DOI: 10.7860/JCDR/2021/50552.15491

Original Article

Health Management and Policy Section

Culture of Interpersonal Communication in ICU Nurses: An Ethnographic Study

TAYEBEH MAHVAR[1], BEHZAD HEMMATPOUR[2], HAMIDREZA SAIEDIBOROJENI[3], HAMIDEH MASHALCHI[4], MASOUD FALLAHI[5], SAHAR EGHBALI[6], SOMAYEH MAHDAVIKIAN[7]

ABSTRACT

Introduction: Interpersonal Nurses Communication (IPC) in Intensive Care Unit (ICU) is known to be important due to the critical situation of patients and the nurses' experience with moral distress. Nurses interpersonal relationships and ways of resolving conflicts are influenced by the culture of this sector.

Aim: To specify the culture of IPC among nurses in ICU.

Materials and Methods: This was a qualitative multi-site ethnographic study conducted from May 2017 to September 2019 at Kermanshah University of Medical Sciences. Data were collected through participatory observation and formal and informal semi-structured interviews. The study environment included four ICUs in two hospitals. Data were obtained from an uninterrupted observation for five months, intermittent observation for six months, 15 formal interviews and 31 informal interviews. The process stems from the research evolutionary cycle model and Spradley's Steps. In order to discover the meaning of the patterns from the obtained themes, the findings were interpreted after analysis. In this study, Spradley method was used to analyse the data.

Results: In this study, 66.7% of the nurses were female, the mean age was 38.66±9.1 years, and mean work experience was 14.43±8.4 years. The three main themes of the high-level code consensus emerged as follows: Grouping which included the formation of groups, cooperation and competition between groups, and demarcation and characteristics of groups. The governing organisational relationships include managerial strategies and nature of the wards. And the individual characteristics that included top-down look, work discipline and experience.

Conclusion: The IPC among the ICU nurses is a dynamic and inevitable process and influenced by factors such as nurses' membership in the groups established in the ICU, nurses' cooperation, management strategies, physical and emotional nature of critical care units, work experience and former communications, discipline, and features such as a top-down attitude.

Keywords: Centralised ethnography, Communication, Confrontation, Intensive care unit nurse, Moral distress, Multi-Site ethnography

INTRODUCTION

Effective communication is one of the important factors in improving the quality of health care [1]. Communication is a key factor in team activities [2]. Nursing is a team profession and communication plays an important role in it [3]. Today one of the important gaps in nursing services is the weakness of nurses' communication skills [4]. Inadequate professional communication in nursing has reduced the quality of care, increased one-sided judgment, anger, over-expectation, sabotage and dismissal [5] and today it is one of the most important sources of stress in nurses [6]. Studies showed that poor relationships among nurses are often unreported [3,7], and the interpersonal relationships of newly graduated nurses lead to different negative perceptions and feelings, including injustice, depression and lack of motivation for work, which directly affect professional development and job satisfaction [8]. Also, considering various studies in Iran, the relationship among medical professions, including nursing, was found as unfavorable [9,10].

Although IPC among nurses is important in all sections, it seems to be more important in ICUs due to critical situations, high moral distress, more need for teamwork, high workload, and caring for critically patients [11]. Due to the existence of these stressful conditions, weaker relationships and the occurrence of imperfect communications among ICU nurses could be more frequent [12]. So that, nurses consider inappropriate interpersonal relationships as one of their major problems [7,13].

According to American Nurses Association in 2010, 53% of ICU nurses stated that their co-workers did not communicate well with them, and 33% had poor and unfair interactions with their peers [5]. A good IPC between nurses in ICU is one of the important factors in creating a suitable work environment that leads to more cooperation, less job leaves, group effort, increasing nurses' participation in retraining, improving professional performance, promoting a culture of support, teamwork, acquiring stress management skills, job satisfaction and increasing the quality of care [14-16].

One of the important factors for a proper communication is culture [17]. Some important factors affecting the culture of IPC in nurses include their spoken language, religious beliefs, education, speech and behavioural skills, work experience, self-confidence, criticism, and peer support spirit [18]. Extensive studies showed that culture cannot survive without communication, and communication without culture shares no content. Habermas considers culture and communication to be inseparable [19]. In fact, culture is not exclusively equivalent to ethnic identity [20]. Research showed that culture plays a key role in the care system, so attention to cultural competencies including the ability of nurses to treat people with respect for culture are so important [21]. Therefore, understanding the culture of IPC among nurses can lead to comprehending the interpersonal nurse-nurse relationship and identifying the factors that develop and inhibit these relationships and help managers to create a healthy work environment in the ICU [22] and ultimately lead to improved quality of care [20].

In Iranian studies, it was found that Iranian culture indicates the resistance of members of society and organisations against the organisational hierarchy, and despite the interest in teamwork in this culture, the organisational environment has a negative effect on the tendency of teamwork [23,24]. Despite the studies

conducted in Iran, many layers of the culture of IPC of nurses in ICU are hidden [19]. It is necessary to use ethnographic methods to obtain these hidden layers [25]. Also, recognising many of the hidden aspects of nurses' IPC culture cannot be directly explored, so it requires an in-depth study of nurses' interpersonal behaviours and relationships, which can be achieved through ethnographic research [19]. Ethnography identifies the inner beliefs of cultural groups and examines conflicting professional perspectives within an organisational culture. In this method, data collection was done with maximum flexibility and the researcher will be given the opportunity to obtain accurate information about the interpersonal relationships of special nurses. In view of the above, recognising and analysing the culture of IPC in ICU nurses is essential and can help to discover hidden relationships among nurses and indirectly increase the quality of patient care [5]. Therefore, the aim of this study was to investigate the culture of IPC in ICU nurses.

MATERIALS AND METHODS

This study was a qualitative multi-site ethnographic study which was conducted from May 2017 to September 2019. The research approval was obtained from the Ethics Committee of The Iran University of Medical Sciences (IUMS) with the letter number (IR.IUMS.Rec.1395.9321199006).

Inclusion criteria: The study population included all ICU nurses who worked at two hospitals affiliated to Kermanshah University of Medical Sciences (KUMS),having a bachelor's degree or higher in nursing and gave consent for participation.

Exclusion criteria: The nurses who were reluctant to continue with the study, were excluded.

A total of 15 interviews of ICU nurses were analysed. Multisite Ethnography was investigated in four ICUs, which were selected based on the criteria of simplicity, accessibility, obtaining permission to enter and the possibility of repetitive periodic activities. Multi-site ethnography is a type of ethnography that is carefully formulated and performed face-to-face, and each researcher can practice it differently depending on the needs of the place [26].

Data collection

The researcher approached the nursing offices of the ICU of two hospitals (Imam Reza Hospital and Taleghani hospital) that were affiliated to KUMS and received a list of the names and shift schedules of nurses in ICUs. Then the researcher started data collection by participatory observation method. First, the goals of the study were explained to nurses, and their written and informed consents were obtained for participation in the study. The observation was performed in general and in three shifts in the morning, evening and night, which lasted from May 2017 to June 2017. Then the purposeful observation continued from June 2017 to March 2018, with the aim of identifying relationships, interactions, behaviours, verbal-non verbal communication, etc. In the second place, the general observation continued from March 2018 to December 2018, in three working shifts in mornings, evenings and at nights. Data collection mainly focused on the elements of site, the structure of the research field, those who attended this field, the activities and relationships of people in this field. In this study, semi-structured face-to-face interviews for half an hour to one and a half hours were used. Interviews were conducted with nurses in different categories.

For collecting data, Spradley procedure (1980) was used. In this procedure, data collection is done by observing, recording and interviewing, by being present in the environment and asking questions to understand the culture. Descriptive, focused and selective observation is the main method for collecting information. Interviews were immediately converted to text word-by-word [19,20]. Spradley method [27] has 12 Steps, (including:

Step 1: Locating informants,
Step 2: Interviewing and making observations,
Step 3: Making an ethnographic record,
Step 4: Asking descriptive questions,
Step 5: Analysing ethnographic interviews and field notes,
Step 6: Making a domain analysis,
Step 7: Asking structural questions,
Step 8: Making a taxonomy analysis,
Step 9: Asking contrast questions,
Step 10: Making a component analysis,
Step 11: Discovering cultural themes,
Step 12: Write an ethnography,

The findings were recorded and transcribed. In addition to the interview, conversational analysis was recorded and analysed the same as the interviews and sampling process continued until that no new data were obtained from interviews with subsequent participants.

STATISTICAL ANALYSIS

Spradley method was performed simultaneously with data collection, so that during the data collection process, domain analysis, classification analysis, component analysis and theme analysis were performed. After extracting the domains, classes, components and themes, the researcher interpreted the findings of the analysis process in order to describe the culture of IPC in ICU nurses, by putting together the extracted themes to get a complete picture of the culture of IPC among nurses.

RESULTS

The findings of the present study were collected during continuous and intermittent observation in each ICU and included 15 formal interviews and 31 informal interviews. In formal interviews, the content of the questions was mostly based on the observations and conversations of the nurses. The nurses determined the time and place of the interview by telephone or in-person. It lasted from 20 minutes to an hour and a half. In informal interviews, whenever it was possible to talk to the nurses (at the nursing station, at the rest and at the patient's bedside), the interview was performed in the form of friendly talking at different times (depending on the nurse's desire). Informal interviews were recorded in the form of friendly conversations accompanied by formal observations and interviews. The 28 texts were observed and 15 texts of interviews were analysed. Eight clinical nurses, two shift managers, two matrons, two head nurses and one assistant were studied [Table/Fig-1].

Degree	Years of Experience	Gender	Age (Years)	Position in hospital
Master's degree	20	Male	40	Matrons
Bachelor's degree	28	Male	52	Matrons
Bachelor's degree	26	Female	49	Head nurses
Bachelor's degree	15	Female	45	Head nurses
Bachelor's degree	18	Female	46	Assistant
Bachelor's degree	14	Male	37	Shift managers
Bachelor's degree	17	Female	40	Shift managers
Bachelor's degree	1	Female	23	Newly graduated nurses
Bachelor's degree	1.5	Male	24	Newly graduated nurses
Bachelor's degree	15	Female	38	Clinical nurses
Bachelor's degree	17	Female	40	Clinical nurses
Bachelor's degree	4	Female	27	Clinical nurses
Master's degree	11	Female	43	Clinical nurses
Bachelor's degree	6	Female	29	Clinical nurses
Bachelor's degree	23	Male	47	Clinical nurses

[Table/Fig-1]: Demographic characteristics of the participants.

In this study, three main domains including grouping, organisational relationships governing and individual characteristics were obtained [Table/Fig-2].

Categories	Domains
Formation of groups	Grouping
Cooperation and competition	
Boundaries and characteristics of groups	
Management strategies	Organisational relations governing the Department
Wards nature	
Top-down look	Individual characteristics
Work discipline	
Experience	

[Table/Fig-2]: Major domains extracted.

1. Grouping

The first domain was grouping, which included formation of groups, co-operation-competition and boundaries-characteristics of groups.

Formation of groups

The formation of groups was based on the variables of gender, religion, type of employment, work experience, interests and communication outside the unit. One of the groupings was based on the nature of the groups. The nurses described the nature of the groups as violent and soft. A soft group was a group whose members were more relaxed and adaptable in interpersonal relationships and did their duties through talking. The violent group, on the other hand, was aggressive and tried to force things by conspiracy. According to the researcher: I saw that nurses work together in groups of two to three and take rest accordingly. This cooperation can be seen in the reception of new patients. Also, they and their families keep in contact outside the ward.

Cooperation and competition

In nurses' IPC, a wide range of cooperation and competition were observed. One of the nurses said: A good co-worker is the one who cooperates when your or her patients' conditions get worse.

Cooperation and competition in these units was a complex process, if the interpersonal relationship of nurses was positive, cooperation would follow to the extent that off-duty collaboration could also be seen. Otherwise, competition was observed: In a shift, a male patient needed a Foley catheter replacement and his nurse was a woman. The nurse replaced the Foley catheter alone. I asked the head nurse the reason, "why did she not ask Mr... for help? The head nurse answered: These two nurses have had problems with each other for many years; they do not support each other even in worse conditions.

Boundaries and characteristics of groups

Boundaries and characteristics of groups played an important role in the interpersonal relationships as the boundaries and characteristics of groups shaped their professional and personal lives. Boundaries in groups were overshadowed by factors such as shifts, religion, work experience, age and type of employment. A nurses stated that: There was a party for nurses at evening and night shifts, I had a close relationship with them. I had no experience working in ICU and they educated me very well. I tried to improve my friendship with them. They did not want the morning shift nurses in their parties, so I did not tell the rest of the nurses about the party.

Leadership was an important feature in friendly groups that nurses made. The following was a report about the role of leadership by a nurse (at a night shift at 1 AM): The ICU was really noisy and crowded. All the nurses were present in the ward; the leader had a serious tone and gave each nurse a task to do. No one protested or reacted against him; the condition lasted until 3 a.m. Then, everything calmed down and tasks were accomplished.

2. Organisational Relations Governing the Department

Organisational relationships were another area that was extracted in this study. Categories in this area included management and nature strategies.

Management strategies

Management strategies played an important role in nurses' IPC. The more popular the strategies were, the more effective the interpersonal relationships could be. In contrast, discriminatory strategies pushed nurses' interpersonal relationships toward inefficient communication. In this regard, a nurse stated: Unfortunately, the officials were just looking for what the nurses did, where they went, what they said. They don't check how nurses take care of their patients, they just control nurses' relationships instead of observing the way nurses react to their patients.

Managers and their strategies were found to be very effective in nurses' interpersonal relationships. If the solutions were to encourage positive actions, it would lead to more effective communication. One of the nurse stated: We have an online group formed by our head nurse. Sometimes when a nurse in charge of a patient in critical condition did her job properly, she was appreciated by the head nurse in the group and other nurses are also informed of the incident.

Ward nature

Due to the strained environment of the ward and high workload in the ICU, nurses' interpersonal communication was formed in an emotional atmosphere. On the other hand, relationships among nurses was usually more than mere work communication. The following report reflects the wide range of these IPC: At 9:00 pm, when I entered, the unit seemed strange. It was completely silent and only the sound of the devices could be heard, a nurse was preparing the patient's medicine. He greeted me calmly. I saw the head nurse at the station. I remember that he did not even greet and communicate others in the morning shift, I told him how the ward was so calm. He replied that in the ICU this silence was quite temporary, in fact in the morning shift the ward was busier and more stressful than the night shift so it would be calm for another hour probably, because they were going to move three patients and get three more and those patient were really sick.

3. Individual Characteristics

The individual characteristics of ICU nurses played an important role in their IPC. It included three categories of top-down look, work discipline, and experience.

Top-down look

A top-down view was observed in the relationships of ICU nurses. Each of them had a special vision of work which gave them the sense of being unique as the result of the idea that they worked in the most important and scientific ward of the hospital. They showed the same behaviour not only to nurses in other units, but also to their colleagues in their own unit. Such feelings of being special, different and knowing everything was directly related to the work experience in the Department. The head nurse said: My work is totally different from other head nurses; I need to be very up to date. What we do here is truly scientific and accurate. While other head nurses are not as busy as me, they may not read a book in their 30 years of work. Their job is routine.

Work discipline

Discipline in relationships reflected the stereotypical behaviours of nurses in similar situations, forcing them to perform routine tasks. As one participant stated: In the ICU, all nurses believe that they must give the services on time and do the follow-up. It is not possible to postpone a task for one minute. Things have to be done quickly. Sometimes patients' lives depend on seconds.

Experience

Experience is a word always used in conversations between nurses, which is also very effective in relationships between them.

Experienced personnel believe that experience is necessary to work in the special Department. In this regard, one of the nurses stated that: when a nurse starts working in a hospital, this is a big mistake that sent her to ICU, they should use experienced personnel in ICUs. Nurses should get experienced to work in ICUs.

DISCUSSION

In this study, three domains of grouping, organisational relationships governing and individual characteristics were obtained. It was found that nurses in the ICU were grouped specifically according to factors such as gender, religion, interests, type of employment, work experience and age. If there were similarities with a specific group but no willingness to join them, the members of that group did not tend to support the nurse and, actually, the nurse was rejected the group. It also led to stress at work, reduced focus on patients, more medical mistakes, fatigue and decreased motivation, and the fastest solution of the situation is to change the work environment. The results of the study by Al-Hamdan Z et al., reported the role of the gender of nurses in their grouping and similarities. They also used different methods in the relationships with other nurses and in resolving conflicts between men and women. Men were more likely to use methods that led to compromise [28].

The present findings also showed that there was a classification among new and experienced nurses that led to problems of cooperation and difficulty in sharing knowledge and experiences [29]. Collaboration between ICU nurses was found to be complex. Dougherty M stated that co-operation between nurses was one of their important tasks that required mutual respect of individuals, and cooperation was necessary to maintain interpersonal relationships [5]. Effective communication due to co-operation among nurses, lead to a shorter hospitalisation period, more comprehensive patient education, higher satisfaction, prevented medical errors, increased care quality, increasing coordination and responsibility [30].

According to the results of the present study, work and personal life of nurses affect each other. Tensions at work and life broke the boundaries between each other. Gender behaviour in nurses also changes and is sometimes in conflict with the prevailing culture in the community. The effect of working conditions such as fatigue, routine life and work stress are known to affect the personal life of nurses and reduce the ability to take care of themselves, the effects of which are felt in their personal lives too. Adaptation or non compliance with conflicts at work or life environment affects nurses' communication. Non compliance with conflicts could lead to problems such as increased absenteeism, reduced productivity, lack of motivation, reduced job satisfaction, and leaving the job [15,31]. In this study, nurses also experienced behavioural changes depending on their gender, such as the sense of leadership of women at home, which was contrary to the role of women in Iranian culture and lead to dissatisfaction of family members.

Hartung SQ and Miller M; showed that the quality of work life affected not only job satisfaction, but also other areas life, overall life satisfaction, personal and family happiness, social life and mental well-being [15]. Heavy responsibilities, long work shifts, exhausting night shifts and disproportionate to women's individual and family status, working overtime and patients 'special circumstances all affected nurses' job satisfaction. In the present study, some female nurses stated that the lack of a male nurse caused them to care for male patients, which had a negative effect on the quality of care and put them under stress. Some male patients also did not allow women to dress, inject, and move them. Kalhorian indicated that the amount of conflict experienced by female nurses expanded with the increase in their work experience. This might affect job satisfaction of these nurses [31].

The higher the work-family conflict of nurses, the lower the job satisfaction and with the decrease in the level of work-family conflict, higher job satisfactions are experienced [32]. On the other hand, the ability of nurses to control work and family affairs decrease due to conditions such as work pressure due to limited staff and, work and family expectations. This results in a decrease in self-efficacy as a result, intensified work-family conflict. Thus, a vicious cycle is formed, the results of which would be negative consequences in both work and family [33]. In most countries of the world, women are still in charge of housework. Due to increased entry of women into the economic sectors of society, it is expected that the conflict between the role of women in the family and the workplace will expand in the future. The results of studies showed that as nurses get more experienced, the conflict between work and family roles increases, so the possibility of increasing absenteeism, leaving the job, endangering physical and mental health and reducing life satisfaction could increase accordingly [31].

Nurses in the ICU have professional relationships with their peer and senior managers. These relationships may lead to negative effect, like mistrust, fear of judgment and disrespect that end in reduction of concentration. Moor LW et al., showed that poor communication was a recurring and important problem in the ICU and often led to care mistakes [34]. The nature of ICU, stress of caring critically patients, unfriendly relationships and fatigue were the factors causing stress in nurses' relationships. Studies showed that the stressful work environment of ICUs directly affected the interpersonal relationships of nurses and patient care [5,12]. Therefore, cooperation among nurses in these departments lead to fewer medical mistakes and higher patient safety [3,22]. Nurses' work experience affected their interpersonal relationships. Experienced staff believed that work experience was essential to work in ICU. Fassier T and Azoulay E showed that communication can be influenced by nurses' work experience, education and personal beliefs, and differences in these cases may hurt relationships [35].

The findings indicated that no strategy was presented to improve nurses' relationships, while it had a direct impact on the quality of patient care. Therefore, it seems essential to inform nursing managers about the importance of these relationships [36,37]. Also, the clinical work of the ICU nurses followed a clear discipline, and one of the most important issues in the ICU was order, however, this order sometimes became routine, without paying attention to the patient's needs. This order, could also be seen in non-clinical tasks such as rest hours. A study showed that nurses paid more attention to routine aspects of care than emotional aspects and they doing work out of habit, sometimes the care contradicted their opinions However due to that is a routine, it must be done [38].

Limitation(s)

Fear of disclosing conversations about facts and problems of the ward and conflicts with superiors was an important limitation in the study process. In order to reduce this limitation, the researcher tried to provide the necessary assurance about the confidentiality of conversations. Also, they were fully assured that recorded conversation tape will be deleted after coding.

CONCLUSION(S)

Interpersonal communication among ICU nurses is a dynamic and multidimensional process that is influenced by factors such as nurses' membership in established groups, the organisational relationships that govern the ICU, and the individual characteristics of nurses. Examining the communication culture among nurses may reduce nurses' problems and increase job satisfaction, and by improving the Interpersonal communication, the quality of professional services to patients would be guaranteed.

Author declaration: This paper was taken from a PhD research project, which was financially supported by IUMS. We thank all the participants that participated in the study and support in carrying out this research.

REFERENCES

[1] Trenholm S.Thinking through communication:An introduction to the study of human communication; 9th edn, New York,Routledge.442 Pages. 2020
[2] Zúñiga F, Ausserhofer D, Hamers JP, Engberg S, Simon M, Schwendimann R. Are staffing, work environment, work stressors,and rationing of care related to care Workers' perception of quality of care? A cross-sectional study.Journal of the American Medical Directors Association. 2015;16(10):860-66.
[3] Azimi Lolaty H, Ashktorab T, Bagheri Nesami M, Bagherzadeh Ladari R. Experience of professional communication among nurses working in educational hospitals:A phenomenological study. Journal of Mazandaran University of Medical Sciences. 2011;21(85):108-25.
[4] Zamani AR, Zamani N, Sherafat Z. Assessment and compare of nurses and physicians views about Dr-nurse relationship cycle in Alzahra hospital. Journal of Isfahan Medical School. 2011;28(120) 8-1:
[5] Dougherty M. The nurse-nurse collaboration scale. The Journal of Nursing Administration. 2010;40(1):17-25.
[6] Berry PA, Gillespie GL, Gates D, Schafer J. Novice nurse productivity following workplace bullying. Journal of Nursing Scholarship. 2012;44(1):80-87.
[7] Stagg SJ, Sheridan D, Jones RA, Speroni KG. Evaluation of a workplace bullying cognitive rehearsal program in a hospital setting.The Journal of Continuing Education in Nursing. 2011;42(9):395-401.
[8] Saghafi F, Hardy J, Hillege S. New graduate nurses' experiences of interactions in the critical care unit. Contemporary Nurse. 2012;42(1):20-27.
[9] Aghabarari M, Mohammadi E, Varvani-Farahani A. Barriers to application of communicative skills by nurses in nurse patient interaction: nurses and patients' perspective. Iran Journal of Nursing. 2009;22(61):19-31.
[10] Barati M, Afsar A, Ahmadpanah M. Professional communication skills of medical practitioners in Bahar city in 2010. J Hamadan Univ Med Sci. 2012;19(1):62-9.
[11] Wujtewicz M, Wujtewicz MA, Owczuk R. Conflicts in the intensive care unit. Anaesthesiology Intensive Therapy. 2015;47(4):360-62.
[12] Martins C, Santos V, Pereira M, Santos N. The nursing team's interpersonal relationships v. stress: limitations for practice. Cogitare Enferm[Internet]. 2014;19(2):287-93.
[13] Tuija Ylitörmänen R. A web-based survey of finnish nurses' perceptions of conflict management in nurse-nurse collaboration. International Journal of Caring Sciences. 2015; (2):263-73.
[14] Ylitörmänen T, Kvist T, Turunen H. A Web-Based Survey of Finnish Nurses' Perceptions of Conflict Management in Nurse-Nurse Collaboration. International Journal of Caring Sciences. 2015;8(2):263-71.
[15] Hartung SQ, Miller M. Communication and the healthy work environment: Nurse managers' perceptions. Journal of Nursing Administration. 2013;43(5):266-73.
[16] Scholtz S, Nel EW, Poggenpoel M, Myburgh CP. The culture of nurses in a critical care unit. Global Qualitative Nursing Research. 2016;3:23. doi: 10.1177/2333393615625996. eCollection Jan-Dec 2016.
[17] Rahimi A, AhmadianMajin N. Investigating health literacy level and relation to demographic factors of nurses in teaching hospitals of at west cities of Iran: 2016. Journal of Health Literacy. 2017;2(1):54-61.
[18] Arnold EC, Boggs KU. Interpersonal Relationships E-Book: Professional Communication Skills for Nurses: Elsevier Health Sciences; 2019.
[19] Munhall P. Nursing research: a qualitative perspective ,5th end, Jones & Bartlett Learning, 606 Pages,2012.
[20] LeCompte MD, Schensul JJ. Designing and conducting ethnographic research: An introduction: Rowman Altamira;2nd end, Atla Mira Press,UK, 2010.
[21] Mareno N, Hart PL. Cultural competency among nurses with undergraduate and graduate degrees: Implications for nursing education. Nursing Education Perspectives. 2014;35(2):83-88.
[22] Moore LW, Leahy C, Sublett C, Lanig H. Understanding nurse-to-nurse relationships and their impact on work environments. Medsurg Nursing. 2013;22(3):172.
[23] Taslimi M. Akbar Farhangi A, Abedi Ja'fari H, Raznahan F. A model for national culture's influence on teamwork in Iran. Strategy For Culture.2010;3(10-11):127-62.
[24] Mirza Suzeni P. Intercultural problems translation of speech. The Journal of Translation Studies. 2007;4(13):54-41.
[25] Cruz EV, Higginbottom G. The use of focused ethnography in nursing research. Nurse Researcher. 2013;20(4):36-43.
[26] Falzon M-A. Multi-sited ethnography: Theory, praxis and locality in contemporary research:1st edn, New York,Routledge, 304 pages,2016.
[27] Chatchumni M, Namvongprom A, Eriksson H, Mazaheri M. Treating without seeing: pain management practice in a thai context. Pain Research and Management. 2016;2016:9580626.
[28] Al-Hamdan Z, Shukri R, Anthony D. Conflict management styles used by nurse managers in the Sultanate of Oman. Journal of Clinical Nursing. 2011;20(3-4):571-80.
[29] Gunawan J, Aungsuroch Y, Sukarna A, Efendi F. The image of nursing as perceived by nurses: A phenomenological study. Nursing and Midwifery Studies. 2018;7(4):180-85.
[30] Chang LP, Harding HE, Tennant I, Soogrim D, Ehikhametalor K, James B, et al. Interdisciplinary communication in the intensive care unit at the University Hospital of the West Indies. The West Indian Medical Journal. 2010;59(6):656-61.
[31] Kalhorian. Conflict of Work and Family: The Role of Support Perception, Governmental Administration in the Purpose of Quitting Service (Case Study of Nurses in Tehran Hospitals).: Tehran University of Management Department; 2011.
[32] Patel C, Beekhan A, Paruk Z, Ramgoon S. Work-family conflict, job satisfaction and spousal support: An exploratory study of nurses' experience. Curationis. 2008;31(1). 38-44.
[33] Tavangar H, Alhani F, Vanak, Z. Decline of self-efficacy: the consequence of nursing work-family conflict. Journal of Qualitative Research in Health Sciences. 2020;1(2):135-47.
[34] Moore LW, Sublett C, Leahy C. Nurse managers speak out about disruptive nurse-to-nurse relationships. Journal of Nursing Administration. 2017;47(1):24-29.
[35] Fassier T, Azoulay E. Conflicts and communication gaps in the intensive care unit. Current Opinion in Critical Care. 2010;16(6):654-65.
[36] Cleary M, Hunt GE, Horsfall J. Identifying and addressing bullying in nursing. Issues in Mental Health Nursing. 2010;31(5):331-35.
[37] Dellasega CA. Bullying among nurses. AJN The American Journal of Nursing. 2009;109(1):52-58.
[38] Yekefallah L, Ashktorab T, Manoochehri H, Alavi Majd H. Futile care: why Intensive care nurses' provide it?A phenomenologic study. Advances in Nursing & Midwifery. 2015;24(87):1-14.

PARTICULARS OF CONTRIBUTORS:
1. Faculty, Department of Nursing, Nursing and Midwifery School, Kermanshah University of Medical Sciences, Kermanshah, Iran.
2. Faculty, Department of Nursing, Nursing and Midwifery School, Kermanshah University of Medical Sciences, Kermanshah, Iran.
3. Faculty, Department of Nursing, School of Medicine, Kermanshah University of Medical Sciences, Kermanshah, Iran.
4. Faculty, Department of Nursing, Nursing and Midwifery School, Dezful University of Medical Sciences, Dezful, Iran.
5. Faculty, Clinical Research Development Centre, Imam Reza Hospital, Kermanshah University of Medical Sciences, Kermanshah, Iran.
6. Faculty, Department of Nursing, Nursing and Midwifery School, Tehran University of Medical Sciences, Tehran, Iran.
7. Faculty, Department of Nursing, Nursing and Midwifery School, Kermanshah University of Medical Sciences, Kermanshah, Iran.

NAME, ADDRESS, E-MAIL ID OF THE CORRESPONDING AUTHOR:
Somayeh Mahdavikian,
Department of Nursing, Nursing and Midwifery School,
Kermanshah University of Medical Sciences, Kermanshah, Iran.
E-mail: smahdavikia@gmail.com

PLAGIARISM CHECKING METHODS: [Jain H et al.]
- Plagiarism X-checker: May 27, 2021
- Manual Googling: Aug 31, 2021
- iThenticate Software: Sep 29, 2021 (6%)

ETYMOLOGY: Author Origin

AUTHOR DECLARATION:
- Financial or Other Competing Interests: Yes
- Was Ethics Committee Approval obtained for this study? Yes
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. NA

Date of Submission: **May 26, 2021**
Date of Peer Review: **Jul 23, 2021**
Date of Acceptance: **Sep 03, 2021**
Date of Publishing: **Oct 01, 2021**