the patient's context and world views
		Building trusting relationship
	Partnership	Nurse educator - Nurse educator
		Nurse educator - nursing student
		Nurse educator - culturally diverse patient
	Recapitalizing internal and external influences on intercultural encounters	Genetic influences
		Environmental influences
		Personal influences

Appendix M

Guide for Memo Writing

Reflexive Memo: describes the researcher's positionality, thoughts before, during, and after the interview, and how the researcher's marginalization and privilege experiences might be influencing or opening up important aspects of data analysis (Charmaz, 2014).

1. Describe the interview location and the interview process.
2. Document key statements that depicted how the participant experienced or taught empathy-based ICC in school, the clinical practicum, and the hospital or clinic.
3. Identify what worked well in the interview process and what could be enhanced in future interviews.
4. What aspects of the participant's experiences were similar or different to mine?
5. How did my own experiences of marginalization and privilege influence the interview process? What did I find myself thinking, feeling and/or behaving in relation to this?

Operational Memo: reports the research process steps, methodological dilemmas (Charmaz, 2014) and reasons for decisions and actions (Birks et al., 2008; Levitt, 2021).

1. What decisions were made during the research process?
2. What challenges were encountered in different phases of the research process?
3. How were decisions made in the study process during challenging periods?
4. What were my reasons for the decisions made and actions took across the research process?

Analytical Memo: describes how the data was examined during the coding process, explained, and conceptualized (Birks et al., 2008; Charmaz, 2014; Levitt, 2021).

1. What are some of the analytical thoughts and reflections that are occurring during the coding process?
2. How are social processes, context, social inequity, structural, political, and representation power relations, complexity in relationships, time and location showing up in the process of data analysis?
3. What categories are starting to be identified? What are some of the important aspects of those categories?
4. What categories and codes are important to the developing theoretical understanding of empathy-based ICC? What is the data saying to me about those codes and categories?
5. What am I learning from the data? How do different aspects of the data fit together? What are the congruences and incongruences?
6. What parts of the data are making me feel uncomfortable, or challenging my understanding of empathy-based ICC in some way?
8. What questions remain for me in the process of data analysis?
9. How can I improve the interviews I am conducting?



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Appendix N

Confidentiality Agreement for Focus Group Participant

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing: An Intersectional Constructivist Grounded Theory Study

I understand that the discussions that occur during the focus group, of which I am a participant, are confidential. I am bound to uphold the confidentiality of the research process. This means that I will keep confidential the identities of fellow focus group participants and will not divulge the content of any focus group discussions to anyone who has not participated in the discussion.

Focus Group Participant _____

Witnessed by Researcher _____

Date _____



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Appendix O

Email for Member Checking

Subject: Request to review emerging findings - Partnering to shape empathy-based intercultural communication in undergraduate nursing education study

Dear Research Participant,

Thank you for participating in the research study entitled, **‘Partnering to shape empathy-based intercultural communication in undergraduate nursing education: An intersectional constructivist grounded theory study’** few months ago.

We have completed data analysis. Please attached find a summary of the emerging theoretical categories and their supporting quotes.

Kindly review and let us know by email or post mail if this summary reflects your thoughts and the experiences you shared by January 15, 2025. What do you think we missed or needs revision? You can add additional comments to each section. If we do not hear back from you by January 15th, we would assume you have no additional comments, and the summary reflects your thoughts and shared experiences.

Please email your feedback to Naomi Armah at [\[Redacted\]](#) or send by post mail to Naomi Armah, College of Nursing, University of Manitoba, 89 Curry Place, Winnipeg, Manitoba, R3T2N2.

Thank you.

Kind Regards,

Naomi Armah, RN, MN, PhD Candidate
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba
Phone: [Redacted]

Email: [\[Redacted\]](#)

Research Supervisors:

Marnie Kramer, RN, PhD, Assistant Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Adjunct Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)



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Appendix P

Email for Final Summary Report

Subject: Summary Report - Partnering to shape empathy-based intercultural communication in undergraduate nursing education study

Dear Research Participant,

Thank you for participating in the research study entitled, **‘Partnering to shape empathy-based intercultural communication in undergraduate nursing education: An intersectional constructivist grounded theory study’** few months ago.

You requested for a summary report which I have attached to this email. Your contribution is very much appreciated as without you, this study would never have been a reality. Please let me know if you have any further comment.

Thanks once again and have a wonderful week.

Kind Regards,

Naomi Armah, RN, MN, PhD Candidate
College of Nursing, Rady Faculty of Health Sciences
University of Manitoba
Phone: [Redacted]

Email: [\[Redacted\]](#)

Research Supervisors:

Marnie Kramer, RN, PhD, Assistant Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)

Christina H. West, RN, PhD, Adjunct Professor
University of Manitoba – College of Nursing
Email: [\[Redacted\]](#)



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Appendix Q

Confidentiality Agreement for Transcriptionist

Title of Study: Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing: An Intersectional Constructivist Grounded Theory Study

I, _____, a transcriptionist, agree to maintain full confidentiality of all research data received from the research team related to this research study.

Furthermore, I agree that:

1. I will hold in strictest confidence the identity of any individual that may be revealed during the transcription of interviews or in any associated documents.
2. I will not make copies of any audio-recordings or other research data, unless specifically requested to do so by the principal investigator.
3. I will store all study-related data in a safe, secure location as long as they are in my possession. All audio recordings will be stored in an encrypted format.
4. All data provided or created for purposes of this agreement, including any back-up records, will be returned to the principal investigator researcher, and permanently deleted at the direction of the principal investigator. When I have received confirmation that the transcription work I performed has been satisfactorily completed, any of the research data that remains with me will be returned to the researcher or destroyed, pursuant to the instructions of the researcher.
5. I understand that the University of Manitoba has the right to take legal action against any breach of confidentiality that occurs in my handling of the research data.

Transcriber's name (printed) _____

Transcriber's signature _____

Date _____

Appendix R

Ethics Approval Certificate for University of Manitoba (2023)



**University
of Manitoba**

Research Ethics and Compliance

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

PROTOCOL APPROVAL

Effective: July 25, 2023

Expiry: July 24, 2024

Principal Investigator:	Naomi Armah
Advisor(s):	Michelle Lobchuk, Christina West
Protocol Number:	HE2023-0164
Protocol Title:	<i>Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study</i>

Merissa Daborn, Acting Chair, REB1

Research Ethics Board 1 has reviewed and approved the above research. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*- TCPS 2 (2022).

This approval is subject to the following conditions:

- i. Approval is granted for the research and purposes described in the protocol only.
- ii. Any changes to the protocol or research materials must be approved by the HEO before implementation.
- iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.
- iv. This approval is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.
- v. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.
- vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans* [Ethics of Research Involving Humans](#) policies and procedures.

Appendix R - 1

Ethics Renewal Approval Certificate for University of Manitoba (2024)



**University
of Manitoba**

Research Ethics and Compliance

Human Ethics - Fort Garry
208-194 Dafoe Road
Winnipeg, MB R3T 2N2
T: 204 474 8872
humanethics@umanitoba.ca

RENEWAL APPROVAL

Effective: July 3, 2024

New Expiry: July 24, 2025

Principal Investigator:	Naomi Armah
Advisor(s):	Michelle Lobchuk, Christina West
Protocol Number:	HE2023-0164
Protocol Title:	<i>Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study</i>

Human Ethics Office as designated by , REB1

Research Ethics Board 1 has reviewed and renewed the above research. The Human Ethics Office is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022)*.

This approval is subject to the following conditions:

- i. Any changes to this research must be approved by the Human Ethics Office before implementation.
- ii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.
- iii. This renewal is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.
- iv. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.

Appendix R - 2

Ethics Renewal Approval Certificate for University of Manitoba (2025)



Human Research Ethics - Fort Garry
 66 Chancellors Circle
 Winnipeg, MB R3T 2N2
 humanethics@umanitoba.ca

RENEWAL APPROVAL

Effective: August 19, 2025

New Expiry: July 24, 2026

Principal Investigator:	Naomi Armah
Advisor(s):	Marnie Kramer
Protocol Number:	HE2023-0164
Protocol Title:	<i>Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study</i>

Office of Human Research Ethics as designated by REB1

Research Ethics Board 1 has reviewed and renewed the above research. The Office of Human Research Ethics (OHRE) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022)*.

Please note the following important information about your renewal approval:

- i. Any changes to the protocol or research materials must be approved by the OHRE **before implementation**.
- ii. Any **deviations** to the research or **adverse events** must be reported to the OHRE immediately through an **REB Event**.
- iii. This renewal is valid for **one year only**. A Renewal Request must be submitted and approved prior to the above expiry date.
- iv. A **Protocol Closure** must be submitted to the OHRE when the research is complete or if the research is terminated.

Appendix R – 3

Ethics Renewal Approval Certificate for University of Manitoba (2026)



Human Research Ethics - Fort Garry
 66 Chancellors Circle
 Winnipeg, MB R3T 2N2
 humanethics@umanitoba.ca

RENEWAL APPROVAL

Effective: July 28, 2026

New Expiry: July 24, 2027

Principal Investigator:	Naomi Armah
Advisor(s):	Marnie Kramer
Protocol Number:	HE2023-0164
Protocol Title:	<i>Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study</i>

Office of Human Research Ethics as designated by REB1

Research Ethics Board 1 has reviewed and renewed the above research. The Office of Human Research Ethics (OHRE) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022)*.

Please note the following important information about your renewal approval:

- i. Any changes to the protocol or research materials must be approved by the OHRE **before implementation**.
- ii. Any **deviations** to the research or **adverse events** must be reported to the OHRE immediately through an **REB Event**.
- iii. This renewal is valid for **one year only**. A Renewal Request must be submitted and approved prior to the above expiry date.
- iv. A **Protocol Closure** must be submitted to the OHRE when the research is complete or if the research is terminated.

Appendix S

Ethics Approval Certificate for Brandon University (2023)



August 10, 2023

Ms. Naomi Armah
c/o Dr. Michelle Lobchuk
Helen Glass Centre for Nursing
University of Manitoba
213 - 89 Curry Place
Winnipeg MB R3T 2N2

Dear Ms. Armah,

RE: Brandon University Research Ethics Application - #23221

The ethics application for the project entitled “**Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study**”, file #23221, was reviewed under the Multi-Site/Multi-Jurisdiction review procedures as outlined in the Brandon University Research Ethics Committee (BUREC) Policies and Procedures. I am pleased to report the approval of this ethics application.

Enclosed is the Ethics Certificate for this project. **Please note that the first Annual Progress Report is due August 10, 2024.**

As per *BUREC Policies and Procedures*, Annual Progress Reports and a Final Report at the conclusion of the project are requirements for the continuing approval of ethics applications. In addition, ethics approval is granted for a maximum of five years. If this project is continuing beyond that time, a new application is required prior to the expiration date. For more information and for access to the Annual Progress and Final Report forms, please visit www.brandonu.ca/burec.

If you have any questions or concerns, please contact Mrs. Shannon Downey, Executive Officer to the Provost & Vice-President (Academic) and Research Ethics Officer, at (204) 727-9712 or downeys@brandonu.ca.

I wish you success in your research endeavour.

Sincerely,

Dr. Rhonda Hinthner
Chair, Brandon University Research Ethics Committee (BUREC)

smd

Enclosure

C Dr. Michelle Lobchuk, University of Manitoba
Dr. Christina West, University of Manitoba

Appendix S – 1

Ethics Renewal Approval Certificate for Brandon University (2024-2026)



ETHICS CERTIFICATE FOR RESEARCH INVOLVING HUMANS

BRANDON UNIVERSITY RESEARCH ETHICS COMMITTEE (BUREC)

The Brandon University Research Ethics Committee (BUREC) has reviewed and approved the following ethics proposal in accordance with the current Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2-2022), the Brandon University Policy on Research Involving Humans, and the Brandon University Research Ethics Committee (BUREC) Policies and Procedures.

Title of Project:	Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study
Principal Investigator:	Ms. Naomi Armah, University of Manitoba
Co-investigators:	
Faculty Supervisor:	Dr. Christina West, University of Manitoba Dr. Marnie Kramer University of Manitoba
Research Ethics File #:	23221
Date of Approval:	August 10, 2023
Ethics Expiry Date:	August 10, 2028

Conditions of Approval:

This approval is subject to adherence to the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures*, including the following conditions:

1. Approval is granted only for the research and purposes as described in the ethics application.
2. Ethics Certification is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports and a Final Report at the conclusion of the project. Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification and/or refusal to review and approve any new research ethics submission. For more information, please refer to the *Brandon University Research Ethics Committee (BUREC) Policies and Procedures*, and the *Brandon University Research Ethics Committee (BUREC) Non-Compliance Policy and Procedures*.
3. All changes made to the approved protocol must be reported to the BUREC and an Amendment Application may be required prior to implementation. See *Brandon University Research Ethics Committee (BUREC) Policies and Procedures* for more detail.
4. Any deviations to the research or unanticipated issues/events must be reported to the BUREC as soon as possible. For more information, please refer to the *BUREC Reporting Unanticipated and Events Issues Standard Operating Procedure*.

For information about Brandon University Research Ethics policies and procedures in relation to this project or in general, please visit www.brandonu.ca/burec or email burec@brandonu.ca.

Chair, Brandon University Research Ethics Committee (BUREC)

Appendix T

Ethics Approval Certificate for University College of the North (2023)



The Pas Campus
 436-7th Street
 PO Box 3000
 The Pas, MB R9A 1M7
 204.627.8500
 Toll Free: 1-866-827.8500

Thompson Campus
 504 Princeton Drive
 Thompson, MB R8N 0A5
 204.677.6450
 Toll Free: 1.866.677.6450
WWW.UCN.CA

PROTOCOL REFERENCE # UCN 2023/24-EXT-01

September 19, 2023

Naomi Armah (Principal Investigator)
 College of Nursing
 University of Manitoba
 Winnipeg, MB
 By email: [REDACTED]

Dear Ms. Naomi Armah,

Re: Your research protocol titled: "Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study"

ETHICS APPROVAL

Approval Date: September 19, 2023
Expiry Date: September 19, 2024

REB writes to inform you that your ethics application relating to the above protocol has been approved.

Please contact REB and/or complete the renewal form (available at <https://ucn.ca/research/>) no fewer than six weeks before the expiry date of September 19, 2024 if you plan to involve human participants in your research past that date.

Any substantive changes in methodology or project design must be reviewed and approved by the UCN REB prior to implementation.

Adverse events (unanticipated negative consequences or results affecting participants) must be reported to the UCN REB Chair, as soon as possible and in any event, no more than 3 days subsequent to their occurrence.

Best wishes on your research endeavour.

Yours sincerely,

Abayomi Orededbe, PhD, CPA, CMA
 Chair, UCN REB

Regional Centres

Flin Flon, Churchill, Swan River, Pimicikamak (Cross Lake), Tataskweyak (Spill Lake), Chemawawin (Easterville), Nisichawayasihk (Nelson House), Bunibonibee (Oxford House), Mathias Colomb (Pukatawagan), Misipawistik (Grand Rapids), Norway House, and St. Theresa Point

Appendix T – 1

Ethics Renewal Approval Certificate for University College of the North (2024)



The Pas Campus
436-7th Street
PO Box 3000
The Pas, MB R9A 1M7
204.627.8500
Toll Free: 1-888-627.8500

Thompson Campus
504 Princeton Drive
Thompson, MB R8N 0A5
204.677.6450
Toll Free: 1.888.677.6450
WWW.UCN.CA

PROTOCOL REFERENCE # UCN 2023/24-EXT-01

September 19, 2024

Naomi Armah (Principal Investigator)
College of Nursing,
University of Manitoba
Winnipeg, MB
By email: [REDACTED]

Dear Ms. Naomi Armah,

Re: Your research protocol titled: "Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study"

ETHICS APPROVAL

Initial Approval Period: September 19, 2023 – September 19, 2024
Renewal # 1 Period: September 19, 2024 – September 19, 2025

REB writes to inform you that your ethics application relating to the renewal of the above protocol has been approved.

Any substantive changes in methodology or project design must be reviewed and approved by the UCN REB prior to implementation.

Adverse events (unanticipated negative consequences or results affecting participants) must be reported to the UCN REB Chair, as soon as possible and in any event, no more than 3 days subsequent to their occurrence.

Please contact REB and/or complete the renewal form (available at: <https://www.ucn.ca/research/>) no fewer than six weeks before the expiry date of September 19, 2025 if you plan to involve human participants in your research past that date.

Best wishes on your research endeavour.

Yours sincerely,

Abayomi Orededbe, PhD, CPA, CMA
Chair, UCN REB

Regional Centres

Flin Flon, Churchill, Swan River, Pimliskamuk (Cross Lake), Tataskweyak (Split Lake), Chemawawin (Easterville), Nisichawayasihk (Nelson House), Bunibonibee (Oxford House), Mathias Colomb (Pukatawagan), Mispawistik (Grand Rapids), Norway House, and St. Theresa Point

Appendix T – 2

Ethics Renewal Approval Certificate for University College of the North (2025)



University College of the North

THE PAS CAMPUS
P.O. Box 3000,
The Pas, MB R9A 1M7
1.866.627.8500

THOMPSON CAMPUS
55 UCN DRIVE,
Thompson, MB R8N 1L7
1.866.677.6450

UCN.CA

PROTOCOL REFERENCE # UCN 2023/24-EXT-01

September 19, 2025

Dr. Marnie Kramer, Dr. Christina West and Ms. Naomi Armah
College of Nursing,
University of Manitoba
Winnipeg, MB
Email: [REDACTED]

Dear Dr. Kramer, Dr. West and Ms. Armah:

Re: Your research protocol titled: "Partnering to Shape Empathy-Based Intercultural Communication in Undergraduate Nursing Education: An Intersectional Constructivist Grounded Theory Study"

ETHICS APPROVAL

Initial Approval Period:	September 19, 2023 – September 19, 2024
Renewal # 1 Period:	September 19, 2024 – September 19, 2025
Renewal # 2 Period:	September 19, 2025 – September 19, 2026

The UCN REB writes to inform you that your ethics application relating to the renewal of the above protocol has been approved.

Any substantive changes in methodology or project design must be reviewed and approved by the UCN REB prior to implementation.

Adverse events (unanticipated negative consequences or results affecting participants) must be reported to the UCN REB Chair as soon as possible, and in any event, no more than 3 days subsequent to their occurrence.

Please contact the UCN REB and/or complete the renewal form available at <https://www.ucn.ca/research/> no fewer than 6 weeks before the expiry date if you plan to involve human participants in your research past that date.

Best wishes on your research endeavour.

Yours sincerely,

[REDACTED]

Abayomi Orededbe, PhD, CPA, CMA
Chair, UCN REB