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## TRANSFORMING GLOBAL LEADERSHIP SKILLS IN GRADUATE NURSING PROGRAMS USING AN INTERCULTURAL SETTING AND A CASE STUDY ON REFUGEES

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### Abstract

Transformation of our world to a more just and equitable system will require a fundamental shift from a domination approach to a partnership-based approach. In nursing and health care, this shift will require a global perspective with culturally humble providers and systems. In this article we share the experience of our international course *Leadership in Nursing - a Global Approach*, a joint project of the University of Iceland Faculty of Nursing and the University of Minnesota School of Nursing. This collaborative immersion course offers a model of global partnership-based health-care education. International partnership-based collaboration in nursing and health-care education prepares students and faculty to take an active role in transforming global systems.

*Keywords:* cultural humility; global leadership; nursing; partnership

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### INTRODUCTION

Our world is going through a fundamental transformation identified as a *macroshift*, which is described as a reality shift that includes the way we relate to each other, to nature, and to the whole cosmos (Laszlo, 2008). The authors of this article believe that the core of the macroshift is the move from a domination approach in whatever concerns life and living to a partnership-based approach (Eisler & Potter, 2014).

In health care, the wave of transformation from the hierarchical domination way of providing services to partnership and equality is manifest in various theories and models emphasized in the last few decades. The knowledge about teamwork and authentic leadership in health care tells us that emphasis on trust, mutual respect, and true collaboration within and between health-care professions, and between health-care professionals and patients, is one indication of this macroshift (Pearson et al., 2006; Salas et al., 2005; World Health Organization (WHO), 2011; Xyrichis & Ream, 2008). The movement to patient-centered care and person-centered care is another indication of the shift to a partnership-based model in which each person receives care based on their unique needs, in a respectful and collaborative process between the patient and their significant others, and health-care providers, taking into account the person's social context (American Geriatrics Society Expert Panel on Person-Centered Care, 2016; McCormack et al., 2017).

Traditionally, health-care services have been male-dominated and paternalistic, with unequal valuing of the different professions (WHO, 2019). Even though most of the health-care workforce is female, health care services are predominantly managed, led, and represented by males, with female professionals hitting a glass ceiling in their career development (Penfold et al., 2019; Vong et al., 2019; WHO, 2019). Global gender inequality in health care includes both power and pay. Most leadership positions in health care today are still occupied by men; the work of women in health care is frequently underpaid or unpaid (WHO, 2019). Although changes are seen in the direction of partnership-based care, the paternalistic model is still active in the relationship between health-care professionals and patients. However, there is a loud appeal for more respect for patients and for shared decision making (Brown & Salmon, 2019; Sánchez-Izquierdo et al., 2019; Subramani, 2020).

As predicted by Ferguson (1997) more than two decades ago, the roles of health-care professionals and of patients are changing. Knowledge is no longer owned by a few professionals, but has become publicly available to anyone with the technology to access the Internet. This transformation requires a global approach (Independent

Group of Scientists appointed by the Secretary-General, 2019; Rosa, 2017) and careful attention to development of partnership-based health care (Eisler & Potter, 2014). Although access to information may make patients feel more empowered, old relationship patterns between providers and patients can still orient toward hierarchies of domination. Likewise, old patterns that rank knowledge from one nation as more important than knowledge from another nation need to be challenged.

## **GLOBAL NURSING AND LEADERSHIP**

Global nursing includes promoting planetary health and justice for all people through its evidence-based nursing process. It is ethical and shows respect to all humans, their rights and diversity. Global nursing takes into account all aspects of health-care services and science, whether individual- or population-based care, leadership, research, advocacy, or policy development, taking social determinants of health and partnership-based care into consideration (Wilson et al., 2016). The roots of global nursing lie in the work of Florence Nightingale and the foundations of professional nursing that she laid; healing, leadership, and global action (Dossey et al., 2005). Global nursing serves within the sphere of global health, striving for the greater good of communities and focusing on health issues that reach far beyond national borders. Global health can be seen as a common denominator of public health and international health. The importance of global nursing within the global health movement has been emphasized in recent years with special initiatives by leading nursing organizations such as the Sigma Theta Tau International Nursing Honor Society's Global Advisory Panel on the Future of Nursing (Sigma Theta Tau International, 2017) and the The International Council of Nurses (ICN) Global Nursing Leadership Institute, whose purpose is to strengthen global nursing leadership (ICN, n.d.). The importance of global leadership in nursing is further emphasized in the recently published WHO (2020) State of the World's Nursing 2020 Report; among other recommendations to strengthen nursing worldwide, the development of global partnership skills in nursing is recommended.

A global leadership role is a lifelong process, as described by six experienced nurse leaders from six different countries who participated in a year-long dialogue described in an article in *International Nursing Review*, the official journal of the ICN (Buckner et al., 2014). From their dialogue six themes were identified: creativity, change, collaboration, community, context, and culture, indicating core elements of global nursing leadership across countries.

Traditionally, the ability to truly communicate cross-culturally has been identified as cultural competence. In recent years however, the term cultural competence has been criticized as based on inequality and the assumption that one can become an expert on another group's culture. Health care professionals are now encouraged to use the term cultural humility (Foster, 2009; Miller, 2009), which is seen as a lifelong, dynamic process characterized by openness, self-awareness, egolessness, supportive interaction, and self-reflection and critique (Foronda et al., 2016). In this article we use the term cultural humility to refer to the ability to purposefully and respectfully think about, view, approach, and act towards and with people of other cultures.

According to Rosa and Morin (2017), the foundation for global nursing is evolutionary leadership. Evolutionary leadership is in concordance with partnership-based practice (Eisler & Potter, 2014) as well as with cultural humility (Foronda et al., 2016), as it requires openness and self-awareness, self-renewal and self-reflection, willingness to grow, respect for different views and opinions, ethical and meaningful partnership, truthseeking, and transforming of self and systems (Rosa & Morin, 2017).

The purpose of this article is to present the international course *Leadership in Nursing - a Global Approach*, a joint project of the University of Iceland (UI) Faculty of Nursing and the University of Minnesota (UMN) School of Nursing, as an exemplar of global education from a partnership perspective. The two universities have a longstanding formal relationship in the health-care sciences, including nursing.

In the spring of 2017, the course instructors assigned a case study of the Syrian refugee crisis. For an entire week, students worked in mixed groups, then presented evidence-based solutions. This learning experience not only gave students the opportunity to practice their intercultural skills through their collaboration with each other, but also allowed them to apply their learning to a current real-life challenge in which a global approach must be used to reach an optimal outcome.

## **THE COURSE**

The course *Leadership in Nursing - A Global Approach* described in this article took place in May 2017 for four consecutive days at the University of Iceland. Participants were Doctor of Nursing Practice (DNP) students in Health Innovation and Leadership from UMN and Master of Nursing Administration students from UI. Although hosted at UI, the course is a joint project coordinated and taught by faculty from both schools. This was the third year the course was offered, but the first time a case study with refugees was assigned.

### **Course Objectives and Structure**

The objectives of the course are to enrich students' knowledge, understanding, and skills in leadership and innovation in nursing locally and internationally; and to train students in analyzing, prioritizing, and promoting emerging topics in nursing and health care globally.

The first day of the course is used for students to get to know each other and to get acquainted with the case and the requirements of the assignment. The rest of the days started with each person sharing one valuable lesson learned from the previous day.

Students were assigned to small groups of about six students. Every day, students worked on the assignment in their groups as well as participating in common activities. Students were encouraged to keep a log during the course, to jot down

ideas, thoughts, and reflections on their cultural immersion experiences. The whole student group met with faculty at the beginning of each day, at lunchtime, and at the end of each day. During these three times, practical issues were addressed, and the day's schedule was reviewed.

### **Faculty and Students**

Two faculty members, one from each school, coordinated the course and were in charge of course development, logistics, instructions, assignments, and grading. In addition to the course coordinators, two additional faculty members from UMN participated in the four-day event.

The design of this course would not have been possible without a partnership approach. When global relations are approached using domination, both parties can feel threatened and disrespected for their unique contributions. A partnership approach encourages mutual respect and a deep commitment to creating processes that align with both cultures (Adams et al., 2016; Garner et al., 2009).

The total number of students was 39, 13 from UMN and 26 from UI. Students were divided into six groups, each of which included students from both schools. Communication was in English, so the Icelandic students helped translate for each other when needed. Each group had a dedicated work area within a classroom where they could leave their notes and material from one day to another.

### **Course Assignment: The Refugee Case Study**

The goals of this global leadership course include educating students in intercultural skills based on cultural humility elements (Foronda et al., 2016) and partnership-based care (Eisler & Potter, 2014). The global case study is therefore a very effective way for students to apply both global thinking and partnership theory to a global challenge.

Every year, universities around the United States form teams of students who compete in a Global Health Case Competition promoted by Emory University Global

Health Institute (2020). Each year there is a unique, highly detailed case written and prepared for these teams. The teams then have one week to work together to develop a solution to the challenge. The theme of the 2016 Global Health Case Competition was the refugee crisis in Syria. The competition was based on a case study originally developed by the University of Virginia Center for Global Health Case Writing Team. The case was used as a resource for our course after obtaining permission from the University of Minnesota Center for Global Health and Social Responsibility.

The groups in our course each received a booklet describing a fictional but realistic case, including a summary of the current situation in Syria, Lebanon, Jordan, Turkey, Iraq, and Egypt, health care in Syria, polio globally and in Syria specifically, health care across regional refugee settlements, women's health, and changing social practices. According to the case description, the United Nations High Commissioner for Refugees had allocated \$25 million USD for creating innovative, sustainable interventions to meet the health and well-being needs of the growing number of refugees in the region (The UVA Center for Global Health Case Writing Team, 2014). Each of the six groups, acting as a non-governmental agency (NGO), had to come up with an idea for an intervention. They were encouraged to be creative in their work, but needed to support their idea and proposed intervention with evidence and valid references.

On the fourth day, each group presented their intervention proposal to the faculty, serving as a standing committee from the United Nations evaluating each proposal and identifying which NGO should receive the funding.

Faculty members quickly learned that the Icelandic students did not feel comfortable with a competition structure. Those students wanted to work in teams, but they did not want to have groups compete. This became a conversation topic about which students mused over why the Icelanders were uncomfortable with competition and the American students were so used to it. Right away this shift in thinking and the consequent restructuring began to model a partnership approach

to global challenges. Too often, nonprofits and aid organizations must compete for limited funds. We wondered what the outcome might be if the global health community begins to shift from rigid hierarchies and scarcity thinking to mutual respect and partnership.

### **Course Evaluation**

Course evaluation included day-to-day debriefings of students and faculty and a whole-group dialogue in a salon-like structure during the final hour of the week, as well as a written anonymous student survey at the end of the course. These discussions generated rich qualitative data. The daily debriefings provided the opportunity to reflect, to learn from each other, and to address promptly any issues that needed to be clarified. The final salon-like dialogue gave everyone the opportunity for non-judgmental, mutual exchange of thoughts, feelings, and learning experiences (Bohm, 2004; Manthey, n.d.).

The written anonymous survey provided quantitative data for the evaluation; it had eight questions using a four-point Likert-type scale ranging from “poor” (1) to “very good” (4), asking students to rate the following factors: course design, course content, content of teacher presentation, course administration, course material, student assignment, field trips, and the course in general. In addition, there were two open-ended questions, one asking students what they liked the best about this course, and what specifics they would change if they were teaching this course.

## **OUTCOMES**

### **Daily Briefings**

The students found dialogue time to be one of the most powerful aspects of this course. Four themes emerged during the daily debriefings: the physical environment, personal health care, the system of health care, and high-profile media topics.



**The physical environment.** For the U.S. students, going on tours and getting acquainted with the country and history at the beginning of their stay in Iceland gave them an appreciation for the fascinating topology of the Geysir geothermal area, volcanos, glaciers, and streams. Every classroom had large windows that were routinely opened to allow fresh air in. The U.S. students also observed that the heat from the radiators was constant and predictable, and the water from the tap was fresh and clean. The students shared these experiences during the daily briefings and described the powerful impact the Icelandic environment had on them. The Icelandic students were surprised - this was an eye opener for them. One Icelandic student commented that Icelanders “do not notice the environment, it is taken for granted.”

**Personal health care.** Personal health care was discussed as it related to maternity care. The Icelandic students were shocked to learn that in the US paid maternity leave is not always guaranteed, and when employees do provide paid leave, it may be as short as 12 weeks. They talked about the importance of having an entire year to recover, get to know the baby, and settle as family. This was discussed as an important Nordic cultural value that is attached to valuing families, mothers, and babies, and the Icelandic students found it “sad to the point of tears” (direct student quote) that U.S. citizens are not provided the same benefits when starting a family.

**Health care delivery.** The discussions that occurred after the field trips to clinical sites were substantial. The similarities and differences between the US and Iceland were compared and contrasted. For example, the group that toured a surgery center discussed the similarity of tracking patients with the use of an electronic patient navigation board; this technology is also routinely used in the US. When the students discussed infection rates and other quality metrics, the Icelandic students shared that these issues are infrequent. In contrast, in some organizations in the US, the rates of hospital-acquired infections far exceed what is acceptable, and many tactics are being used to reduce infection rates.

**Topics in the media.** During this course the US had just elected a new president. Much discussion occurred describing the US political system, the different political parties, and the candidates who ran. The Icelandic system of government was also discussed, and it served as a point of pride that Iceland has elected both women and openly gay individuals to political office.

Robust discussions regarding racism also occurred. The U.S. students discussed recent shootings by police and other violence against persons of color. This was shocking to the Icelandic students, as police there do not carry guns and they could not recall any recent incidents of shootings in Iceland. The Icelandic students talked about lack of real experience with cultures of color; they shared about the work that is being done to welcome Syrian refugees into the country, including the Icelandic president hosting the most recent arrivals with a dinner at his home.

Faculty members supported the deepening of these discussions by encouraging the students to explore the differences between the two countries with curiosity rather than judgment, and coaching them to discuss the cultural values associated with the differences, and some of the structures that exist in each of the countries. By the end of the week students were exchanging contact information, social media connections, and commitments to each other to continue dialogue.

### **Survey Results**

As seen in Figure 1, the findings from the survey indicated that most of the students found all aspects of the course good or very good. A number of the Icelandic students pointed out that the assignment had been very challenging, and it would have been better to send the case description in advance so they could be prepared. This may be due to the fact that for most of the Icelandic students, English is not their first language, so reading a long description in a short period of time was challenging.

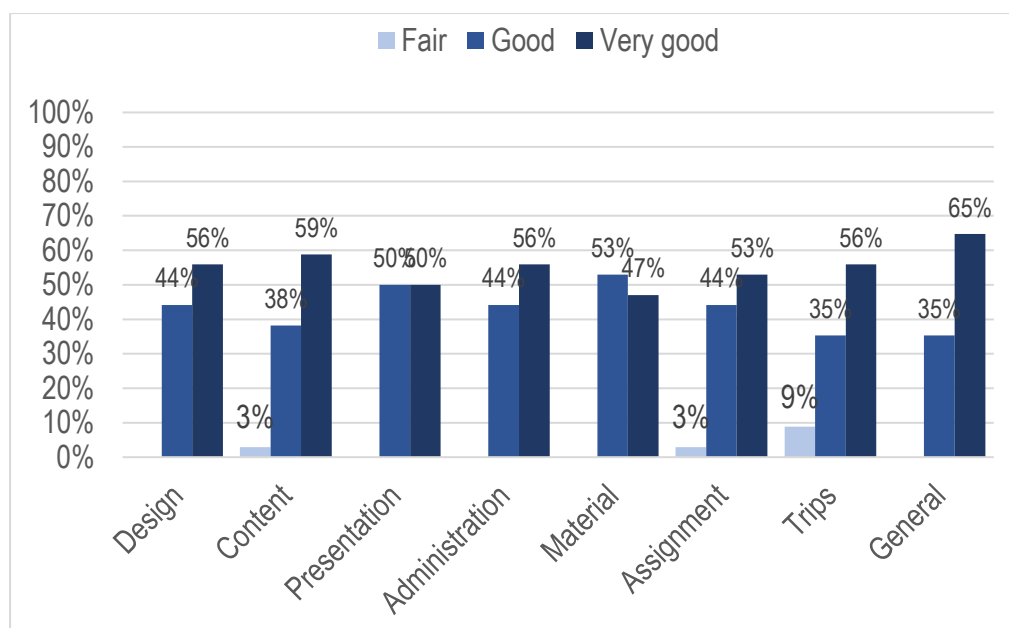


Figure 1. Course evaluation by students

Comments from the open-ended questions included liking being able to meet and work with health-care students from another country and appreciating the true teamwork and partnership they experienced during their challenging group work. One student stated,

Having the opportunity to dialogue with each other was the best part of this course. I appreciated the openness of both cultural groups to answer questions about their cultural identity. I also enjoyed the field trip experience very much. Working on the case was an incredible opportunity.

Another student wrote, “This week has been an extraordinary experience. I’ve learned so much working with the Icelandic and other U.S. students. Problem solving together is powerful. Being here has been an amazing growth experience.”

Not only did the students learn from this experience, but the participating faculty learned as well. Besides coaching the student groups in their assignment, faculty members took part in the field trips and all the salons, seeing them as opportunities to grow in partnership with students while being good role models.

## **DISCUSSION**

Nurses play a key role in global health (Ferguson, 2015) as global or, even better, glocal leaders (thinking globally while acting locally; Wilson et al., 2016). The ICN has for some years been at the forefront of programs to support nurses as leaders (ICN, 2020). Global leadership requires mutual respect and collaboration, key characteristics of an orientation toward partnership, and for true partnership, individuals need to be culturally humble (Eisler & Potter, 2014; Foronda et al., 2016).

Our survey results indicate that students increased their cultural humility through the international collaboration as well as having to work together on the case study on refugees. The feedback also demonstrated that the experience of our course gave students the opportunity to develop cultural humility by “learning to bring the different realities together to provide effective care in a culturally diverse context” (Blanchet, Garneau, & Pepin, 2015, p. 1064). What students shared during the debriefings and what is seen from their answers to the open-ended questions indicates that the development of their cultural humility resembled that of nurses and undergraduate nursing students in Blanchet et al. (2015) during clinical work in community settings in the US. Based on their findings and on the literature, these authors propose a constructivist theory of the development of cultural competence in nursing with three developmental dimensions on three levels. The developmental dimensions are: 1) building a relationship with the other, 2) working outside the usual practice framework, and 3) reinventing practice in action. The three dimensions interact and influence each other, evolving with increased complexity through the three levels. At level one, nurses are open to the varying realities of practice in a culturally diverse context; at level two, nurses challenge their own practice; and at level three nurses combine in an integrated way the different realities of practice. The development of our students’ cultural humility was evident in their briefings as well as their comments in the survey. The content and assignments of the course gave them the opportunity to reflect on the culture, situation, and health-care services in their home country while learning from each

other about how health care is delivered elsewhere in the world and how each and every person, community, and nation is part of a larger global community.

Both students and practicing nurses may benefit from cultural humility education and training (Dabney et al., 2016; Delgado et al., 2013; Elminowski, 2015; Gallagher & Polanin, 2015). Some studies indicate that nursing students of foreign origin and/or having experience with other countries and languages are more culturally competent than their counterparts who do not have this experience (Jalal et al., 2017; Repo et al., 2017). Therefore, nursing programs should continuously provide opportunities for students to be exposed to internationalization, whether by traveling abroad or with the help of technology such as Collaborative Online International Learning (Bragadóttir & Potter, 2019).

Teaching and training current and prospective nursing leaders about cultural humility and global leadership is essential, and an immersion like ours in our global leadership course has strong potential to enhance global health (Adams et al., 2016; Brown et al., 2012; Garner et al., 2009). In our course, students identified both shared and distinct issues between their countries, which allowed them to learn something new about their own reality through the experience of others. Such experiences can empower nurses as glocal leaders, indicating their growing competence as leaders acting locally while thinking globally (Rosa, 2017).

## **CONCLUSION**

By emphasising global leadership in nursing, based on partnership and evidence, we could say we are back to the basic core of Florence Nightingale's visionary leadership (Harper et al., 2014). Global leadership requires cultural humility, which truly cannot be practiced without practicing partnership. By offering students at all levels the opportunity to learn and exercise international collaboration, they, as well as their faculty, can and will become culturally humble glocal leaders in health care. Giving students the challenging assignment of studying the Syrian refugee crisis, requiring them to stretch to their full potentials made them realize not only how

complicated health care can be for these groups (Almontaser & Baumann, 2017; Doocy et al., 2016; Farley et al., 2014), but also empowered and encouraged them as global leaders.

In their group work every student had the opportunity to practice and advance their individual cultural development. Some may have been in their initial stage of development, just gaining cultural self-awareness, while others may have been further along, already having cultural knowledge and cultural sensitivity (Blanchet et al., 2015; Papadopoulos et al., 2008). Whatever level of cultural humility our students had reached by the end of our course, they benefitted from participation and had progressed in their development as true partners in health care. Last but not least, offering an international course based on partnership, in which cultural humility and global leadership are the core, is an excellent opportunity for faculty to develop as competent academics and role models (Jafari et al., 2014; Montenery et al., 2013). We highly recommend international partnership-based collaboration in nursing and health-care education, to benefit both faculty and students, and thereby the whole health-care system.

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