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Cultural meetings experienced by nurses in Nordic Healthcare settings

A literature review

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Summary

Background: Culture is a part of every person, culture forms people both consciously and unconsciously and culture shows itself in our behavior and world views. Nurses in Nordic countries work in multicultural societies were the meeting between nurses and patients from other cultures can create experiences that form certain views. Cultures impact on people's behaviors can create experiences that form attitudes and approaches of nurses towards patients from other cultures.

Aim: The aim of this study was to illuminate experiences of meeting patients with another ethnic cultural background among nurses in the Nordic countries..

Method: Ten peer reviewed articles found in the databases Cinahl and PubMed with qualitative study approach from the Nordic countries of Sweden, Norway, Denmark and Finland are presented in the result. Articles were analyzed using a content analysis aimed for qualitative data as suggested by Graneheim and Lundman`s (2004) interpretation of Krippendorf`s (1980).

Result: The result of the study identified three major areas of experiences from participating nurses. The participating nurses felt that communicating with patients who did not speak the same language was problematic. Despite this interpreters were seldom hired and relatives were mostly used as interpreters even though this was seen as unsatisfactory. Relatives approach and culturally bound behavior when a family member turned ill was unwanted. Patients acting differently that the majority culture was also identified by the nurses. Finally nurses could acknowledge feelings of prejudice, racism and discrimination but meeting patients from other cultures opened their eyes to be more accepting and there was an urge to learn more about different cultures in order to perform better in the nursing field.

Conclusion: There is a need for cultural appropriate education in the nursing profession, as well as a tool for nurses to obtain useful information about patients' cultural needs. There is also a need to implement transcultural education and training for nursing students.

Key words: (Experiences, Nordic countries, Nurse patient relationship, Transcultural nursing, Qualitative data)

Contents

Introduction

According to Jeffrey`s (2006) the migration of people all over the world puts adequate cultural competence demands on nurses as well as other healthcare staff when they come in contact with patients from other cultures. Jeffrey`s (2006) further explains that culture can make great difference for nurses while preventing illness, promoting wellness, facilitating coping, enhancing quality of life and restoring health to their patients. According to Leininger (1997) transcultural meetings between nurses and patients can create culture clashes due to various cultural factors attitudes and practices that might transpire and bring down the quality of nursing care. Leininger (1997) also states that lack in knowledge about the patients culture and way of life can affect the nurse patient relationship in a negative way therefore knowledge about transcultural nursing and how to give culture congruent care is vital instruments for the nurse`s to apply. According to Leininger (1997) there is a substantial amount of research involving nurses' experiences dealing with patients from other culture. But as Willman, Stoltz, and Bahtsevani (2011) states there is not enough systematic synthesis of conducted studies in order to get an overview of collective results. Horsley (1983) states that synthesis of studies can improve the evidence of a subject as many studies show the same result. With this in perspective, it is therefore relevant to carry out a literature review with the aim of creating a synthesis around nurses' experiences when meeting patients from other cultures.

Identifying the experiences of nurses who come in contact with patients from other cultures existing practices and linked issues should be acknowledged and this in turn contributes to transcultural nursing knowledge as well as evidence based nursing science.

Background

Culture and Transcultural nursing

According to Leininger and McFarland (2002) most of the western countries in the world today can consider themselves multicultural societies, healthcare institutions in the multicultural societies have become interactive spaces for transcultural meetings between the new multi-cultural oriented patient group and nurses as well as other healthcare staff.

Leininger and McFarland (2002) states that culture has to be a central term when nurses and cultural oriented patients meet in what they call transcultural encounters. Leininger and McFarland (2002) explains that culture is an essence of people that has been refined from birth. Leininger and McFarland (2002) states that a culture is formed, learned and taught and includes views, values, lifestyles, symbols, norms, actions as well as a culture can have religious connections. The learned characteristics of a culture are something carried over from generation to generation and thus lives on and forms strong roots within a group of people.

When nurses attend to culture oriented patients, nurses have to apply transcultural nursing strategies. Transcultural nursing is defined through yet another term which is called culture congruent care. Culture congruent care means that the nurses should treat a patient according to the patients specific cultural lifestyle. Leininger and McFarland (2002) also states that giving proper cultural congruent care depends on nurses having a ability to be sensitive, understanding and knowledgeable of peoples cultures, world views, ways of communication, views on disease, sickness and health status. Further Nurses don't have to be experts in the fields of patients' cultures, but to be able to give culture congruent care the nurses have to be able to see to that each individual personal need are attended to.

The nurse patient relationship

According to Gebru and Willman (2003) the relationship that forms between a nurse and a patient represents a central aspect of nursing care. Gebru and Willman (2003) explain that if a good relationship is established the patient usually feels like he or she has the right to be the distinct individual that they are. According to Giger and Davidhizar (2002) the views and attitudes formed by nurses after experiencing patients from other cultures plays a significant part in the patient nurse relationship. Any type of disturbance in the experiences can be the outcome of a positive or a negative relationship between nurse and patient. In a study by Levitt (1999) an experience is often described as an event that took place and the person involved in the event gained some sort of wisdom and knowledge from it, hence experience was gained and an experience was formed. Nurse`s experience can shine some light on the nurses representation of thoughts and attitudes in the nursing workforce while dealing with patients from other cultures.

Leininger and McFarland (2002) explains that nurses that come in contact with patients from other cultural backgrounds have to have some kind of understanding of who that patient is

and what influences has shaped that patient. Galanti (2008) describes patients from other cultures based as individuals that are connected to their culture through ethnic belonging, their family and way of life. Further Smith (1996) describes an approach to ethnicity called essentialism.

Essentialism means that a person's cultural identity will always remain immutable, as long as a sense of belonging and connection with the original ethnicity and culture is present (ibid). Leininger and McFarland (2002) also speak about a person's belonging to his or her culture through ties to family, language and traditions as well as sense of belonging.

According to De Santis (1994) when a nurse and a patient from another culture meets there is a meeting between three cultures. The patient's own culture, the nurses own culture but also the environment which the meeting takes place in that is the culture of the work environment. De Santis (1994) states that the nurse should be reflective and acknowledge his or her own cultural baggage. Only then can the nurse reflect on cultural diversity and what impact culture has on people to better understand points of views and behaviors.

According to Maier-Lorentz (2008) nurses are challenged to meet up to the different cultural accosted needs of the patient. Maier-Lorentz (2008) also states that due to the fact that nurses often are the ones who have the most contact with patients in the healthcare team, the nurses need to show a genuine interest to learn about other cultures in order for the patient nurse relationship to be successful.

The ethical code for nurses

According to the international council of nurses (ICN) (2012) the need for healthcare is an essential service worldwide and when people come in contact with healthcare facilitators there is a need to be treated morally correct as well as with respect. The ICN code of ethics for nurses (2012) was developed as a guideline for nurses to apply as nurses would face morally and ethically challenging encounters in their field of work. The code is founded on human rights views that all people should be treated with respect and dignity and the code stretches through many topics including that the nurse has an obligation to see to that patients cultural and religious needs are being meet accordingly (ICN, 2012).

The culture care nursing theory

According to Leininger`s (2002) culture care theory nurses can with the help of the sunrise model make decisions to provide beneficial, meaningful and appropriate care that either preserves, maintains, accommodates, negotiates, re-patterns or reconstructs aspects of the nursing care to fit the patients need. The culture care theory's implication in nursing care is intended to make the outcome of the nursing care the most beneficial for patients from other cultures as cultural differences between healthcare staff and patients many times make for misunderstandings and complications.

According to Leininger (2002) the care that nurses offer to patients should always be tailored to the individual need of the patient. Within the culture care theory there is the sunrise model which a tool that is aimed to help healthcare staff detect potential elements that contribute to an understanding of the patients' needs and heath requirements. These sorts of elements can be historical, cultural or how the patients perceive his or her life situation. The sunrise model focuses on detecting several different cultural aspects that can be helpful for the healthcare staff to know about when treating their patients (See Annex 1 for the sunrise model). If nurses do not acknowledge patients cultural needs the patients can tend to feel insecure as well as a successful nurse patient relationship can be jeopardized. Nurses can also fail to spot risk factors in patients' lifestyles or patients' behaviours that are culturally bound which in turn can lead to treatments being unutilized or that information is given in a sense that it does not reach the patient on a level that the nurse intended it to.

The sunrise model also aims to enhance the meaning of religion, heritage, as well as political and financial circumstances that characterizes the world the patient lives in. Nurses can use Leininger's (2002) model to find out hidden information about the patients situation by thorough structured questioners, actively attending, and believing in what the patient shares. Leininger (2002) believes that all people have a story that they want to be told and valued. The nurse should also find out if the patient trusts the healthcare system that they are now in or if the patient prefers their own cultures healthcare system. For the model to be successful the nurse has to be interested and conscious about for example gender, class differences and communication needs. Whether the nurse is in touch with his or her own cultural background and how that background has shaped them and influenced them will determine how well the model will be put to use and interpreted by the nurse (Leininger, 2002).

Aim

The aim of this study was to illuminate experiences of meeting patients with another ethnic cultural background among nurses in the Nordic countries.

Method

The literature review is build up around a descriptive synthesis. A foundation in content analysis was conducted using Graneheim and Lundman`s (2004) interpretation of Krippendorf`s explanation of how to conduct content analysis on qualitative data that aims to contribute to evidence based care. The material used is made up by ten scientific articles with qualitative study methods. The objective was to present a descriptive synthesis that lead to analyzing the material collected. In the end categories were presented to highlight the results of the analysis process. The result is a descriptive summary of the findings in the articles.

Selection process

Inclusion and exclusion criterias

Inclusion criteria's: Peer reviewed, English language, qualitative studies, articles that were published between 2000-2014. Articles from the Nordic countries of Norway, Sweden, Finland and Denmark.

During the analysis articles were excluded due to various reasons: Articles were the nurses themselves did not belong to the majority culture, articles were the perspectives and experiences were from nursing students. Studies from neonatal care where the focus was of dealing with parents of babies with different cultural backgrounds.

Search Methods

The focus was put on databases that Blekinge institute of technology had to offer. Searches were done in PubMed and Cinahl. Swedish Mesh (2014) was used to generate synonyms from search terms. Since Swedish Mesh (2014) only gave a certain variation of terms Microsoft word was used to find further synonyms of different words. Two books Helman (2007) and Leininger (1997) relevant to the aim were read to generate applicable search terms related to the aim of the literature review. Words directly from the aim was also used as search terms.

A search schematic was formed to keep an overview of search results and search terms used (See Annex 2). Before starting the searches literature and scientific articles were studied to ensure the right search techniques would be used (Willman et al., 2011; Brenner and McKinins, 1989; Wilczynski, Marks & Haynes, 2007; Evans, 2002). The searches in Cinahl were often done in Cinahl headings which according to Willman et al. (2011) works as the thesaurus. This was to make sure relevant search terms were in coherence with Cinhals thesaurus index terms as well as choosing the right sub headings. No search terms that were outside Cinahls own thesaurus index terms were used in order to make sure that the search terms could be spotted in Cinhals library.

The search terms which are presented in Annex 2 are the search terms used that generated the articles used in the result of the literature review. Although several searches were carried through to identify search terms relevant to the aim of the literature review the search terms represented in Annex 2 were used. The entire search terms used in Cinahl was also used in PubMed and the other way around. In Cinahl 26 different search terms were used in different combinations with the smart text search options of AND/OR. Using the limitations tools applied in this study, peer reviewed and English language; Cinahl generated 1480 results in total. Out of the 1480 hits that Cinahl generated, 456 abstracts were read. 989 out of the 1480 hits were from the wrong countries, 28 articles that were the same were found in different searches. Several other articles found not in line with the aim of the studies were also left out. In the end eight articles from the Cinahl searches were picked for the result generated from the search terms: Transcultural nursing, Nurse patient relations, Qualitative studies, Transcultural care Cultural competence and Finland.
In PubMed the same search terms and the same combination of search terms was used alongside the same limitation tools as used in Cinahl. PubMed generated 1859 results and a total of 631 abstract were read. 1228 articles were from other countries than the Nordic and therefore excluded. The search on both databases generated several articles that did not fit the aim of the study. In the end two articles were used from PubMed in the result using the search terms: Sweden, Transcultural nursing and Transcultural care.
In the diagram illustrated in Annex 2 which is a concise description of the search schematic, it shows that the search term Finland was used in Cinahl and the search term Sweden was used in PubMed, but all of the Nordic countries were searched for in both databases. In retrospect the search schematic represented in this work is intended for the sole purpose of illustrating how the search was carried out. When conducting the search for articles relevant

to the aim of this literature review, a common reoccurring factor that is important to note is that while searching in the two databases used, (PubMed and Cinahl), similar articles in both databases were found, even when different search term were used.

After searching different search terms in Cinahl headings the search history was looked through combining different search terms using the smart text search options AND/OR.
In the searches done in PubMed the search terms were put into the advanced search window. In PubMed the thesaurus is shown directly as a search term is being written. As well as in Cinahl the index terms that were available in PubMed were used to ensure results. After that the search history was looked through and the search terms were combined using AND/OR. When the database Cinahl showed its result list the title, subject headings or the subject terms for each article was read through. If the subject heading is matching with the words and terms that were relevant to the aim, and the search terms used, the abstracts were read. If the abstracts were thought to be of relevance the articles study method and findings were looked through. PubMed in adversely to Cinahl does not displays the result lists of articles with subject terms or subject headings PubMed only displays the title of a published study. Therefore in PubMed abstracts and articles had to be read more frequently as titles of published studies did not give a clear insight into what the articles contents were. When all search terms had been used in both in Cinahl and in PubMed and a substantial amount of articles had been found to form a relevant synthesis the searches were considered done. The articles were then printed and read through. Ten scientific articles with qualitative study approaches which fit the aim of the literature study were chosen. After the ten final articles had been quality approved a manual search of the articles reference lists were looked through but no results were generated apart from spotting articles that had already been found.

Critical appraisal

Willman et al. (2011) quality assessment sheet with some modifications was used as a tool of determining the quality of the articles found (Se Annex 3). The sheet was modified excluding questions about saturation of data and saturation of analysis. Willman et al. (2011) supports this by stating that if the study has answered its aim using credible sources and the trustworthiness of the study is strong saturation of analysis and saturation of data can be excluded. The scoring system that was developed also using inspiration from Willman etal.,

(2011) where positive answers should be rewarded points but inadequate or negative answers receives zero points in order to maintain a truthful quality assessment. The scoring system used gave one point for each yes answer, zero points for each no answer and each don't know answer. According to Willman et al. (2011) questions with inadequate answers or a negative answer should be rewarded zero points as these answers do not contribute to quality. A article could receive a total amount of 13 points at most. Articles were accessed as high quality if they had a total score of between 10 and 13 points, articles which had between 5 and 9 points would be considered as medium quality and only articles that were given a minimum of 5 points were to be used in the result. According to Polit, Beck and Hungler (2001) an article of medium quality might have few participants or it can have a loss of participants, it may also lack in self-critical examination of confounding factors or causes. However if it provides for a studies essential components it can be used as a source (ibid).

Data analysis

Content analysis was done with inspiration from Graneheim and Lundman`s (2004) interpretation of Krippendorf`s (1980) explanation of qualitative content analysis. The analysis was a manifest analysis with latent elements. The articles were read one by one thoroughly 5 times, each time to gain more insight into the depth of the content. Reading the article the first time was to touch the surface of what the article was about. The second time the articles were read words and terms that were hard to understand were taken down by hand on a separate sheet of paper. The words and terms were then studied to a level of basic understanding. This allowed for a better comprehension of the text, consequently allowing for an easier read, without putting too much emphasis on separate words and terms. After that the articles were read two more times to really get familiarized with them. The fifth time the article was read the emphasis was strictly on the result quantities of the text. The articles results were read trough in a detailed manner and unit of analysis were taken out and then divided into areas of content and labelled with a subject term. According to Graneheim and Lundman (2004) an area of content is an area that is identified with little interpretation it is an area of the text which addresses a specific topic. An example of a labeled content area that was used was the topic of communication which included areas of linguistics and interpreters. The unit of analysis that made up the areas of content were subjects that were strictly relevant to the aim. When it was considered that all the units of contents that fit the aim had been picked out from each article and been separated into areas of content the process of condensing and coding was done. The condensation process referred to shortening the unit of

content while still keeping the core and the meaningfulness of the text intact. After the condensation process was done coding of the condensed units were conducted. The coding was to label the unit of content. After the coding had been done codes were compared in similarity and matched together to form categories. When the content analysis was considered done three categories emerged from the analysis, capturing nurses experiences (See Annex 4 for example of analyzing process).

Result

The result of read articles concluded in three major categories: Difficulties in communication, culturally bound behaviors and willingness to understand. These are presented bellow with relevant quotations as support.

Difficulties in communication

The participating nurses of the study expressed that patients lack in linguistic knowledge of the country of residence was a barrier. This meant that nurses and patients could not communicate or get vital information through to one another (Degni, Suominen, Essen, El Ansari & Vehviläinen-Julkunen, 2012; Ekblad, Marttila & Emilsson, 2000; Fatahi, Mattsson, Lundgren & Hellström, 2009**;** Hultsjö & Hjelm, 2005; Høye & Severinsson 2010; Høye & Severinsson 2008; Nielsen & Birkelund, 2008; Thyli, Atlin & Hedelin, 2006).

> *"It is difficult to communicate with the Somali women, because they do not understand Finnish and one cannot talk to them directly"* (Degni, Suominen, Ess`en, El Ansari & Vehviläinen-Julkunen, 2012, p.336).

Further participating nurses had the perception that patients who did not understand the language often did not state the fact that they did not understand. Further a sense of irritation over the patients lack of linguistic skills as the attempts to transfer information took time from other tasks as well time from other patients. The participating nurses also acknowledge a gap in linguistic knowledge based on age. The participating nurses found that younger immigrants had a better knowledge in language and could therefore communicate in an appropriate level (Nielsen & Birkelund, 2008). Older immigrants had a severe lack of linguistic knowledge and could therefore not make themselves understod or take in information given by the nurses (Ekblad, Martila & Emilsson, 2000; Nielsen and& Birkelund, 2008). Even though the majority of the participating nurses felt that language was

an obstacle, the participants explained that the use of professional translators did not occur often as translation sometimes needed to be rapid, or that the coast of translators were too expensive (Hultsjö & Hjelm, 2005; Nielsen & Birkelund, 2008).

> *"We spend enormous amounts of money on interpreters and therefor the family is used"* (Nielsen & Birkelund, 2008, p.434).

Some participating nurses expressed that interpreters were not used as the patients did not want outsiders to interpret for them. (Degni, Suominen, Essen, El Ansari &Vehviläinen-Julkunen, 2012; Hultsjö & Hjelm, 2005;). Furthermore the participating nurses stated that relatives were often used as interpreters. In using relatives as interpreters the participants felt that they could not be sure that the information that was given to the patient and the information received from the patient was absolutely accurate, the participants saw this as a negative aspect as vital information got lost in translation (Ekblad, Martila & Emilsson, 2000; Hultsjö & Hjelm, 2005; Høye & Severinsson, 2009; Nielsen & Birkelund, 2008). Some participants which expressed that interpreters were used often as it made communication and understanding successful as well as it made the patients feel secure (Fatahi, Mattsson, Lundgren & Hellström, 2009). Some participating nurses expressed the involvement of gender roles in communication. These nurses expressed that in many cases the husbands of female patients were the only ones that were to handle the communication between nurses and patient. The same nurses perceived this to be problematic as they felt that information might have been withheld and the patient's own wishes might not be translated (Hultsjö & Hjelm, 2005; Høye & Severinsson 2010).

Culturally bound behaviours

The participating nurses perceived that when a patient from nonwestern migrant families turned ill the family take the role as caretakers (Debsay, Harlöf, Rechel &Vike, 2014; Hultsjö & Hjelm, 2005; Høye, Severinsson 2010; Skott & Lundgren, 2009). Furthermore the participating nurses expressed that patients become passive when they turned ill and the patient rather do nothing but to lie in a bed and be taken care of (Debsay, Harlöf, Rechel &Vike, 2014; Hultsjö & Hjelm, 2005; Skott & Lundgren, 2009).

> "*The forign family often assumes the responsibility, and unfortunately the patient then becomes passive"* (Skott & Lundgren, 2009, p.227).

Some participating nurses expressed that passive patients was an obstacle in nursing care as the participating nurses instinctively wanted the patient to become self-helping as well as independent (Skott & Lundgren, 2009). The participants also experienced that relatives of the patients came to visit as much as they could, many times in large groups. The same participating nurses felt that this was a negative aspect as the patients needed to rest as well as the relatives disturbing the other patients around them (Hultsjö & Hjelm, 2005; Høye &Severinsson 2010; Nielsen & Birkelund, 2008).

> "*A lot of visitors came. It was difficult, because the unit was crowded and about 30 people arrived. They were all over the ward, in the corridor, and other families had no space. We had to restrict the number of visitors"* (Høye & Severinsson, 2009, p. 862).

The participating nurses also felt that many patients exaggerated and dramatized their expression of pain. This made the participating nurses feel insecure as to what treatment was appropriate (Hultsjö & Hjelm, 2005; Høye, Severinsson 2010; Nielsen, Birkelund, 2008).

> *" I have found that they show it a little more easily or faster than we do. They are louder. It is often more dramatic around migrants, they tear their hair in despair and they cry with more emotion"* (Hultsjö & Hjelm, 2005, p.280).

Participating nurses also felt that it was irritating when migrant patients' expression of pain were loud as it might disturb other patients in the nearby surroundings (Nielsen & Birkelund, 2008). The participating nurses also expressed that when patients were religious they could feel a sense of uncertainty towards attending to the patient not knowing what was appropriate behavior (Debesay, Harslöf, Rechel & Vike, 2014; Kyungu Nkulu Kalengaayi, Hurtig, Ahlm & Ahlberg, 2012; Skott & Lundgren, 2009).

> *"I know they wear special headgear. They may have a beard too, in which case I feel uncertain about whether he thinks it`s okay that I wash his beard…. How does he really feel about what I do?"* (Debesay, Harslöf, Rechel & Vike, 2014, p.5).

Participating nurses stated two specific experiences when dealing with different behavior from patients. One was that patients only accepted being treated by doctors, nurses expertise was not relevant to these patients. In coherence to this behavior the same nurses expressed that when patients were told that it was not possible to see a doctor the patients many times got aggressive towards the nurses. The second behavior that the nurses experienced was religiously bound. Participating nurses found it difficult to engage patients who were fasting and inform the patients of the risks of disrupting their treatments due to fasting (Kyungu Nkulu Kalengaayi, Hurtig, Ahlm, Maina Ahlberg, 2012).

Willingness to understand

The participating nurses felt that racism and prejudice was sometimes present in the nursing teams when dealing with foreign patients. The participating nurses felt that by continuously meeting patients from other religions and cultures there was a development of openness and a positive change of attitude towards the patients (Degni, Suominen, Ess`en, El Ansari & Vehviläinen-Julkunen, 2012; Ekblad, Marttila, Emilsson, 2000; Skott and Lundgren, 2009; Thyli, Athlin & Hedelin, 2006).

> *"I am aware of the fact that when somebody with a forign sounding name comes in, one immediately begin to send other signals*" (Nielsen & Birkelund, 2008, p.433).

Participating nurses also expressed that members of their nursing team sometimes discriminated people due to the fact that they were from another country. The nurses stated that the discrimination of these people where done because the nurses had a lack in cultural knowledge about the specific people (Kyungu Nkulu Kalengayi, Hurtig, Ahlm & Ahlberg, 2012). The participating nurses further

expressed the feeling of professional insecurity when dealing with the patients and their relatives as the nurses felt they did not have enough knowledge about the patients culture. Nurses also expressed an urge to learn more hands on facts about different cultures and religions that would be useful in their profession so that interaction between nurse and patient could be successful (Debesay, Harslöf, Rechel & Vike, 2014; Skott & Solveig, 2009; Thyli, Athlin & Hedelin, 2006).

> *"My racism passed by. I have learned to respect different nationalities and religions…you become humble …everyone has a background and a special narrative to tell"* (Skott & Lundgren, 2009, p.226).

Some participating nurses also expressed that there was a negative attitude to a development in multicultural knowledge, due to the fact that these nurses saw it as another demand in an already stress filled occupation (Thyli, Athlin & Hedelin, 2006).

Discussion

Method discussion

The aim focus on nurses from the Nordic countries. This might be seen as too much of a limitation as according to Leininger (2002) transcultural encounters occur in all multicultural societies. But as Anell (2004) states that there is several similarities in characteristics of the Norweigan, Swedish, Finnish and Danish healthcare systems organization and financing. All of the systems are tax funded and the healthcare services are organized on the basis of the public sector. According to Blank and Burau (2010) there are models built up around tax funded healthcare systems that are consider to be the most profitable. In all systems of the countries mentioned above, there are similarities how the systems are built up and how patients take part of the healthcare system. Blank and Burau (2010) also makes a key point in that the healthcare systems of the Nordic countries allows for all of its citizens to be able to get access to the healthcare that they need (ibid).

The reason for choosing only Nordic countries in the result of the literature review was to ensure that the experiences of the Nurses did not differ on a basis that was due to the healthcare systems of countries explored being different on a larger scale.

By only choosing two of the databases that were provided by Blekinge institute of technology there was a risk of limiting the results. But as time was of the essence the limitation of databases had to be made. Willman et al. (2011) states that time limit as well as resources and experience are factors that should be taken into consideration when starting any study.
The positive aspect of only using two of the databases was the knowledge from using them in the past but also the knowledge growth that occurred over time as searches gave more insight into how the databases worked. According to Katcher (2006) if you are not a frequent well taught Medline searcher it is better to start with a search engine that has its own interface to Medline such as PubMed. Evans (2002) also states that Cinahl is a better database than Medline due to the fact that Cinahl has more index terms to choose from than the search engine Medline. Evans (2002) furthers his meaning by saying that Cinahl also had a more accurate index term descriptions of the qualitative study design (ibid). Willman etal,. (2011) also supports this by stating that databases thesaurus index terms should be used frequently as this tend to show more results.

The method of combining words with the smart text search options AND/OR was positive in that it generated less as well as more specific results in contrary to not using AND/OR where the search results were very extended. Brenner and McKinins (1989) advocates that when using Cinahl the best combining of search terms with smart text search model AND/OR will generate the most specificity when retrieving qualitative studies. Willman et al. (2011) also confirms Brenner and McKinins (1989) theory that when searching in databases it's the combination of search terms that generates the best results. Furthermore the limitation tools that were used were the basic tools. This was a good starting point in the search techniques as results did not get to restricted. On the other hand sometimes search results could get very wide. Brenner and McKinins (1989) describes that when you add limitations in Cinahl the search engine will perceive that as a definite. Evans (2002) also suggests being really careful when using smart text searching options AND/OR in Cinahl as it can limit the search, although using AND/OR with the right combination of search terms in the right way can generate great results. Wilczynski, Marks and Haynes (2007) suggests that the search limitation tools should not be used to harshly in the beginning of a search due to them restricting the search engine.

By looking at the different search terms in aftermath there is one search term in particular which could have generated more results and precision, "Scandinavia". Though the search

term would have excluded Finland it probably would have generated results from the other countries.
Furthermore Willman et al. (2011) quality assessment sheet was a good tool to use. Although in aftermath the scoring system that was used and influenced by Willman et al. (2011) could have been morestrict. All the articles that were used had a score above 10 and they were therefore high quality. The scoring system used stated that articles that had a minimum of 5 points would be used. Considering that each yes answer was 1 point only 5 questions out of 13 had to be answered with yes to be used in the result this could have led to a wrongfully assessment of quality. This might have been the case when including the study by Kyungu Nkulu Kalengayi, Hurtig, Ahlm and Ahlberg (2012) as the study only included two participants as two participants experiences does not show a wide spread relevance throughout the nursing profession.

Using Graneheim and Lundman`s (2004) interpretation of Krippendorf was a good choice for analyzing qualitative data as it was not to strict as to keeping the analyzing process strictly manifest nor latent and it allowed for interpretation. The division into content areas in the beginning of the analyzing process was of use as it was easier to get an overview of what topics the result could include. It was further discussed whether the article used in the result presented by Ekblad, Marttila and Emilsson (2000) should have been used, based on the fact that the researchers in the study did not define nurses from other occupation groups in the participant description, the study simply stated that majority of the 10 staff members were nurses. Concerning the relevance of the concept “nurses experiences when treating patients with a different cultural background” The article referenced on several occasions in the text that the interviewees were nurses. Therefore in this article only part of text was used in the result, text that clearly spoke of nurses as interviewees.

Result discussion

The result of the study shows that a vast majority of Nordic nurses whom have encountered patients from different cultural background, has been faced with circumstances whereby communication had been problematic, nurses also experienced that this interaction widened their horizons and they acknowledged that education about culture is essential, as they became more involved with patients from other cultures. Lastly a focal perception of the

Nordic nurses in respect to patients from foreign cultures is that, the approach of the patience relative during treatment can be disconcerting.

The language barrier between patients and nurses was the enhanced problem in the result. Leininger (2002) further explains that communication and language is a problematic barrier for nurses to overcome. Though communication is mainly through language it also consists of nonverbal body language, expressions and gestures all in which are culturally connected. Leininger (2002) explains that if nurses have the urge, interested and knowledge about nonverbal communication as well as proper cultural communication it might help the nurse when in contact with patients that do not speak the same language as the nurse. By taking a look at the ICN (2012) ethics code "The nurse ensures that the individual receives accurate, sufficient and timely information" (ICN, 2012, p. 2). Nurses have to have and understanding about communication, how it differs between countries as well as it is the nurse's duty to make sure that proper information reaches the patients.

Further the result showed that the participating nurses wanted to learn more about cultures and religions due to the fact that they felt professionally insecure at some point when these aspects were involved in patient nurse encounters. The participating nurses also had an urge to perform their profession in the right manner that benefitted the patients. According to The International Council of Nurses (2012) (ICN) ethics code "An environment where human rights, values, customs and beliefs of the individual, family, and community are respected". "Initiate and support measures that meet, especially weak population groups, health and social needs" (ICN, 2012). In order for the ICN (2012) ethics code to be of any guidance use in the practical work nurses have to receive proper training and education before going out to preform practical work. Leiningers (2002) sunrise model can work as a tool for the nurses to gain more insight into whom the patient is as the model deals with almost all aspects of culture. Leiningers (2002) sunrise model brings up the aspect of culture that has to do with religious and philosophical extension these two factors can be studied by nurses to a level of basic understanding so that when dealing with these aspects of culture it does not make for misunderstandings and incomprehension.

According to the result participating nurses also expressed experiences where relative's actions while visiting were not thought of as good behaviors in compliance with the healthcare setting which the participating nurses worked in. In a study by Al-Shahri (2002)

which explains views of Islam. Relatives are of upmost importance to Islamic patients or patients from Islamic cultures due to the fact that they feel security and support from relatives. It is therefore important to not violate the patient's integrity and allow relatives and visitors to come and show support in the way that they know how to do it (ibid). As (De Santi's, 1994 and Leininger and McFarland (2002) explains, that nurses have to be aware of their own cultural baggage before they can understand and accept another person's way of life. In this case the nurses behaved and thought accordingly to their own believes that there should not be to many visitors, that the visitors should not be with the patient all the time due to the patient needing to rest as well as the relatives presence disturbed other patients. According to Leininger (2002) nurses should try to understand peoples' behaviours. So in the case of the nurses in the result there might not have been enough knowledge surrounding why the relatives acted the way they did instead of just seeing it at a disconcerting factor when dealing with patients from other cultures.

According to Leininger (2002) it is important for the nurses to have consideration for the patient's wishes and integrity as well as having an understanding for family views. Knowledge about family structures could be important for nurses working in multicultural societies. Triandis (1995) explains Individualism and collectivism cultures. In the aspect of individualism the individual is expected to becoming more self-dependent and independent from the family. The individualistic aspect of culture is often found in western countries. In contradiction to a individualistic culture Triandis (1995) speaks about the collective oriented culture. Where family is the most high, family members stay closely knitted as well as the whole family is kept in mind when making a decision.

As the result showed the participating nurses in the Nordic healthcare systems having visitors surrounding a patient all day long was looked upon as an obstruction. In paradox patients from the collective cultures as Triandis (1995) defines collective culture probably expects their relatives to be around them at all times to be there as support and act as care takers, which in this case would contribute to person centered care for these patients.

Three aspects of the whole result were discussed but all the experiences that were presented in the result should be brought up for discussion among health professionals as well as within the healthcare system as a whole. Policies, health education, health administration are all parts that relate to the challenge of building a working multicultural healthcare setting where nurses and patients can interact on a successful level thus with the presence of different cultural views. According to Leininger and McFarland (2002) the sunrise model can help nurses to get a wide picture of a patient's cultural views and needs to better understand the

patient and to better care for the patient. For example the sunrise model includes questions about a patients' kinship and social life, language, religious as well as cultural values and how these elements forms the person that the nurse is dealing with and helps the nurse in her decision making. Perhaps if the sunrise model was a tool for the participating nurses in the Nordic articles the experiences of uncertainty might have been different. Leininger's (2002) cultural care theory and the implementation of the sunrise model can be a profound starting point for all nurses as a base of education and understanding of cultures impact on nursing care and how the obstacles can be meet and overcome this in turn can benefit the knowledge about how to give optimized person centered care.

Conclusion

There is a major need for cultural knowledge in the nursing profession. The Nordic countries that were represented in this litterer review are multicultural societies. But there is a lack in organized education for nurses as well as a method for nurses to obtain information from patients about their cultural needs, needs that might affect how the nurses perceives their patients. It is understandable that Nordic nurses will experience numerous obstacles when treating patients with differential cultural background. An acceptable idea is that education and hands on meetings between nurses and patients from different cultures can create better understanding and mitigate a positive attitude from the nurses in their approach towards the patients. Invariably, creating a foundation to build substantial knowledge around which in turn, can spawn a more functioning multicultural healthcare system. A solution to reduce culture clashes or prejudice amongst nurses might be to implement transcultural education and training for nursing students before they run into these encounters in the workplace. Further studies can be aimed at the Leinigers (2002) sunrise model as a questioner tool for the nurses to imply whenever meeting patients from other cultures and then evaluate the outcome. Studies may also include with a starting point from the ICN (2012) code of ethics chapters regarding cultural aspects of care if the ethics code is being utilized in practical work, and what factors are or may jeopardized the correct implementation and approach of the edict of the ICN (2012) ethics code.

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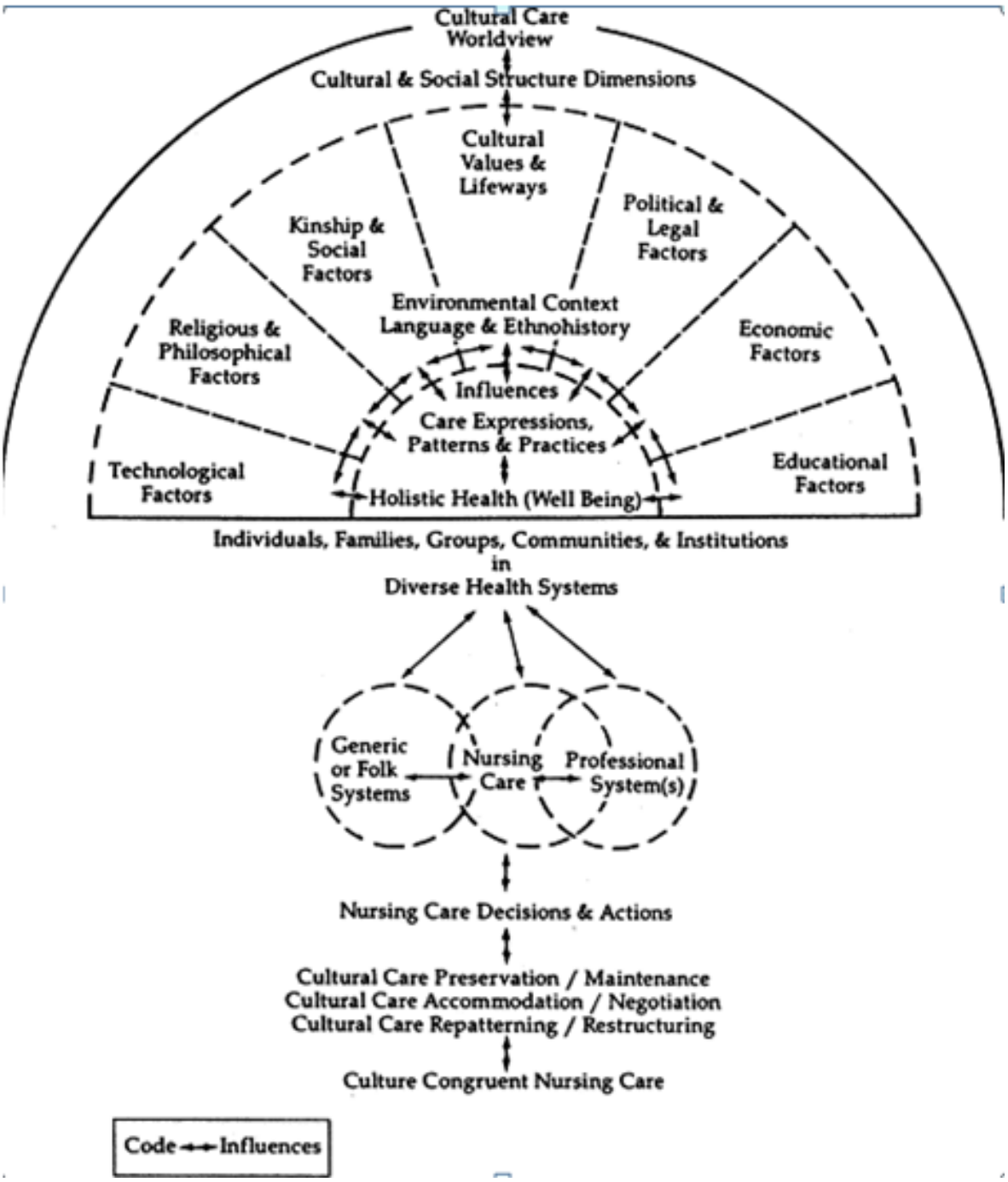
Annex 5. FIGURE 1.1 Sunrise Model. Source: Leininger, M. M. (1995).



Annex 2. Search schedule

Database **Cinahl**	Search terms	Results	Results after limitation	Read	Quality accessed	Used	Date
	Cinahl Headings						*25/02/2014*
1	Transcultural Nursing	2838					*25/02/2014*
2	**Nurse patient relations**	20069					*25/02/2014*
3	1 and 2	320	62	9	4	4	*25/02/2014*
4	**Qualitative studies**	56380					
6	Transcultural nursing or transcultural care	4709					
7	**4 and 6**	304	234	15	3	3	*25/02/2014*
8	Cultural competence	6051					*18/03/2014*
9	**Finland**	8843					*18/03/2014*
10	8 and 9	19	19	1	1	1	*18/03/2014*
PubMed							
11	**Sweden**	234330					*27/02/2014*
12	Transcultural Nursing	3344					*27/02/2014*
13	**Transcultural care**	1944					*27/02/2014*
14	11 and 12 and 13Advanced	27	27	3	2	2	*27/02/2014*

PROTOCOLL FOR CRITICAL APPRAISAL OF STUDYS WITH QUALITATIVE STUDY

Original from Wt.al, 2011. With adjustments.

-
- ***Description of the study, text. method.....***
  .....
  .....
  .....

Is there a clear purpose? Yes No ?

Participant Charactarstics

Number.....

Sex.....

Age.....

- ***Is the context presented?*** ☐ Yes ☐ No ☐ ?
- ***Ethical reasoning?*** ☐ Yes ☐ No ☐ ?

Selection

- ***Relevant?*** ☐ Yes ☐ No ☐ ?
- ***Strategic?*** ☐ Yes ☐ No ☐ ?

Method of

- ***Selection procedure clearly described?*** ☐ Yes ☐ No ☐ ?
- ***Collection of data clearly described?*** ☐ Yes ☐ No ☐ ?
- ***Analysis clearly described?*** ☐ Yes ☐ No ☐ ?

Validity

- ***Is the result logical and comprehensible?*** ☐ Yes ☐ No ☐ ?

-
-

Communicability

- ***Is the result presented clearly?*** ☐ Yes ☐ No ☐ ?
- ***Is the result presented in relation to a theoretical framework?*** ☐ Yes ☐ No ☐ ?

Is a theory generated? ☐ Yes ☐ No ☐ ?

What are the main findings?

……

……

…….....

Total amount of points……

Summarized assessment of quality

High	**Medium**	**Low**
☐	☐	☐

Reviewers sign…….....

Medium = 10 points

☐

Annex 4. Analysis process

Unit of analysis	Condensation	Code	Category
It is not easy to build a good relationship with a person who does not speak your language, does not know you, who has been traumatized by civil war, been abused sexually, does not trust anybody and feels like living in a different world.	Not easy to build a good relationship with a person that does not speak the same language and from a different background	Language	
Using a relative as interpreter can lead to complications, they may interpret selectively.	Relatives translating leads to selective translations	Relatives influences correct communication	**Difficulties in communication**
We spend enormous amounts of money on interpreters, and therefore the family is used, since this is the cheapest.	Lack of financial aid leads to relatives being used as translators	Reason for not using professional translator	

Unit of content	Condensation	Code	Category
When you mix cultures you let go of prejudice, like putting people together into different boxes, when you are there together with that person you feel that we are all alike each other – even if some has brown eyes – we are the same.	Mixing cultures breaks down prejudice.	Overcoming prejudice	**Willingness to understand**
I would like to know a little more about the traditions in other countries in relation to what we do?	Wanting to know more about traditions in relation to work	Interested in learning	

Unit of content	Condensation	Code	Category
But a negative thing with many of the ethnic patients is, well generally many of them are in bed, then many visitors come and it`s a big problem when 10-12-14 relatives come in to one room where three other patients are already lying	A large group of visitors in a room where patients share one space Is a problem	Relatives visiting	**Culturally bound behaviors**
The foreign family often assumes responsibility, and unfortunately the patients then become passive	Family resumes responsibility and patient becomes passive	Passive patients	
"They do not want to be examined by a man, because in their religion, a woman is not allowed to be naked in front of a man who is not their husband"	They feel that no man should examine a woman due to religious believes.	Religion and Gender	
I also think they express, more often than Danes, that they have more pain. Occasionally we talk about this and call them ethnic pains, which I think some of them have.	Patients express more pain.	Different expressions of pain	

Annex 5. Article overview

Author/Year/Country	Titel of article	Method	Selection of participants	
Debesay, J., Harsløf, I., Bernd, R. & Vike, H. (2014) Norway	Facing diversity under institutional constraints: challenging situations for community nurses when providing care to ethnic minority patients.	A hermeneutic approach with tape recorded semi-structured in depth interviews. Qualitative Content analysis according to Nvivo. 4 researchers compared their content analysis to ensure that interpretations were well supported.	19 Nurses	High
Degni, F,. Suominen, S,. Essen, B, El Ansari, W & Vehviläinen-Julkunen, K. (2011) Finland	Communication and Cultural Issues in Providing Reproductive Healthcare to Immigrant Women: Health Care Provider`s Experiences in Meeting Somali Women Living in Finland	Open-end questions interviews and field notes. Qualitative content analysis according to Silverman (2004)	7 Nurses	High
Ekblad, S.,Marttila, A. & Emilsson, M. (2000). Sweden	Cultural challenges in end-of-life care: reflections from focus groups 'interviews with hospice staff in Stockholm.	Taped focus group interviews. Formed questions aimed at exploring staff's attitudes, thoughts and perceptions. Analysis of qualitative data according to (Krueger 1994)	19 persons staff, majority nurses	High
Fatahi, N., Mattsson, B., Solveig M. Lundgren, S M. & Hellström, M. (2009) Sweden	Nurse radiographers' experiences of communication with patients who do not speak the native language.	Taped open interview questions. Focus group interviews Content analysis of data by (Graneheim & Lundman , 2004)	11 Nurses	High
Hultsjö, S. & Hjelm, K., (2005) Sweden	Immigrants in emergency care: Swedish health care staff´s experiences	Taped Semi-structured interviews in focus groups. Qualitative content analysis according to (Krueger & Casey 2000)	35 Nurses	High

Høye, s. & Severinsson, E. (2010) Norway	Professional and cultural conflicts for Intensive care nurses.	Taped Focus groups interviews with open discussions about different topics. Qualitative content analysis by Graneheim & Lundman, 2004	16 Nurses	High
Kyungu Nkulu Kalengayi, F., Hurtig, .K., Ahlm, C., Maina Ahlberg, B. (2012) Sweden	"It is a challenge to do it the right way": an interpretive description of caregivers experiences in caring for migrant patients in Northern Sweden	Semi structured interviews and field notes Thematic analysis approach according to Braun and Clarke. (2006).	2 Nurses	Medium
Nielsen, B. & Birkelund, R. (2009). Denmark	Minority ethnic patients in the Danish healthcare system – a qualitative study of nurses' experiences when meeting minority ethnic patients.	Taped qualitative interviews as well as field notes, Qualitative content analysis according to (Malterud, 2003)	4 Nurses	High
Skott, C. & Lundgren, S. (2009). Sweden	Complexity and contradiction: home care in a multicultural area.	Group Interviews and discussions. Open end questions. Qualitative analysis according to (Ricoeur 1977, 1981, 1991)	5 Nurses	High
Thylib, B., Athlin, E. & Hedelin, B. (2007) Sweden	Challenges in community health nursing of old migrant patients in Norway – an exploratory study	Questioner with both structured and open questions Descriptive manifest content analysis according to Morgan 1993; Berg, 1995; Coffey and Atkinson, 1996	18 Nurses	High