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What is This?
Transcultural Encounters in a Medical Ward in Sweden: Experiences of Health Care Practitioners

Lisen Dellenborg, PhD1,2, Carola Skott, PhD, RN1, and Eva Jakobsson, PhD, RN1

Abstract

The aim of this study was to explore the approach adopted by health care practitioners when handling transcultural encounters. The study was performed by means of action research, a reflective process led by practitioners and researchers working together to improve practice and solve problems. Data were collected through participant observations at a coronary unit in Sweden and group discussions with the health care professionals and were analyzed and interpreted using a hermeneutic approach. The narratives in the interview text illustrated a switch between three levels of understanding human behavior: the individual level (personality), the collective or group level (what is termed culture), and the universal level (human nature), focusing on differences in the first two and similarities in the third. This study highlights the importance of practitioners comprehending the complex relationship between individuality and cultural context and understanding cultural identity as being fluid and coexisting with other differences, such as class, education, gender, and age.

Keywords

transcultural health, focus group analysis, hermeneutical, dialectical, participant observation, continuing education/staff development, participatory action research, transcultural, multicultural, health care encounters, multiprofessional, gender

Introduction

Initiated by health care practitioners at a coronary unit at a Swedish hospital this study was performed by means of action research—a reflective process led by practitioners and researchers working together to improve practice and solve problems. Located in a suburban area, the hospital’s catchment area includes a large proportion of patients from various parts of the world. Transcultural encounters are thus part of everyday life. Besides technology skills, the practitioners in the coronary unit—nurses, physicians, and assistant nurses—are required to make valid assessments of the patient’s health status by asking questions and observing and interpreting signs of changes in status. It was the practitioners in the unit who initiated this study with a request for greater expertise and preparedness to meet cultural and religious diversity among patients in their care.

Many studies from the West (i.e., the United States, Canada, and Central and Northern Europe) draw attention to the need for heightened cultural sensitivity among health care personnel when patients do not share the same views on health and illness and the dominant biomedical perspective (Sachs, 2002; Weerasinghe & Mitchell, 2007), including language barriers and linguistic expression leading to miscommunication and disapproval (Andersson, Johansson, Nilsson, & Sahlberg-Blom, 2009; Robertson, 2003), have been documented. Some studies indicate that care practitioners often devalue their contribution to mutual understanding in encounters with patients with different cultural experiences (e.g., Richardson, Thomas, & Richardson, 2006). On the other hand, studies also have revealed a need for transcultural training (e.g., Douglas et al., 2009; Polacek & Martinez, 2009). Variations have been observed regarding the ideas held by practitioners and patients of what constitutes relevant cultural competence in clinical encounters (Johnston & Herzig, 2006). Several studies indicate problems with the attitudes of practitioners toward foreign
patients, such as difficulty in providing care (Festini, Focardi, Bisogni, Mannini, & Neri, 2009), the processes of “Othering” intensifying presumed “cultural differences” (Browne, 2007), perceptions that ethnicity is associated with intelligence, the likelihood of risk behavior and adherence to medical advice (Van Ryn & Burke, 2000), disinclination to seek care because of negative experiences (Wamala & Bildt, 2006), and, as shown in a review, limited access to health services (Groglopo & Ahlberg, 2006). In contrast, a study revealed that practitioners with greater motivation to learn culturally appropriate provider behavior were likely to work at clinics with a high percentage of staff from different parts of the world (Paez et al., 2008). Studies have also demonstrated the need to improve cultural sensitivity and communicative skills of both health care practitioners and patients. This concern is characterized as “cross-cultural clinical communication gaps” created by practitioners as well as patient behavior during clinical encounters, resulting in reduced patient participation in care processes (e.g., Schouten, Meeuwesen, Tromp, & Harmesen, 2007). Hence, one study revealed that training of both physicians and patients in transcultural communication may improve health care encounters (Harmsen et al., 2005). Overall, more research is needed into ethnic discrimination and its effects on health (Wamala & Bildt, 2006).

The many differences in study design, sample selection, and methods make comparison of studies difficult, and yet the findings above demonstrate significant concerns about transcultural encounters in the health care sector in many Western countries. Contemporary Sweden is a transcultural society and Swedish national policies propose extending research in the area of transcultural health encounters (Groglopo & Ahlberg, 2006; Institute of Public Health, 2005). Health statistics reveal important differences in health and illness between people born in Sweden and those born elsewhere (Björk Brämb erg, 2008; Groglopo & Ahlberg, 2006; Vogel, Hjerm, & Johansson 2002). Studies from other Western countries show a strong link between perceived discrimination and psychological and physiological health among individuals born outside the host country (see, Wamala & Bildt, 2006). In a review, Lasseter and Callister (2009) conclude that studies have shown that the influence of migration on health is complex and there is proof of good as well as bad effects among voluntary migrants in Western countries. However, the protective effects that migration may in certain cases have on health seem to vanish with time. Swedish studies have pointed out an increased need among health care professionals to explore cultural meanings in clinical encounters in order to help patients from foreign countries to orient themselves in new contexts, where perspectives of illness and healing might differ from their own, as might the role and function of caregivers and local health care services (Bääinheim & Ekblad, 2008).

As a first step, this study aimed to explore the care approach adopted by health care practitioners in the coronary unit in question as a means of handling transcultural encounters. The notion of transcultural encounter is used here to depict the particular situation where caregiver and patient have different cultural experiences, and has been brought to the fore as many individuals cared for in this unit were born outside Sweden. The concept of transcultural nursing (Leininger, 1978, 2002) focuses on the comparison and analysis of different cultural caring behaviors with the aim of developing culture-specific and culture-universal nursing care practices, which is not our aim here. All human encounters, regardless of the individuals’ origin and upbringing, are cultural: We constantly interpret each other’s words and body language.

The Setting

The suburban area in which the hospital is located comprises a district with high-rise apartment blocks built in the 1960s and 1970s, now inhabited by a large proportion (more than 50%) of persons born abroad, mostly from the Balkans, the Middle East, Somalia, and Asia. Many would agree that the area has a low socioeconomic status. The coronary unit in this study is divided into an emergency care unit for the most critically ill and an intermediate care unit for patients who are rehabilitating or who have been diagnosed as not critical. The unit has 36 beds. The average period of care is 4.4 days. The ward environment is high-tech and the treatment regimen offers full supervision of the patients and preparedness for emergency intervention by the personnel. The personnel consist of 60 nurses, 40 nursing assistants, and 43 physicians. About 60% of the physicians and 25% of the nurses are men. The overwhelming majority of the nursing assistants are women. The personnel have vast experience of caring for patients from various parts of the world. They do not, however, have any formal training in cultural competency.

Action Research

Action research has a long history and was first described by Lewin (1946) as “comparative research on conditions and effects of various forms of social action and research leading to social action.” Participatory action research involves a spiral of reflective cycles: planning—acting—observing—reflecting—replanning with critical reflection as an important step in each cycle (Kemmis & McTaggart, 2005).

Group discussions and interpretation of texts. The planning cycle started with two initial meetings with the health care practitioners followed by a few days of participant observation in the unit in order to meet the practitioners and learn about the day-to-day care work. One or two weeks later group discussions with the practitioners were held. About 70 persons participated. Nurses, physicians, and assistant nurses, both male and female, were divided into 11 groups of 5 to 8 persons. The discussions took place outside the hospital and lasted for about 45 to 60 minutes. The personnel were asked to tell about and reflect on experiences of transcultural
encounters in the unit. The aim was to explore the practitioners’ experiences and their suggestions for improvement. Observation was conducted in each encounter with the practitioners and reflection was an essential part of the whole research process. When we later evaluated the group discussions it appeared that the action step in the research spiral had already been initiated through the mutual reflections of the personnel during the sessions. In this article, we present and discuss the general content of the group discussions. The theoretical point of departure is hermeneutic, emphasizing human experience and offering an accessible way to handle the multiple, interpretive layers of the research encounter (Ricoeur, 1981).

The unit of analysis consisted of the group discussion texts, documented on tape and then transcribed. We used a narrative form to represent our findings since we wanted to reflect on events as told in order to embody them in successive totalities. Ninety-three narratives were identified from the research text, defined as a sequence of clauses separated by one or more temporal junctures (Labov, 1982). An important quality criterion within a hermeneutic research process is that the authors are aware that understanding is gained from personal involvement in the reciprocal processes of interpretation. The analysis was made as part of an extensive comparison of the narratives and in numerous discussions between the authors. A pattern emerged from the narrow reading of the narratives. In a critical reflection session the findings were discussed with nurses in the unit. In line with the hermeneutic approach, the formulation of a comprehensive theme was then tested against the totality of the text. A final listening to the tape provided insight that allowed the theme to become deeper and reach a level of coherence that captured the meaning of the text. Close collaboration between the authors throughout these steps helped ensure the most probable interpretation of the text.

Findings and Reflections

The overall theme of the 93 narratives was differences. Gender expressions, manners and customs, acting and reacting, values, attitudes, status, and emotional responses were presented by the practitioners as being different from the general perception of “Swedishness.” This in turn led to the creation of stereotypes, falling into dichotomous categories of “us” and “them,” “Swedes,” and “immigrants.” The dichotomies, however, were regularly balanced by less rigid comments on universal human needs and similarities between the categories. The narratives illustrated a switching between three levels of understanding human behavior: an individual level (personality), a collective or group level (“culture”), and the universal level (human nature), focusing on differences in the first two and similarities in the third. Gender expression was the most sensitive and frequent illustration of the purported difference between “us” and “them.” There was also a marked gender difference in the reactions of the practitioners to, and possible interpretation of, the transcultural encounters that they experienced.

As a point of departure, we present a verbatim account (see the appendix) that comprises four dialogical narratives: The spontaneous comments, interruptions, and laughs by the participants in the groups influenced the content. The narratives relate to a patient who appeared in the three discussion groups. The dialogical narratives about this man, who has been given the pseudonym Karim, are in many ways extreme. Nevertheless, they neatly illustrate the main themes of the differences identified in the 93 narratives. Karim was described characteristically as patriarchal, aggressive, uncooperative, self-righteous, and offensive to women, both in his own group and among the health care personnel, as illustrated in the conversation between female caregivers and the comments they made (see the appendix for the entire narrative):

... he wrapped himself in a large sheet and then wandered around the corridors and, as I felt, looked down on us. (Female caregiver 4, Story no. 68)

... we were going to serve him coffee in the evening but he refused to order from me. He waited for one of our male personnel. (Female caregiver 1, Story no. 36)

That’s a typical patient that we really find it difficult to care for as they are so condescending towards women . . . (Female caregiver 3, Story no. 36)

Bow and scrape and do as he says, but I won’t . . . (Female caregiver 1, Story no. 36)

... he also takes up a lot of space and doesn’t want to . . . his view of women is almost grotesque . . . (Female caregiver 5, Story no. 82)

Significantly, these descriptions of Karim correspond to the female practitioners’ descriptions of a typical “immigrant man.” The reactions of the personnel to immigrant men varied according to gender, reflecting sensitivity to power relationships among the female personnel that were provoked by assumed attitudes among immigrant men. Among male practitioners there was silence on this issue. Female practitioners found that immigrant men were reluctant to be cared for by women, something they took as a personal affront. In particular, the case of Muslim men refusing to shake hands with women generated a feeling among female personnel of being belittled and disrespected as professionals. They described this behavior as clearly differing from how they were usually treated by patients. Interestingly, female physicians did not recognize such behavior in their encounters with immigrant men. Male nurses, however, were used to immigrant women refusing to accept them as caregivers, to shake hands, or to look them in the eye.
In contrast to their female colleagues, the male practitioners never expressed feelings of being affronted by the above-mentioned behavior nor did they regard it as a lack of respect on the part of the female patients. Typically, the attitudes of immigrant women to male personnel were compared with the sensitivity with which they had to deal with female patients in general, and were thus seen in relation to a broader dilemma facing male caregivers. The general discomfort felt by female patients—immigrants as well as nonimmigrants—when undressing in front of a male nurse was an example of a reaction female practitioners identified with and male practitioners recognized. Male personnel described these situations, particularly noticeable in encounters with immigrant women, as frustrating as it prevented them from doing their job, sometimes forcing them into attitudes they clearly did not feel comfortable with. A male nurse stated that to avoid affronting female patients he consciously endeavored to neutralize his gender identity by adopting a strict and professional attitude of “being a caregiver.” Unfortunately, he said, this made him “more robot-like”—more technical and less emotional. Noticeably, professionalism in this context was linked to a detached attitude, which did not mean that empathy in other contexts was considered unprofessional. A female nurse agreed, saying that sometimes she reacts in a similar way to gain the respect of elderly men. Emotional distance as a way of “gaining respect” was general advice female practitioners shared with one another on how to best handle encounters with immigrant men. The female personnel said that by acting in a self-assured, detached manner, these men would come to respect them.

The experience of female practitioners of encounters with female immigrants, particularly Muslim women, was also characterized by preoccupation with perceived patriarchal attitudes of immigrant men. A female patient’s male kin were viewed with mistrust because of their reluctance to allow the woman to speak for herself. Implicitly, it was felt there was a sharp difference between “us” and “them”; implying that “Swedes” usually act for themselves and female immigrants, particularly Muslim women, was also characterized by preoccupation with perceived patriarchal attitudes of immigrant men. A female patient’s male kin were viewed with mistrust because of their reluctance to allow the woman to speak for herself. Implicitly, it was felt there was a sharp difference between “us” and “them”; implying that “Swedes” usually act for themselves and female practitioners identified with and male practitioners recognized. Male personnel described these situations, particularly noticeable in encounters with immigrant women, as frustrating as it prevented them from doing their job, sometimes forcing them into attitudes they clearly did not feel comfortable with. A male nurse stated that to avoid affronting female patients he consciously endeavored to neutralize his gender identity by adopting a strict and professional attitude of “being a caregiver.” Unfortunately, he said, this made him “more robot-like”—more technical and less emotional. Noticeably, professionalism in this context was linked to a detached attitude, which did not mean that empathy in other contexts was considered unprofessional. A female nurse agreed, saying that sometimes she reacts in a similar way to gain the respect of elderly men. Emotional distance as a way of “gaining respect” was general advice female practitioners shared with one another on how to best handle encounters with immigrant men. The female personnel said that by acting in a self-assured, detached manner, these men would come to respect them.

The refusal by male immigrants to be cared for by female practitioners was a representative of “a culture”: I do remember that he wanted me to do it in a way that would not have worked and then I stated very clearly, “Here I’m the one who can do this, and I’ll do it this way and it will be fine.” And it was fine and he also realised that it was fine and then things turned around. In some way I succeeded in gaining his respect and after that we were really good friends. But before that I could really have given him such a kick. That was how I felt when I saw him... Situations like that are not optimal, as he needed help. He wanted it his way and yet I was forced to do it in another way. I know I know, but it turned out fine in the end. (Female caregiver 4)

Although the female narrator did not find the specific situation fortunate as she had to use her authority as a professional to convince Karim of what was best for him, she thought that it “turned out well,” and that they even became “really good friends.” Visibly, for the encounter to turn into a good encounter and for the uncooperative patient to change into a “good patient,” the person must meet certain criteria, such as obedience and compliance. The female practitioners envisaged that having “gained respect” and having made the patient comply, they could let go of the detached attitude and (re-)assume an empathic, friendly, and caring position.

Encounters with people who behaved in ways that were deemed to deviate from a typical “Swedish” way were often characterized as dramatic. They provoked strong feelings in both the male and the female personnel, and sometimes they were experienced as insulting and abusive. Karim was described as ordering others around, family as well as personnel. He was seen to be disturbing the state of order by demanding a lot of space, such as lying down on the sofas in the public areas in the unit, walking up and down the corridors wrapped in a sheet, and talking loudly on the phone. His refusal to speak Swedish, despite the fact that he was knowledgeable in the language, thus forcing the personnel to speak English, was a factor that further rendered him strange and uncomfortable. To explain what was for the personnel an unfamiliar manner, they fluctuated between two positions: on one hand, seeing him as an individual who was deviant, unique, and very ill, and on the other hand seeing him as a representative of “a culture”:

I admit that I’m incredibly provoked by him and I can’t see any way out with him at all. I feel it’s a real mixture and you can’t [blame] a special culture... no, this is the man himself. (Female caregiver 5, Story no. 82, see the appendix)

... the whole of [that national group] are well-known [for this behaviour], it’s not something we should sweep under the carpet... (Female caregiver 1, Story no. 36, see the appendix)
In the narratives generally, the latter explanation was more common and a picture emerged of Karim as a male “Other,” personifying the idea of an African or Arab patriarch. Interestingly, a narrative of an immigrant woman acting similarly, that is, ordering others around and demanding a lot of space was perceived quite differently:

... that [African] woman who we have here sometimes / ... / I think she’s a queen / ... / She acts with such ... the same grace in the corridor although she is naturally wearing clothes she is also dressed in very colourful veils and her sons come to visit her and they run up and down. They all run up and down for her. She is really uplifted then ... wonderful to see. I wish my children acted in the same way. (Female carer 6, story no. 84, see the appendix)

This “queen” was admired by the female personnel for her grace and authority making her family members “crawl on their knees.” Clearly, such behavior was interpreted as a counterstory to the generally perceived victimized immigrant woman who, according to the personnel, neither has the right to speak nor make decisions regarding her situation as a patient.

The immigrant families play a particular role in practitioners’ accounts of cultural differences. A prominent topic involves immigrants in general “not understanding their best interests.” Family members were seen ambiguously as not only caring and as an asset to the caregivers but also as demanding, numerous, and even dangerous as they were considered to be “lacking in insight” regarding the patient’s illness. These ambiguous feelings are clearly illustrated in Story no. 83 (see the appendix):

His daughter was here and she was going to heat up food for him and he had high, high, high sugar levels and it was such a massive portion. We’d just got our new furniture, our new fabrics and the food spilled out over the chairs and ... with grease spots on the new chair ...

We learn how a daughter served the old man Karim enormous amounts of food despite him having diabetes mellitus and problems adjusting his blood glucose levels. The food was perceived as dangerous for the patient, invading not only his body but also the unit, destroying the furniture with crumbs and grease spots.

The personnel emphasized the challenges transcultural encounters make on them, that is, being able to “read” the incoming patients, interpret their symptoms, quickly judge the situation to improve the prognosis, and offer good care. They articulated that in acute, stressful situations and when working arduously, there is a tendency to simplify a complex reality. The overall picture that emerges from the group discussions is the practitioners’ ambivalence and struggle with common stereotypical attitudes of “the Others,” fluctuating between empathy for their position as patients and immigrants in an unfamiliar cultural setting, and frustration at the strange behavior of “the Others.” Immigrants were commonly described as rigid, governed by rules, rituals, and religions compared with “Swedes,” who were generally depicted as reasonable, compliant, and easy to care for. Although not clearly visible in the four chosen narratives, counterarguments demanded explanations, such as human nature or individual variation emphasizing the challenge of diversity that constantly emerged in the dialogical narratives.

Discussion

As noted, the main finding in this study was differences, of which the most sensitive and recurrent area expressed involved gender relations. These findings substantiate what the personnel in the group discussions implied: Gender relations have implications for the care encounter. The concept of intersectionality (Crenshaw, 2002) is important in understanding how gender relations interact on multiple and simultaneous levels with other forms of socially and culturally constructed categories of discrimination, such as class and ethnicity, as perceived in this study.

The study demonstrates the practitioners’ struggle with stereotypic images of “us” and “them” as identities locked in culture. Reflecting the discriminatory social discourses on immigrants (Allwood & Johnsson, 2009; Johnsdotter, 2008), and a general trait where Swedish public debate on multiculturalism focuses on cultural differences rather than economic and social inequalities (Carlbom, 2003; Sernhede, 2002); the use of a static culture concept clearly hampers the understanding of cultural diversity. The assumptions of culture as used by the practitioners plainly illustrate how these simplistic notions block interaction and understanding. However, the personnel’s counterarguments to stereotypical understandings of “the Others” regularly underscored the variation in behavior within the group of “immigrants” as well as “Swedes” (as the personnel called them). This generated a balancing view of humankind as universal and natural, and led to the conclusion that everything comes down to personality. These alternating forms of understanding represented by the practitioners were dichotomized or elaborated on depending on the line of discussion in the particular interview group: too much focus on the specific rendered comments on the universal and vice versa. Significantly, neither understanding seemed to help the practitioners understand their experience of transcultural encounters as seriously complicating “recognition,” influencing the ability to relate to the patient and thus hampering the ability to provide good care.

Björk Brämb erg (2008) argues for the dismissal of the culture concept and proposes a person-centered perspective: Irrespective of ethnic identity or cultural experiences each individual has a personal “life world.” By focusing on this,
Björk Brämberg suggests that each patient is dealt with as a person. Notably, her argument mirrors a dilemma inherent in the ideal of person-centered care, that is care should be focused on the individual. Can a person be understood outside his or her social and cultural context? We argue, in line with Allwood and Johnson (2009), that for care to be person-centered, understanding an individual in his or her social and cultural context is imperative. However, without recognizing that “culture” is created and negotiated in encounters, and that cultural identity intersects with other differences, for example, class, education, gender, and age, in complex ways, personnel will face the dilemma of a static understanding of culture, that is culture understood as traits, behaviors, and traditions that make persons from certain “cultures” essentially different from oneself (Kleinman & Benson 2006). At a birth clinic Johansen (2006) found that the tendency of midwives to relate immigrant women’s behavior to an alleged cultural identity was a major contribution to the many misunderstandings between them and which at times led to reduced quality of health care. This dilemma is illustrated by Wachtler, Brorsson, and Troein (2006), who explored general practitioners’ consultations with immigrant patients and found that commonly consultations were described as encounters between individuals. However, when mutual understanding was poor and consultations were unsuccessful, cultural differences were seen as central.

In the present study, silence in political and socioeconomic contexts in present-day Swedish society was revealed. Power relationships between patients and health care practitioners in general or at a specific unit were not discussed in the narratives. Situations of marginalization, exposure to misunderstanding, prejudice, and mutual lack of trust were absorbed into the practitioners’ interpretations by them adopting a view of culture as a universally prevailing explanatory model. This exuberant and often-used concept threatens to conquer other more complex and arduous ways of understanding and encountering difference. To call the concept of culture into question might increase the need to consider the relationship between context and social structure in care encounters. Diversity may emanate from a combination of individual, situational, and structural differences. In an increasingly globalized world, understanding culture as bounded rather than fluid is not useful and does not assist in the analysis of migrants and the complex changes that migration involves (Eastmond & Åkesson, 2007).

Using the culture concept as a single explanatory framework seems to be of limited value and, more important, might conceal economic and social injustices and marginalization of immigrants (Sernhede, 2002). Lila Abu-Lughod (1991) proposes “narrative ethnographies of the particular,” which focuses on discourse and practice showing negotiation and variation, as a useful alternative to the culture concept. The term transcultural encounters also continues to lock patients and personnel, and their interaction, into “culture.” Notably, it conceals differences, which would involve the patient category as a whole—not just “ethnic” others—which relates to power and agency in the care setting. Following this line of reasoning, “insurgent multiculturalism” (Giroux, 1995; Wear, 2002) may be useful as a critical approach that focuses on power relationships in a society where “interrelationships of different cultures and identities become borderlands, sites of crossing, negotiation, translation and dialogue” (Giroux, 1995, p. 340).

In line with several studies (e.g., Garroutte et al., 2008; Richardson et al., 2006), the group discussions and the wish of practitioners to participate in action research show a high degree of self-criticism and a willingness to become better in encounters with patients depicted as “cultural others.” Individual suggestions of care in those situations were offered that went far beyond prejudice and unreflected responses. The care practitioners initially proposed a number of different tools to be developed as a solution to their perceived problems, such as dictionaries, simple board books, and training in, as they put it, “how other cultures want to be cared for.” As the research process proceeded with repeated discussions these proposals were elaborated on and deepened and the importance of sharing experiences and feedback came to the fore.

The heterogeneity of encounters in present-day health care may not only be a source of frustration and lack of confidence on the part of both patients and practitioners but also an inventive way to increase and extend the imperatives of good care. By understanding relationships as being created dynamically in particular contexts, health care practitioners have the possibility to provide the conditions for understanding dialogues across different lines of experience.

**Recommendations for Practice**

Health care practitioners should be repeatedly offered the opportunity to reflect on care encounters, focusing on their own attitudes and care practice. Continual reflection and supervision should be part of every care unit’s professional development.

**Conclusions**

The personnel in the coronary unit initiated this study based on an expressed need for more knowledge in order to be better equipped to address the “transcultural” encounters they face every day. The group discussions revealed that the diversity represented by patients and the extreme complexity on both the individual and collective levels, left the practitioners confused as to what kind of knowledge they need to increase the cultural competence. We assume that information about different “traditions,” “cultural practices,” and “values” would not enhance their ability to understand the incoming patients and offer good care, but risk reinforcing a stereotypic understanding of patients.
Considering that the process of change had already been initiated by the practitioners’ mutual reflections during the group discussions, practitioners and researchers together identified a need for continuous discussion and guidance in attitudes and beliefs regarding patients coming from various parts of the world. In the spiral of reflective cycles that participatory action research entails, the replanning phase will introduce cooperative groups made up of health care practitioners. Together with researchers in regular sessions they will evaluate and improve encounters in the unit through critical self-reflection and elaborated discussions on the meaning of diversity and differences. Group processes as well as changes that take place in the unit will be studied continuously.

Appendix

The Karim Narrative

All narrators were female nurses and nursing assistants who participated in three different discussion groups.

Story No. 36 (Group No. 1)

Storyteller 1 (S1): Once we had a [male patient], he went around talking on his mobile all day, up and down the corridors wrapped in a sheet.
S2: Karim?
S1: Karim, yes . . . we were going to serve him coffee in the evening but he refused to order from me. He waited for one of our male personnel.
S3: That’s a typical patient that we really find it difficult to care for as they are so condescending towards women . . . Really that’s a very typical kind of clash.
S1: Bow and scrape and do as he says, but I won’t. But the whole of [that national group] are well-known [for this behaviour], it’s not something we should sweep under the carpet, it’s really, man . . . woman . . .

Story No. 68 (Group No. 2)

S4: Not long ago we had a patient. We called him Karim./ . . . / he wrapped himself in a large sheet and then he wandered around the corridors and, as I felt, looked down on us. On one occasion he needed help with something, I can’t remember what the situation was exactly, but I do remember that he wanted me to do it in a way that would not have worked and then I stated very clearly that here I’m the one who can do this, and I’ll do it this way and it will be fine”. And it was fine and he also realised that it was fine and then things turned around. In a way I succeeded in gaining his respect and after that we were really good friends. But before that I could really have given him such a kick. That was how I felt when I saw him.

Interviewer (I): Was it a facilitating factor, that you gained his respect?
S4: Yes, but still only because he needed help with something. Situations like that are not optimal, as he needed help. He wanted it his way and yet I was forced to do it in another way. I know I know, but it turned out fine in the end.

Story Nos. 82, 83, and 84 (Group No. 3)

Story No. 82

S5: Yes, he’s a very special person. We call him Karim./ . . . / [he] refuses to speak Swedish although he understands Swedish fluently as he’s been here for many years and we’ve asked why he doesn’t speak Swedish. No, but you can all speak English and I think it’s easier so that’s why I speak it. And he does so and he also takes up a lot of space and doesn’t want to . . . his view of women is almost grotesque./ . . . he’s a very strange person. He’s very difficult and we can’t reach him. / . . . / our former boss could do it . . . with her authority she got him up from the sofa and away and so in some way he realised. Oh, it wasn’t possible to refuse or do something because . . . he acted as if he owned the whole . . . It’s clearly provocative
S6: mmm
S5: I admit that I’m incredibly provoked by him and I can’t see any way out with him at all. It’s a real mixture I feel and you can’t [blame] a special culture . . . no, this is the man himself.
S6: Yes exactly
S5: It doesn’t matter where you’re from but now we’ve just talked about it. He’s very special. When relatives come to him you can see that they almost apologise. There was that young boy who came. He said hello and was laughing and they ran around getting him cutlery and they were so helpful that you could imagine that . . . we spoke previously about them perhaps expecting that women should do it but they ran around like mad for him. I can imagine in order to . . . we’re not like that . . . no, that’s what he’s like as a person.
S6: Yes, he is.
S5: He’s in fact an !!! person . . . but then he’s actually very sick and that’s a shame but, no, I can’t see anything for him . . . my god how cruel I felt now but Participants: /laughter/

Story No. 83

S5: I remember a small, stupid thing. His daughter was here and she was going to heat up food for him and

(continued)
Appendix (continued)

he had high, high, high sugar levels and it was such a massive portion. We’d just got our new furniture, our new fabrics and the food spilled out over the chairs and/considerable laughter/with grease spots on the new chair, yes /laughter/ mmm . . .

Participants: /laughter/

Story No. 84

S6: He [Karim] . . . he acts as if he were king . . .
S5: Yes but . . .
S6: But I don’t think he is. But that [African] woman who we have here sometimes, yes the older one, she however . . .
S7: Yes
S6: I think she’s a queen
S7: Is that so?! . . . /
S6: Yes
S7: Do you mean for real?
S6: Yes for real, yes, yes!
S5: But her . . . king is dead, he doesn’t exist any more
S6: Yes I thought he had abdicated
S5: No abdicated . . . /laughter/ . . .
Interviewer: Tell me about her!
S6: She acts with such . . . the same grace in the corridor although she is naturally wearing clothes but she is also dressed in very colourful veils and her sons come to visit her and they run up and down. They all run up and down for her, she is really uplifted then . . . wonderful to see. I wish my own children acted in the same way.

Participants: Laughter
S6: I try to explain to them but
Participants: Laughter/ . . .

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