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# **CULTURAL COMPETENCE IN NURSING**

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## ABSTRACT

The overall aim of this thesis is to explore, analyze and clarify how cultural competence is understood. This is explored from the perspective of nurses, nursing students, nurse educators, and nurse researchers in relation to the Swedish care context. The field of transcultural nursing and cultural competence was founded in the United States in the 1950s in response to an increased awareness of cultural diversity arising from immigration. In Sweden an interest in transcultural nursing and cultural competence has emerged only recently and therefore knowledge in this area is quite sparse. In **Study I**, an instrument for measuring cultural competence was translated, adapted and evaluated for use in Sweden. By following guidelines in the literature, this process was carefully laid out and the content and internal structure of the instrument was evaluated. The findings indicated that the instrument did not meet appropriate validity and reliability levels, and the evaluation of the content indicated a weak relation between the instrument and the constructs. Therefore, it was concluded that the instrument could not be used in Sweden. In **Study II**, the aim was to analyze the core components found in the descriptions of the most frequently cited theoretical frameworks of cultural competence. Nine theoretical frameworks of cultural competence were analyzed using a documentary analysis method. The data were analyzed using qualitative content analysis. The findings revealed four themes that characterized cultural competence: an awareness of diversity among human beings; an ability to care for individuals; non-judgmental openness for all individuals and; enhancing cultural competence as a long-term continuous process. In **Study III**, the aim was to identify the core components of cultural competence from a Swedish perspective. The Delphi technique was used and 24 experts took part in the study. The first round was conducted with qualitative interviews and was followed by three rounds with questionnaires. In total, consensus was reached on 118 core components that were grouped into five categories, with 17 associated sub-categories. These categories are: cultural sensitivity; cultural understanding; cultural encounter; understanding of health, ill-health and healthcare; and social and cultural context. In the final study, **Study IV**, qualitative interviews were conducted with 10 nursing students, five with an immigrant background and five with a Swedish background, to explore their experiences of communication in cross-cultural care encounters. The interviews were analyzed using the framework approach. Four themes were identified: conceptualizing cross-cultural care encounters; difficulties in communication; strategies employed; and factors influencing communication. The synthesis of the findings from the four studies is illustrated in Figure 1 as the common patterns in the constituent elements of cultural competence in the Swedish context, which are identified as: the nurse's cultural awareness, personal beliefs and values; cultural assessment; and cross-cultural communication. The thesis concludes that transcultural nursing and cultural competence is about nurses being able to take the patient's cultural background, beliefs, values and traditions into consideration in nursing care. Cultural competence should not only be employed when caring for immigrants or ethnic minority groups, but also in encounters with all patients.

Key words: cultural competence, transcultural nursing, cross-cultural encounters, cross-cultural communication, nurse education, instrument evaluation, psychometrics, documentary analysis, content analysis, Delphi method, framework approach

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## LIST OF PUBLICATIONS

This thesis is based on four studies referred to by their Roman numerals I-IV. The studies described explored different aspects of cultural competence in nursing. In the first study (Paper I) an instrument measuring cultural competence was translated, adapted, and tested for validity and reliability. In the second study (Paper II) the core components of cultural competence in the international nursing literature were analyzed. The third study (Paper III) focused on identifying the core components of cultural competence from a Swedish perspective and in the fourth and final study (Paper IV) nursing students' experiences of communication in cross-cultural care encounters were explored.

- I. Olt, H., Jirwe, M., Gustavsson, P., & Emami, A. Psychometric Evaluation of the Swedish Adaptation of the Inventory for Assessing the process of Cultural Competence among Healthcare Professionals- Revised (IAPCC-R). *Accepted subject to minor modification for publication in Journal of Transcultural Nursing.*
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- IV. Jirwe, M., Gerrish, K., & Emami, A. Student nurses' experiences of communication in cross-cultural care encounters. *Submitted for publication.*

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*The difficulty lies, not in the new ideas, but in escaping the old ones, which ramify, for those brought up as most of us have been, into every corner of our minds.*

*John Maynard Keynes, 1936*

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# 1 INTRODUCTION

The overall aim of this thesis is to explore, analyze and clarify how cultural competence is understood. This is explored from the perspective of nurses, nursing students, nurse educators, and nurse researchers in relation to the Swedish care context. It is hoped that the knowledge gained from the studies presented here can inform the nursing curriculum in Sweden. In order for nurses to take patients' cultural backgrounds into consideration as they carry out nursing care, they need to be culturally competent. Having taught nursing courses that address cultural issues, my experience has been that nursing students consistently seek knowledge concerning immigrants<sup>1</sup>, but what they hope to find is a simple cookbook approach, with guidelines for what to do when caring for a person from a specific cultural group. I have always wondered why they have this expectation in relation to patients with an immigrant background and not with patients with a Swedish background. Cultural competence is not about immigrants, it is about the ability to care for patients, and take their cultural background into consideration in the context of nursing care.

My interest in a cultural perspective derives from my years working as a nurse within different paediatric intensive care units in Sweden. I specifically recall two similar episodes that instigated my own critical reflections over how similar situations can be interpreted quite differently; in this case one episode involved a mother with an immigrant background and the other episode a mother with a Swedish background. The mother with an immigrant background had just learned from the doctor that her child was going to die. The mother started to run down the corridor, screaming loudly and then started to cry. All of us - nurses, assistant nurses and doctors - explained this reaction as having been related to her cultural background. It was her cultural expression for grief and we talked about it as being something odd and very different – something “they” did. A few months later a mother with a Swedish background received the same information as the other mother and reacted in the same way as the first, yet we did not explain this as a cultural expression of grief, but as a perfectly natural way of behaving when receiving this sort of information. In other words we interpreted it from a psychological not a cultural perspective. Why did we explain this reaction as cultural behaviour, something “they” did, one day, and on another day explain it as a natural behaviour, something perfectly normal? These episodes and other experiences from my clinical work as a nurse and later as a nurse educator preparing nursing students for their work with patients, have led to my own interest in cultural competence: how it can be assessed, how it is defined in the literature and in practice and how it is experienced by nursing students.

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<sup>1</sup> It is recognized that different terms are used in different countries to describe someone who is not of the majority population. In the UK the term ‘ethnic minority group’ is used to describe people who may for example have originated from or who have family ties with Pakistan. By contrast in Sweden the term ‘ethnic minority’ is used to refer to the Sami people who are an indigenous group in north Sweden, Norway and Finland. The term ‘immigrant’ is used in Sweden to refer to people whose origins lie outside the country. In the national statistics a person is registered as born abroad if he or she was born in a country other than Sweden or if a person has two parents that were born abroad. In colloquial speech they are referred to as an immigrant or a second generation immigrant. A person can be an immigrant as a refugee, a migrant worker or in relation to family reunion.

## 2 BACKGROUND

An interest in transcultural nursing arose in the 1950s in response to a concern for nurses to address cultural diversity among the recipients of health care services in the USA (Leininger & McFarland, 2002). Leininger has been credited with developing the term 'transcultural nursing' to describe an approach to providing nursing care based on an anthropological perspective. Leininger defines transcultural nursing as:

*“a formal area of study and practice in nursing focused upon comparative holistic cultural care, health, and illness patterns of individuals and groups with respect to differences and similarities in cultural values, beliefs, and practices with the goal to provide culturally congruent, sensitive, and competent nursing care to people of diverse cultures”* (Leininger, 1995, p. 4).

According to Leininger, in order to provide culturally competent care nurses need to develop a detailed understanding of the cultural backgrounds of their patients and apply this knowledge to practice. Whereas Leininger has undoubtedly made a highly significant contribution to the field her work has been subject to criticism. The approach has been criticised because it adopts an essentialist view of culture which is seen as a property that people possess that is static. Nurses become 'experts' in cultural knowledge about particular ethnic groups, for example the Chinese population in the USA. However, such an approach assumes, incorrectly, that people from a particular ethnic group are all the same, that differences between ethnic groups are more important than similarities and it fails to recognise that culture is dynamic and constantly changing as individuals react to the context in which they live out their lives (Culley, 2001; Mulholland & Dyson, 2001). Additionally, by 'focusing on culture as the formative force in determining patterns of behaviour' (Bruni, 1988, p. 26) other pertinent structural factors such as class, gender and the impact of racism are excluded (Bruni, 1988; Gerrish, 1999; Gustafsson, 2005; Hanssen, 2002; Mulholland & Dyson, 2001).

Leininger's work has acted as a catalyst for others to develop theoretical frameworks under the broad umbrella term of 'transcultural nursing'. Whereas many of these have evolved in the USA (e.g. Andrews & Boyle, 2003; Purnell & Paulanka, 2003) others have been developed in Europe (Papadopoulos, 2006) and New Zealand (Ramsden, 2005). As will become apparent from the analysis of these frameworks I present in Paper II, although these frameworks have similarities, they also have differences. Some of these differences address the criticisms of Leininger's framework outlined above.

In terms of the work presented in this thesis, I use the term 'transcultural nursing' to refer to the broad field of study which is concerned with equipping nurses with the skills to provide culturally competent care, and not the particular approach put forward by Leininger.

Within the broad field of transcultural nursing, cultural competence is considered essential for nurses to be able to address health care disparities among vulnerable populations. For nurses to develop cultural competence, nursing programs need to incorporate cultural issues into the curricula. In Sweden, cultural competence is a relatively new issue of concern to nurse educators; knowledge about and an understanding of cultural competence is limited. The work presented in this thesis contributes towards further developing an understanding of cultural competence within the context of nurse education and nursing practice in Sweden.



## **2.1 WHY IS CULTURAL COMPETENCE NECESSARY?**

Cultural diversity is not a new phenomenon in society, but an awareness of and an interest in cultural diversity has been brought to the fore due to immigration. In Swedish health care services, cultural diversity can appear in different constellations. Examples are a Swedish nurse caring for a patient with an immigrant background, a nurse with an immigrant background caring for a patient with a Swedish background, a nurse with an immigrant background caring for a patient from another immigrant background, and finally, a Swedish nurse caring for a Swedish patient from a different cultural background than her/his own. In Sweden, 87% of the population has a Swedish background while 13% of inhabitants are categorized as having an immigrant background, from over 200 countries (Swedish Statistical Central Board, 2007) In relation to nursing, approximately 7.5 % of the nurses in Sweden have an immigrant background, and in the Stockholm County Council the numbers are even higher, with 15.1 % of the nurses having an immigrant background (The Swedish Association of Health Professionals, 1999).

Transcultural nursing began as a response to the challenges nurses faced when caring for patients from another cultural background, a necessity that arose with immigration. Transcultural nursing and cultural competence were regarded as the solutions to meeting immigrants' special needs (Leininger & McFarland 2002). Transcultural nursing and cultural competence is about caring for patients and responding to their expectations and needs, harkening back to the teachings of Florence Nightingale who emphasized that nurses should respond to patients' needs, providing them with the care they need and not with the care the nurse thinks the patient needs. In 1859 Nightingale stated:

*“What Nursing ought to do”*

*“I use the word nursing for want of better. It has been limited to signify little more than the administration of medicine and the application of Poultices. It ought to signify the proper use of fresh air, light, warmth, cleanness, quiet, and proper selection and administration of diet - all at the least expense of vital power to the patient.”* (Nightingale & Barnum, 1992, p. 6)

In order for nurses to be able to care for the patient and to take his/her cultural background, beliefs, values and traditions into consideration within the context of nursing care, the literature emphasizes the need for nurses to develop cultural competence.

## **2.2 WHAT IS CULTURAL COMPETENCE?**

The concept cultural competence consists of two components - “culture” and “competence”- which will be defined below. An overview of the state of knowledge surrounding cultural competence within nursing and in the nursing education is also given.

### **2.2.1 Culture**

The concept of culture is multidimensional and complex with several definitions proposed by anthropologists and sociologists. It includes attitudes, beliefs and ideologies (Purnell & Paulanka, 2003). Culture has been studied for a long time in accordance with different aspects of language, history, art, spirituality and kinship (Leininger & McFarland, 2002). In relation to nursing, Papadopoulos (2006) defines culture as “the shared way of life of a group of people that includes beliefs, values, ideas, language, communication, norms and visibly expressed forms such as customs, art, music, clothing and etiquette. Culture influences individuals' lifestyles,

personal identity and their relationship with others, both within and outside their culture” (Papadopoulos, 2006, p. 10). Cultures are not static; they are dynamic and change over time in different ways, under different circumstances and under different conditions (Leininger & McFarland, 2002; Purnell & Paulanka, 2003). Even though there are several different definitions of culture, there are a few general criteria that are common to all definitions, including: a) culture emerges in adaptive interactions, b) culture consists of shared elements and c) culture is transmitted across period and generation (Triandis 1994). Culture has an impact on people’s health-related beliefs and behaviours and therefore it is an important factor to take into consideration when caring for a person from a culture different from one’s own. Culture is not homogenous, and therefore one cannot make generalizations about a member from a group since generalizations usually lead to stereotypical attitudes, cultural misunderstandings, prejudices and discrimination (Ahmad, 1996; Helman, 2000; Holland & Hogg, 2001; Kleinman & Benson, 2006).

### **2.2.2 Competence**

Competence originates from the Latin word *co’mpeto* and is often used synonymously with knowledge and qualification (Hammare, 2004). Competence, originally a one-dimensional concept used for describing formal qualifications, has become a multidimensional concept that describes formal qualifications as well as cognitive and psychomotor factors necessary for a specific task. The concept competence has been discussed since the beginning of the 20<sup>th</sup> Century. Competence has been given a general meaning in accordance with attributes for mankind and the knowledge and skills necessary for life, and a specific meaning in accordance with the competence acquired through a specific educational program or the characteristics required to carry out a specific job. If an individual or group is competent, this assumes that the competence results in a desired condition which in turn can bring benefits to the one who is competent or to her surroundings (Johansson, 1996; Lindblad Fridh, 2003).

In relation to nursing, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) defines competence as: ‘the ability of the nurse to practice safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice (UKCC, 1999). The International Council of Nurses (ICN, 2005) defines competence as ‘a level of performance demonstrating the effective application of knowledge, skills, attitudes and judgement. In Sweden, the National Board of Health and Welfare (2005) declares the competencies a person must possess to work as a nurse in Sweden. Generally, the meaning of competence found in nursing standard includes the ability, desire, knowledge and skills to succeed as a nurse. The Nursing Standards in Sweden (National Board of Health and Welfare, 2005) comprise necessary competencies for meeting the health care needs of today and in the future. Necessary competencies are described from a global perspective and include independency, scientifically evidence-based work, multicultural knowledge and professional responsibility.

### **2.2.3 Cultural competence in nursing**

Cultural competence refers to the knowledge and skills nurses should possess to care for a patient from a cultural background different from their own (Betancourt, Green & Carrillo, 2002; Emami, 2000; Campinha-Bacote, 2002; Gebru & Willman, 2002; Leininger, 2002; Papadopoulos, 2006). Several definitions of cultural competence are found in the nursing literature. One proposed by Gerrish (2005) is a level of performance demonstrating the effective

application of knowledge, skills, attitudes and judgement to practice safely and effectively in a multicultural, multiethnic society. One way to tackle cultural competence has been to develop theoretical frameworks that define and describe what cultural competence is. Several different frameworks of cultural competence exist (e.g. Leininger & McFarland, 2002; Papadopoulos, 2006; Ramsden, 2002).

Leininger and McFarland (2002) refer to the knowledge base that nurses need to be able to deliver culturally competent care to all patients irrespective of the patient's cultural background. Leininger defines cultural competence as highly developed skills for assessing, planning, implementing and evaluating nursing care for individuals, families, groups and communities representing different cultures in society (Leininger & McFarland, 2002). Leininger emphasizes that nurses require specific knowledge about the patient's culture to be able to provide culturally competent care (Leininger, 2002). Leininger not only refers to cultural differences, but to other differences among people in society like race, ethnicity, nationality, religion, age, sex, sexual orientation, ability/disability, social and economic status or class affiliation or education (Leininger & McFarland, 2002).

In 1998 Papadopoulos, Tilki and Taylor published the PTT model for developing cultural competence (Papadopoulos, 1998). The model refers to the nurse's capacity to provide effective health care that takes the patient's cultural beliefs, behaviours and needs into consideration in the nursing process. The model includes cultural awareness, cultural knowledge and cultural sensitivity as components of cultural competence. The fourth stage, Cultural Competence, comprises the synthesis of cultural awareness, knowledge and sensitivity along with practical skills. Papadopoulos et. al. also emphasize the need for nurses to have both culture-generic and culture-specific knowledge. Apart from these areas, they also emphasize the need for nurses to promote anti-oppressive and anti-discriminatory practice.

In New Zealand, Ramsden (2002) developed a framework for cultural competence which in New Zealand is referred to as cultural safety. Cultural safety is about delivering care to patients regardless of the patient's culture and is defined as an outcome of nursing and education that enables safe service to be defined by those that receive the service. Today, cultural safety is part of the nursing competence standards, issued by the Nursing Council of New Zealand (Ramsden, 2002). Ramsden claims that cultural safety should be seen as a partnership between the patient and the nurse based on the model, Negotiated and Equal Partnership Model (Cooney, 1994; Coup, 1996). The model describes a process for attitudinal changes in contrast to e.g. Leininger and McFarland (2002); Ramsden does not emphasize culture-specific knowledge due to the risk for stereotyping. The nurse's skill lies, therefore, not in knowing the customs and health-related beliefs of the patient, but in the step before that, in the acquisition of trust (Ramsden, 2002).

The theoretical frameworks described above are some of the frameworks proposed in the nursing literature. While frameworks like Leininger's and Papadopoulos' emphasize the need for culture-specific knowledge to be able to provide culturally competent care, Ramsden emphasizes the opposite, arguing that achieving culture-specific knowledge may increase the risk of stereotyping patients. Despite these differences, the common focus and goal for all of these theorists is to enable nurses to acknowledge and provide care that takes patients' cultural needs into consideration.

#### **2.2.4 Cultural competence and nursing education**

The Nursing Standards of proficiency for nursing education (Nursing & Midwifery Council, 2004) emphasize that nurses should be able to acknowledge patient's cultural practices and take cultural influences into account when providing nursing care. In Sweden the Nursing Standards declare that nurses shall be competent to meet patients' physical, psychological, social, cultural and religious needs (National Board of Health and Welfare, 2005). Moreover, the Stockholm County Council (County Council Assembly, 2002) published "A value framework" for health and medical care which emphasizes that care shall take into consideration the patient's physical, psychological, social, cultural and existential needs. Even though these documents emphasize the importance of cultural sensitivity in care of all patients, they do not provide a specific explanation for what they mean by this nor do they provide guidelines for how the cultural aspect could be taken into consideration.

There are several scientific articles published that address cultural competence in nursing education. Lister (1999) describes what cultural competence means and how it can be achieved in nursing education by developing a taxonomy that includes five areas: cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity and cultural competence. Others have studied how cultural competence is approached in the nursing curriculum, and note that different models have been used to help students organize their thinking. For example, Lipson and DeSantis (2007) identified four approaches used in North America. Some incorporated cultural competence content throughout the curricula. Others used models of cultural competence in the curricula. The third approach was immersion into experiences, i.e. students meet other cultural and socioeconomic groups through different assignments. The fourth approach was the use of distance learning and simulation exercises related to cultural issues. Brathwaite and Majumbar (2006) evaluated how a specific course in cultural competence could improve the students' actual cultural competence while Koskinen and Tossavainen, (2003) and Torsvik & Hedlund, (2008) evaluated exchange students' development of cultural competence after an ordinary exchange program.

### **2.3 CONCLUSION**

Immigration and the growth of multicultural societies have highlighted the need for culturally competent nurses. In turn, this has generated demands for knowledge development in the field of nursing. With the knowledge we have today, we know that nurses' encounters with the patient always include a cultural understanding of how they view their situation. We also know that cultural diversity not only refers to a patient with an immigrant background or from an ethnic minority group. The demands on nurses to possess knowledge and skills that are necessary to care for all patients who seek help from the health care services, regardless of their cultural background, have increased. Nurses need to be aware of and acknowledge patients' cultural needs as well as incorporating them in the nursing process (National Board of Health and Welfare, 2005). However, it is not only the demands on nurses that have increased; nurse educators also face greater expectations. Due to the need for culturally competent nurses, nurse educators must have the ability to educate nurses to become culturally competent. To undertake this challenge, nurse educators must understand cultural competence; what cultural competence is, what comprises it, and how to incorporate appropriate and necessary content into the nursing curriculum, how to educate nursing students on this topic, and how to evaluate the outcome of educational interventions. Although cultural competence has been studied in other countries from a variety of angles, in Sweden, the interest in and knowledge about cultural competence is limited.

### **3 AIM**

The overall aim of this thesis is to explore, analyze and clarify how cultural competence is understood. This is explored from the perspective of nurses, nursing students, nurse educators, and nurse researchers in relation to the Swedish care context.

#### **Paper I**

To describe the translation, adaptation, and psychometric evaluation process in relation to validity and reliability of the Swedish version of the instrument, Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals - Revised (IAPCC-R).

#### **Paper II**

To analyze the core components found in the descriptions of the most frequently cited theoretical frameworks of cultural competence

#### **Paper III**

To identify the core components of cultural competence from a Swedish perspective

#### **Paper IV**

To explore student nurses' experiences of communication in cross-cultural care encounters.

## **4 RATIONALE FOR THE THESIS**

In Sweden, as in other Western democracies, the growth in economic and political migration has been significant with approximately 13% of the population of migrant origin (Swedish Statistical Central Board, 2007). Whereas Sweden has some long established migrant communities, especially from Nordic countries such as Finland, it has experienced a recent influx of economic migrants from former East European countries and asylum seekers and refugees from politically unstable countries more globally (Government offices of Swedish, 2002). The changing composition of Swedish society presents challenges in terms of providing health care services which are responsive to the needs of a multi-cultural society. It is therefore paramount that nurse education equips student nurses with the skills to provide culturally competent care.

However, as I have stated in Chapter 2, although an interest in cultural competence evolved from a concern that nurses should be able to respond to the needs of immigrant patients, culture should not be viewed as something that only people of immigrant origin possess. Rather it is a property that the majority Swedish population has as well as people of migrant origin.

Guidelines for how to implement a cultural perspective in nursing curricula are many and the available literature is rich with examples (e.g. Koskinen & Tossavainen, 2004; Lipson & DeSantis, 2007; Mahoney, Carlson & Engebretson, 2006). However research from the UK (Gerrish, husband & Mackenzie, 1996) has indicated that nurses are not fully skilled in providing culturally competent care. Detailed research on cultural competence in Sweden is lacking. However, a longitudinal study of student nurses started in 2002 that included 24 of 26 nursing schools in Sweden. Among the 1100 participating students (67% of all students in Sweden), only 41% stated that their education had contributed to their understanding of people with a cultural background that differed from their own (Schuldt Haard et al. 2008). This is in line with Momeni, Jirwe and Emami's study (In press) which showed that the nursing education in Sweden had failed to implement cultural perspectives in the nursing curricula. Only three of the 26 nursing schools provided students with specific training on cultural issues. Momeni, Jirwe and Emami argue that this may explain why the majority of nursing students are unprepared to work in a multicultural society.

When nurses gain cultural competence, they are able to meet the unique needs of their patients, which in turn can lead to increased patient satisfaction (Pergert, 2008; Betancourt et al. 2005) and a reduction in health disparities (Gerrish, 2001). In Sweden there is an increased interest among nurses and policy-makers to offer culturally competent care services for diverse populations. However, a deeper understanding of what should constitute cultural competence and how it should be achieved is still lacking. Therefore it was necessary to explore and clarify cultural competence in a Swedish care context.

## **5 THE THESIS**

This doctoral work is part of an overarching research programme being undertaken within the Nursing Division at the Karolinska Institutet concerning cultural competence in Swedish nursing education. The aims of this research programme have been to contribute an understanding of how nursing students can be prepared most effectively to work in multi-cultural Sweden and to inform curriculum development within the Karolinska Institutet.

The research studies presented in this thesis are the areas of the research programme for which I have been primarily responsible. In this chapter I describe these studies and highlight the key aspects of each study, including methodological considerations (choice of methods and how they were utilized), choices that were made, the rationale for making them, and their significance for the overall knowledge that was attained based on the findings of the studies.

As the aims of the thesis specify, my focus has been on enhancing an understanding of cultural competence in relation to nursing in Sweden. In this regard the studies build upon each other sequentially. Study I involved translating, adapting and then testing the reliability and validity of a North American instrument for assessing cultural competence. This study arose from an initial concern within the nursing division that we should seek to assess how effective the curriculum was in developing cultural competence in our students. However, as explained below, this study identified fundamental flaws with the instrument design and raised questions about the applicability of the concept of cultural competence as defined by the author of the instrument (Campinha-Bacote, 2003) to the Swedish context. This led me in Study II to focus on examining other published theoretical frameworks of cultural competence in nursing which, according to their authors, could be used to inform the nursing curricula. Many of the published frameworks originated from the USA but I felt that it was important to look at frameworks from Europe and Oceania. The analysis of these frameworks led to a recognition that although they have much in common, the frameworks are also a product of the historical, political and social context in which they are developed. Questions remained about the applicability of these frameworks to a Swedish context. In view of the lack of an established body of knowledge about cultural competence in Sweden, Study III was developed to identify what experts (researchers, educators, practising nurses) working in this field in Sweden identified as the core components of cultural competence. The findings from Study III highlighted the importance of cross-cultural communication and this led to my final study, IV. My focus in this fourth study was on nursing students experiences in line with the overall aim of the research programme to inform the education of nursing students in Sweden.

### **5.1 STUDY I**

Study I considers the translation, adaptation, and validity and reliability testing of an instrument designed to measure cultural competence. The purpose of conducting this study was to develop an instrument that could be used to measure cultural competence prior to and after completion of the nursing program. Our intention was to use this instrument in future studies that we planned to conduct in the overarching research programme. In this section I will describe the rationale for undertaking this study, the design and method used together with the findings.

#### **5.1.1 Background**

Initially, the research team's intention was to use an instrument to measure cultural competence among our nursing students when they entered their nursing program and at the conclusion of

their studies. This was perceived as a tool for quality assurance when teaching about issues relevant to cultural perspectives and care within the program. We wanted to be able to measure the outcomes of education, but we were also looking to identify a tool to assist us in improving our curricula such that we would best impart upon our students skills that would enable them to tackle cultural issues in care giving. The instrument we identified was the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals-Revised (IAPCC-R) (Campinha-Bacote, 2003) that the author claimed could be used for measuring cultural competence among nursing students, teachers and practising nurses. The instrument was based on Campinha-Bacote's model of cultural competence "The Process of Cultural Competence in the Delivery of Healthcare Service" which could be used in planning the nursing program's curricula.

Campinha-Bacote's model (Campinha-Bacote, 2003) consists of five areas: Cultural Desire, Cultural Awareness, Cultural Knowledge, Cultural Skill and Cultural Encounter. Cultural Desire is to show a genuine interest and a motivation for "wanting to" instead of "having to" become involved in the process of developing cultural competence. Cultural Awareness is the understanding of one's prejudices towards others and the awareness of one's own culture. Cultural Knowledge refers to seeking knowledge about other cultural groups and an understanding that culture affects perceptions, values, beliefs and views related to health, illness and treatment. Cultural Skill means being able to collect and assess culturally based information when conducting physical assessments on people from different cultures. Cultural Encounter includes the opportunity to gain experience from face-to-face meetings with patients from other cultures. The instrument IAPCC-R, which is based on this model, is a self-assessment instrument consisting of 25 questions evenly distributed between the five areas, i.e. five questions measure Cultural Desire, five measure Cultural Awareness, etc. The questions are responded to along a four-point Likert scale.

We gained permission from Campinha-Bacote to use the instrument and consulted with her throughout the entire process. We recognized that our knowledge of translating, adapting and evaluating such instruments was limited as we were mainly experienced in using qualitative research methods. As such, we looked to compliment our skills with those of someone who could provide guidance on how to evaluate the instrument, e.g. to select the most accurate method, determine the appropriate sample size for each validity test and reliability test, and on conducting statistical analyses in SPSS. Therefore we included a fourth researcher (PG), who acted as an advisor and provided us with information on how many surveys we needed to distribute and receive, to what groups of respondents we needed to distribute the instrument, how to use SPSS, and how to carry out the actual statistical calculations in SPSS. With this study, we aimed to describe the translation, adaptation, and psychometric evaluation process of the Swedish version of IAPCC-R. A copy of the instrument IAPCC-R has not been included in my thesis due to copyright issues. Although we were given permission to translate and use the instrument in our research, we were told that we could not copy, re-produce or publish the instrument in any way.

### **5.1.2 Design, method and analysis**

Geisinger's (1994) guidelines were followed for translating, adapting and testing the instrument. The guidelines consist of 10 steps, of which we followed the first five. The remaining five steps are to be taken once a decision has been made to use the instrument. The instrument was



translated and adapted individually by three authors (HO, MJ, AE) and a first draft was agreed upon (1). Three experts reviewed the translated and adapted instrument (2). The research group (HO, MJ, AE) and the three experts from step 2 then revised the drafted instrument based on the feedback (3). A pilot test, using the cognitive method “think aloud” (Sudman et al. 1996) was conducted with 15 respondents to identify whether any further problems existed with the instrument (4). Finally, field tests were undertaken with seven respondents to examine the content of the instrument, and the internal structure of the instrument was examined based on 334 questionnaires using SPSS 14.0 (5). Due to a request from Campinha-Bacote, the translated instrument was back-translated even though this is not in line with the guidelines (Geisinger, 1994). Since the back-translated instrument did not elicit any additional feedback from Campinha-Bacote, it was assumed that the Swedish version of IAPCC-R was in line with the original instrument. Campinha-Bacote was informed during this process, as it was felt that this was ethically correct.

### **5.1.3 Findings**

The findings showed that although we followed the guidelines thoroughly, acceptable validity and reliability levels could not be demonstrated. When testing the content of each item in relation to the sub-scales, Cultural Desire, Cultural Awareness, Cultural Knowledge, Cultural Skill and Cultural Encounter, high validity was demonstrated for only five of 25 items as all seven experts were able to relate these items to their correct sub-scales (i.e. the correct area in the model). In contrast, only four or less than four of the seven experts could relate 15 of the 25 items to their correct sub-scales, indicating low validity. The most correctly placed items were items related to the sub-scales measuring Cultural Desire and Cultural Knowledge. However, it should also be noted that during the first pilot test (step 4), several of the 15 participants expressed that three out of the five items in the sub-scale Cultural Desire seemed to be identical.

When validating the internal structure of the instrument, the desirable correlation (i.e. how strongly the item correlates or connects with the scale or sub-scale it is measuring) is 0.40 or higher in a negative or positive direction (maximum levels of 1.0 and -1.0, respectively). When evaluating to what extent each item correlated with (i) the total scale, (ii) the sub-scale it belonged to, and (iii) its association with the other sub-scales, only five of the 25 items had a correlation of .40 and above with the total scale (i). Three of these items belonged to the sub-scale Cultural Desire and two to the sub-scale Cultural Encounter. In relation to the sub-scales (ii) Cultural Desire showed the strongest validity with four of five items that correlated of .40 and above and the sub-scale Cultural Knowledge with two items correlated above .40. In the other sub-scales we identified problems with the items. In sub-scale Cultural Skill not one item correlated above 0.40 and four of the five items correlated stronger with sub-scales other than the one it was supposed to correlate with. Similar problems were identified in the other sub-scales as well. Cronbach’s alpha was 0.65 on the total scale varying between -0.01 to 0.65 on the different sub-scales, with the highest levels of correlation attributed to the sub-scales Cultural Desire and Cultural Knowledge.

Apart from the statistical analyses, another important issue emerged. During the process of testing responses during the interviews as well as when students and nurses were responding to the questionnaires, it became evident that their understanding of cultural competence was limited. Not only were students and nurses not familiar with the concept cultural competence, but neither were they aware of several of the issues that were addressed in the instrument IAPCC-R.

#### 5.1.4 Evaluation of Study I

I used Polit, Beck and Hungler's (2001) guidelines for evaluating Study I. Their guidelines for critical appraisal identify five areas to be evaluated: *substantive and theoretical dimension*, *methodological dimension*, *ethical dimension*, *interpretive dimension* and the *presentation and stylistic dimension*. The *substantive and theoretical dimension* refers to whether the research is worthwhile, if there is congruence between the research question and the method used, and if the researcher has placed the research problem within a theoretical context. In terms of the *substantive and theoretical dimension* this study has focused on translating and adapting an instrument for use in a new context. Murphy-Black (2006) identifies the benefit of using an existing instrument wherever possible as the developmental work has been undertaken and there should be published information about the validity and reliability of the questionnaire with specific populations. However she then goes on to stress the importance of testing the instrument for use with other populations as it cannot be assumed that concepts which are developed in one context are directly applicable to another. It was important therefore to examine the relevance of the IAPCC-R in a Swedish context. Moreover, there was very little evidence of the validity and reliability of the instrument which justified the need for us to do further testing. The different methods that were used in this study were selected to address the research aims of translating, adapting and evaluating the instrument. The instrument was placed within the context of cultural competence and evaluated in relation to how well each construct in the instrument correlated with the same construct in the model of cultural competence on which the instrument is based.

The *methodological dimension* refers to the research design, research sample, data collection and data analysis. In this regard we followed a rigorous and systematic approach. We based our approach on established guidelines on instrument translation, adaptation and evaluation developed by Geisinger (1994) and followed Spector's (1992) framework for summated rating scale construction which included defining the construct, designing the scale, conducting an item analysis, and studying the validity and reliability of the instrument. We drew upon the literature and sought statistical advice (from PG) in determining the sample size for each component of the study. Expert advice (from PG) was also sought in identifying the appropriate statistical tests to use throughout the study. We included the full range respondents (nursing students, and registered nurses undertaking specialist nursing programmes) for which the instrument was designed and with whom we intended to use it in Sweden. Moreover, the data analysis methods we used to evaluate the content and internal structure of the instrument were recommended by the literature.

With respect to the *ethical dimension*, we gave careful consideration to the ethical issues arising from the study. Approval was sought from the appropriate University ethics committee. We followed accepted national ethical guidance (The Swedish Research Council, 2003) which included ensuring voluntary participation, informed consent and maintaining confidentiality. However, a further ethical consideration arose in relation to the author of the instrument. We informed her throughout the process of translation and adaptation, and solicited her views for clarification and suggestions. This enabled us to make adaptations while preserving the original instrument as much as possible for the purposes of comparison with studies using the original instrument. We also have been cautious when writing the paper, and allowed the results 'to speak for themselves', rather than explicitly critiquing the flaws of the instrument.

The *interpretive dimension* is related to the interpretation of the findings, the support they lend to a theoretical framework, implications for nursing and identifying limitations in the study. The findings from this study have led us to voice caution about the appropriateness of this instrument for use within a Swedish context. However the limitations of our work need to be acknowledged. The study sample originates from one large city and we cannot rule out the possibility that the instrument might work in a different context. Another limitation would be the sample size in relation to the internal validity and reliability testing. A larger sample could have provided us with different results.

The *presentation and stylistic dimension* of the study was challenging. Despite all the different field tests and the different methods used, the results needed to be clearly presented in an understandable style. Repeated redrafting of the paper has enabled us to address this to the satisfaction of peer reviewers of the paper.

## **5.2 STUDY II**

The purpose of this study was to analyze the literature to acquire a critical understanding of the concept cultural competence. To fulfil this goal, documentary analysis was utilized. In this section I describe in more detail the rationale for conducting this study, the design and method I used and summarize the findings.

### **5.2.1 Background**

When undertaking the literature review at the beginning of my doctoral studies I became aware that many authors referred to established theoretical frameworks for cultural competence. Most of these frameworks originated from the USA (e.g. Andrews & Boyle, 2003; Leininger & McFarland, 2002; Purnell & Paulanka, 2003) although there were some from Europe (Papadopoulos, Tilki & Taylor, 1998) and Oceania (Ramsden, 2005). The more I read the more I realized that although these frameworks addressed cultural competence they did so from different perspectives. For every new piece of literature I reviewed, a new nuance of the concept of cultural competence was presented. I therefore felt that I needed to gain an understanding of what cultural competence was; I wanted to find *the* description of cultural competence. This was all the more important as the findings of Study I had raised questions about the appropriateness of applying a North American framework in a Swedish context. Therefore we began to design Study II to acquire an understanding of the core components of the concept cultural competence, as presented in literature.

### **5.2.2 Design, method and analysis**

The aim of this study was to analyze the core components of cultural competence as set forth in the most frequently cited theoretical frameworks of cultural competence. I carried out a documentary analysis (Abbott, Shaw & Elston, 2004; Appleton & Cowley, 1997; Elston & Fulop, 2002; Murray & Sixsmith, 2002) and utilized qualitative content analysis to analyze the data (Graneheim & Lundman, 2004). One advantage of documentary analysis is that the result can provide a base for forthcoming research, which was important for my thesis as well as for the overarching research programme.

I used four different search methods to identify the most frequently cited theoretical frameworks of cultural competence: (i) a literature search for scientific papers in Pub Med, Medline and Cinahl; (ii) for those continents for which there are only a limited number or no published

scientific articles using theoretical frameworks of cultural competence, a web search was conducted; (iii) book reviews published in the *Journal of Transcultural Nursing* were scrutinized; and (iv) a review of the reference lists in the identified scientific papers was conducted (Bhandari et al. 2004). In total, 11 theoretical frameworks were identified of which two were excluded from the study since they were not describing cultural competence and they were related to anthropology and not to nursing. After the search, nine theoretical frameworks representing North America ( $n=7$ ), Europe ( $n=1$ ) and Oceania ( $n=1$ ) were included in the study for further analysis, see Table 1.

**Table 1: Publications included in the documentary analysis**

Data selection	Continent of origin	Country of origin
Andrews, M. M., & Boyle, J. S. (2003). <i>Transcultural concepts in nursing care</i> (4. ed.). Philadelphia: Lippincott Williams & Wilkins.	North America	USA
Campinha-Bacote, J. (2003). <i>The Process of Cultural Competence in the Delivery of Healthcare Services: A Culturally Competent Model of Care</i> (4. ed.). Cincinnati: Transcultural C.A.R.E. Associates.	North America	USA
Giger, J. N., & Davidhizar, R. E. (2004). <i>Transcultural nursing: assessment &amp; intervention</i> (4. ed.). St. Louis: Mosby.	North America	USA
Leininger, M., & McFarland, M. R. (2002). <i>Transcultural nursing: concepts, theories, research and practice</i> (3. ed.). New York: McGraw-Hill.	North America	USA
Lipson, J. G., & Steiger, N. J. (1996). <i>Self-care nursing in a multicultural context</i> . Thousand Oaks, Calif.: Sage.	North America	USA
Papadopoulos, I., Tilki, M., & Taylor, G. (1998). <i>Transcultural care: a guide for health care professionals</i> . Dinton: Quay Books.	Europe	Great Britain
Purnell, L. D., & Paulanka, B. J. (2003). <i>Transcultural health care: a culturally competent approach</i> . Philadelphia: F.A. Davis.	North America	USA
Spector, R. E. (2004). <i>Cultural diversity in health &amp; illness</i> (6. ed.). Upper Saddle River: Prentice Hall.	North America	USA
Wepa, D. (Ed.). (2005). <i>Cultural Safety in Aotearoa New Zealand</i> . Auckland: Pearson Education.	Oceania	New Zealand

In this study the documents consisted of theoretical books in transcultural nursing. Since only a small amount of data in the books was relevant for the analysis, ranging from only a few lines up to several pages of text, a data extraction sheet was used. All the data were read thoroughly and the sections with descriptions or definitions of cultural competence were marked and copied verbatim to new documents, i.e. data extraction sheets, one for each author/researcher (Abbott et al. 2004). Each data extraction sheet was analyzed individually by reading the texts and then by marking the meaning units that correlated with the aim of the study. The meaning units were condensed and, where possible, an interpretation was made of the condensed meaning unit. The texts from the text documents were not as rich as an interview text and therefore it was difficult to condense these further. After a discussion with one of the founders of the content analysis method that we used (Graneheim & Lundman, 2004) we were advised to follow a different guideline in the paper, rather than the one I was following. Therefore in the analysis, after

condensing the meaning units, I abstracted the condensed meaning units into sub-themes and thereafter linked the sub-themes together to form broader themes (Graneheim & Lundman, 2004).

### **5.2.3 Findings**

From the analysis of the frameworks, four themes were identified: (i) awareness of diversity among human beings, (ii) ability to care for individuals, (iii) non-judgmental openness for all individuals, and (iv) enhancing cultural competence as a long-term continuous process. All frameworks emphasized the need for (i) an awareness of diversity among human beings along different dimensions, which includes awareness of one's self as well as of the other. Awareness was seen as the first step towards becoming culturally competent; to understand one's own cultural background in relation to cultural values, attitudes and belief systems, as well as one's prejudices and stereotypical attitudes. After becoming aware of one's own cultural background, it is possible to acknowledge other people's cultural values, attitudes and belief systems. The other theme identified was (ii) an ability to care for individuals, which includes being skilled in performing cultural assessments, to be knowledgeable about other cultures and to be able to meet specific cultural needs. To be skilled in performing cultural assessment is related to the nurse's ability to collect culturally relevant data about their patients, as well as the actual assessment process itself. The need for nurses to consider patients' verbal and non-verbal communication was emphasized. To be knowledgeable about other cultures includes theoretical cultural knowledge, using documented cultural knowledge, having knowledge about worldviews and having knowledge about cultural encounters between people from different cultures. The final sub-theme is to be able to meet specific cultural needs, which is related to a nurses' ability to understand the patient's cultural beliefs and to be able to accommodate the patient's perspective when making healthcare and lifestyle recommendations. Non-judgmental openness towards all individuals (iii), which is the third theme, included the nurses' willingness to overcome prejudices and ethnocentrism and to have a genuine interest in people from other cultures. Equality and sensitivity was also emphasized. The last theme (iv), enhancing cultural competence as a long-term continuous process, suggests that cultural competence is something you always strive for; it is not an end point.

### **5.2.4 Evaluation of Study II**

I used Thorne's (Thorne, 1997) criteria for evaluating Study II. She addresses four areas in the evaluation of qualitative research; *epistemological integrity*, *representative credibility*, *analytical logic* and *interpretive authority*. *Epistemological integrity* refers to whether the researcher has followed a defensible line based on the study's theoretical and methodological frame of reference. The aim of the paper was to analyze the core components found in the descriptions of the most frequently cited theoretical frameworks of cultural competence. With regard to epistemological integrity, two different methods of analysis were considered for use; content analysis versus concept analysis. The reason for using content analysis was that I wanted to find out how cultural competence was described and addressed in the texts (Graneheim & Lundman, 2004) rather than examine the structure of the concept of cultural competence, a research question which would be examined more appropriately by using a concept analysis method (Walker & Avant, 2005). The findings of the analysis fit well with the aim of the study, which legitimizes the choice of method.

Studies also need to ensure *representative credibility*, which refers to how the sample is selected and whether it represents the study population (in the case of my study, the breadth of literature). I undertook a rigorous search process to identify existing theoretical frameworks and am confident that the frameworks cited most frequently in the literature have been included and that the sample is international. However, representative credibility can only be claimed in relation to frameworks published in English, Swedish, Norwegian and Danish since I was unable to extend my search to frameworks that were presented in languages other than those I am conversant with.

*Analytical logic* refers to the researcher's ability to provide proper argumentation for justifying the process of collecting the data and to point out what knowledge can be learnt from the study. In writing up Study II I sought to provide a clear, transparent account of the process of identifying theoretical frameworks, extracting data and analyzing them. However, while the description of the method is quite rich, the description of the analysis is fairly limited. Since the study was presented in a paper to be published in a scientific journal, the space limitation was a crucial issue to be taken in consideration. Therefore, the description of the analysis process had to be limited to give more room for richer descriptions of the method and result.

*Interpretive authority* refers to how trustworthy the researcher's work is, i.e. if the result presented in the study is likely to be true. In order to strengthen this aspect, I discussed the analysis with my supervisors to confirm that my analysis was accurate. However, in this study, the trustworthiness of the interpretation is limited since I did not take into account the chronological time in which the theoretical frameworks were developed. Although the first theoretical framework of cultural competence was originally developed over 40 years ago, I did not include this perspective in the analysis. Therefore I cannot exclude the possibility that differences and similarities identified in the analysis were related to the temporal context of when the framework was developed.

### **5.3 STUDY III**

We concluded in Study I that we could not use the standard instrument IAPCC-R in a Swedish context. Integrating this knowledge with the findings from Study II we found that the theoretical frameworks of cultural competence should reflect the context in which they were developed. Therefore we designed Study III. In this section I will describe in more detail the rationale for conducting this study, the design and method I used and summarize the findings.

#### **5.3.1 Background**

Parker (2006) questions whether theories constructed in one context are transferable to another, i.e. whether they are universal. Given the problems respondents encountered when trying to understand the term cultural competence in Study I, and the indication that the theoretical frameworks of cultural competence reflect the contexts in which they are constructed in Study II, I found it necessary to understand the meaning of cultural competence in the Swedish context. Therefore, I had to elicit what cultural competence might mean in Sweden. I had to approach this in a way that would provide me with an agreed upon description of the components of cultural competence. The question was how to reach this agreement. One way of doing this was to use a consensus method, specifically the Delphi technique, which originally was developed by the RAND Corporation for gathering a consensus from a group of experts (Keeney, Hasson & McKenna, 2001; Linstone & Turoff, 1975).

### **5.3.2 Design, method and analysis**

After identifying the Delphi method as the most appropriate method for fulfilling the aim of this study, the next issue of concern was selecting the respondents, i.e. the “experts” (Keeney et al. 2006). The issue of selecting the experts was twofold, i.e. what type of experts and how many experts to include. The type of experts is related to the research area. The experts could be clinical experts, scientific experts, or have expert status as someone who has experience from the area under investigation. Murphy et. al. (1998) suggests that it could be necessary to include experts from all three areas. In this study it was necessary to include experts from areas that in some way intersected with issues related to cultural competence. After deciding which areas the experts should be associated with, we had to establish inclusion criteria. In most published studies, the experts are described in an arbitrary way. At best, they are described according to grade, professional role, or by geographical location or region (Reid, 1988). In this study the inclusion criteria were carefully designed for each group of experts. The experts were purposely selected for being knowledgeable on cultural issues and were recruited to three equal groups: researchers, teachers and practising nurses. The inclusion criteria for the first group of experts, the nurse researchers, were that they should be actively conducting research within the field of cultural issues and that they should have published at least one scientific article or presented their research at an international conference. The inclusion criterion applied to the second group of experts, the teachers at nursing programs in Sweden, was that they should be currently teaching about cultural issues. For the third and final group of experts, practising nurses, the inclusion criterion was that they should be working with a multicultural population. Another criterion was that each of the expert panel’s three groups should reflect the same composition of backgrounds found in the general population that is approximately 12.5% (Swedish Statistical Central Board, 2006) or 1 out of 8 of the experts should have a non-Swedish background in each of the three groups.

The issue of the number of experts is another area of concern. Panel sizes between 20 and 50 are most frequently used and recommended (Endacott, Clifford & Tripp, 1999; Linstone & Turoff, 1975). However, there is no explanation for why this size is recommended. The literature review revealed panel sizes that ranged from 7 (Dalkey & Helmer, 1963) to 2340 (Annells et al. 2005). In this study, 24 experts were recruited, which is within the recommended panel size.

Another concern that needs to be taken into consideration when using the Delphi technique is how to define consensus. Consensus is most commonly described as a percentage (Powell, 2003), but the level of consensus researchers consider to be acceptable varies. Powell’s literature review revealed percentage levels ranging from 51 % up to 100 %. Some published papers leave it to the reader to decide or suggest that the consensus is implied by the result (Powell, 2003). In this study the consensus level was set at 75% which, according to the literature review, is fairly high. After designing the inclusion criteria, deciding upon the number of experts to include in the panel and the consensus level, the recruitment process began. Twenty-four experts were recruited and included in the panel from three areas: eight researchers, eight teachers and eight practising nurses. Each expert was contacted personally by telephone or if it was difficult to get in touch with the person, an e-mail was sent to decide upon a time to speak with her/him by telephone. The study was described to the experts, including the aim of the study, research process and estimated time commitment, as recommended by Hasson, Keeney and McKenna (2000).

This study included four rounds which are in line with the literature (Bond & Bond, 1982). The first round was conducted with qualitative interviews that were analyzed using content analysis (Graneheim & Lundman, 2004). Round two to four were undertaken with questionnaires. During the analysis of the questionnaires, the two points at the upper and lower ends of the 7-point Likert scale were combined, which has been demonstrated before by McIlpatrick and Keeney (2003). This resulted in a 5-point scale. However, the 5-point Likert scale was only for the analysis; when returning the next questionnaire to the experts, a 7-point Likert scale was used again. The decision to use this approach was based on the comments from experts written on the first questionnaire. For the analysis, SPSS version 14.0 was used.

### **5.3.3 Findings**

In total, 127 core components were identified in the first round and grouped into five categories and 17 sub-categories. In the second round, i.e. the first round with a questionnaire, another ten core components were identified. The core components were categorized into five areas: cultural sensitivity; cultural understanding; cultural encounters; understanding of health, ill-health and healthcare; and social and cultural contexts. After all four rounds, 118 out of the 137 core components had reached the predetermined consensus level of 75%.

Cultural sensitivity has two underlying sub-categories - personal attributes and self-awareness. Personal attributes include the ability to be flexible and open towards things that are different from what one is used to. Nurses also need to be aware of their own prejudices and stereotypical attitudes and have an understanding of what culture is and their own cultural identity. There were two sub-categories in the category cultural understanding - cultural awareness and knowledge of ethnic and cultural identity. Cultural awareness includes an understanding of culture and how it contributes and shapes cultural identity while knowledge of ethnic and cultural identity refers to the knowledge nurses need about a patient's ethnic and cultural identity. Cultural encounter has four underlying sub-categories; awareness of cultural encounters, skills in cultural encounters, language awareness and communication skills. This theme is comprised of the necessary awareness and skills nurses need to be able to interact in a cross-cultural encounters.

The fourth category is an understanding for health, ill-health and healthcare and is comprised of three sub-categories: health and illness beliefs, preferences and experiences of healthcare and strategies for self care. This category includes the understanding and knowledge nurses need to have about a patient's health and illness beliefs, their preferences and experiences of healthcare and strategies for self-care in relation to nursing care. The last category, social and cultural context, has six underlying sub-categories: religion and spirituality; gender dynamics; family and social aspects; nutrition and dietary preferences; educational background; and occupational and economic status. These are areas that influence and shape a person's identify and response to health and illness.

### **5.3.4 Evaluation of Study III**

As with Study I, Polit, Beck and Hungler's (2001) guidelines were used to evaluate Study III. As mentioned previously, their guidelines for critical appraisal address five areas for evaluation: *substantive and theoretical dimension*, *methodological dimension*, *ethical dimension*, *interpretive dimension* and the *presentation and stylistic dimension*.



In terms of the *substantive and theoretical dimension* the aim of study III was to reach agreement regarding the core components of cultural competence. The study was justified on the basis of the findings from Study I that revealed that there were questions about the appropriateness of the concept of cultural competence as defined in a North American framework and Study II that identified contextual differences of cultural competence among a number of frameworks. As such, it was important to establish a solid understanding of cultural competence in a Swedish context. The choice of the Delphi method as a means of gaining consensus was justified on several grounds. Other consensus methods such as the nominal group technique (Murphy et al. 1998) and the consensus development conference (Murphy et al. 1998) require face to face contact between participants and the researcher. However this was not feasible due to the costs and practicalities of gathering experts together from across Sweden. Additionally, the Delphi technique avoids the risk encountered in face to face consensus methods that experts may feel pressured to change their opinions to follow majority opinion.

The *methodological dimension* relates to the research design, research sample, data collection and data analysis. Decisions concerning the design, sample, data collection and analysis were based on extensive reading about the method and gained specialist advice from an established expert in the field (SK). The methodological aspects of the study are clearly outlined in the paper with detailed explanations for the choices that were made throughout the process.

With respect to the *ethical dimension*, approval to conduct the study was sought from the ethics committee of the Karolinska Institutet and the research conducted in accordance with national guidelines (The Swedish Research Council, 2003). Participation was voluntary and participants were given detailed information about the study prior to recruitment. During the course of the study every effort was made to preserve the anonymity of the experts. However as more than one teacher, researcher or nurse from the same place of work was included as a result of the snowball sampling (Polit et al. 2001) it may be that participants became aware of others taking part. However, as the primary researcher, I did not disclose the identity of one expert to another and I ensured that information obtained from individual participants was confidential.

The *interpretive dimension* is related to the interpretation of the findings, implications for nursing and identifying limitations in the study. The findings from the study provide a comprehensive account of the components of cultural competence from the perspective of a panel of Swedish experts in the field. However, it is recognized that this approach has drawn upon the perspective of nurses and does not include that of patients. Further work is therefore required to examine the extent to which the components identified in the current study are important to patients. The findings were discussed within the context of existing frameworks for cultural competence. It was noted that many published frameworks make general statements about the different components of cultural competence but provide little in the way of precise detail. By contrast Study III provides a comprehensive breakdown of the five dimensions of cultural competence.

The sample size of the three groups of experts is a potential limitation of the study. A decision was made from the outset to treat the three sub-groups of experts (researchers, lecturers and practising nurses) as one group. The analysis indicated that there may be differences between the views of practising nurses and researchers/lecturers. However, the sample was too small to undertake sub-group comparisons and this is an aspect that merits further investigation.

In considering the *presentation and stylistic dimension* of the study every effort was made to ensure that the presentation of information, especially that relating to the different rounds was presented clearly. As with most scientific journals, there was a word limit but since the results are presented predominately in statistical terms, this could be written rather succinctly.

## **5.4 STUDY IV**

In Study III, all experts emphasized one area in particular - the importance of nurses engaging effectively in cross-cultural care encounters. In that study the category cultural encounter is comprised of: awareness of cultural encounters; skills in cultural encounters; language awareness; and communication skills. Therefore, we decided to explore this area further and designed Study IV, which aimed to explore nursing students', experiences with communication in cross-cultural care encounters. In this section I will describe in more detail the rationale for conducting this study, the design and method I used and summarize the findings.

### **5.4.1 Background**

The existing frameworks of cultural competence studied in Study II emphasized the need for nurses to engage effectively in cross-cultural care encounters. In Study III, the Delphi study, experts also regarded this as important. The experts identified factors influencing cultural encounters, interpersonal skills necessary to establish an effective encounter and language and communication skills. They emphasized the need for nurses to have the ability to communicate effectively regardless of whether or not the nurse and the patient shared a common language.

Apart from the results from Studies II and III, previous research has shown that language barriers are a problem for nurses when they are trying to establish a trusting relationship with their patients (Boi, 2000; Ekblad, Marttila & Emilsson, 2000; Gerrish, 2001). Also to take into consideration is that the nurses' ability to communicate effectively and to overcome language barriers needs to be addressed in the context of nursing education. Since communication in cross-cultural care encounters is important, and due to my interest in nursing education, I chose to explore nursing students' experiences of communication rather than those of practicing nurses, since I wanted to be able to ask questions about their nursing education in relation to the descriptions they would provide me with on cross-cultural care encounters.

### **5.4.2 Design, method and analysis**

The aim of this study was to explore nursing students' experiences of communication in cross-cultural care encounters. The study was conducted as an exploratory study with qualitative interviews. Since it was necessary for the students to have had as much experience from clinical education as possible, they were recruited during the last year of their education. In total ten students were recruited; five students with a Swedish background and five students with an immigrant background. The interviews lasted between 20-45 minutes and took place at the university, at their clinical placement or over the telephone, depending on what the student wished. After transcribing the interviews, I analyzed the transcripts with the framework approach developed at the National Centre for Social Research in the UK (Ritchie & Spencer, 1994, Ritchie, Spencer & O'Connor, 2003, Spencer, Ritchie & O'Connor, 2003). With the framework approach, a matrix is used for organizing and synthesizing the data (Bhui et al. 2008; Emmett et al. 2006; Ritchie et al. 2003). There are five stages of analysis involved in the framework approach: familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation (Ritchie & Spencer, 1994, Woodward, Webb & Prowse, 2005).

The familiarization phase started already during the transcription of the interviews and continued by reading the transcripts several times to get an overview of the data and to identify key issues. After the familiarization, a thematic framework based on the identified key issues from the previous phase was constructed. The thematic framework was then used and refined with four of the transcripts and some new key issues were incorporated into the framework. Thereafter, the framework was coded, with a code of 1 given to the first theme, 1.1 to the first sub-theme, 1.2 to the next and so on. In the indexing phase, all the transcripts were coded using this thematic framework. During the charting phase, summarized data from each participant's transcript were transferred to spreadsheets, one for each sub-theme, with one column for each participant. This made it possible to get an overview of what all participants had said about one specific sub-theme. The spread sheet included references to specific lines in the actual transcripts, and useful quotes from the participants that illustrated the sub-theme. In the last phase, mapping and interpretation, and mapping of the range and diversity of each theme and sub-theme in relation to communication in cross-cultural care encounters was carried out. After I had analyzed the interviews, my supervisors confirmed my analysis.

### **5.4.3 Findings**

Four themes were identified during the analysis; conceptualizing cross-cultural care encounters, difficulties in communication, strategies employed, and factors influencing communication. One thing that was revealed already during the interviews was that the nursing students equated "culture" with "immigration" and "the country of origin". All the cross-cultural care encounters described by the students involved patients from an immigrant background. Nursing students experienced particular difficulties when communicating with patients with whom they did not share a common language. This led to care becoming mechanistic and they felt it became impersonal. They were anxious about making mistakes and lacked skills and confidence when questioning patients. Various strategies were used to overcome communication barriers, including the use of relatives to interpret, non-verbal communication, gestures and artifacts. Other factors which influenced communication included the student's attitude, cultural knowledge acquired through education and life experiences.

### **5.4.4 Evaluation of study IV**

To evaluate Study IV, The same criteria used to evaluate Study II were used to evaluate Study IV (Thorne, 1997). The four areas - *epistemological integrity*, *representative credibility*, *analytical logic* and *interpretive authority* - were considered.

*Epistemological integrity* refers to whether the researcher has followed a defensible line based on the study's theoretical and methodological frame of reference. The aim of Study IV was to explore nursing students' experiences from cross-cultural care encounters. The framework approach (Ritchie & Spencer, 1994; Ritchie et al. 2003; Spencer et al. 2003), which was used as an analytic tool, fit well with the type of data we collected and was suited to the aims of the study.

*Representative credibility* refers to how the sample is selected and whether it represents the study population. All the participants included in the study had an interest in cultural diversity and therefore it can be argued that they are not representative of all students in general. However, they are representative in other respects, e.g. age and experiences of health care. An area for which the *representative credibility* might appear to be compromised is the background of the

participants. Approximately 85 % of the students in nursing programs in Sweden have a Swedish background and 15% of the students have an immigrant background (Swedish National Agency for Higher Education, 2008) compared to the participants in the present study with 50% students with an immigrant background. One of the intentions of this study was to explore whether there were similarities or differences between students with immigrant backgrounds in contrast to those from a Swedish background. Previous studies conducted by others in my research group indicated that the experience of immigration may give nurses more skills in relation to entering into cross-cultural care encounters compared to nurses without this experience, i.e. nurses with a Swedish background (*c.f.* Conte, 2003; Emami & Nasrabadi, 2007).

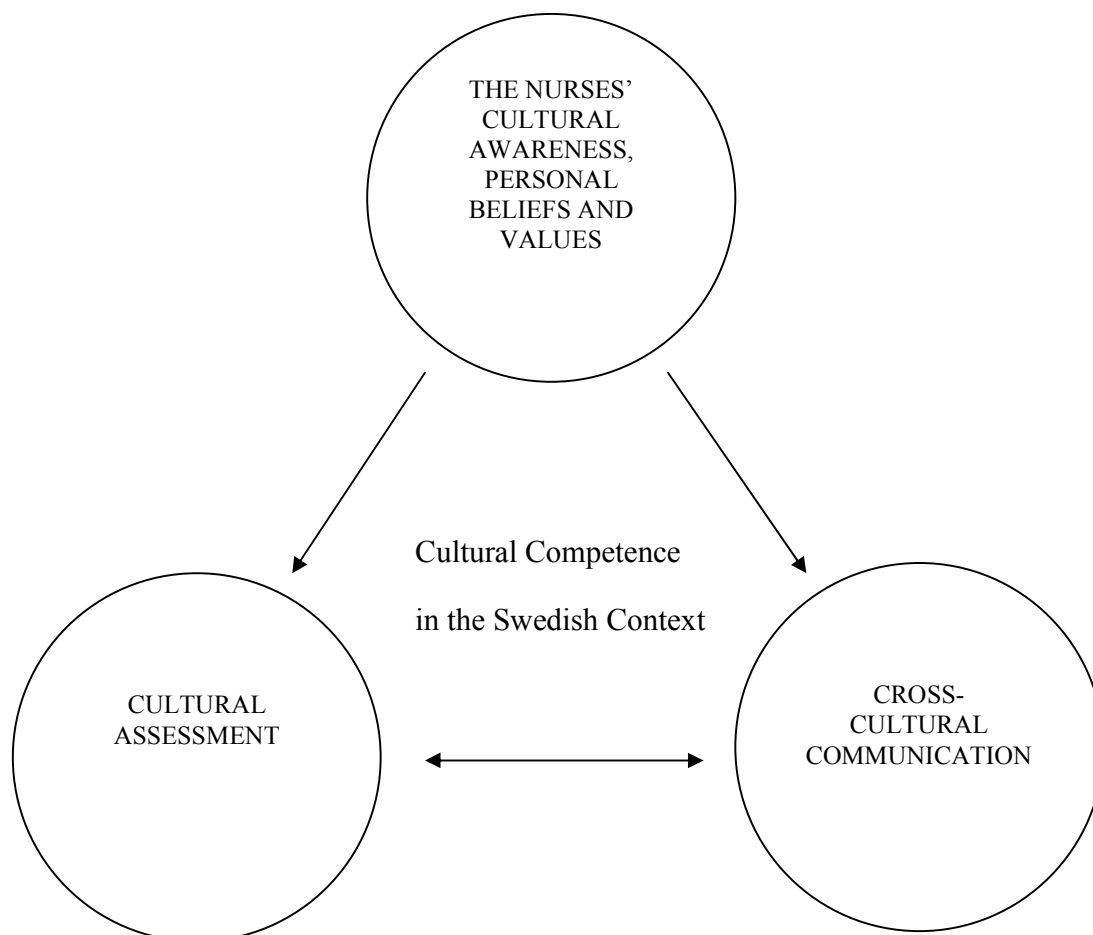
*Analytical logic* is the researcher's ability to provide information about the process of collecting the data and to identify what was learnt from the study. As in Study II, *analytical logic* was not entirely satisfactory in the paper that presented this study. Due to the word limit for publishing a paper in a scientific journal I had to limit the scope of the text, sometimes at the cost of a complete illustration of the *analytic logic* that was followed in the actual study.

*Interpretive authority* refers to the researcher's trustworthiness. One issue that arose in this study was that all interviews were conducted in Swedish, which my co-supervisor did not understand. Therefore the approach I used for reaching *interpretive authority* was that my main supervisor read all the interview transcripts and the analysis. For my co-supervisor to have as full an understanding of the interviews as possible, I used two approaches. The first approach was to construct a visual model of the results based on the analysis. The second approach was to provide a large volume of preliminary results where I included many translated quotes for each theme that were presented in the overall result. This enabled her to grasp the content of the interviews as fully as possible and it was then possible for my supervisor and my co-supervisor to evaluate the accuracy of my analysis. By confirming my analysis, my supervisors ensured the *interpretive authority* of Study IV.

## 6 SYNTHESIS OF THE FINDINGS FROM STUDIES I-IV

Cultural competence has been described by several authors and yet there is still a lack of clarity around its meaning. Undertaking these studies allowed me to identify some new areas related to cultural competence as well as to shed light on some of those areas already described in the literature. The findings of the studies included in this thesis provide an understanding for how cultural competence is described and experienced by nurses, nurse researchers, nurse educators and nursing students. Even though these studies in many ways were different from one another, there is clear link between them and they build upon each other, as I described in the previous section. What emerged from the four studies was a common pattern in what were viewed to be the constituent elements of cultural competence in the Swedish context. Figure 1 below illustrates the synthesis of these findings, showing the constituent elements: *the nurses' cultural awareness, personal beliefs and values; cultural assessment; and cross-cultural communication.*

Figure 1. COMMON PATTERNS IN THE CONSTITUENT ELEMENTS OF CULTURAL COMPETECE IN THE SWEDISH CONTEXT



### **The nurses' cultural awareness, personal beliefs and values**

All four studies, explicitly or implicitly suggested that elements of cultural competence are grounded in the nurse's strong desire to understand the patient from his or her cultural point of view. The findings showed that the nurses felt it was crucial to be culturally competent. However, a lack of cultural awareness among the participants was identified in **Study I**; nursing students and nurses responding to the instrument were not aware of several of the issues that were asked for in the items. This was identified both in written comments on the questionnaires as well as in verbal comments when responding to the instrument in the classroom. In **Study II**, cultural awareness was identified as the foundation of cultural competence and it was described as the first step of cultural competence. According to the findings from **Study II**, if nurses do not become culturally aware they cannot become culturally competent. The need for cultural awareness was also identified in **Study III**. Cultural awareness was identified as necessary for the nurse to be able to understand cultural differences. Unless the nurse is aware of his/her own cultural background, beliefs, values, traditions and traits and understands how they have been shaped and how deeply rooted they are within a person, it is unlikely that he/she is going to understand, appreciate and acknowledge cultural differences. Furthermore it was clarified in **Study III** that certain personal attributes were necessary for the nurse to become culturally competent; e.g. to have a humane outlook, to show respect towards others, to respect differences between people, to be flexible, reflective and perceptive as well as to be willing to provide culturally competent care and to have the ability to empathize with culturally different people. To be non-judgmental was described as being closely related to cultural awareness in **Study III**. Being non-judgmental towards others as well as towards cultural differences was identified as an important factor for being able to care for patients from culturally different backgrounds. In the theoretical frameworks in **Study II** it was mainly emphasized that the nurse needed to become aware of his/her own stereotypical attitudes and prejudices and in **Study III** cultural awareness was identified as critical for nurses to be able to identify their own stereotypical attitudes and prejudices, as well as to be aware of the risk of discriminating based on cultural differences. Thus, apart from cultural awareness, personal attributes and being non-judgmental, adaptability is crucial. In **Study IV** the findings suggested that adaptability is crucial for cultural competence. Nursing students with an immigrant background were largely more adaptable than nursing students with a Swedish background. This was of great importance to the former group when caring for patients from a cultural background that differed from their own. Nursing students with immigrant backgrounds were more comfortable and secure when they interacted in cross-cultural encounters and therefore were more prepared for this. This, they emphasized, was related to their "immigrantness" or experiences of living in multi-cultural neighbourhoods.

### **Cultural assessment**

It was evident that in becoming culturally competent it is important to gain knowledge through a cultural assessment. In **Study II**, the findings suggested that it is important to conduct a cultural assessment of patients from other cultural backgrounds, and to have specific cultural knowledge of different cultural groups. The findings from **Study I** identified that the nursing students and nurses responding to the instrument were not knowledgeable in cultural assessment. Several of the questions in the instrument addressed areas in relation to cultural assessment and comments from the respondents indicated that they were not aware of the importance of exploring some of these areas. At the same time, the respondents also identified that a cultural assessment should not only be conducted on patients from "other" cultural backgrounds, but on all patients. Cultural

assessment was further clarified in **Study III**. In **Study III** several important areas were identified in detail that nurses need to assess when caring for their patients. **Study II** acknowledged ethnohistory as important to assess, but this was not explicitly identified in **Study III**. Instead, participants described in detail specific areas in relation to ethnohistory that needed to be assessed, e.g. strategies for self-care, health and illness beliefs, preferences and experiences of healthcare both from their country of origin and from the country in which they now lived in. Other areas that were addressed were religion and spirituality, gender dynamics, family and social aspects, nutrition and dietary preferences, educational background, and occupational and economic status. However, even though they possessed knowledge about which areas were important to assess, the nursing students in **Study IV** also expressed difficulties related to assessing these questions and the uncertainty they felt when doing so. Even though their education had covered cultural assessment and which areas were important to address, they explained that the patients could become offended when asked for information about such areas as they interpreted this as being stereotyped. Therefore, when conducting a cultural assessment, it is important to bear in mind that this should not only focus on generating information about certain areas, but also on how to ask questions without insulting the patient.

### **Cross-cultural communication**

Well-functioning communication is crucial when caring for all patients. Language insufficiency is a barrier for well-functioning communication. Surprisingly, the instrument in **Study I** does not include anything specific on communication. **Study II** identified the importance of the role of communication in relation to cultural assessment but both **Study III** and **Study IV** pointed out and clarified several important aspects in cross-cultural communication, e.g. its importance and the challenges of carrying out well-functioning communication. **Study II** described the importance of nurses assessing and considering patients' verbal and non-verbal communication. In **Study III**, this issue was further explained as including how to assess the patient's language skills, preferred spoken language, assess whether an interpreter is necessary and to be able to communicate through an interpreter if one is needed in the communication with the patient, and issues in relation to using family members as interpreters (under what circumstances, who is appropriate to use, etc). Furthermore, the participants in **Study III** regarded basic communication skills as important. They identified, for example, the need to listen actively, to be aware that non-verbal communication can differ between countries, to be knowledgeable in communication theory, to be aware of symbolic language and to be able to use non-verbal communication and body language.

In **Study IV**, cross-cultural communication was further clarified in relation to difficulties in communication, e.g. limiting available information, patients' inability to convey messages to the nursing students, anxiety about communicating with culturally different patients due to making mistakes, the impact on communication in relation to different pre-understandings which could lead to misunderstandings, and asking questions in an inoffensive way. In **Study IV** the participants described communication strategies that could be used when no common verbal language could be established. Nursing students used body language, family members provided interpretation, some students learned some words in the patient's language, and where more than one language was possible to communicate in, the nursing students let the patients choose their preferred language. Other techniques used included mirroring patients' emotions and active listening. **Study IV** also shed light on factors that influence communication in situations regardless of whether or not a common verbal language was spoken; e.g. adopting a positive

approach (meaning that nursing students adopted the approach that communication problems could be solved) was identified as one important factor for influencing communication positively. Also cultural knowledge was seen as an important factor for influencing and improving communication, but in different ways. Nursing students with an immigrant background did not emphasize the cultural knowledge that they had gained from education, but noted instead that knowledge which was gained from their life experiences due to their “immigrantness”. In contrast, nursing students with a Swedish background emphasized that the cultural knowledge they attained through their nursing education was an important factor influencing and improving communication.

### **Relationship between the elements in figure 1**

The relationship between the three elements is clarified by the arrows in Figure 1 but will be further described here. *The nurses’ cultural awareness, personal beliefs and values*, is crucial for becoming culturally competent. If the nurse is not culturally aware and has an understanding for his/her own personal beliefs and values, it is difficult for him/her to understand why a cultural assessment needs to be undertaken, what areas to assess and how to undertake it. Also the nurse needs to be culturally aware to be able to communicate cross-culturally. Therefore *the nurses’ cultural awareness, personal beliefs and values* are prerequisite for the other two elements in Figure 1. The other elements are *cultural assessment* and *cross-cultural communication*. These two elements are related to each other. To be able to conduct a cultural assessment, the nurse needs to be able to communicate cross-culturally with the patient, but to be able to communicate cross-culturally, nurses also needs to be able to assess the patient in relation to language, communication skills, the need for an interpreter etc.



## 7 DISCUSSION

Conceptual models and nursing theories describe what should be regarded as necessary knowledge for nurses, and thereby proscribe in various ways how nursing practice and research should be improved upon (Fawcett, 2000). In the field of transcultural nursing and cultural competence, several theories and models are available (Papadopoulos, Tilki & Taylor, 2004). Even though knowledge about transcultural nursing and providing cultural competence has grown over the last decades, nurses, nursing students and other health care staff still struggle when caring for patients and families from cultural backgrounds that differ from their own (Galanti, 2006, Lundberg, Backstrom & Widen, 2005; Paez et al. 2008). The four studies included in this thesis were synthesized and a pattern of what constitutes cultural competence was illustrated in the previous section. The illustration includes three constituent elements: *the nurse's cultural awareness, personal beliefs and values; cultural assessment; and cross-cultural communication*. In this section I will discuss some of the key issues that are highlighted based on the knowledge that was gathered through the process of conducting the studies included in my doctoral thesis.

### Conceptualization of culture

Culture is something that belongs to all individuals and as mentioned in chapter 2, culture is dynamic and not static. In the nursing sciences literature, it is defined as:

*“the shared way of life of a group of people that includes beliefs, values, ideas, language, communication, norms and visibly expressed forms such as customs, art, music, clothing and etiquette. Culture influences individuals' lifestyles, personal identity and their relationship with others both within and outside their culture”* (Papadopoulos 2006, p. 6).

*“a set of guidelines (both explicit and implicit) which individuals inherit as a member of a group of a particular society, which tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation... by the use of symbols, language, art and rituals”* (Helman 1994, p. 2).

Neither a line nor word in these two quotes indicates that culture is something that only belongs to the “other”, or to a person with an immigrant background. These definitions are broadly inclusive and do not exclude any individual. Thus, culture exists, influences, and is influenced in the lives of people with an immigrant background as well as in those from the majority population. Even so, in **Study III** as well as in **Study IV**, it was evident that the respondents had not adopted a broader definition of culture, but a narrow one. Often they referred to culture when they talked about people with an immigrant background. Even the respondents with an immigrant background themselves had conceptualized culture in this way. In **Study III** and **Study IV** the questions asked in the interviews were carefully designed so as not to impose cultural background only in relation to people with an immigrant background. However, the participants made the links deliberately and the examples and anecdotes they shared related only to situations in which they provided care to people with an immigrant background.

Transcultural nursing theories and models have mainly been applied in studies about or related to care interventions for ethnic minorities or immigrants (c.f. Andrews & Boyle, 2003; Campinha-Bacote, 2003; Giger & Davidhizar, 2004; Leininger & McFarland, 2002; Lipson & Steiger, 1996; Spector, 2004). Even though transcultural nursing theories and models do not exclude the majority population in their definitions of culture, the cultural groups that are the subject of their studies are immigrants or ethnic minorities (Hall et al. 2007; Harle et al. 2007; Lee-Lin et al. 2007; Wu & Bancroft, 2006; Zoucha & Broome, 2008). However, there is a risk involved in using cultural theories and models merely in studies about immigrants and ethnic minorities; namely, that these groups will be marked as the “other”, leading to stereotyping and racialization. This in turn will prevent other important factors, such as social class and economic status, from being included and studied as crucial factors impacting on how we perceive health, illness and disease (Ahmad & Bradby, 2007; Emami, Benner & Ekman, 2001; Gustafsson, 2005).

I suggest that the reason the participants in **Studies III** and **IV** conceptualize culture in health care research as something that belongs to immigrants or ethnic minorities instead of adopting a broader approach is that almost all of the transcultural nursing literature is focused on these groups. If understanding cultural background is only important when caring for immigrants or ethnic minorities, other patients’ (i.e. from the majority population) cultural beliefs, values and traditions can be neglected. The need to consider patients’ cultural backgrounds, beliefs, values and traditions in nursing care is the reason for why the area of transcultural nursing was founded in the middle of the last century. Even though the interest in transcultural nursing was due to an increased awareness of cultural diversity in relation to immigration, the knowledge generated in this field should be applicable in any care situation. Thus, transcultural nursing and cultural competence is about the knowledge and skills nurses need in order for them to be able to provide equal care for all patients. Existing inequities in health care for immigrants and ethnic minority groups should as well be discussed in the light of socio-economic factors rather than as merely a matter of culture.

### **Specific cultural knowledge versus general cultural knowledge**

In the nursing literature, specific cultural knowledge is acknowledged as crucially important when caring for a diverse population (c.f. Leininger & McFarland, 2002; Purnell & Paulanka, 2003). Due to its roots in anthropology, theories and models describe how specific cultural knowledge can be gained and how with this, the nurse will reach an “emic”, i.e. an insider’s perspective and understanding of that person’s worldview, beliefs, values and traditions (Leininger & McFarland, 2002). Leininger suggests that it is crucially important to search for and gain this knowledge to be able to provide holistic care for the patient and developed the ethnonursing research method for generating this “emic” knowledge of diverse and similar cultural groups worldwide (Leininger, 2002). The counterpoint to this is Ramsden (Ramsden, 2002) who argues against this view, emphasizing that this is not possible for a nurse since she can never gain an “emic” perspective of another cultural group’s worldview. She suggests that the nurse will always have an “etic” perspective, i.e. an outsider’s perspective. Even though nurses explore and gain knowledge about other cultural groups’ worldviews, the nurse will still understand these from her own point of view.

Many sources (c.f. Leininger & McFarland, 2002; Papadopoulos, 2006; Purnell & Paulanka, 2003) are available that present specific cultural knowledge that nurses can use when caring for

patients from a specific cultural group. However, to have specific cultural knowledge is not always helpful; in fact it can sometimes be more problematic to have this kind of knowledge. Kai et. al. (2007) found in their study about health professionals that personnel that had training in cultural competence still felt unequipped and were anxious about “getting it wrong”. Several of the students in **Study IV** also expressed such uncertainty and felt uneasy when approaching patients from different cultural groups even though they all had passed their course in transcultural nursing. One student even expressed that she, despite knowing she was wrong to assume that the patient was very different based on her looks, avoided going in to the patient’s room, out of fear of making a mistake. Another student expressed that by using specific cultural knowledge gained from courses and practice in relation to food preferences, she still struggled when she had to probe this area with patients, since she had experienced having a patient become offended by her. When asking a patient whether he ate pork, the patient expressed that she was stereotyping him due to his background, coming from an Islamic country.

Kai et. al. (2007) suggests that there needs to be a shift away from specific cultural knowledge towards a focus on individual care. Participants in **Studies III** and **IV** emphasized that there are more individual differences than cultural differences and that it is the individual they care for, not the culture. The participants in **Study III** expressed that the issues they had emphasized as necessary when caring for a patient from another cultural background were valid for all patients, Swedish patients as well as patients with an immigrant background. Gerrish and Papadopoulos (1999) suggest that nurses need both specific and generic cultural knowledge to be able to provide care that is culturally competent. However, Kai et.al. (2007) and Ekman and Emami (2007) suggest that culturally sensitive care is more than a question of knowledge, but rather a question of humane and emotional investment; characteristics identified by the participants in **Study III** as important when caring for patients from a cultural background different from their own.

### **Entering into a cross-cultural care encounter**

Entering into a cross-cultural care encounter is a challenge and it can be a difficult task for nursing students and nurses. The practicing nurses in **Study III** described different cross-cultural care encounters and challenges they faced when caring for patients from different cultural backgrounds. The practicing nurses expressed insecurity in relation to how patients expressed their emotions and the nurses did not know how to respond to this. The respondents in **Study IV** expressed the insecurity and uncertainty they felt when approaching a patient or a family from a cultural background that differed from their own. They expressed that they did not always know how to approach or address them, not only due to cultural differences, but also due to linguistic differences. It is a common phenomenon to categorize other persons that you meet and this categorization is often based on the person’s country of origin, e.g. England, Germany or Australia, etc. When approaching a person with a background that differs from your own, you can experience anxiety (Gudykunst & Kim, 1992). In line with Gudykunst and Kim I believe that educational programs for nurses should focus on helping nursing students reduce their uncertainty and anxiety when communicating with a person from another culture. Kim (1992) suggests that communicating with a person from another cultural background not only brings feelings of anxiety, but also a lack of confidence. Therefore it is imperative that nursing education programs incorporate training modules into their curricula that give students the possibility to develop necessary skills for communicating with the diverse people they will meet.

## 8 CONTRIBUTION TO KNOWLEDGE

**Study I** – This study has reinforced the need to examine the validity and reliability of an instrument for use in a different context. It has also highlighted how different validity tests can give different answers and therefore indicated the need to use a variety of tests. The study also raises questions about whether there can be a generic tool to measure cultural competence, when existing ones e.g. Campinha-Bacote's IAPCC-R (2003) and Lees' Papadopoulos & Tilki's CCATool (2002) are linked so closely to a particular theoretical framework for transcultural nursing.

**Study II** – This study has provided a broad overview of how cultural competence is portrayed in the main theoretical frameworks cited most frequently in the literature. To date, although concept analyses of cultural competence have been undertaken, there is no published work that has undertaken this type of content analysis. The study has identified some similarities between frameworks and highlighted some differences which arise from the different social, historical and political contexts in which they originated.

**Study III** – The findings from the study provide a comprehensive account of the components of cultural competence. Many published frameworks make general statements about the different components of cultural competence but provide little in the way of precise detail. By contrast Study III provides a comprehensive breakdown of the five dimensions of cultural competence. In the study an inductive approach was used to identify the core component of cultural competence from 'experts' in the field and then consensus methods was used to gain agreement on the importance of these components. Many of the existing published frameworks have been developed by nurse academics and then applied to practice. By taking a more inductive approach in seeking the views of practising nursing in addition to researchers and lecturers the components of cultural competence are more grounded in practice. However it is acknowledge that the components identified require further development and testing in nursing practice and also there is a need for gaining the patient perspective of the identified components.

**Study IV** – This study has shed further light on the challenges nurses face in communicating in cross-cultural care encounters and identified the different techniques that are used to establish communication. Much of the existing research on cross-cultural communication originates from outside Sweden, where arguably the context of providing nursing care may be different. The study is unusual in its focus on the experiences of nursing students (as opposed to qualified nurses) and provides useful insights into the support that students need to develop skills in cross-cultural care encounters in practice setting.

## **9 IMPLICATIONS FOR NURSING SCIENCE**

Nursing science is the systematically developed knowledge of the discipline of nursing, which encompasses what nursing is and what nurses do (Cody, 1997). Nursing science is a basic science that focuses on human-universe-health processes addressed in nursing frameworks and theories (Parse, 2000). To be able to build a unique body of knowledge it is essential that we define key terms and specify philosophical underpinnings (Parse, 1997), ensuring congruence between these definitions and philosophical underpinnings (Barrett, 2002).

In the field of transcultural nursing, different key terms are used in relation to cultural competence. For example, cultural-bound health care needs and cultural-specific care needs seem to address the same issue but with different labels attached to them. Such unclear terminology can make it difficult for nurses to conceptualize and implement these concepts in practice. An even more important key term or concept within transcultural nursing is cultural competence. In the nursing literature the definition of cultural competence varies depending on who has described the concept. The descriptions are cross-referenced, compounding the issue as students try to discern the true meaning of cultural competence. The main focus of this thesis is the concept of cultural competence and the knowledge that has been generated contributes to conceptual clarity around cultural competence in a Swedish context.

Previous knowledge in the field of transcultural nursing science and cultural competence has in many ways been addressed in relation to patients with immigrant backgrounds or from ethnic minority groups. The studies in this thesis challenge such a view, and suggest that cultural competence should be applicable when caring for any patient regardless of whether or not they have immigrated or have an ethnic minority status. Cultural competence addresses a person's view of life, health and illness.

Therefore, to make culturally competent nursing care available and beneficial for all individuals, it is time that we broaden the focus in the field of transcultural nursing science by not only considering culture as an important factor in the care of all patients, but also by including all other factors that can be related to the individual's understanding of his or her life, health and illness, e.g. socio-economic status, gender, education, political, geographical, physical, mental and spiritual factors. Unless nurse researchers conduct "cultural" studies on people from the majority population and we include this focus in nursing education, nursing students and nurses will continue to view culture as something that belongs to "the other".

## **10 IMPLICATIONS FOR NURSING PRACTICE AND EDUCATION**

This thesis has provided new knowledge in relation to cultural competence in nursing. Cultural competence was mainly developed due to an increased awareness of and interest in cultural differences in relation to patients with immigrant backgrounds. Today, cultural competence is an area of competency that is necessary for nurses when caring for all patients. The synthesis of the findings from the four studies identified a common pattern in the elements that are considered to constitute cultural competence in the Swedish context, and which are important for nurses. These are: the nurse's cultural awareness, personal beliefs and values; cultural assessment; and cross-cultural communication. For nurses to be able to acknowledge and consider patients' cultural backgrounds, beliefs, traditions and traits, it is important to provide them with opportunities during their education that will increase their cultural awareness and help them identify their personal beliefs and values. It is also important to teach nursing students how to conduct a cultural assessment and how to acknowledge and incorporate the outcome of the assessment in their nursing care. Furthermore, it is necessary to develop nursing students' cross-cultural communication skills so that they can communicate with their patients. Finally, the studies also identified that in general, Swedish nurses, nurse lecturers, nurse researchers and nursing students conceptualize culture as something belonging to immigrant patients instead of having adopted a broader definition of culture. It is our task as nurse educators to prepare nursing students for their future work and help them understand that culture does not belong to immigrants; it is something that belongs to us all.

## 11 FUTURE RESEARCH

The studies in this thesis have provided new knowledge in relation to cultural competence in nursing but there are still areas that need to be further explored. For example the patient perspective is missing in this thesis. In **study III** several components were considered important for nurses to address in relation to nursing care. This however does not necessarily mean that patients emphasize the same components as important as the experts did. It is also possible that patients would identify and emphasize other components of more importance for them than those identified in **study III**. It is therefore necessary to explore the components identified in **study III** with patients.

Another important area in this thesis that merits further research is nurses experiences in clinical practice. In **study III** I wanted to identify areas that were important for nurses to assess on their patients. However even if the areas identified by nurse researchers, nurse lecturers and practising nurses were regarded as of being important it is not certain that practising nurses assess and acknowledge them in their practice. In relation to the findings from **study IV**, it is important to further explore cross-cultural communication in relation to nursing students as well as qualified nurses. It is possible that other communication strategies are used than the ones described in **study IV** but also other factors influencing cross-cultural communication than those identified in study IV may be identified.

## 12 POPULÄRVETENSKAPLIG SAMMANFATTNING

Det övergripande syftet med detta avhandlingsarbete var att undersöka, analysera och klargöra vilken innebörd kulturell kompetens. Detta har belysts ur sjuksköterskors, sjuksköterskestudenters, lärare i sjuksköterskeutbildningen och omvårdnadsforskarens perspektiv. Kunskapsområdet transkulturell omvårdnad och kulturell kompetens grundades i USA på 1950-talet då den ökade invandringen ledde till en ökad medvetenhet kring kulturella skillnader. I Sverige har intresset för transkulturell omvårdnad och kulturell kompetens uppstått relativt nyligen och kunskapen inom detta område är därför relativt begränsad. I studie I eftersökte forskargruppen ett instrument som skulle kunna användas för att mäta kulturell kompetens. Vi identifierade ett instrument från USA, IAPCC-R som vi efter tillstånd från konstruktören översatte till svenska och anpassade för att det skulle fungera i Sverige. Efter att översättningen och anpassningen hade genomförts prövade vi den svenska versionen av instrumentet med hjälp av ett flertal olika pilotstudier och statistiska tester för att undersöka om instrumentet skulle fungera i Sverige. Resultatet visade att instrumentet inte nådde upp till motsvarande validitets- och reliabilitetsvärden som originalinstrumentet från USA, vilket gjorde att vi drog slutsatsen att den svenska versionen av instrumentet inte bör användas. I studie II analyserades de centrala komponenterna för kulturell kompetens hos de teoretiska ramverk som ses mest i omvårdnadslitteraturen. Nio teoretiska ramverk rörande kulturell kompetens identifierades och analyserades med dokumentanalys. Texterna analyserades sedan med kvalitativ innehållsanalys. Analysen identifierade fyra teman som karakteriserar kulturell kompetens: en medvetenhet rörande olikheter hos människor; en förmåga att vårda människor; att vara öppen och icke fördömande mot andra människor; samt en ökad kulturell kompetens som en fortgående process. I den tredje studien var syftet att identifiera de centrala komponenterna för kulturell kompetens ur ett svenskt perspektiv. Delfitekniken användes och 24 experter deltog i studiens fyra omgångar. Första omgången genomfördes med kvalitativa intervjuer och efterföljdes av tre omgångar med enkäter. Totalt sett uppnåddes en enighet kring 118 olika centrala komponenter som grupperades i fem kategorier med 17 tillhörande underkategorier. Dessa kategorier är: kulturell känslighet; kulturell förståelse; kulturella mötet; en förståelse för hälsa, ohälsa och hälsovård; och socialt och kulturell kontext. I den fjärde och sista studien genomfördes kvalitativa intervjuer med 10 sjuksköterskestudenter, fem med invandrarbakgrund och fem med svensk bakgrund för att belysa deras erfarenheter av kommunikation i kulturella vårdmöten. Intervjuerna analyserades och fyra teman identifierades: förståelse av kulturella möten; kommunikationssvårigheter; kommunikationsstrategier; och faktorer som påverkar kommunikationen. Genom att sammanföra resultatet från de fyra studierna kunde ett mönster identifieras med tre områden; sjuksköterskans kulturella medvetenhet, personliga övertygelser och värderingar; kulturell bedömning och kulturell kommunikation, som tillsammans belyser kulturell kompetens ur ett svenskt perspektiv. Slutsatsen är att transkulturell omvårdnad och kulturell kompetens rör sjuksköterskans förmåga att ta hänsyn till patientens kulturella bakgrund, övertygelse, värderingar och traditioner i omvårdnadsarbetet. Kulturell kompetens är inte enbart betydelsefull vid vård av patienter med invandrarbakgrund utan vid vård av alla patienter.



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