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Ethnically diverse patients' perceptions and expectations on the importance of culturally competent care in primary health care settings

A Literature Review

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The purpose of this final project was to discover the perceptions and expectations of ethnically diverse population regarding culturally competent care. We also wanted to find out what the patients considered to be the main barriers in providing culturally competent care. We aimed to find studies specifically in primary care settings.

This final project is a part of Local and Global Development in Social Services and Health Care (LOG-Sote) project. This project aims to develop heath care services in Finland towards a more immigrant-friendly direction. The methodology of this final project was a systematic literature review consisting of fifteen research articles obtained through CINAHL, PUBMED and OVID (MEDLINE) databases.

The findings indicated that the patients expected the care they received from the health care providers to be family-orientated, respectful and holistic. Patients also wanted their cultural, religious and traditional beliefs and practices to be taken into account throughout their care. The main barriers to culturally competent care, according to the patients from various different ethnic backgrounds, were mostly related to communication, lack of common language between the patients and the healthcare providers, inadequate information provided to the patients by the healthcare providers and unmet health care need.

If the patients' expectations and perceptions regarding culturally competent care are discovered, it would help the health care professionals to understand their patients' needs and provide culturally appropriate care. This could help the health care professionals to further develop their cultural competence skills, thus, improving the cooperation with patients from different ethnical backgrounds.

Keywords	ethnic patient, perceptions, expectations, primary care, culturally competent care

Tekijät Otsikko Sivumäärä Päivämäärä	Afshan Afzal ja Rosa Salmela Erilaisiin etnisiin ryhmiin kuuluvien potilaiden käsityksiä ja odotuksia kulttuurillisesti kompetentin hoitotyön tärkeydestä perusterveydenhuollossa 37 sivua + 18 liitteitä Marraskuu 2012
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Opinnäytetyömme tarkoitus oli saada selville erilaisiin etnisiin ryhmiin kuuluvien potilaiden käsityksiä ja odotuksia kulttuurillisesti kompetenttiin hoitotyöhön liittyen. Halusimme myös saada selville, mitä potilaat pitivät pääasiallisina esteinä kulttuurillisesti kompetentin hoitotyön toteuttamiselle. Yritimme löytää tutkimusaineistoa erityisesti perusterveydenhuollon alueelta.

Tämä opinnäytetyö on osa LOG-Sote-projektia (Lokaali ja Globaali kehitys sosiaali- ja terveysalalla). Hanke pyrkii kehittämään suomalaisia terveydenhuoltopalveluita maahanmuuttajaystävällisempään suuntaan. Aineiston kokoaminen ja analysointi suoritettiin soveltaen systemaattisen kirjallisuuskatsauksen menetelmää. Kirjallisuuskatsausta varten kerättiin 15 tieteellistä tutkimusartikkelia käyttäen CINAHL, PUBMED ja OVID (MEDLINE) tietokantoja.

Tämän kirjallisuuskatsauksen löydökset osoittivat, että potilaat odottivat hoitotyön olevan perhekeskeistä, potilasta kunnioittavaa ja holistista. Potilaat halusivat myös, että heidän kulttuurilliset, uskonnolliset ja perinteiset uskomukset ja käytännöt otettaisiin huomioon hoitotyön eri vaiheissa. Potilaiden mukaan suurimmat esteet kulttuurillisesti kompetentin hoitotyön toteuttamiselle liittyivät pääasiallisesti kommunikointiin, yhteisen kielen puuttumiseen potilaan ja terveydenhuollon ammattilaisen välillä, riittämättömään tiedonsaantiin ja potilaiden terveydenhoidollisten tarpeiden toteutumattomuuteen.

Selvittämällä, millaisia odotuksia ja käsityksiä erilaisista kulttuureista lähtöisin olevilla potilailla on hoitotyöstä, voivat terveydenhuollon ammattilaiset oppia ymmärtämään syvällisemmin potilaidensa lähtökohtia ja tarpeita hoitotyöhön liittyen. Tämä voisi auttaa terveydenhuollon ammattilaisia kehittämään omaa kulttuurillista kompetenssiaan ja näin ollen parantamaan yhteistyötä erilaisista kulttuureista lähtöisin olevien potilaiden kanssa.

Avainsanat	etninen potilas, käsitykset, odotukset, perusterveydenhuolto, kulttuurillisesti kompetentti hoitotyö

Contents

1 INTRODUCTION

Transcultural nursing is a concept which is closely related to culturally competent care, which arrived about 30 years ago when Madeline Leininger started to create a theory regarding transcultural nursing (Tortumluoglu 2006: 2). Culturally competent nursing has been a very common topic of interest for the past years with the increasing ethnic diversity of patients. There is a constant growth of ethnic minorities in Western countries which creates a need for more knowledge in the area of culturally competent health care. According to Statistics Finland (2012) there has been a continuous increase in the past six years in the number of immigrants who have received a Finnish citizenship. The greatest increase of immigrants receiving Finnish citizenship was in the year 2008, with a number of 6682. In the past decade the number of asylum seekers in Finland has increased by few thousands per year, the highest number being 5988, in the year 2009. Apart from this, there are over a 150,000 foreigners living in Finland without a Finnish nationality, and the statistics show a yearly increase as well. There are immigrants who have migrated not only from the neighbouring countries, but from all over the world, including countries in Asia and Africa. (Statistics Finland, 2012.) These statistics show clearly that the immigrant population has only been on the rise, which makes Finland an increasingly multi-cultural country.

The increase of immigrants in Finland creates a need for the health care providers to be more aware of how different cultural backgrounds can affect the patient's health beliefs and practices. According to Wallin and Ahlström (2010) patients' beliefs about health and illness are formulated by their culture, which have an effect on the decisions they make regarding their treatment. In order to provide patients with high-quality and culturally competent care there is a need for further research regarding minority cultures. (Wallin & Ahlström 2010.)

Perron, Secretan, Vannotti, Pecoud and Favrat (2003) have shown that in the past several decades researchers and clinicians have emphasized the importance of bringing forth the patient's perspectives and expectations regarding illness. With the increasing ethnic diversity in our society it is necessary to take into consideration the cultural identity of individuals. According to Elliot (2011: 28), "Ethnic groups should be treated appropriately - but not identically. Their different needs should be taken into account."

Keeping this in mind, nurses should acknowledge that perceptions, expectations and needs of people even within the same culture can be different. In order to bring awareness, the health care providers need to find out more about the expectations, needs and perceptions of the ethnic minorities regarding the given care.

We chose this topic in order to get a better understanding on existing research on the ethnically diverse population's perceptions and expectations of culturally competent care in primary health care settings. Traditionally patients have been seen just as passive recipients of care rather than clients who are entitled to care that is tailored to their needs. Patients are also encouraged to speak out their wishes and they expect them to be fulfilled. Garrett, Dickson, Lis-Young, Whelan and Roberto-Forero (2008) also state that patients are considered as individuals and each patient-health care provider interaction is unique, therefore patients' own evaluations and opinions should have a bigger effect in health care. The study argues that the patient's views should even have a decisive role. Haugaard Christensen presented the findings of her study (2010) in a presentation given in Metropolia, University of Applied Sciences, where she mentioned that "The patient's frame of reference decides the nursing intervention and care is validated with the patient's view". This also indicates a need for more focus on the patient`s views instead of focusing too heavily on the views of the health care professionals.

This final project aimed to find studies related to care in primary health care settings, because primary care serves as a provider of initial contact health care services and also coordinates other specialized health care services that the patient may need. According to Stanhope and Lancaster (2004), primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with the patients, and practicing in the context of family and community. As primary care can usually be considered the starting point of a care relationship between a patient and health care providers, the importance of establishing a good working partnership can be considered crucial in order to ensure high quality and continuity of care.

From a health care provider`s perspective in order to build a partnership with a patient, it is important to gain more knowledge about the patient. Understanding patient`s perspectives relating to the care can help the health care professionals further develop the health care field towards a more individualized approach. According to Suliman, Wel-

mann, Omer and Thomas (2009), Leininger (1988) noted that caring is a universal phenomenon, which is likely to be perceived differently by patients and nurses if they come from different cultural backgrounds. Due to the fact that people have individual ways of perceiving different concepts, understanding what these perceptions are and how they might affect behavior related to health care issues can help to improve primary health care services. A deeper understanding of patients` perceptions can provide the health care professionals with more tools to develop patient care towards a more individualized approach. The ICN Code of Ethics for Nurses (2006) emphasizes that nurses should respect cultural rights, and care should be respectful and unrestricted by considerations of the personal looks of the client, their nationality, social status, or the form of their illness. Every client should be treated as a unique individual, regardless of their background.

Our final project focused on how patients from ethnically different backgrounds perceive professional caring behaviors, and what are the possible barriers in primary health care from the patient`s point of view. We examined how understanding these perceptions could be helpful in overcoming the barriers. Further we took a brief look at some of the pre-existing theories and models, to see how they could be applied in providing culturally competent care when taking into consideration our findings regarding patient`s perceptions. The purpose of this literature review was to discover the perceptions and expectations of ethnically diverse population regarding culturally competent care in primary health care settings.

2 DEFINING CONCEPTS

2.1 Ethnicity, ethnic minorities and ethnically diverse population

In our final project database search, we included the term ethnic minority as a search word because through our preliminary searches we found out that it is commonly used to describe immigrant people from various cultures living in Western countries. After careful consideration, we concluded that the term ethnically diverse population would be more appropriate in the title of our final project because it has a more positive tone. According to Giger and Davidhizar (2004) a groups is often considered a minority due

to its lack of power, assumed inferior traits and supposedly undesirable characteristics. This negative image and assumption of inferiority behind the word minority, can lead to discrimination of people from other cultures.

In the study by Stanhope, Solomon, Finley, Pernell-Arnold, Bourjolly and Sands (2008: 357) the authors explain why they chose to use the term diverse in relation to race and ethnicity;

> *The training approach the study incorporates the belief that the assignment of a person to a majority or minority group does not reveal the information needed to make services culturally competent. It also implies there are only two groups of people. The term diversity represents the presence of many differences.*

Trying to determine if a certain individual belongs to an ethnic minority can sometimes be difficult. According to Finnström and Söderhamn (2006: 424) defining the population of interest can be problematic due to the fact that in some cases members of an ethnic minority consider themselves more as representatives of the majority or mainstream culture group. This also gives indication to why the word diverse could be more applicable than the term minority.

Ethnicity is a concept that is considered common to all humans. According to Culley and Dyson (2010), ethnicity refers to people who identify with each other by common ancestry and associate themselves with an identifiable geographic region. Sharing of one or more of such factors as religion, language, dress, diet, and customs is also possible but not considered necessary. Everyone has connections to certain territories, a heritage, and a variety of social rituals around major life events e.g. birth and death. (Culley & Dyson 2010.) According to Giger and Davidhizar (2004) an essential characteristic of ethnicity is that people who belong to an ethnic group feel a sense of identity.

2.2 Expectations and perceptions

First we defined the words “expectation” and “perception” as general concepts according to dictionaries, then we explained how they are more specifically related to our topic.

According to the Oxford Advanced Learner’s Dictionary (1992), the word “expectation” has been defined as a “firm belief that something will happen; hope of gaining some-

thing/that something will happen". Definition of "expectation" according to the Collins English Dictionary (2009): "The act of expecting or the state of being expected; something looked forward to, whether feared of hoped for." According to the Oxford Dictionary (2012), perception can be defined as the ability to see, hear, or become aware of something through the senses or alternatively the way in which something is regarded, understood, or interpreted. Perception can be considered an individual way of understanding and interpreting different concepts and matters.

Prakash (1984) has described patient expectation of care as "what patients expect as a result of their own or others' experiences and the care they would like and/or hope for." (McKinley, Stevenson, Adams & Manku-Scott 2002: 333-334). This shows how patient's expectations are created; patients may hear from others what their experience was regarding their care, and develop their own expectations based on that, or they might hope for a certain type of care based on what is preferred. As expectations can arise from what the patients perceive other people`s experiences have been like, it is easy to see how the concepts of perception and expectation intertwine with each other and are often strongly connected. It is difficult to identify patient's expectations unless they are directly asked from them, and Perron et al. (2003: 428) have stated that it becomes an even bigger challenge in a multi-cultural population. The authors further explained how health care professional assume immigrant patients to have different levels of expectations compared to native patients, immigrants having more demanding expectations. According to Cortis (2000), patient perceptions of caring may differ greatly from health care provider perceptions, particularly when the patient and the health care provider do not have similar cultural backgrounds. The author further explains that this may lead to the situation of health care providers and patients having different interpretations of concepts related to caring behaviors.

2.3 Cultural competence

According to Taber`s Cyclopedic Medical Dictionary (2009: 555) cultural competence is described as a "sensitivity to the cultural, philosophical, religious, and social preferences of people of varying ethnicities or nationalities. Professional skill in the use of such sensitivities facilitates the giving of optimal patient care."

In a community where the population is ethnically diverse, health care professionals often provide care for individuals who are from a different cultural background than their own. Thus, having knowledge about diverse cultures would help the health care professional understand beliefs and values of their patient, which would facilitate a culturally relevant care. According to Elliot (2011: 30), cultural competency requires one to be aware that individuals may have values and beliefs that may not necessarily be the same as the person providing the care. One must acknowledge and accept that the individual being cared for may have a different worldview than one's own, and they should be provided care that is culturally appropriate. Purnell and Paulanka (1998) note that the term cultural competence is the act whereby a health care professional develops an awareness of one's existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided. Further, the authors conclude that cultural competence is the adaptation of care in a manner that is congruent with the client's culture (Giger & Davidhizar 2004).

According to Smith (1998), cultural competence is a continuous process of awareness, knowledge, skill, interaction, and sensitivity that is demonstrated among those who render care and the services they provide (Giger & Davidhizar 2004). Servonsky and Gibbons (2005: 52) have described cultural competency as a complex developing process which involves an understanding of one's own culture and values and the awareness of cultural differences between groups. The authors also believe that diverse cultural groups have their own way of communicating, behaving and interfering in matters regarding health and illness, such as health beliefs, and health seeking behaviors.

There may be major differences between cultures, but sometimes even the smallest of things could be very important to an individual from a cultural group. Knott (2002) has put an emphasis on the importance of the health care staff being culturally sensitive also to the minor factors, for example, eye contact, dietary preferences, conversation styles etc., which may conflict between cultures (Suliman et al. 2009: 293).

Vandenberg (2010: 241) has noted that many of the people who support cultural competent care would want the nurses to learn about different cultures, and customs of different groups which would help them to acquire skills for working with clients from different cultures than their own and most importantly have a positive attitude and open-mindedness towards them. Stanhope et al. (2008: 359) demonstrates the different stages of becoming a culturally competent health care provider, starting from un-

derstanding one's own cultural beliefs as well as their patients' and as a result being able to provide culturally competent care.

2.4 Culturally unique individuals

In providing culturally appropriate and competent care it is important to remember that each individual is culturally unique and as such is a product of past experiences, cultural beliefs and cultural norms. Cultural expressions become patterned responses and give each individual a unique identity. Although there is as much diversity within cultural and racial groups as there is across and among cultural and racial groups, knowledge of general baseline data relative to the specific cultural group is an excellent starting point to provide culturally appropriate care (Giger & Davidhizar, 2004).

Finnström and Söderhamn (2006: 424) have discovered that many authors have paid attention to the risk of stereotyping, and they believe that there is usually more diversity within cultural groups than between cultural groups. This idea has been also mentioned by Vandenberg (2010), if one would accept an individual as a member of some cultural group, it can lead to stereotyping and making generalizations about them. Thus, health care professionals should learn about cultures, but also more importantly understand that there exist also many differences within cultures. According to Elliot (2011), individuals belonging to a cultural group may adapt beliefs and values of their group differently than other members of the group, may it be their family or relatives. Further the author has emphasized the importance of using our knowledge and information of different cultures to guide us when providing care to patients from diverse cultures. Our knowledge about different cultural customs and norms should not lead us to believe that every individual belonging to a certain cultural group will have the same beliefs. It is a very sensitive issue, as merely the knowledge of various cultures is not enough, it needs to be dealt with a good understanding of the concept of culturally unique individuals.

Dogan, Tschudin, Hot and Özkan (2009) have pointed out that the concepts of illness, health and disease are a part of everyday life and they may not be clearly explained in different cultures. The meanings of these concepts differ in all cultures, and individuals also understand these differently. An individual's understanding of these concepts can affect their behavior, actions and decision making, and the whole course of their illness

as they interpret these differently. Unless patients are made aware of these concepts through discussion it can be very problematic to compare them transculturally.

The concept individualized care is closely related to culturally unique individual, as they both strive to provide care which focuses on the individual's needs. According to Waters and Easton (1999), care that is provided as individualized care, will see the human being as an individual and how they all are unique and not similar to one another. This type of care can be provided by applying different ways of providing care, such as involving the client more in their care, allowing them to be a part of decisions regarding their treatment, and hearing them out. (Radwin & Alster 2002.)

2.5 Pre-existing models and theories of culturally competent care

2.5.1 Madeleine Leininger's Culture Care Theory

According to Leininger (2002), it was challenging to acquire the nurses attention to the "Culture Care Theory" she built in the mid 1900's, as the nurses were more interested in the medical treatments. She also found that according to the nurses care was "too soft, feminine and nonscientific" and also that "culture was irrelevant and unnecessary". As of today, her theory is well known by nurses, and is thought to be "broad, holistic yet culture-specific focus to discover meaningful care to diverse cultures" (Leininger, 2002). The theory brings out the meaning and importance of culture in an individual's health and their caring behaviors. Because the theory is holistic and has culture-specific care practices, and entirely focuses on culture and care, it can be useful for nurses to use in their practice as guideline to providing care.

Leininger (2002) has stated that the Culture Care Theory till date is one of the oldest in the nursing profession, and it is the one and only theory which focuses on the "close interrelationships of culture and care on well-being, health, illness and death". The theory primarily explains the different cultural factors which influence an individual's health and over all well-being. The theory includes both abstract and practical characteristics. It also has three practical models for providing culturally consistent care, i.e the Sunrise Model.

2.5.2 The Giger and Davidhizar Transcultural Assessment Model

A multi-culture society creates a need for a culturally diverse assessment tool in the health care centers. The assessment of a patient is a crucial part of the nursing process, it provides all necessary information regarding the patient, thus it is important for the assessment tool to be transcultural. According to Tortumluoglu et al. (2006: 3) the transcultural assessment model was developed in 1998 by Giger and Davidhizar, and was initially created for students who could use this model to assess and care for patients from culturally diverse backgrounds. The metaparadigm for the transcultural assessment model includes "1) transcultural nursing and culturally diverse nursing, 2) culturally competent care, 3) culturally unique individuals, 4) culturally sensitive environments, and 5) health and health status based on culturally specific illness and wellness behaviors" (Giger and Davidhizar, 2008: 5). Giger and Davidhizar have classified six cultural phenomena in their transcultural assessment model; environmental control, biological variations, social organization, communication, space and time orientation (Tortumluoglu et al., 2006: 3, Giger & Davidhizar, 2008: 7). These different cultural phenomena "serve to present the diversity that exists between cultural groups" (Tortumluoglu et al., 2006: 3). The cultural phenomenas provide a framework for the health care professionals to provide culturally sensitive care to patients from various different cultures, ethnicities and races.

2.6 Primary health care

According to the World Health Organization (2012), primary health care is health care received in the community given by health care professionals. The WHO states that primary health care should be universally accessible to people by means acceptable to them, with their full participation and at an affordable cost. According to the WHO (2012) "Primary health care (PHC) refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system."

In the 1978 Declaration of Alma-Ata primary health care as a concept was defined as "..a set of guiding values for health development, a set of principles for the organization of health services and a range of approaches for addressing priority health needs and

the fundamental determinants of health." (WHO 2012). Some important values according to the declaration were that there would be:

> *..equal access to health and an end to exclusion; health services that are centred around people's needs and expectations; health security for the communities in which people live; a more holistic approach towards health, taking into consideration that sectors other than health have a huge impact on peoples' health; and a health systems approach in which primary care would play an integral and central role. (WHO 2012).*

These values clearly indicate the importance of taking into consideration human being as a whole and providing people with care that is focused on their individual needs.

Definition of "Primary care" according to the Webster's New World Medical Dictionary (2009) is that it is patient's primary source for regular medical care and that it would provide continuity of care and integrated health care services. The aims of primary care are to provide the patient with a broad spectrum of preventive and curative care over a period of time and to coordinate all the care that the patient needs to receive. According to Taber`s Cyclopedic Medical Dictionary (2009: 1892) a primary care provider is the health care provider (i.e. the nurse practitioner) to whom a patient first goes to address a problem related to his or her health. Primary health care is considered synonymous for primary care.

According to the Ministry of Social Affairs and Health (2010), the provision of primary health care in Finland is the responsibility of municipal health centres. Municipalities may either have their own health centres or form joint municipal health centres serving the participating municipalities. Municipalities may also obtain health centre services from private service providers. Under the Primary Health Care Act (66/1972) the functions of the health centres are to provide guidance in health related issues and to carry out prevention of diseases; to organize medical examinations and screenings for local people; to run maternity and child health clinics; to arrange for school, student and occupational health care services; to organize the provision of dental health care; to organize the provision of medical treatment for local residents; to organize home nursing services; to provide rehabilitation services; to arrange provision of those mental health services which can appropriately be provided in health centres and to provide a local ambulance service (The Ministry of Social Affairs and Health 2010).

3 PURPOSE OF THE FINAL PROJECT AND STUDY QUESTIONS

Our purpose was to find out the perceptions and expectations of ethnically diverse population regarding culturally competent care in primary health care settings.

Specifically we aimed to answer the following questions;

- What are the perceptions and expectations of the ethnically diverse population regarding professional caring behaviors and primary care?
- What are the main barriers in providing culturally competent care for an ethnically diverse population in a primary care setting; from the patient's perspective?

4 METHODOLOGY AND DATABASE SEARCH

The methodology of this final project is a systematic literature review. We familiarized ourselves with our topic by carrying out searches related to our final project's main concepts through nursing and medical databases available through Metropolia University of Applied Sciences' library. The material collected through these databases was analyzed using content analysis.

4.1 Literature review

Literature review is a systematic and critical appraisal of the most important literature on a certain topic. According to Hart (2001), the articles chosen for a literature review should contain information, ideas, data and evidence written from a particular standpoint to fulfill certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed. Lobiondo-Wood and Haber (2010: 59), state that a systematic literature review should be applied by determining what is known and unknown about a particular subject, discovering consistencies and inconsistencies in the researched literature, synthesizing strengths, weaknesses and findings of the studies available, and generating suggestions to enhance evidence-based practice on a specific subject.

4.2 Data collection

During the initial phase of our final project, we carried out several preliminary searches to find published research articles related to our topic. When we were doing the first searches we did not mark down the number of articles retrieved from each search. We also did not use the exact same key words in all the databases. Since we did not take into consideration the usefulness of marking down the number of the retrieved articles, we carried out a second set of searches. During the second search we marked down the number of articles retrieved and used the same key words in different databases. We found the same selected articles from the first and second searches and removed duplicates.

The literature review was done by a thorough collection and analysis of research based knowledge on what are the patient`s perceptions and expectations on culturally competent care. The database search engines used were CINAHL, PUBMED, COCHRANE and OVID (MEDLINE). These databases were chosen because they cover the majority of current, published nursing and medical articles. We used key words that were relevant to our topic, such as individual care, culturally competent, primary care, patient`s expectations, experiences and needs, and ethnic minorities. A description of the searches was put into table format (Appendices 1 and 2). We found that most of the information that was related to our topic was found using search words culturally, competent, expectation, patient and primary. In the beginning it was problematic to find articles about ethnically diverse population’s expectations and perceptions related specifically to primary health care settings. Therefore, we decided to use different search words in order to find more relevant research articles.

4.3 Limitation criteria

Articles were first chosen based on their titles and only after reading the abstracts the articles were chosen for further analysis. Our main selection criteria was that the research articles contained relevant and appropriate information regarding our topic and research questions. The articles were obtained only from peer-reviewed journals to enhance the credibility of the chosen articles. When the selection criteria was met and

the article was found suitable for the review process, only then we proceeded by reading the entire article. For our findings, we only included empirical studies.

To make sure we would make a relevant search for our literature review, and that it addressed our topic/research question we had a well-defined inclusion and exclusion criteria. The inclusion criteria for our literature review was: research articles published between the time frame of 2001 and 2012 to make sure that the literature chosen contained current data, written in the English language only, provided a link to free full text and that the articles were scientifically peer reviewed. The exclusion criteria for our literature review were: research articles before year 2001, unpublished and non-peer-reviewed research articles, not in the English language.

4.4 Data analysis

The data was analyzed based on content analysis. The articles we found in the database search were analyzed by using a modified version of the inductive content analysis method by Elo and Kyngäs (2008). “The use of inductive content analysis is recommended when there are no previous studies dealing with the phenomenon or when knowledge is fragmented.” When using an inductive approach the categories are derived from the data (Elo & Kyngäs 2008: 113). Common/unifying themes from the analyzed articles were identified and categorized. We found that the information was fragmented and this made it challenging to analyze the content and pick the most appropriate material for our final project. For our data analysis we reviewed 15 research articles.

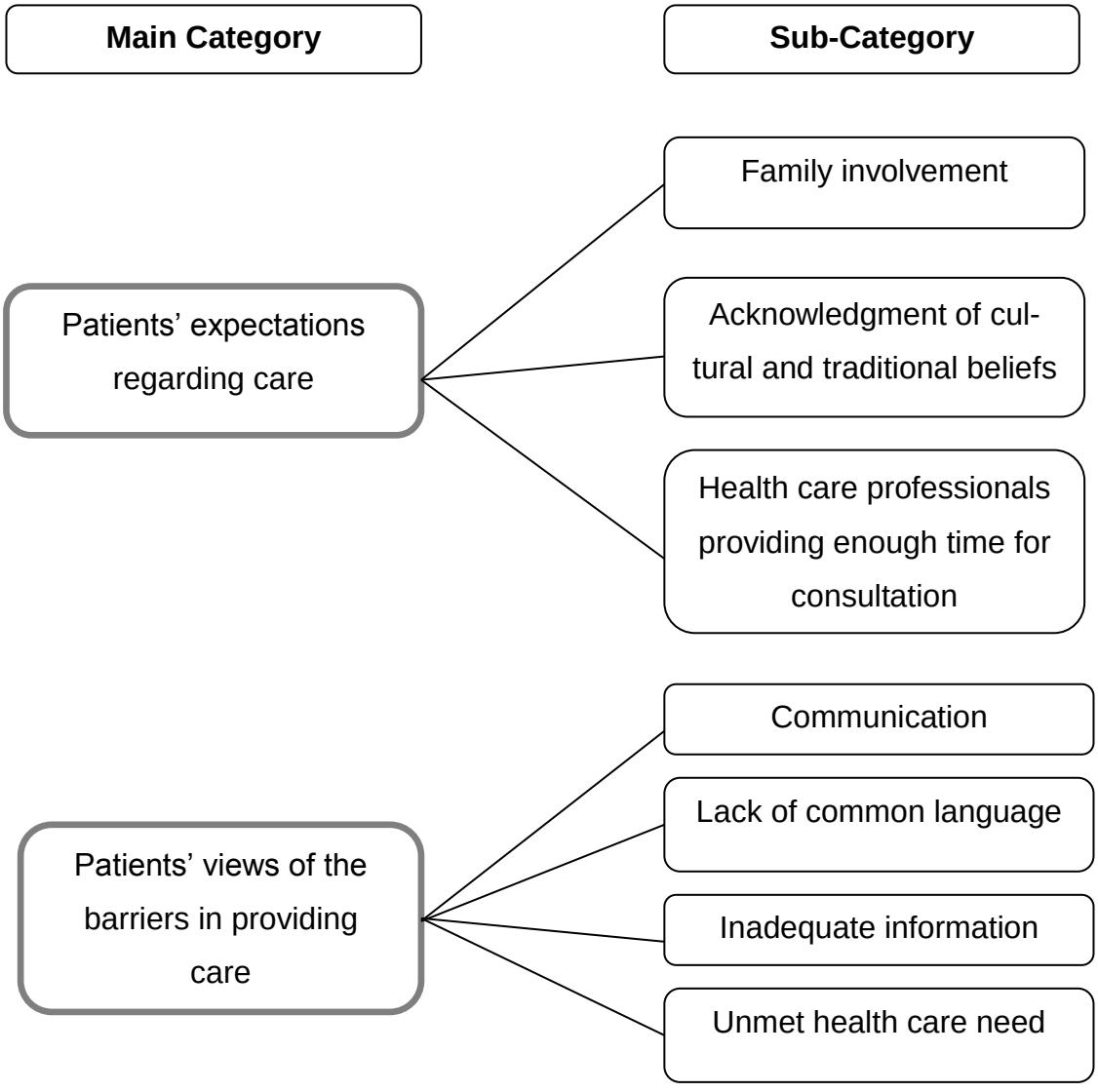
Inductive content analysis has three phases, preparation, organizing, and reporting the analyzing process and results. We started with the first phase of data analysis, preparation, by selecting the relevant and appropriate material, immersing in the data and making sense of the data as a whole. After analyzing the data, it was organized into a table format (Appendix 3). During the second phase, organizing, we grouped the data into similar themes which occurred through-out the selected research articles. From the findings of the selected research articles, we were able to find similarities and make connections which helped us to get a better understanding and to gain more knowledge of the findings. The similar themes were categorized and then further subcategorized in order to clarify the found themes. The appropriateness of the categories

and sub-categories was assessed by the authors simultaneously while writing the text. In the last phase, the findings were explained in detail. Throughout this process, the authors paid close attention that the findings of the research articles would be portrayed accurately, meaning as they were described in the studies, and refrained from commentating the findings.

5 FINDINGS

Fifteen relevant research articles were included in our systematic literature review. The findings of the articles are presented in categories and further explored in subcategories (Figure 1).

Figure 1. Findings categorization



5.1 Patient's expectations regarding care

Perron et al. (2003) carried out a search in which they aimed to find out health care expectations of Swiss and immigrant patients and compare them. Their findings showed that regardless of the patients' origin, their expectations of health care were similar. In the Swiss out-patient clinic, patients expected and hoped for the physicians to listen to them, receive physical examination, counseling and a diagnosis and information regarding prognosis and medication. The authors also assessed how well physicians were able to identify their patients' expectations, and they found that the physicians were not able to identify their patients' expectations too well, regardless of the patients' origin. In some areas physicians underestimated their patients desires for counseling, investigations, information for prognosis and referrals to a specialist. However, in some areas the physicians overestimated their patients' expectations; reassurance, prognosis, and medication specifically among immigrant patients.

Lee, R., Rodin, G., Devins, G. and Weiss, M. G. (2001) studied health seeking behaviors in Chinese patients living in Canada with chronic fatigue and weakness and found that prior to their consultation to a Western physician the patients had looked for help from a number of other physicians with no useful outcome. Only after this they visited a Western physician and this was because they wanted to see if modern Western technology could find out if they have any major illnesses. However, because of the benefits of the government's health insurance many of the participants in the study had consulted Western physicians first, although they did not have any high expectations from these family doctors, as they had more belief in their own traditional and cultural therapies. On the other hand, Perron et al. (2003) concluded based on their study, that immigrant patients did not consult health care professionals any sooner than Swiss patients. Although the physicians in that study assumed that immigrants have higher expectations and more demands regarding health care, that was not the case.

Patient's satisfaction of the care is often linked to their expectations to the care, thus emphasis should be put on finding out the patient's expectations regarding their care. McKinley et al. (2002) have shown that patients were more satisfied if their care as what they had hoped for compared to patients who were not provided the care they had hoped for. According to Perron et al. (2003), previous studies have pointed out that

factors such as race, ethnicity, origin and culture have an effect on the outcome of the health care and patient satisfaction.

McKinley et al. (2002) have mentioned that if health care provider is unable to meet the patient's expectation, it can be a factor in determining the patient satisfaction in received care. The authors believe that dissatisfaction will be reduced if the patients know what to expect from the care and receive it according to these expectations. This shows how expectation and satisfaction are very closely related to each other. According to McKinley et al. (2002), if the patient's idealized expectation is not met, the outcome may be lower levels of satisfaction. It is also concluded in the study that dissatisfaction can have an impact on the patient's expectation for future care.

5.1.1 Family involvement

The importance and different aspects of the involvement of family was found in three of the reviewed articles. According to the study by Vogler, Altmann and Zoucha (2010), numerous participants considered that family involvement in health care related issues was important. Spouse was stated as a support person by more than half of the participants. Dogan et al. (2009) found through observation that the Turkish people living in Germany expected affection by touching, and liked to be greeted, and have many visitors. In the study it was concluded that the Turkish patients would like to have their relatives in the hospital with them throughout the day and night, which isn't often possible in Germany. Grewal, Bhagat and Balneaves (2008) studied immigrant Punjabi women's perinatal experiences in Canada and found that various family members participated to the care of the expectant mother throughout the pregnancy. Husbands were commonly consulted and involved in important matters. These studies give an indication for the health care professionals to give the chance for family members to be included throughout the care. The studies also suggest that family members could provide the patients with added support, therefore leading to more positive health care experience for the patient and also improved outcomes of care.

5.1.2 Acknowledgment of cultural and traditional beliefs

This theme was found in six of the analyzed articles. Vogler et al. (2010) state in their study, that Native Hawaiians expect care from health care providers to include cultural aspects. The study participants expressed that it was important to them that health

care professionals took into consideration their cultural beliefs. The participants thought that the health care professionals should ask if any cultural and traditional beliefs were practiced and also what they included. The study showed that learning and knowing the cultural history of the patient was expected to be included in the care provided by the health care professional.

Similar results were found in a study by Reitmanova and Gustafson (2008), in which the authors explored from the perspective of immigrant Muslim women, the maternity health care needs and the barriers to accessing maternity health services. In the study, the participants reported the importance of their health care provider being familiar with their health-related cultural and religious beliefs and practices, and also respect them. However, when the participants expressed this to their health care providers, they in turn showed frustration or anger to participants, as well as giving insulting and insensitive remarks which were based on stereotypes. For example, “one nurse assumed that one participant covered her body because she was ashamed of her appearance” (Reitmanova & Gustafson 2008: 107). One reason for this was the health care providers’ lack of information regarding Muslim women’s religious and cultural habits.

In a study by Wallin et al. (2007) regarding diabetic Somalian immigrants and their experiences in managing diabetes-related issues, the researchers pointed out how religious practices can have an impact in managing a chronic illness. According to the study fasting during Ramadan was important to many participants and they did not consider diabetes as a barrier to this practice. Even though it is not necessary according to Islamic rules it is common for patients to fast. One reason for this can be feeling less spiritual if not fasting, also upholding traditions can be considered as a mean of preserving one`s identity and increasing the sense of belonging to an ethnic group. One of the four themes found in the study was titled “Experience of distress in everyday life” and it mentioned having to give up traditional eating habits and diabetes as an obstacle to celebrating Ramadan which resulted giving a bad conscience to the patient. Due to the need for strict daily management patients felt that diabetes had restricted their freedom. Though finding it hard to follow dietary advice because of it was not considered culturally appropriate a lot of the patients adhered to what was ordered by the health care professional. The findings of the study display the significance of taking into consideration the cultural background and religious traditions when caring for diabetic patients.

According to Garrett et al. (2008) an indication of the importance of cultural beliefs was shown by the Arabic group by emphasizing female modesty in the case of undressing, showering and placing both men and women in the same ward. Particularly Muslim women preferred a female as a care provider. The practice of mixed gender wards was seen negatively by both sexes in the Arabic, Italian and Serbian groups. The study also mentions how several patients of Arabic, Italian and Croatian descent "integrated health care with spiritual and religious beliefs evidenced through thankful invocations to God. The central importance of God or higher spiritual beings seemed to help make sense of their experience." (Garrett et al. 2008: 486.)

In a study by Wilson (2008) the researcher states how deeper knowledge of the Maori women`s traditional view of health and well-being can optimize health care outcomes. Recognizing what the challenges are related to the mainstream health care approaches from the cultural and traditional perspectives of the Maori women can help in overcoming these obstacles. Cultural beliefs and practices can strongly shape and influence health care practices, therefore acknowledging cultural traditions can be extremely valuable to the health care providers (Wilson 2008).

The significance of traditional beliefs could also be seen in a study by Lee et al. (2001). The participants of the study believed that blood samples which are commonly part of Western health care, took away their positive energy (yang) and weakened their body due to the loss of blood. Their research had a small sample but it portrays some of the cultural beliefs of the Chinese participants and how they perceive Western health care services. This data could help health care professionals understand if the patient from this same culture would easily be dissatisfied with the treatment or not too compliant.

5.1.3 Health care professionals providing enough time for consultation

This theme was found in two of the research articles, highlighting the importance of health care professionals providing an adequate amount of time with their clients. Marshall et al. (2010) observed the discussion of the participants during the focus group interviews about how they experienced lack of response from the health care system due to the limited time of consultation with they received with their family physician. Lee et al. (2001) has also found that according to the patients the health care consultants did not spend sufficient time to listen and examine them.

5.2 Patient's views of the barriers in providing culturally competent care

5.2.1 Communication

We found that the topic communication was discussed in three of the reviewed articles. Wiking et al. (2009) studied the immigrant patient's experiences and reflections related to consultations in primary care. One of the aims of the study was to analyze whether migration-related factors had an association with patient satisfaction regarding the consultation. The qualitative part of the study resulted in findings which highlight the need for effective communication and delivery of information. It was concluded that an interpreter is required to achieve patient centered consultation which in turn increases patient satisfaction and all in all lead to better medical care results. Adequate time for the consultation was underlined as well as including the patient as a partner instead of a reporter of the symptoms when discussing the medical issues. There were some limitations to the study due to small sample size and losing respondents. Also due to the uneven distribution of the selected ethnic groups it is difficult to draw general conclusions.

Dogan et al. (2009) aimed to find out if there were any health care problems existing between Turkish people living in Germany and German health care personnel. In the findings there emerged several concepts regarding communication, such as need for good communication and telling the truth. In the authors opinion language differences can create ethical problems in transcultural nursing. Their findings showed that the most common problem expressed by the patients and the health care personnel poor communication due to language barriers. However, this study has limitations due to a small study sample and the fact that not all of the participants were randomly selected.

Dogan et al. (2009) further explain that even if people share the same language, the communication can be affected by the multiple meanings of the words and conclude that not all cultural misunderstandings necessarily are an outcome of language barriers. But they believe that culture, health and communication are closely related. The authors have suggested that non-verbal communication such as body language also plays a supportive role between the patients and the health care professionals because it helps transmit the patient's cultural background and perception of illness.

According to Vogler et al. (2010) the researchers identified that Native Hawaiians consider that communication by health care professionals should be direct, open, and expressed with concern, only then it could be considered caring. Vogler et al. (2010) state that Native Hawaiians anticipate health care professionals to communicate openly, acceptingly and honestly. The study participants wanted health care providers to give holistic and respectful care, meaning e.g. that the health care professionals gave direct answers, were willing to answer questions, explained things easily and offered advice.

Studies (Vogler et al. 2010, Dogan et al. 2009 & Garrett, et al. 2008) also showed that patients valued direct, open and honest communication which would include answers, explanations and advice regarding the patients care. Patients are not able to express themselves because of language barriers which in turn affect their care, hence personal interpreters (i.e. family members) are commonly used by the patients, which could be useful, but also may impose risks concerning their care. By using personal interpreters (Dogan et al. 2009) there is a chance for miscommunication and misunderstanding when using medical terminology that the personal interpreter does not understand, as well as confidentiality problems. However even if patients and health care providers share the same language, there could be cultural misunderstandings (Dogan et al. 2009).

5.2.2 Lack of common language

Lack of common language was identified as a barrier in three of the analyzed articles. Suliman et al. (2009) made a study in Saudia Arabia, in which they explored Saudi patients perceptions of important caring behaviors and how frequently they were attended by the staff nurses in a multicultural environment. In Saudia Arabia where patients' native language is commonly Arabic, care is provided to them by nurses with insufficient Arabic language skills Suliman et al. (2009). In this kind of a situation there are bound to be communication problems between the nurses and the patients which in turn can affect their relationship. Suliman et al. (2009) have mentioned about a research which was also carried out in Saudia Arabia, in which due to the nurses' little fluency in Arabic, tension was created between them and their patients which resulted in miscommunication. However, a positive outcome has been reported by Hernandez and Quinn (2004), who have found that nurse's little knowledge of the patient's language, a few words or phrases, is interpreted by the patients as a willingness to connect to them,

and this has found to reduce the communication barriers between patients and the nurses.

In a study by Garrett et al. (2008: 485) the researchers found that problems in communication lead to barriers in care i.e. in medication administration and patient compliance to treatment. According to the study “the patients reported not being able to understand anything at all, sign language miscommunication, problems in replying to questions, difficulties with the speed and complexity of language and difficulties in understanding medical terminology. Patients expressed concerns about not being able to express or contribute to simple aspects of their daily care such as reading a hospital menu or going to the toilet.” It was found that having professional interpreters as part of the care was necessary in overcoming language barriers and obtaining accurate information.

When the health care provider and the client do not share any common language, a need for a translator arises. It is one solution to the problem, but it itself can cause more problems in the communication between the care provider and client. According to Dogan et al. (2009), the Turkish patients in their study had often had their family members to play the part of a translator, which resulted in improper translation and confidentiality problems. This lead the patients to feel that they received limited care and were being neglected, Dogan et al. (2009). In such situations more problems can arise because of weak communication. Patients would start to pretend that they understood the conversation, and also feared that misdirected treatment may have been planned for them. Due to miscommunication and misunderstanding, one problem can lead to another. Dogan et al. (2009) also found the constant complaining buy the Turkish women’s of their pain, increased as they were not being understood by their health care providers.

5.2.3 Inadequate information

Three of the reviewed articles mentioned patients not receiving adequate information as a barrier in care. Lee et al. (2001) showed that the health care providers, particularly Western, did not provide enough explanation regarding the patient’s illness, and due to receiving unclear and short responses to their questions, patient’s felt frustrated. Disappointment was reported after waiting for long to meet the health care consultant. Suliman et al. (2009) believe that in a multicultural environment it is important for the patient and the nurse to have an effective communication and a relationship based on

trust and respect. They mentioned another study in which the patients expressed that they required adequate explanations, which resulted in improved communication and feelings of more safety and less anxiousness in patients. These findings show that inadequate explanations about the patient's health given by the health care providers can cause frustration and insecurity in patients.

According to Vogler et al. (2010: 96) "Native Hawaiians expressed uncaring as behavior that lacked concern and acceptance, negatively impacted access to care, and limited or prevented the health care provider from forming relationships with the individual and family." Participants of the study said that they wanted health care professionals to be respectful. Uncaring behavior was then described as care that lacked respect and acceptance. One participant stated that a health care professional should not be condescending but clear and use practical examples to make things easier to remember. Another participant further explained that, "some health care providers don't give any health information unless you ask for it. If they don't give you any, you can't improve your lifestyle; thus, it means more visits to the doctors and more money for them."

5.2.4 Unmet health care need

Unmet health care need was mentioned by Marshall et al. (2010) who studied how Chinese and Punjabi speaking immigrants living in Canada perceived unmet health care needs, and see if their primary health care experience is related to their unmet health care needs. From their analysis of the focus group interviews, they found two themes, which consisted of defining what an unmet health care need is and identifying it. Their findings showed that the participant's unmet health care needs were mostly related to barriers regarding access to care, and the participants' inadequate knowledge of the health care system. Their results suggest that the lack of knowledge of health care services can also have an impact on the immigrants' unmet care needs. As immigrants from diverse cultural and social backgrounds may have different experiences of the health care services from their home country, thus, they might not know what they can expect. Therefore, it may be useful to give adequate information to immigrants regarding the health care services they are entitled to.

In Marshall et al. (2010) research, the focus group interviews helped the participants ponder about their unmet needs during their discussions, as many participants did not mention any unmet health care need on the questionnaires which were given to them

before the group interviews. During the discussion many questions were raised, which showed that sharing ideas and opinions with each other helped the participants understand the researcher's questions more comprehensively.

5.3 Patient's perceptions regarding professional caring behaviors

Several of the reviewed studies discussed about patient's perceptions regarding professional caring behaviors. Siluman et al. (2009) have noted a study, Cortic (2000), which has reported the contradictions of the perception of caring behavior between patients and nurses, especially if their cultural and ethnic background is different. According to Leininger (2002), caring is a universal phenomenon and that the way people perceive and understand caring may be influenced with the cultural background they belong to (Suliman et al. 2009).

As the interpretation and meaning of caring can differ in people with different cultural and ethnic backgrounds, it can also be also vary by the care environment one is in. Patients with cancer, in an intensive care unit, and in the emergency ward all had different caring needs, some considered the technical competence as more important caring behavior, some considered the compassion aspect of caring more important, and some thought both to be of equal importance. On the other hand patients from medical-surgical wards emphasized the physical aspect of caring (Suliman et al. 2009).

Suliman et al. (2009) concluded through their study that the most important caring behaviors, categorized in subscales, reported by the patients were: "humanism/faith-hope/sensitivity, supportive/protective/corrective environment and human needs". Keller (2008) did a pilot study on Mexican American parent's perceptions of culturally congruent interpersonal processes of care during childhood immunization episodes, and discovered that trustworthiness as a trait for the nurse was considered important by all of the participants of the study. According to Lui, Mok and Wont (2009), nurses can help change the patients experience of their illness in a positive way if they are respected, given comfort and have a care giver available for them (Suliman et al. 2009).

Ogden and Jain (2005) explored the impact of ethnic group on patients` experiences and expectations of their general practice consultation. The study included 4 different ethnic groups; white British, black African, black African Caribbean and Vietnamese. The conclusion of the study was that there were no differences between the black Afri-

can and black African Caribbean groups, whereas the Vietnamese group reported receiving better care than the white British group. According to the study this is in contrast to previous research. However the Vietnamese also reported lower expectations and lower expectations are easier to fulfill.

6 VALIDITY AND LIMITATIONS OF THE FINAL PROJECT

6.1 Validity

"Validity is the extent to which an instrument measures the attributes of a concept accurately." (LoBiondo-Wood & Haber 2010: 286). Validity can be examined by evaluating the data collection, methodology, the relationship between the researchers and the object of the study, how the analysis of the data was done, the ethics of the study including an evaluation of the strengths and weaknesses, and how the reporting of the findings was done (LoBiondo-Wood & Haber 2010).

In this final project, the authors used professional, distinguished nursing and medical databases to retrieve scientific, peer reviewed articles. Authors of the articles were considered experts in the area of the study. Only after both of the authors had read the selected articles several times, and ensured that they contained the relevant data to answer the research questions, an article was considered valid for the literature review. During data analysis, the authors had continuous discussions related to the process to further ensure the validity of the selected studies.

6.2 Ethical considerations

The characteristics of qualitative research generating ethical concerns contain the following; 1) naturalistic setting creates a need for more careful consideration and approach when asking for consent of the participants of the study, 2) the changing situations in the course of the study, e.g. new information gained during data collection, thus creating a change in the direction of the study and a need for the researcher to renegotiate the consent of the participants, 3) focus of the study might be clouded due to the developed relationships between the researcher and the participants, 4) researcher being the instrument of the study interpreting the reality of the participants (Lobiondo-Wood & Haber 2010: 117-118).

During data analysis, the way in which the ethical aspects and good scientific conduct were presented in the reviewed research articles, was taken into consideration. The quality of the article was evaluated by examining if the article had clear, logical structure and if it was well organized. The article also needed to have a clear study question and purpose, and also the methodology and conclusion had to be well presented. Considering the ethical concerns related to specifically qualitatitive research, we paid attention that the anonymity and privacy of the participants was considered in the studies we reviewed.

The findings were presented without the authors own opinions and information was presented without altering the original meaning of the content. Different phases of the literature review were described openly and the authors were appropriately referenced. This literature review was written according to the Metropolia University of Applied Sciences Guidelines for Writing Papers.

6.1 Limitations

This literature review has the following limitations; 1) The authors are beginners and new to the field of research, thus data collection, analysis and further examination of the findings may be less thorough and conclusive than that of a more experienced researcher. 2) Financial limitations caused the loss of potentially useful articles and prohibited access to some of the primary sources. 3) Due to time limitations the authors were refrained from carrying out a more thorough research on this topic.

7 DISCUSSION

In the findings of our literature review, we discovered that ethnically diverse patient`s expectations could be considered universal. This could be demonstrated by the fact that the studies we selected for our literature review came from around the globe and they included a wide variety of different ethnic groups, some of the studies also including majority populations` views. The different ethnicities we came across were; Chinese, Somali, Chilean, Iranian, Turkish, Native Hawaiian, white British, black African, black African Caribbean, Indian Punjabi, Saudi, Punjabi, Maori, Serbian, Arabic, Italian and Croatian. Regardless of the ethnicity of the participant, we found that the partici-

pants of the studies often shared the same views on how they wish to receive care from the health care providers.

Due to the information being so fragmented, first it seemed very challenging to draw general conclusions related to ethnically diverse population's perceptions and expectations in a primary care setting. This said, some common themes could be found and identified throughout the reviewed articles, which answered our research questions to some extent. The themes we categorized were divided into three main areas: Patient's expectations regarding care, patient's view of the barriers in providing care and patient's perception about professional caring behaviors. We looked deeper into these themes and found underlying sub-themes, which further enhanced our understanding regarding the expectations of patients from different backgrounds. The sub-themes that emerged during the analyzing process were: family involvement, acknowledgement of cultural and traditional beliefs, health care professionals not providing enough time for consultation, communication, lack of common language, inadequate information and unmet health care need.

The reviewed research articles had unifying findings which showed similar themes and some of them were more often addressed by the authors. However, some themes were less common and mentioned only in a small number of the analyzed research articles. The most common sub-themes regarding patient's expectations of care included the involvement of the patients' family in their care and acknowledgement of cultural and traditional beliefs. What patients thought to be the most common barriers related to receiving care were: communication, lack of common language and not receiving adequate information. Regarding professional caring behaviors we identified some general characteristics in the behaviors and attitudes of the health care providers which make up the backbone of culturally competent care according to the patients.

The findings of our literature review clearly indicated that the patients expected the care they received from the health care providers to be family-orientated, respectful and holistic. According to several studies we reviewed, patients also wanted their cultural, religious and traditional beliefs and practices to be taken into account throughout their care. Patient`s perspective of the importance of the health care providers considering these beliefs could be demonstrated in some of the reviewed articles. It was also found that the patients experienced that the health care providers did not spend sufficient time for consultation, however, there were some contradicting results. Patients

might have lower expectations to begin with and these lower expectations are naturally easier to fulfill. This shows that knowing the background of the patient and their level of expectation could help the health care field to develop more accurate ways to evaluate patient expectations.

According to many of the reviewed articles language and communication barriers proved to be very common from the patient`s perspective. The Statistics Finland (2012) state that “one person in ten living in the capital region is a foreign-language speaker”. This may cause a problem between the health care provider and the client as the chances of them sharing a common language could be lower. Communication problems may lead to difficulties in the care of ethnically diverse patients and may also affect the health care provider-patient relationship negatively. This highlights a need for effective, patient-centered consultation which could be achieved e.g. by the use of an interpreter and adequate time for the consultation. Through the findings we recognized that the patients expected and hoped for the health care provider to listen to them and give adequate information regarding their care. These are some basic requirements that the patients can have of their care, which one would expect to be provided to every patient.

Though this review of literature concentrated on the views of ethnic minorities, the expected and perceived caring behaviors found, could be thought as universally applicable. Some of the findings showed that important caring behaviors consisted of sensitivity from the health care provider, supportive and protective approach, also being compassionate and respectful of the patient and human rights were considered meaningful. If patients are treated with lack of respect, face racist behavior and feel neglected, they may feel insecure and frightened. Throughout the findings it came evident that the patients respected active engagement, adequate consultation time and provision of information.

Brunton and Beaman (2000) determined ten important caring behaviors according to the nurses, of which three were similar to our findings of the patients’ perception of caring behaviors. These were “showing respect for the patient”, “talking with the patient” and “listening attentively to the patient” (Suliman et al, 2009: 294.) These important caring behaviors reported by the nurses are consistent with our findings, as the patients have also expressed similar expectations from the health care providers, e.g. “being compassionate and respecting patient and human rights”, “respectful and caring

attitudes, well-explained, consultative care was highly valued" (Garret et al. 2008: 488.) However, some important caring behaviors reported by the nurses according to Brunton and Beaman (2000) were not found in our literature review, such as, "treating patient information confidentially" Brunton and Beaman (2000: 294). This is quite understandable, as it can be considered that, the patients pay more attention to the concrete care provided to them. When compared, these findings show that the nurses and the patients have similar ideas about what are the most important caring behaviors.

7.1 Applicability of The Culture Care Theory and The Transcultural Assessment Model

Mcfarland and Eipperle (2008) proposed the Culture Care theory of Leininger can be a useful theoretical model of nursing for nurses to provide culturally congruent care to the culturally diverse population in primary care. The authors have also showed that Leininger's theory, according to Fawcett et al (2004) criteria for theory application in nursing, could be applied to minor groups within a larger cultural group, because it covers all cultures, races, ethnicities and minority groups. They have further stated that Leininger's theory provides three models which can help the nurses and clients to make culturally appropriate assessments, care plans, and decisions. Because Leininger's theory has an individualistic approach, it can be used for an individualized care plan, and it also supports the core values of nursing, such as respect which is required in a good nurse and client relationship.

The Transcultural Assessment Model would be useful to help the health care provider assess the patient from a cultural perspective. In the guidelines of the Model, it is suggested that the health care provider communicates to their patient in a non-threatening manner, by "follow[ing] acceptable social and cultural amenities", e.g. avoid direct eye-contact with patients from Filipino Americans. It is also suggested in the guidelines to "adopt special approaches when the patient speaks a different language", this can be done by using a soft tone, not speaking too fast, using simple words, repeating your message frequently and in different ways, using assisting tools to convey your message, for example using pictures, videos and possibly using an appropriate language dictionary. It further advices the use of an interpreter if required, but it is important to confirm that the patient has been told the whole message by the interpreter and confirm that the patient has understood it. (Giger & Davidhizar, 2008: 35.) Overall the guidelines that the Transcultural Assessment Model provides, could be used in differ-

ent ways to enhance and improve communication between the health care professional who is providing care to patients from different cultural backgrounds and the patient itself.

The Giger and Davidhizar Transcultural Assessment Model could help the health care professionals to assess patients from different cultural backgrounds, identify their patients' cultural needs, and make a care plan accordingly. Tortumluoglu et al. (2006: 5) have stated that this Model was used for structural interviews as it included interview questions and guidelines for observing. Tortumluoglu et al. (2006: 5) believe that the six cultural phenomena that are included in the Model do not fully incorporate all the dimensions of cultural descriptions, because there are various diversities that are found all over the world. According to our findings in this literature review, we believe that the Transcultural Assessment Model could be used in many aspects, through its practical guidelines, in order to obtain a culturally sensitive assessment of a patient. The patients' perception of barriers to care that we have identified in our literature review, are mostly covered by the six cultural phenomena in the Transcultural Assessment Model.

7.2 Implications for clinical practice

In the findings we identified several recommendations that would be useful for nurses in implementing culturally appropriate care. An assessment of the patient can be considered as the beginning phase of a nurse-patient relationship and the start of the whole care process. Through our findings, in order to provide culturally competent care, the nurse should carry out an extensive assessment of the patient that includes the following:

1. Patient`s origin and how long the patient has been residing in the current country
2. Patient`s cultural/traditional/religious beliefs and practices; how they would like these to be taken into consideration regarding their care
3. Patient`s language; what language the patient prefers to use
4. Does the patient require an interpreter
5. Family involvement in care; how does the patient want the family members to be included in their care

Throughout the findings, we recognized traits regarding professional caring behaviors that the patients valued. The patients' perceptions of possible barriers in provision of care could be overcome by using different approaches. Ways that nurses could enhance the provision of care to patients from diverse ethnic backgrounds include:

1. Having a respective, supportive and open attitude towards the patient
2. Gaining knowledge of different ethnicities and cultures while keeping in mind that differences within cultures exist
3. Avoiding undermining and stereotyping the patient
4. Provision of adequate information regarding the given care by using clear and simple, understandable language and avoiding the use of too complex medical terms
5. Confirming that the given information was understood by asking the patient
6. Ensuring that the time of consultation is sufficient so that the information exchange between the nurse and the patient is adequate for the given situation

7.3 Need for further studies

Due to the limitations of our literature review it is difficult to determine if there is enough existing research related to our topic. However we do believe that there is a need for more research regarding patients' expectations and perceptions of care and professional caring behaviors, which would specifically include different ethnic and cultural groups. Rather than assuming what the patients' needs are, if the patients' expectations and perceptions regarding culturally competent care are discovered, it would make it easier for the health care professionals to provide culturally appropriate care. The authors also found in this literature review that the health care providers have a poor awareness of their patients' expectations, regardless of their origin. If health care providers would put more effort in trying to find out the patient`s expectations and perceptions, it would yield in more effective care. Thus less frequent visits to the hospital would be required by the patient and the patients would be more satisfied with the care.

7.4 Reflection

During the final project the authors have learned a lot about the process of performing a systematic literature review. The authors developed their skills on doing data search-

es, defining appropriate selection criteria, formulating relevant research questions and reporting findings.

8 Conclusion

Through the findings it became evident that the patients valued health care providers who took into consideration the patient`s values regarding cultural beliefs and practices. As nurses' role is to be the patients' advocate, it is crucial to learn to implement culturally competent care without signs of prejudice and provide their patient`s with more individualized care. Patient-centeredness should be one of the main focuses of nursing and only through gaining more knowledge of what constitutes high quality care-from the patient`s perspective, can nurses develop health care to meet the needs and expectations of their patients. Learning to understand and recognize what is expected from health care providers can enhance the forming of true partnerships with the patients, thus improving the whole care process.

When going through the findings of the review of the literature, the authors recognized that if health care professionals wanted to provide truly culturally competent care more emphasis should be put on the individual patient`s view of what constitutes cultural competence when referring to caring behaviors. As more studies are done regarding ethnically diverse populations` health care disparities, it is evident that there is a real need for culturally-sensitive health care. In order to achieve this goal culturally appropriate and sensitive health care should be incorporated for all patients. To provide high quality care to diverse patient populations, it requires the health care providers to take into consideration what is expected from them. According to our interpretation of the findings, the patients expected the health care providers to communicate effectively, encourage family involvement, take an interest in cultural and spiritual practices, and have a caring attitude.

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APPENDIX 1

TABLE 1. FIRST DATABASE SEARCH

	Database	**Dates/year**	**Search words**	**Limitations**	**Results**
1	CINAHL with full text – advanced search	1986-2011	individual AND cultural		629
2	PUBMED	1991-2011	patient AND culturally AND sensitive	link to full text	6228
3	CINAHL	1991-2011	family AND culture AND sensitivity	link to full text	74
4	CINAHL	1991-2011	promote AND culture AND care	link to full text	111
5	CINAHL with full text – advanced search	1993-2011	practical AND cultural AND competent AND care		24
6	Academic search elite, CINAHL	1991-2012	expectations AND cultural AND care	link to full text	106
7	PUBMED	1991-2012	expectation AND culture AND patient	link to free full text	23
8	CINAHL with full text	1991-2012	experiences AND cultural AND care AND patient	link to full text	187
9	PUBMED	1991-2012	Expectation AND cultural AND patient	link to free full text	18
10	CINAHL with				

	full text	1991-2011	Primary AND cultural AND care		355
11	PUBMED	2001-2012	Chinese AND care AND expectation	link to free full text	6
12	CINAHL with full text, Academic search elite	2001-2011	cultural AND Somali	full text	17

APPENDIX 2

TABLE 2. SECOND DATABASE SEARCH

	Database	**Dates/year**	**Search words**	**Limitations**	**Results**	**Articles retrieved**
1	CINAHL	2001-2012	primary AND care AND expectation AND patient	Full text	5	1
	PUBMED	2001-2012	primary AND care AND expectation AND patient	link to full free text	60	6
	OVID (MEDLINE)	2001-2012	primary AND care AND expectation AND patient	link to full text	39	6
	COCHRANE	2001-2012	primary AND care AND expectation AND patient		466	0
2	CINAHL	2001-2012	Culturally OR competent AND expectation AND patient	Full text Published Date from: 20010101-20120331 Subject: Major Heading	547	29

				• Cultural Compe-tence • Cultural Sensitivity • Cultural Diversity • Immi-grants • Transcul-tural Care		
	PUBMED	2001-2012	Culturally OR compe-tent AND expectation AND pa-tient	link to free full text	16	2
	OVID (MED-LINE)	2001-2012	Culturally OR compe-tent AND expectation AND pa-tient	full text	9	0
	COCHRANE	2001-2012	Culturally AND com-petent AND expectation AND pa-tient		31	0
	PUBMED	2001-2012	needs AND expectation AND pa-		8	2

			tient AND primary			
	OVID (MEDLINE)	2001-2012	needs AND expectation AND patient AND primary	Full text	6	0
4	CINAHL	2001-2012	ethnic OR minorities AND expectation AND primary	Source type: academic journals subject: major heading: ethnic groups minority groups culture	32	1

APPENDIX 3

ARTICLE ANALYSIS

AUTHOR(S), YEAR, TITLE, JOURNAL	PURPOSE	PARTICIPANTS (SAMPLE SIZE)	METHOD,DATA COLLECTION AND ANALYSIS	MAIN FINDINGS	LIMITATIONS	CONCLUSIONS/ REMARKS
Dogan, H., Tschudin, V. Hot, I. and Özkan, I. (2009) Patients' transcultural needs and carers' ethical responses. *Nursing Ethics* 16 (6), 683-696.	To find out if health care problems exist between Turkish people living in Germany and German health care personnel and what underlies those identified.	Total 150 participants; 50 patients of Turkish origin, 50 German nurses, and 50 German physiotherapists	Qualitative research. Questionnaire; free choice and open-ended questions. Data analysis; frequency counts and percentages.	Concepts about nursing practice, such as the need for good communication, affection, truth telling, coping, compliance with treatment, and the ethical foundations of nursing were reflected in the expressions and needs of the patient group. The most common problem for both patients (100%) and health care personnel (95%) was poor communication because of language barriers. Health care personnel participants claimed that habits based on culture, such aseating, having visitors in the patient's room, and hygiene were very important when caring for foreign patients. Sixty per cent of the nurses believed that an education programme would be helpful, but the other 40% claimed that education would not	This was a small study; it is therefore limited in its application. Although the Turkish patients were chosen randomly, some of the health care professionals were recruited on the basis of some personal contact, but still randomly.	A great deal of further work needs to be done in the area of ethical concerns in multicultural care.

				help because the problems were relevant to the nurses' personality and would not benefit from educational intervention.		
Garrett P. W., Dickson, H. G., Lis-Young, Whelan, A. K. and Roberto-Forero (2008) What do non-English-speaking patients value in acute care? Cultural competency from the patient's perspective: a qualitative study. *Journal of Ethnicity & Health* 13 (5), 479-496.	To locate cultural competence within the experiential domain of the non-English-speaking patient.	49 patients and 10 carers of patients with limited English.	Seven language-specific focus groups were held to better understand the patients` experience and to identify critical factors leading to their constructions of care. Grounded theory analysis within a constructivist perspective was undertaken.	While the majority of patients were positive about their hospital experience, the theme of powerlessness appeared central to many patient experiences. Language facilitation was the most common issue. Inattention to specific cultural mores and racism in some instances contributed to negative experiences. Patients primarily valued positive engagement, information and involvement, compassionate, kind and respectful treatment, and the negotiated involvement of their family.		Because of the specific nature of each patient-provider interaction within its particular social and political environment, culturally competent behaviour in one context may be culturally incompetent in another. We propose a model of cultural empowerment that reflects the phenomenological basis of cultural competence in that cultural competence must be consistently renegotiated with any particular patient in a particular healthcare context. Similarly, ongoing community consultations are needed for health services and organisations to retain cultural competence.

Grewal, S. K., Bhagat, R. and Balneaves, L. G. (2008) Perinatal Beliefs and Practices of Immigrant Punjabi Women Living in Canada. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 37, 290–300.	To describe new immigrant Punjabi women's perinatal experiences and the ways that traditional beliefs and practices are legitimized and incorporated into the Canadian health care context.	Fifteen first-time mothers who had immigrated in the past 5 years to Canada from Punjab, India, and had given birth to a healthy infant in the past 3 months in a large urban center in British Columbia, Canada. Five health professionals and community leaders also took part in a focus group to confirm the study findings and to offer recommendations.	Naturalistic qualitative descriptive, individual interviews. Line-by-line analysis was conducted on all transcribed interviews, highlighting key terms and emerging categories. Data were grouped according to major categories and themes were then analytically developed where possible.	Three major categories emerged: the pervasiveness of traditional health beliefs and practices related to the perinatal period (e.g., diet, lifestyle, and rituals), the important role of family members in supporting women during the perinatal experiences, and the positive and negative interactions women had with health professionals in the Canadian health care system.	With the study sample limited to first-time mothers who had recently immigrated to Canada from Punjab, India, the findings cannot be confidently transferred to South Asian immigrants from other regions of India as well as different countries of origin Findings may not accurately portray the perinatal experiences of Punjabi women with different immigration histories, such as those individuals who immigrated as a child or are second- and third-generation South Asians.	Change is required at the levels of the health professional, the heath care system, and the community to ensure that culturally safe care is provided to immigrant Punjabi women and their families during the perinatal period, which is an important and sensitive period of interaction with the Canadian health care system.
Keller. T, (2008) Mexican American parent's perceptions of culturally congruent interpersonal processes of care during childhood immunization episodes- a pilot study *Online Journal of Rural Nursing and Health Care*. 8 (2),	Explore the nature of a meaningful and beneficial relationship between the clinic nurse and Mexican-American parents and their children.	Twelve participants were interviewed for this pilot study. All participants were women between the ages of 17 and 35 with children between the ages of six months and 11	A qualitative research. A semi-structured interview format was selected and open-ended interview questions developed based on the research purpose. Interview transcripts were analyzed for emergent themes,	Three common themes that emerged were trust, confidence, and language concordance. Every participant described the need for the nurse to be trustworthy. Every participant expressed the view that the immunization encounter should be conducted in the language with which the mother was most comfortable.	All the participants were regular clientele of the community health center and their childrens' vaccination status was current. From the interviews, it was evident that participants were mostly satisfied with the care provided by the nurses at this particular center.	Nurses, who demonstrate friendliness, are attentive to the needs of both the mother and the child, are able to take time t answer questions and comfort the child and demonstrate competence in professional skill and communication, are

33-41		years.	using a grounded theory approach.			more likely to be viewed as trustworthy and obtain the confidence of their Mexican-American clients.
Lee, R. et al. (2001) Illness experience, meaning and help-seeking among Chinese immigrants in Canada with chronic fatigue and weakness *Anthropology & Medicine* 8 (1), 89-107.	Examined patterns of distress (namely, clinical symptoms and their social contexts), self-perceived stigma, perceived causes of illness, and various aspects of prior help-seeking in Chinese patients with chronic fatigue and weakness	50 Chinese patients; of which 28 were women and 22 were men. All participants were first-generation Chinese immigrants to Canada.	Semi-structure interview. Qualitative and Quantitative data. Non-numerical Unstructured Data Indexing Searching and Theorizing (NUD*IST), SPSS for statistical analyses	All 50 participants described the onset of their problems as gradual, and 86% considered these problems serious. Accounts of psychological distress typically emphasized impaired cognition and social functioning (58%), and loss of self-confidence. The vast majority (86%) of respondents blamed insomnia for their fatigue. Concern about disclosure of their condition was the major theme in the narratives of stigma. The impact of migration was the predominant theme in narrative accounts of illness, which typically included multiple somatic symptoms. Narrative accounts indicated that experience as immigrants played a key role in accounting for their problem, although migration experience was not itself coded as a speci. c category of perceived cause. The vast majority (90%) of respondents attributed their illness to traditional Chinese medical concepts of		The study suggests that clinicians working with patients in multicultural settings may benefit substantially from the guidance that cultural epidemiological data provide.

				yin-yang imbalance.		
Marshall, E. G. et al. (2010) Perceptions of unmet healthcare needs: what do Punjabi and Chinese-speaking immigrants think? *BMC Health Services Research* 10 (46).	To examine the perceptions of unmet needs and any relationship to primary healthcare experiences.	78 Punjabi and Chinese participants: 12 focus groups (6 Chinese and 6 Punjabi groups)	Interview: focus groups Thematic analysis and phenomenological approach.	Analysis revealed two overarching themes: 1) defining an unmet healthcare need 2) Identifying an unmet need. Participants had unmet healthcare needs in relation to barriers to accessing care, their lack of health system literacy, and when the health system was less responsive than their expectations.	Using focus groups may not have allowed for the depth of discussion that occurs with individual interviews. Simply asking whether someone ever had a time when they needed healthcare but did not receive it could underestimate unmet need.	More work needs to be done in developing reliable and valid measures that can examine the strength of the relationships between unmet need, individuals' expectations of their health visits, and utilization of primary healthcare.
McKinley, R. K., et al. (2002) Meeting patient expectations of care: the major determinant of satisfaction with out-of-hours primary mecial care? *Family Practice* 19 (4), 333-338.	Determine the effect of 'patient expectations of care' on satisfaction with care provided by out-of-hours services.	2000 patients, 55% females, 45% younger than 12 years and 17% older than 65 years.	Questionnaire. SPSS 8.0 for Windows was used for analysis.	Patients who received care that they hoped for were more satisfied than those who did not. Patients who received care from the co-operative were significantly more satisfied than those who received care from the deputizing service.	Patients were surveyed during late 1997. Large study of a large population, around 700 000 people. Response rate was moderate, and could have introduced unknown biases.	This study suggests that meeting or failing to meet idealized expectation of care is an important determinant of patient satisfaction.
Ogden J. and Jain	To explore the	Questionnaires	Cross-sectional sur-	No differences were found for the	The population of the gen-	Vietnamese patients

A. (2005) Patients' experiences and expectations of general practice: a questionnaire study of differences by ethnic group. *British Journal of General Practice* 55, 351–356.	impact of ethnic group on patients 'experiences and expectations of their general practice consultation.	were given to 1000 consecutive patients attending their general practice and who described their ethnic group as white British, black African, black African Caribbean or Vietnamese. Completed questionnaires were received from 604 patients (response rate = 60.4%).	vey; a new questionnaire was developed in which questions relating to experiences could be matched with questions relating to expectations. The reliability of the measure was assessed using Cronbach's α and total scores were created by summating the items. All Cronbach's α results were higher than 0.7, indicating an acceptable level of internal reliability. Data was analyzed by describing the subjects' profile characteristics using descriptive statistics and by examining differences by ethnic group in terms of patients' experiences of general practice and what patients expect from a consultation using ANOVA and post hoc tests.	black African or black African Caribbean patients. The Vietnamese patients reported better experiences of communication, more focus on their agenda and more attention to their choices than the white British patients. However, they also reported expecting lower levels of communication, less focus on their own agenda and reported wanting less GP consistency than the other ethnic groups.	eral practice consisted of a high percentage of minority ethnic groups, therefore may not generalize to patients who attend practices where they are more in the minority. The sample consisted of those attending their practice and was not a postal survey of all those registered. Thus, the results reflect the views of general practice patients who visit their GP rather than the population as a whole. The questionnaire involved a translated version for some of the participants. Accessing non-English-speaking patients is problematic as all methods are flawed.	state that they are receiving better standards of care in general practice than other ethnic groups. However, they also state that they expect less. This may illustrate a problem with assessing experiences of primary care. Higher scores of experience may not illustrate better consultations as such, but only better when compared with a lower level of initial expectation. A lower expectation is easier to fulfill.

Perron, N. J. et al. (2003) Patient expectations at a multicultural out-patient clinic in Switzerland. *Family Practice* 20 (4), 428-433.	Identify and compare health care expectations of Swiss and immigrant patients attending the out-patient clinic of a Swiss university hospital and to assess physicians' ability to identify their patient's expectations.	343 patients, of which over 50% immigrants and 333 physicians. 15 physicians completed questionnaires about perceptions of their patients' expectations.	Questionnaire; pre-consultation patient surveys and post-consultation physician surveys. Conducted a pilot study among 15 patients to make sure that questions were understandable and relevant. SPSS software for analysis. Chi-square test, logistic regression, kappa coefficient.	Most patients hoped for reassurance, physical examination, diagnosis, counseling, information about prognosis and medication. Physicians both failed to identify patients' expectations (underestimation) and erroneously identified expectations where they were absent (overestimation). The main areas where physicians systematically underestimated both Swiss and immigrant patients' expectations were counselling, investigations and referrals to a specialist. They also underestimated immigrant patients' expectations of information for prognosis. Overestimation of patients' expectations occurred principally with regards to reassurance, prognosis and medication among immigrant patients.	This study only looked at differences in expectations between Swiss and non-Swiss patients rather than specificifying into social, cultural, racial or ethnic subgroups. This study had a structured questionnaire with closed-ended questions might have affected the patients' spontaneous response by inducing unified and/or increased expectations. This study did not assess patients' satisfaction with the consultation nor health outcomes, and therefore are unable to evaluate the impact of unfulfilled expectations on such issues among both groups of patients.	Most patients share similar expectations, regardless of their origin. In the study, immigrant patients did not consult more quickly than Swiss patients. The physicians in the study have a poor awareness of their patients' expectations, regardless of patients' origin.
Reitmanova, S. and Gustafson D. L., (2008) ''They Can't Understand It'': Maternity Health and	To document and explore the maternity health care needs and the barriers to	The sample consisted of six Muslim women aged 25– 40 years who delivered at least	Data was collected by in-depth semi-structured interviews. The interview protocol consisted of fifteen	Three metathemes emerged in this research. Women experienced discrimination, insensitivity		While this study provides rich documentation of the experiences of the St. John's participants, these findings

Care Needs of Immigrant Muslim Women in St. John's, Newfoundland *Maternity Child Health Journal.* 12:101–111	accessing maternity health services from the perspective of immigrant Muslim women living in St. John's, Canada.	one of their children in St. John's between 1995 and 2005.	semi-structured and open-ended questions about maternity health needs during their pregnancy, labor, and postpartum period both in hospital and at home. The protocol also included questions about barriers to maternity health care services. Data were analyzed using a two-step process of Content analysis.	and lack of knowledge about their religious and cultural practices. Health information was limited or lacked the cultural and religious specificity to meet their needs during pregnancy, labor and delivery, and postpartum phases. There were also significant gaps between existing maternity health services and women's needs for emotional support, and culturally and linguistically appropriate information.		are not generalizable to all immigrant Muslim women. The views and perspectives of Muslim women living in different social locations such as those living with an extended family or in an environment with strong cultural networks, those who are refugees or single mothers, or those who experience poverty or ill health may differ from the findings.
Suliman, W. A., Welmann, E., Omer, T. and Thomas, L. (2009) Applying watson's nursing theory to assess patient perceptions of being cared for in a multicultural environment. *Joumal of Nursing Research* 17 (4), 293-300.	Explore Saudi patient perceptions of important caring behaviors and how frequently such were attended by staff nurses in a multicultural environment.	Patients (n=393) admitted to medical and surgical wards in three hospitals in three different regions of Saudi Arabia. Sample ensured equal number of males and females, aged 20-50 years old.	A questionnaire survey was designed for the patients. Descriptive analyses, inferential statistics, whitney *U* test.	The most important caring behavior subscales included humanism/faith-hope/sensitivity (96.7%), supportive/protective/corrective environment (95.7%), and human needs assistance (95.4%).	The length of the assessment tool and the potential burden of such on patients represented a potential limitation of this study.	Majority of participants perceived overall caring behaviors as more important (97.2%) than frequently occurring (73.7%), with a statistically significant difference for men and women. The study recommends that the nursing management should provide more language assistance through

						proficient bilingual interpreters in cases where the nurses who cannot speak the same language as their patients. The study suggests that Watson's theory which was developed in the west could also be applied in Middle Eastern cultural settings.
Wallin, A.-M., Löfvander M., and Ahlström G. (2007) Diabetes: a cross-cultural interview study of immigrants from Somalia. *Journal of Clinical Nursing* 16 (11C), 305-14.	To describe how diabetic immigrants from Somalia experience everyday life in Sweden and how they manage diabetes-related problems, with inclusion of a gender perspective	19 diabetic adults born in Somalia and now living in Sweden.	Cross-cultural interviews with the aid of an interpreter. The tape-recorded interviews were transcribed verbatim in Swedish and were subjected to qualitative latent content analysis, resulting in sub-themes and themes.	Four themes emerged: experience of distress in everyday life; everyday life continues as before; comprehensibility gives a feeling of control; and being compliant. A major finding was the variation in how the participants managed the fasting month of Ramadan. Several participants fasted and did not see the diabetes as an obstacle; others did see it as an obstacle or indicated that fasting was not compulsory for a sick person.		This study provides healthcare staff with information about how a minority group experience and manage diabetes. The results indicate the importance of considering cultural background, as well as religious traditions such as Ramadan, in diabetes care. They also indicate that men and women differ in their reaction to diabetes and that care should be adapted to this. It is important to develop evidence-based guidelines for diabetes care

						in ethnic groups that are fasting during Ramadan to prevent complications and promote relevant self-care. Further, the prescribed dietary advice must be culturally appropriate.
Wiking, E., Saleh-Stattin, N., Johansson, S.-E., and Sundquist, J. (2009) Immigrant patients' experiences and reflections pertaining to the consultation: a study on patients from Chile, Iran and Turkey in primary health care in Stockholm, Sweden. *Scandinavian Journal of Caring Sciences* 23, 290-297.	To explore the immigrant patient's experiences and reflections regarding consultations in primary health care where interpreters are used. To study whether demographic and migration-related factors are associated with the patient's satisfaction with the consultation and feeling of consolation given by the general practitioner.	78 consecutive immigrant patients from Chile, Iran and Turkey at 12 primary health centres (PHC) around Stockholm. Number of respondents was 52. Sixteen were from Chile, 9 from Iran and 27 from Turkey. Twelve patients of the nonrespondents, four males and eight females, with age distribution of 45–89 years, refused to participate and the rest could not be	A questionnaire, specifically developed for this study, translated and culturally adapted to the respondents' home language by authorized interpreters. The questionnaires and written information about the study were distributed at the receptionist's desk before visit to the doctor. The patients were asked to answer the questionnaires directly after the consultation at the PHC and leave them to the receptionist. The questions covered facts about the	The quantitative part of the study showed that demographic and migration-related factors were not related to the outcome variables. Nor did time from the booking to the consultation, SRH, different symptoms and the patient's experiences (feeling of respect for their personality, wishes and culture) seem to be related to the patient's satisfaction with the consultation or the consolation given by the GP. The qualitative content analysis of the open-ended questions resulted in some interesting and important findings: Effective communication and delivery of information were important for the patients' satisfaction. An interpreter is needed to make patient centredness possible during the consultation and results in better medical outcomes and a more satis-	Quantitative part: one possible explanation to the lack of significant relations might be due to the small sample size and the high nonresponse rate. Also as the number of respondents is not equally distributed among the three selected groups, it is difficult to draw general conclusions about these groups in Sweden.	

	To analyse whether these feelings are related to the time from the booking to the consultation, to self-reported health, symptoms and the patient's experiences.	located. Forty-three patients answered one or more of the openended questions.	background and health status of the respondents. There were also openended questions concerning the patients' own reflections and comments about consultations. For validating the questionnaires, a reference group including specialists in ethics, statistics and in methods for developing questionnaires made reviews. The questionnaires were tested for clarity and evaluated by two interpreters and one GP before the study started.	fied patient. It is important that there is enough time for the consultation and that the approaches by the GP and the interpreter include the patient as a partner in the medical dialogue.		
Wilson, D. (2008) The significance of a culturally appropriate health service for Indigenous Maori women. *Contemporary Nurse* 28, 173–188.	To explore Maori womens understanding of health, and their interactions with mainstream health services.	Thirty-eight women aged between 24 to 61 years.	Semi-structured interviews with individuals and groups (dependent upon their choice and congruent with a Maori centred approach). The interview questions were designed to enable	The research identified three major categories; 1) `Mana Wa-hine', explains the important components for the health and well-being i.e. family, spirituality, traditional and contemporary knowledge, and self-care behaviors. Outlines areas that health care providers should explore by eliciting		The grounded theory generated is dynamic and responsive to the societal and environmental changes impacting on Maori women, and has the potential to be modifiable.

			issues to be explored as they arose, and areas for theoretical sampling to be identified. Data was collected with detailed field notes and a reflective journal. It occurred simultaneously with data analysis using constant comparative analysis to generate codes, emerging concepts and categories.These were verified and refined until saturation was reached – that is, when no new information could be added to a concept or category. Theoretical sampling purposefully guided data collection, The development of the ideas and emerging meaning were captured by recording of memos that also assisted in tracking the conceptualisation of codes, concepts, categories and their	their view of health and well-being to ensure the cultural integrity is maintained. 2) 'The Way It Is' explains challenges and barriers. This category provides an indication as to what prevents Maori women from accessing health services in a timely manner. 3) 'Engaging with Health Services', explains the needs of Maori women, based on both positive and negative experiences when interacting with health care providers.		

			relationships and the basic social psychological process (BSPP) of weaving.			
Vogler, J., Altmann, T. K., and Zoucha, R. (2010) Native Hawaiian Attitudes of Culturally Sensitive Healthcare Provider Traits and Behaviors. *Journal of Cultural Diversity* 17 (3), 90-98.	To query Native Hawaiians about their attitudes and perceptions of what constitutes culturally sensitive healthcare provider traits and behaviors.	The participants (n = 61) included 36 men, 23 women, and two who chose not to identify their gender. The majority were between the ages of 30 and 59 years, and lived in the areas where there are higher than average concentrations of those with Native Hawaiian ancestry (82%).	This study used a cross-sectional, exploratory, descriptive method. Data were collected using a self-administered survey developed by the research team because of lack of funding and to support the participatory aim. If funding had been available, interviews would have been the method of choice within the design. The survey included 12 multi-part, open-ended questions that allowed the participants to think about the questions without the pressure of time or suggested responses.	Three themes were identified that were representative of the majority of participants reflected and found in the data. Native Hawaiians: 1; expect care from healthcare professionals that is family centered, holistic, respectful, and accepting 2; view caring communication when it is direct, open, and expressed with concern as caring. 3; expressed uncaring as behavior that lacked concern and acceptance, negatively impacted access to care, and limited or prevented the healthcare provider from forming relationships with the individual and family.	The study design was selected because of limitations in funding and logistical constraints for data collection. The major limitation of this pilot study was the use of a newly created instrument and the fact that the data was not collected using interviewing or focus group methodology. This limited the depth, breadth, and richness of the data. In addition, the use of a one-time survey did not allow the researcher the opportunity to clarify or confirm the data in repeated contact with the participants nor did it permit theme validation.	The findings of this research study suggest that culturally competent healthcare requires healthcare providers who communicate effectively, encourage family involvement, take an interest in cultural and spiritual practices, and have a caring attitude. Findings also suggest that improvements in education and access will enhance the healthcare of Native Hawaiians.