CE 1.5 ANCC Contact Hours

Students' Observations of the Nursing Role in Seven Nations

Sheri P. Palmer and Leslie W. Miles

Abstract

AIM This exploratory, qualitative study was conducted to compare nursing tasks/roles in Ecuador, Finland, Ghana, Navajo Nation, Russia, Taiwan, and Tonga.

BACKGROUND The definition of *nurse* varies internationally, with little description of the specific tasks nurses perform. To better know the profession, nurses must understand what their counterparts do in different parts of the world.

METHOD Students and faculty traveled to seven nations to conduct an observational study. Students observed nurses ($n = 71$) over a period of three weeks using a checklist of basic tasks/skills, advanced skills, critical thinking, communication, public health, and professionalism.

RESULTS Similarities in nursing tasks/roles were found, with a few stark differences between countries. Autonomy of practice and communication styles varied; all nurses were found to be effective patient advocates.

CONCLUSION Sufficient nursing personnel, resources, patient load, and technology affect nursing tasks/roles.

KEY WORDS Culture – Global – Nursing Profession – Nursing Roles

Although the nursing profession exists in nearly every nation of the world and nurses have a similar title internationally, the responsibilities of nurses worldwide may differ. Researchers have looked at nurse satisfaction in other countries, but there is limited literature regarding the actual tasks and roles of nurses in various nations. Each nation has its own educational system, laws, and professional guidelines that dictate what tasks nurses perform. The organization of health care systems, nurses, economics, and cultural factors also influence the nurse's role.

The purpose of this exploratory, mixed-method study was to observe the tasks or roles of nurses in several nations (Ecuador, Finland, Ghana, Navajo Nation, Russian Federation, Taiwan, and Tonga). Our findings will provide readers with a better understanding of differences and similarities in tasks, roles, and responsibilities of nurses from these different nations and promote accountability.

BACKGROUND

The Brigham Young University College of Nursing has had a required public and global health course since 2006. In any one year, we have study abroad groups (total > 100 students) that travel to 8 to 10 nations; sites have been developed over many years and represent different health care systems. A main objective of the course is to assist students in understanding how the role of the nurse may vary among nations. During this clinical course, students observe different health systems, nurse-patient ratios, and professionalism.

As faculty and students worked alongside nurses, they noted obvious differences in approaches to patient care and nurses' responsibilities. For example, in many places, nurses do not use stethoscopes for assessments, and there are wide variances in documentation requirements. In some cultures, attending to daily care activities is the responsibility of the family, not the nurse. We came to the realization that our opportunity to observe nurses from many nations could serve as a resource for a study comparing nursing tasks and roles and increase awareness about nursing globally. An extensive literature search found minimal national comparisons about specific nursing tasks or roles in providing nursing care. However, comparing nursing roles among multiple nations is a challenge due to different definitions of *nurse*.

DEFINITION OF NURSE

Currie and Carr-Hill (2013) discussed the differing definitions of nurse used by three large global institutions: the International Council of Nurses, the Organization for Economic Cooperation and Development (OECD), and the World Health Organization (WHO). The fact that these institutions use different definitions has resulted in no international consensus and no definite conventions about what constitutes the role of nurses globally.

The differing roles of nurses within and among nations worldwide have been explored in similar studies (Gardner, Duffield, Doubrovsky, Bui, & Adams, 2017; Maier & Aiken, 2016). A discussion paper by a task force for the Global Advisory Panel on the Future of Nursing (Klopper & Hill, 2014) analyzed literature concerning global health and nursing. Several themes related to global nursing were identified: interdependence, advocacy, collaboration, "glocal" (reference to connection between global and local health), caring, cultural competence, respect for diversity, partnerships, equity, holistic, and sustainability. It is important to have consensus on the expectations of a global nurse, which should subsequently influence the role of nurses in all nations.

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For the purpose of our study, we implemented the definition of nurse that most closely represents the observational tool we employed for this study. This is the definition outlined by the International Council of Nurses:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (International Council of Nurses, 2019, "Nursing Definitions," para. 1)

FACTORS AFFECTING THE NURSING ROLE

Distribution

It is estimated that, worldwide, nurses and midwives make up more than 50 percent of the health care workforce (WHO, 2018). There are striking differences in the availability of nurses from one nation to the next. The Organisation for Economic Cooperation and Development (OECD) represents 34 democratic governments with economies that strive to promote economic and social well-being. Even among OECD participating nations, striking variability has been reported in the availability of nurses. For example, per 1,000 inhabitants, there were 1.2 nurses in South Africa, 8.1 nurses in the Czech Republic, and 17.7 in Norway (OECD, 2019).

The World Bank (representing most nations of the world) compiles nurse and midwife density data demonstrating a large disproportion of nurses per 1,000 inhabitants. For the context of our study, the following density statistics (nurse/1,000 inhabitants) were obtained from 2018 World Bank data: United States, 9.9; Finland, 8.9; Russian Federation, 8.6; Tonga, 3.9; Ecuador 1.6; and Ghana 1.0. The world average proportion of nurses/1,000 inhabitants is 3.1 (WHO, 2018). Taiwan and the Navajo Nation are not recognized by the World Bank as nations, but other data have indicated that Taiwan has 1.6 nurses/1,000 inhabitants (Statistics Portal, 2019). No data on nurse/inhabitant ratio were found for the Navajo Nation.

Europe has the highest ratio of nurses to population (per 1,000 population), and Africa and Southeast Asia have the lowest ratios (see Table 1). Ratios of nurses to the population/patient directly influence the time a nurse has available to perform patient care. Research suggests more patients die when there are not enough nurses to provide care. This correlation has been shown in recent studies across several nations (Aiken et al., 2017; Ball et al., 2018; Cho et al., 2015; Olds, Aiken, Cimiott, & Lake, 2017).

Health Care Systems

Quality of health care systems, economics, and mortality rates vary widely among nations. Some organizations have attempted to compare national levels of personal health care access and quality. For instance, the Global Burden of Diseases, Injuries, and Risk Factors Study put together an analysis using the Healthcare Access and Quality Index (Global Health Data Exchange, 2019), which measured differences between ages and death risks. Using extensive statistical calculations, rankings (scale of 0 to 100, with higher scores representing better performance) of the nations included in this study were as follows: Finland, 96; Taiwan, 85; United States, 81; Russian Federation, 75; Ecuador, 62; Tonga, 60; and Ghana, 39. The Navajo Nation was not included in the report.

WHO (2000) also used a ranking system to compare the quality of different health care systems (scale of 0 to 100, with higher scores representing better performance). Ranking of the seven nations in this study found: United States, 91.1; Finland, 90.8; Ecuador, 73.8; Tonga, 76.7; Russian Federation, 74.3; and Ghana, 65.8. Unfortunately, rankings for the Navajo Nation and Taiwan were not included as they are not recognized members of the United Nations. WHO has not repeated their health care rankings from 2000. This article deals with seven nations that are a good representation of varying health care systems, economics, population data, and availability of nurses worldwide.

Cultural Influences

Culture also affects the nursing role. Cultural theory indicates that political structure, environment, social, religion, tradition, and other beliefs influence behavioral responses. Culture can direct thought processes, activities, and expectations (Giger, 2016), and a nurse's personal cultural may impact his or her role and responsibility in providing patient care. However, culture does not equate to a specific nation, as there may be many subcultures within one location, and it is unfair to say that where a nurse works will determine how the nurse will act. It was important that our students and researchers understand this as we undertook the project of comparing nursing tasks/roles among nations.

METHOD

Design

This mixed-method observational study of nurses in several nations was designed to enumerate the roles or tasks that nurses perform. Institutional review board approval was obtained from the originating university. All nursing students who were participating in the global health course attended a culture class where data collection procedures were taught by researchers. Oversight was provided by trained student researchers (n = 7) for each site. Nurse faculty site directors (n = 7) were also trained and mentored in the collection and processing of data.

Identification of the nurse was determined by the health care system in each nation. Nurses were recruited by the facility to work with visiting nursing students; the host nurses (5 to 16 per nation) provided verbal consent prior to student observation. A total of 81 nurses (hospital nurses [HNs] and public health nurses [PHNs]) worked with our undergraduate nursing students during their global clinical rotations as follows: Ecuador, 14 HNs; Finland, 10 PHNs; Ghana, 3 HNs, 10 PHNs; Navajo Nation, 8 HNs, 8 PHNs; Russian Federation, 5 HNs; Taiwan, 11 HNs, 2 PHNs; Tonga, 5 HNs, 5 PHNs.

Descriptive statistics were used to count the occurrence of each nursing task (a manual nursing function) or role (demonstration of critical thinking) observed by nursing students in each site using an observational checklist of nursing tasks. Qualitative written descriptions about the observed task or role were additionally analyzed by researchers.

Observational Checklist

The observational checklist of nursing tasks was based on: a) literature reviews and past studies from EBSCO databases that explored

Table 1: National Data Comparisons

Country	Total Population	Gross National Income per Capita	Life Expectancy at Birth (Male/ Female)	Total Expenditure on Health as % of Gross Domestic Product	Nursing and Midwifery Personnel Density (per 1,000 Population)	No. of Hospital Beds (per 10,000 Population)
Ecuador	16,624,858	5,890	74/79	8.5	1.98	15
	(2017)	(2017)	(2016)	(2015)	(2009)	(2013)
Finland	5,511,303	44,580	79/84	9.4	11[a]	44
	(2017)	(2017)	(2016)	(2015)	(2016)	(2015)
Ghana	28,833,629	1,490	62/64	5.9	0.09	9
	(2017)	(2017)	(2016)	(2015)	(2010)	(2011)
Navajo	356,890[b]	7,825[c]	59/72[b]	NA	NA	7[d]
	(2016)	(2010)	(2010)			(2018)
Russian Federation	144,495,044	9,230	67/77	5.6	0.86	9.7
	(2017)	(2017)	(2016)	(2015)	(2015)	(2006)
Taiwan	23,540,000	24,900	80	6.3	1.6	69.3
	(2018)[e]	(2017)[f]	(2018)[e]	(2016)[e]	(2017)[f]	(2018)[e]
Tonga	108,020	4,010	70/76	5.86	3.881	2.6
	(2017)	(2017)	(2016)	(2015)	(2013)	(2010)

[a]Eurostat Statistics Explained (2018).
[b]Navajo Division of Health Navajo Epidemiology Center (2013).
[c]Arizona Rural Policy Institute (n.d.)).
[d]Federal Health Program for American Indians and Alaska Natives (n.d.)
[e]Ministry of Health and Welfare (2018).
[f]Statistics Portal (2019), World Bank Group (2018), and World Health Organization (2018).

the roles of nurses (Bekker, Coetzee, Klopper, & Ellis, 2015; Durosaiye, Hadiri, Livanage, & Bennett, 2018; Lee & Jung, 2015), b) American Association of Colleges of Nursing's (2008) *Essentials of Baccalaureate Nursing for Professional Nursing Practice,* and c) the contributions of an expert panel of nurses who were clinical faculty. The checklist was focused on tasks or roles that could be observed by nursing students. To reduce subjectivity, we defined and explained each task or role as definitively as possible (Beins & McCarthy, 2017) in the checklist (see Supplemental Digital Content, available at http://links.lww.com/NEP/A159, for sample checklist).

Data Collection

Each student used a paper version of the checklist for each clinical day. Students were typically assigned to different host nurses for each shift and observed one nurse during the course of the entire shift. Prior to observation, students explained the purpose of the project to their host nurse and received verbal consent. Depending on the site, some students participated in hands-on care with the host nurse. Checklists were collected for at least eight observation days for a maximum of 16 days over a 3-week period. When needed, the student observer asked questions of the host nurse to clarify observations; for example, when a nurse was adjusting an IV, the student observer could ask if the task was a usual nursing function.

Nursing tasks or roles observed were tallied, representing the quantitative data. A positive response (yes) was given for nurses being responsible for specific nursing tasks or roles (see Table 2). The qualitative data consisted of written comments and descriptions; these were analyzed, and the findings were included in the portrayal of nursing tasks or roles.

Using the checklist, nursing students tabulated the tasks or roles observed for their site. During each clinical postconference, the nursing students and faculty site director/researcher discussed the student observations. After discussion to ensure correct categorization, the student group researchers brought their data to a final analysis meeting to identify similarities and differences across sites.

Table 2: Nursing Tasks/Roles: Comparison of Nations

Nurse Task/Role	Responsible	Comments
ADLS		
Nourishment	Yes	Majority by nurse aides or family; RF – patient goes to dining room; TO and TW – family brings food
Housekeeping duties	No	Sometimes family
ADLS, feeding, skin care	Yes	Family helps in many countries
Delegation of tasks	Yes	Not as much delegation in high-acute care
Skills		
IVs and phlebotomy	Yes	All except TO where it is the doctor's responsibility
Administering medication	Yes	Evident in all sites
EKGs or other tests	Yes	Doctor only in EC, GH, and TO
Wound care	Yes	TW – wound care division
Immunizations	Yes – PHN	FN – infants in home first visit; GH – door-to-door
Communication		
Therapeutic communication	Yes	PHNs – close relationship in FN, GH, and NN; more businesslike in EC
Charting	Yes	Different styles (from meds only to all nursing actions) and types (paper to computer)
Arranging discharge	Yes – PHN	FN, GH, and NN major responsibility; doctor only in RF; SW help in EC and TW
Care collaboration with other health providers	Yes	PHN's major role; limited in EC
Patient advocacy	Yes	GH – well-child home visits; NN – resources not readily available, evaluate home safety; TO – doctor's role with nurse present
Case management	Varied	RF and TW doctors or case managers
Mental health counseling	Low participation	FN – yes; GH, NN, and RF – consult or referral; EC – none
Think		
Critical thinking skills	Yes	Evident in all sites
Community assessment	Varied – PHN	NN – assess safety, sanitation, food availability, water; FN and GH – assess needs of area
Program development	Varied	FN – maternity and child care classes; GH – higher level administration only; RF and TO – government direction
Public health		
Home visits	Yes	PHNs; not observed in EC and RF
Disease outbreak investigation	Varied	GH – records and maps to track; NN – PHNs
Tuberculosis testing	PHN	GH – administer DOTS, counsel family and refer to hospital; RF – yearly in schools

(Continues)

Table 2: Nursing Tasks/Roles: Comparison of Nations, Continued

Nurse Task/Role	Responsible	Comments
Emergency preparedness	Varied	FN – works with paramedics; GH – very little; NN – PHN health fairs; RF – ambulance
Health promotion	Varied	FN – present in schools with yearly physical exam, brochures; GH – school teaching, home visits, programs for TB and guinea worm; NN – PHN health fairs; RF – smoking cessation and alcohol education
Outreach to vulnerable population	Varied – PHN	FN – home care, refugee camps, elderly, rural, teenagers; TO – prisoners
Population-based screenings	PHN	FN – vision, scoliosis, hearing, mental health, home situation, alcohol, depression; GH – skin, growth, HIV, vision, lice, TB, polio, mosquito netting, pregnancy prophylaxis; NN and TO – blood pressure and blood sugar; TO – waist/hip ratio and height/weight; RF – TB and HIV
Professionalism	Continuing education requirements varied between nations (none, implementing in-services to specific requirements) Evidence-based practice varied (lacking infection control and equipment)	

Note. EC = Ecuador; FN = Finland; GH = Ghana; NN = Navajo Nation; RF = Russian Federation; TW = Taiwan; TO = Tonga; ADLS = activities of daily living; PHN = public health nurse; SW = social worker; DOTS = Direct Observed Treatment, Short Course; TB = tuberculosis; HIV = human immunodeficiency virus.

Data Analysis

Descriptive statistics were used to count the occurrence of each nursing task (a manual nursing function) or role (demonstration of critical thinking) observed by nursing students at each site using the observational checklist of nursing tasks. To increase rigor and ensure accurate transcription, a separate analysis of raw tabulated student data was completed by faculty researchers (El Hussein, Jakubec, & Osuji, 2016). This double counting process helps avoid "group think" results from the student data analysis meeting.

Qualitative analysis was based on the Miles, Huberman, and Saldana (2014) theory. The students used the checklist to record explanations or provide examples of observed nursing tasks or roles. Qualitative analysis was completed by categorizing themes; the identified themes helped clarify and validate the quantitative findings.

RESULTS

Clinical settings were recorded to provide context for the data as follows: Ecuador, general, maternity, and pediatric hospitals; Finland, community health clinics; Ghana, general hospital, community health clinics; Navajo Nation, general hospital, community health clinics; Russian Federation, general hospital, community/school health clinics; Taiwan, general hospital, public health; Tonga, general hospital, community health clinics, public health. Categories identified by student observers at their respective sites included activities of daily living, tasks/skills, communication, critical thinking, public health, and professionalism (see Table 2).

Activities of Daily Living

Activities of daily living tasks (bathing, oral hygiene, feeding, dressing, basic skin care) were most often performed by nurses' aides or family members. Food preparation was sometimes done by family members and then brought to the hospital for the patient (Taiwan, Tonga). In the Russian Federation, patients who were able to ambulate independently went to the ward dining room for meals; housekeeping duties were most often done by custodial workers, with families sometimes performing these tasks. Nurses were often observed delegating tasks to family members (linen changes, bathroom assistance, feeding, and ambulation).

Tasks/Skills

The performance of nursing skills in which training was needed varied by location. Many advanced nursing skills (e.g., ordering labs, performing EKGs, and obtaining cultures) were dependent on available resources in the health care settings. The use of technology (e.g., computer charting, infusion pumps) was often performed by nurses if available. Differences in responsibility for tasks existed in Tonga, where physicians started the IVs but nurses handled the fluid management. Physicians performed EKGs in Ecuador, Ghana, and Tonga, whereas nurses performed them in Finland and Taiwan. Nurses in Finland and Taiwan were able to perform advanced nursing skills (measuring iron levels, analyzing lab results, performing ultrasounds, and evaluating urine tests) in high-acuity settings.

Administering medications and performing wound care were completed by nurses in all observed nations. Taiwan had a dedicated wound care division. Immunizations were provided by PHNs in most sites. PHNs went door-to-door for polio immunizations in Ghana; in Finland, PHNs provided immunizations during well-baby checks in the home.

Communication

Nurses everywhere, in all settings, participated in various types of communication. Therapeutic communication was observed in all areas of patient care, especially in high-acuity settings. Patient advocacy was also witnessed in several locations. In the Navajo Nation, patient advocacy was very important as community resources were not readily available on the reservation. Patient and family education,

especially medication teaching, was universal among nurses. A common variation in teaching was the absence of family during patient education in Ecuador.

Interprofessional communication, where the nurses consulted with other medical providers, was seen in most sites. Ecuador was an exception; there appeared to be a greater barrier between physicians and nurses than in other sites. In sites where a PHN role was present, nurses were observed consulting often with other health care professionals. Case management, discharge planning, and referral responsibilities varied among sites. PHNs in Ghana, Finland, and the Navajo Nation had a greater responsibility for care management and referrals. Discharge planning was performed by physicians in the Russian Federation, whereas in Ecuador and Taiwan, social workers performed that responsibility.

Critical Thinking

The students observed many examples of HNs demonstrating critical thinking where they followed the nursing process and utilized problem-solving skills. For example, in the Navajo Nation, nurses were observed repositioning a nasogastric tube, identifying a compromised airway and altered skin integrity, and advising physicians. Life and death decisions by nurses were observed in high-acuity settings in Taiwan, resulting in nurses altering task prioritization. Taiwanese nurses were seen performing assessments, addressing alarms, and meeting the needs of intubated patients. Nurses in Ecuador altered intravenous fluid rates according to the blood pressure in acute settings. The ordering, coordinating, and performing of ancillary services (drawing labs, physical therapy, respiratory therapy) were mostly performed by physicians or other technicians. Developing and updating nursing care plans were observed in some locations. Nursing care planning appeared to vary more with the observed nurse and not the site. Interestingly, in Ecuador, physicians were observed writing care plans.

Critical thinking was also observed among PHNs. In Ghana, PHNs ordered, performed, and coordinated ancillary services, such as malaria rapid tests. These PHNs were also seen consulting with physicians about incorrect doses of medication, administering medications based on signs and symptoms, and altered immune systems. In Finland, PHNs assessed patients and reviewed information for recommended care. Finnish school nurses assessed children on a yearly basis in consultation with parents. Conducting community assessments was a large part of the job description among PHNs in Ghana and the Navajo Nation. Nurses assessed safety, sanitation, and food and water availability. In Ghana, nurses assessed the needs and education of the village members.

Health care program development was observed at higher levels in the administration or government in many areas, including Ecuador, Ghana, Russian Federation, and Tonga. Finnish nurses were observed developing maternity and childcare classes.

Public Health

Positive examples of PHNs were identified in Finland, Ghana, the Navajo Nation, Taiwan, and Tonga. Tracking and disease outbreak investigations were observed in Ghana, where nurses followed guinea worm, cholera, and malaria cases and outbreaks. Population-based screening occurred in the Navajo Nation and Finland through blood pressure and blood sugar testing. Ghanaian schoolchildren were checked for skin infections, growth and development, vision screening, and communicable diseases (HIV, lice, tuberculosis). Ghanaian PHNs gave daily tuberculosis medications and polio vaccines, handed out mosquito netting, dispensed prenatal vitamins and Vitamin A, and counseled with families and referring community members. PHNs in the Navajo Nation were observed contacting patients, evaluating homes for safety, assuring treatment was completed, and identifying problems. Tonga PHNs assessed blood pressure, blood sugar, waist/hip ratio, and height and weight in community settings. PHNs in Finland school and clinic settings tested patients for visual acuity, scoliosis, hearing, iron and blood sugar levels, tuberculosis, and HIV.

Health promotion activities were observed in the Navajo Nation (health fairs and conferences), Ghana (billboards and signs, school teaching activities, home visits, implementing government programs for tuberculosis and guinea worm), Finland (public education through classes, brochures, and books), and the Russian Federation (campaign for better behavior, e.g., smoking, alcohol, and healthy lifestyles teaching in schools). Emergency preparedness was seen in the Russian Federation and Finland, where nurses work directly with the ambulance services.

Professionalism

Continuing professional education requirements for nursing licensure varied widely. For example, in Ecuador, there were no observed regulations. In Finland and the Navajo Nation, continuing education was highly valued as part of the profession. Some nations, including Ghana, had quarterly training and ongoing in-services for nurses. Knowledge and application of evidence-based practices (EBP) ran the spectrum from lacking awareness, aware but not performing due to lack of equipment, to application of EBP. For example, in Finland, EBP was implemented into infection control protocols.

Nurses in all nations were professional in their dress; uniforms ranged from white dresses and caps in Ecuador to tan-colored lavalavas (skirts) in Tonga. All nurses had graduated from nursing programs/schools (two to five years in length), with appropriate certification from their respective nation. As can be expected, nursing wages differed tremendously from one nation to the next (range US $6,000 to US$65,000/year).

DISCUSSION

Nurses' roles were found to vary when it came to performing basic patient care. This study was successful in exploring expectations and actual performance of nursing tasks or roles to help prepare our students in becoming global citizens. The spectrum of the nursing role varied, from being totally responsible for all patient care to the family providing a large portion of care. Even though observed nursing tasks or roles and responsibilities varied, the basic tenet of nurses caring for patients existed in all nations. Students observed genuine compassion and concern expressed by nurses in each location. Cultural and historical professional development of nursing in individual nations could also account for differences in nursing tasks or roles. The impact of these variables on current nursing roles is multifactorial and too complex for inclusion in this discussion.

Available economic resources are another variable that has an impact on nurses. Resources included the ability to hire enough nurses, obtain medications and supplies, and hire other health care personnel. In lower resource areas (Ghana, Ecuador, Navajo Nation, Russian Federation, Tonga), patient load at times reached 30 to 40 patients for each nurse. In these instances, nurses were observed mostly giving medications and charting. Nurse assistants provided more of the hands-on care for patients.

Unfortunately, many nurses had to spend time doing menial tasks, such as making cotton balls, folding sheets, or distributing meals. The use of a symbolic nursing instrument, the stethoscope, varied. For example, stethoscopes were not used in the Russian Federation and were not available in Tonga, while in Finland, a high-resource country, there was little reliance on stethoscopes for physical assessment. Nations with higher economic advantage (Finland and Taiwan) had evidence of technology resources to assist the nurse (computer charting, IV pumps) as well as assistant personnel. Nurses were seen working with teams frequently, especially in high-acuity settings. A large patient load was not as common in high-resource nations, consistent with WHO (2012) reporting of nurse-to-patient ratios.

Across all the nations, patient and family teaching was an essential nursing role. Nurses in high-acuity settings were observed providing patient teaching less often than other nurses. PHNs in all nations focused heavily on patient teaching when providing care. Quality communication was a common factor in all observed nurses.

Even with the notable differences among nations and cultures, the quality of nursing care did not appear to be associated with the economic status of the nation. Indeed, many nurses observed in low-resource nations were some of the most caring, invested, and knowledgeable about patient care. Nursing students commented multiple times that these nurses knew how to "really critically think" to solve challenges. All observed nurses were adept at crucial implementation of successful interventions in every nation observed. In addition, family involvement in providing care did not seem to be influenced by economic circumstances but seemed to relate more to traditional or cultural norms.

An observational checklist as described should be replicated for additional studies of nursing roles. If not a formal study, utilization of the observational checklist by nursing students as a learning activity while studying in a culture different than their own can serve to address ethnocentric beliefs of the role of a global nurse.

Limitations of this study include that observations were limited to one point of time with available nurses and clinical sites. In addition, observations were conducted in one area of a nation only. Thus, generalizability of findings for specific nations is limited. In addition, student observers may have interpreted a nursing role with an "American lens" rather than with a culturally appropriate focus. Being nursing students from another country, observers may not have noticed discreet nursing functions that were being performed and may not have had the experience to identify communication or cultural nuances.

Comparisons of health care systems literature is limited to decades-old data (WHO, 2000), which can skew perceptions about current health care systems. Because nurses have an essential role in all health care systems, our study contributes to current knowledge of the roles or tasks nurses provide internationally. Because there is no international consensus about the definition of a nurse (Currie & Carr-Hill, 2013), this observational study identifies multiple commonalities among nursing roles or tasks in different nations.

CONCLUSION

The exploration of nursing tasks and roles globally can challenge ethnocentric beliefs about what a nurse "should" do as a professional. Furthermore, being mindful of similar and different nursing tasks or roles in other nations and health care systems contributes to nursing education and adds awareness to the nurse. From this new awareness, there can be greater understanding of differences in nursing care within an increasingly culturally and linguistically diverse workforce. With increasing globalization of the nursing workforce, it is essential that nurses appreciate the variations seen in providing nursing care so that miscommunication and perceptions do not negatively impact the care provided to others.

Understanding nursing roles from other countries increases cultural awareness and positions the largest contingent of global health care personnel to become better unified as a profession. Even though economic or cultural factors influence nurses to appear different in each nation, it is the commonalities of providing care, critical thinking skills, therapeutic and interprofessional communication, patient advocacy, public health, and teaching that are the threads of the profession of nursing. International boundary lines should not divide the profession because nurses cross all borders.

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