Nurses' experiences of caring for children with cancer and their families from other cultures

A qualitative literature study
Abstract

Nursing practice should pursue to reach the stage of cultural competency and in addition to that nurses should have an understanding about others cultures in order to deliver best possible care to children with cancer and their families from diverse cultural backgrounds. The aim of this study is to describe what nurses’ experiences in connection with the care of children with cancer and their families from other cultures other than their own. The method that has been used is a qualitative literature review. Evans descriptive synthesis is used as analysis method. The finding presents three themes and seven sub themes which are relevant to the aim of this thesis. Importance of communication in caring; hinders to the caring situation and aspiration for further education presents as themes. The subthemes are: language as an important instrument, experiences of using interpreters, lack of cultural competence, experience of frustration due to conflicts, lack of support and guidelines, desire for more exposure and need for further education. This thesis concludes that nurses have to be experienced in identifying the needs of the patients as well as the family members and has to respond according to it. More over nurses have to work out to widen their scope on nursing on a cultural perspective and even strive to attain cultural competency.

Key words: cultural competence, nurse, childhood cancer, cultur*, pediatric oncology

Sammanfattning


Nyckelord: cultural competence, nurse, childhood cancer, cultur*, pediatric oncology
TABLE OF CONTENTS

1. INTRODUCTION .................................................................................................................. 5

2. BACKGROUND ..................................................................................................................... 5
   2.1 Children in hospitals ........................................................................................................ 5
   2.2 Childhood Cancer ............................................................................................................ 6
   2.3 Cultural understandings .................................................................................................. 6
   2.4 Caring science perspective .............................................................................................. 7
   2.5 Cultural competence in nursing ....................................................................................... 7
   2.6 The role of nurses ........................................................................................................... 8
   2.7 Previous researches ......................................................................................................... 9
   2.8 Problem formulation ....................................................................................................... 10

3. AIM ...................................................................................................................................... 10

4. METHODOLOGY ................................................................................................................ 11
   4.1 Data collection and selection methods ........................................................................... 11
   4.2 Data analysis method ..................................................................................................... 12
   4.3 Ethical considerations .................................................................................................... 13

5. RESULT .............................................................................................................................. 13
   5.1 Importance of communication in caring ........................................................................ 14
      5.1.1 Language as an important instrument .................................................................... 14
      5.1.2 Experiences of using interpreters ......................................................................... 15
   5.2 Hinders to the caring situations .................................................................................... 16
      5.2.1 Lack of cultural competence .................................................................................. 16
      5.2.2 Experiences of frustration due to conflicts .............................................................. 17
      5.2.3 Lack of support and guidelines ............................................................................ 18
   5.3 Aspirations for further improvement ............................................................................ 19
      5.3.1 Desire for more exposure ....................................................................................... 19
      5.3.2 Need for further education .................................................................................... 19
   5.4 Result synthesis .............................................................................................................. 20

6. DISCUSSION ....................................................................................................................... 20
   6.1 Method discussion ......................................................................................................... 20
6.2 Result discussion

6.2.1 Influence of communication in caring

6.2.2 Obstacles to culturally oriented nursing care

6.2.3 Factors that favor cultural competency

6.3 Suggestions for further research

6.4 Ethics discussion

6.5 Conclusion

REFERENCES

Appendix 1

Appendix 2
1. INTRODUCTION

My interest to this topic derived from my years of encounters and experiences with the Swedish health care system where nurses struggle to give culturally competent care to childhood cancer patients and their families from other cultures. I found out that lack of knowledge about others cultures create misunderstanding between the patient and the nurse. The ever-increasing multicultural population in Sweden and other western countries is creating challenges to nurses. This forces nurses to recognize cultural differences in healthcare. Thus, it is believed that nurses must acquire the knowledge and skills needed to assess and care for clients from diverse cultural backgrounds. With immigration, global travel and language variations; big differences are seen in health needs of children and their families. Delivering care for children and their families from another cultural background is not an easy task. Especially when a child suffers from cancer, the entire family’s interactions with the healthcare system increases. But a child’s family with another cultural background than the nurse itself has different expectations, experiences and attitudes towards the healthcare system. Therefore treating a child with cancer and diverse cultural background needs very specific demands on health care, and expected more from nurses. To meet the requirements of today’s care for culturally diverse children suffering from cancer nurses need to have cultural competence. Since having knowledge about cultural competence eases nurses’ understand others across cultures without problem and effectively, even paves a way for a very god and effective communication with others.

2. BACKGROUND

In the background it is important to include definitions and theories that are necessary for a better understanding of the rest of the thesis. In this part; children in hospitals, explanation about childhood cancer, cultural understandings, caring science perspective, cultural competence in nursing, the role of nurses, previous researches and problem formulation are presented.

2.1 Children in hospitals

In order to get information on factors that affect nurses’ relationship with their patients it is important to get insights on what children experiences during their time in hospitals. Bad experiences by the child affect the families experience and further hurt nurse-patient/family relationship. Hospitalization is a stressing experience for children but their experience of illness and hospitalization is influenced by age, previous experiences and the nature of the disease (Hurwitz, Duncan and Wolfe, 2004). Separation from family and friends; being in an unfamiliar environment; receiving investigations and treatments; and loss of self-determination are some of the difficulties children experiences. Hospitalization changes the child’s life style and routine. Routines like playing with friends, attending school and other activities are affected greatly and the child exposed to a strange environment. This creates anxiety and fear (Coyne, 2006). In order to decrease the above mentioned pressure experienced by the child, parent participation is very important. Power and Franck (2008) found out that parents want to extend their role in participating and supporting daily living activities they usually perform at home. Even if parent participation is very important nurses are key workforce in child care, because they carry the bulk of the work there. Their goal is to promote children's health, security and development, to reduce harmful stress for parents and children (The national Board of Health and Welfare, 2009). The experience of hospitalization should be pleasant for the child. The United Nations convention on the rights of the child
(UN, 1989) requires that the child has to enjoy the highest attainable health care and expected facilitated treatment of health and rehabilitation of health.

2.2 Childhood Cancer
Cancer is the second leading cause of death in the west world. The diseases affect all age groups, causing more death among children 3 to 15 years of age than any other diseases. Cancer is a result of altered cell differentiation and growth and it is not a single disease, it can also originate anywhere in the body. The variety of cancers that affects children differs from those that affect adults. Childhood cancer is a general term used to describe a range of cancer types found in children. Today, scientists know that the adults' cancer depends largely on the lifestyle, but why a child develops cancer cells is not yet known. A child, for example, do not smoke and do not have time to be exposed long enough for external influences that causes risk of cell changes. Little is known about the possible causes of childhood cancer but factors like environment for example radiation, parental occupation and socioeconomic status such as work condition and poor lifestyle have a great deal of contribution to the development of childhood cancers (Porth, 1998). Most children who become ill from cancer is around 4-5 years then decreases the number of sick children to be at its lowest around the age of 8 (Barncancerfonden, 2010). Brain tumors, cancer in the nervous system and leukemia are the most common cancers in children (Socialstyrelsen, 2005a). Due to the improved treatment and specialized care by nurses the number of children surviving childhood cancer is rising steadily. The need for pediatric oncology centers has proven to be very essential. Nurses are very important as they are very near to the sick child than any other professionals (Socialstyrelsen, 2009).

2.3 Cultural understandings
Explaining the relationship between culture and communication is very important. This understanding helps to give impressions on how culture affects communication; further more gives an insight on how those nurses giving care to the sick children affected by communication due to cultural differences. Culture is an extremely complex idea, and it has been defined, interpreted and analyzed from a variety of disciplinary perspectives. Culture is acquired early in life, by the age of five and continues to grow without substantial learning activities (Andrews & Boyle, 2008). According to Leininger (1995) the concept of culture includes perceptions such as culturally learned, shared and transmitted values, beliefs, norms and lifestyles of a specific group that controls and produces patterns of their thinking and their decisions. According to Giger and Davidhizar (2008) communication and culture are closely interrelated and argues that culture affects verbal and non-verbal expressions. Language as a verbal communication instrument is a significant factor that shapes every individuals understanding in all cultures and in that context language and culture are inseparable. Whenever there are differences between two communicating parties concerning culture the harder it becomes to communicate each other verbally. At this time the two communicating parties forced to use other means of communications that facilitates understanding between them. Non-verbal communication and the use of interpreters are classic examples that have been proved very important (Hanssen, 2007). Leaninger (1995) underlines the importance of language as its relationship with culture is intimate. Nurses expected to identify the clients’ way of expressions; while they express themselves using non-verbal communications, as these factors influences caring. Hanssen (2007) mean that non verbal communications often convey a truer picture of one's thoughts and emotions than words do. It is believed important for nurses to give attention to the non-verbal communication as that of verbal ones. If these verbal and non-verbal means of communications unable to convey the desired information, the nurse forced to use interpreters in order to make sure the information is transmitted to the desired party. The use of professional interpreters is a very important means to
communication whenever there is a problem in exchanging information. Equally the use of interpreters has its own problems. A loss of information can occur through the process of interpretation. Interpreters’ who is not having sufficient language skills is one of the many factors that contribute to loss of information.

2.4 Caring science perspective
Theories of two theorists have been used as a caring science perspective. Katie Eriksson does not talk so much about caring in a cultural context like Madeline Leininger does. Using both theorists is believed to be very important in order to gain a better understanding about each subject. Leininger (1991) developed the theory of culture care and even introduced the concept of transcultural nursing in order to develop cultural competency. Culture care theory is used as a caring science perspective and is believed to be the right theory that focuses on culture as a main instrument in addressing individual’s health and the nurses caring behaviors. The theory of culture care encourages nurses to study and discover cultural aspects so that they can give effective care for culturally different patients. Caring is the core of nursing and it is unique to nursing. Health refers to a state of well-being that is culturally defined and valued by a designated culture. As to a holistic view nurses also need a comparative view of cultural differences and similarities while they deliver care. It has been described that both the nurse and the patient can design a new form of care that addresses the well-being of the client. Nurses need cultural knowledge in order to reach the goals and acknowledge that care occurs in a cultural framework.

Transcultural nursing is the other theoretic area where Leininger (1995) developed to as a formal area of study. It is an area where nurses practice focusing upon holistic culture care, health and illness with respect to others cultural backgrounds, values and beliefs Transcultural care is described as that with respect to each individual’s culture to adapt nursing patient's cultural values, beliefs and lifestyle. This focuses on care as core of nursing and argues that care is dependent on culture and that culture cannot survive without care. Care receivers will be mismanaged without a proper transcultural nursing skill but through this skill the nurse can promote good health and wellbeing to the patient.

It is assumed important to include theories about suffering. Leininger doesn’t talk distinctly about suffering as Eriksson does, Eriksson (2006) the theory about suffering is appropriate to use and she uses the word suffering as an explanation of human being’s struggle between good and evil and she believes that suffering is not synonymous with pain. Suffering is a unique experience that every individual perceiving it in different ways. Suffering is an evil by itself but every human being once passed through it assigns a meaning to it. There are three different forms to suffering; suffering that comes because of illness and that is a suffering which is experienced due to illness and treatment. The suffering of care: it is the suffering which is experienced in relation to the caring situation. The suffering of life: the suffering that is experienced in life. Suffering affects a person’s life experience and questions one’s existence. It’s believed that in its genuine meaning suffering is a form of dying. Suffering is a struggle between life and death. If human beings win suffering there is a possibility of new life (Eriksson, 2006)

2.5 Cultural competence in nursing
The concept of cultural competence is very important in this thesis and it can be used as a basis for analysis so it is important to have it in the background. Campinha-Bacote (2007) defined cultural competence as the continuing process in which the health care professionals strives to gain the capability and availability to work effectively and efficiently within the cultural circumstance of the patient either in an individual, family or community level.
Cultural competence consists of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. The model depicts the following: Cultural awareness involves exploration of one’s own culture; cultural knowledge involves the process of obtaining information about other cultures, cultural skill is about collecting information or having understanding about the client’s culture and further performs assessments culturally specific to the client. Cultural encounter is the process that encourages nurses to interact with patients from culturally diverse background. The last component of the model is cultural desire and is about motivation in which nurses are willing to accept, acknowledge and respect cultural differences and ready to learn from other cultures. Maximizing sensitivity and minimizing insensitivity towards other cultures is part of becoming culturally competent and advised to have knowledge, skills and self awareness about own and other cultures.

According to Leininger (1997) cultural competence is a highly developed and organized skill for assessing, planning, implementing and evaluating nursing care for individuals, families, groups and communities which are representing different cultures in society. Weight also given to the importance of knowing and acknowledging patients’ culture and it is important to have knowledge about patient’s culture in order to deliver culturally competent care. Giger and Davidhizar (2008) mean that in order to develop cultural competence the nurses should gain knowledge from theoretical models of culturally proper care. These skills and knowledge of cultural competence assists the nurse to deliver the best possible care without dilemmas of race, ethnicity, gender identity, sexual orientation and cultural heritage.

2.6 The role of nurses
Having good understandings about the role of nurses is very important. In order to come to the problem it is very important to know what the nurses’ obligations are. The Code of Ethics of the International Council of Nurses (ICN) forms the basis of the nurse ethical action and behavior. The nurse should show concern and respect for the integrity and dignity of the patient; this includes human rights, respect to other culture, sexual orientation, race or social status. Nurses are expected to deliver care to the patient, families and the whole community and are responsible to give the service fairly and without bias and in a trustworthy way.

Competence description for nurses (Socielstyrelsen, 2005b) clarified also that the nursing profession should act according to competencies that focus on patient’s autonomy, integrity and dignity. The description clarified that the nursing profession regardless of scope and form is characterized by ethical conduct and science and experience. Furthermore, it is important that the nurse can provide support and guidance in dialogue with patients / families receiving care. The description further clarified that nurses expected to meet the patient’s basic and specific needs, it might be physical, mental, social, cultural and spiritual. Nurse expected to communicate with patients and relatives with a respectful manner and further required to construct conversations with the patient and family members and ensure patient/family participation in care and treatment. Nurses have responsibilities in ensuring the care receivers understand the information given.

Health-care professionals have an obligation under the Health Care Act (SFS 1982:763), § 2 to give all patients good care on equal terms and care should be given with respect to all human beings equality and with dignity. The patient should be given individualized information about his health situation and about the methods of investigation, care and possible treatment which are available. The Prohibition of Discrimination Act (SFS 2008:567) clearly depict that an individual should not be disadvantaged or treated less favorably than any other on the basis of gender, ethnicity, religion, sexual orientation or disabilities or other belief. According to SOSFS (1996:24) the nurse has to maintain the
training, experience and skills needed to perform the above mentioned and other duties and responsibilities. In order to fulfill the requirements of good healthcare and further to provide culturally competent care, nurses should have knowledge and education on culture and cultural differences that exists.

2.7 Previous researches

Rollins (2005) conducted a study using quantitative and qualitative method with a grounded theory approach. The aim of the study was to compare and explore the nature of stressors and coping measures they use to manage stressors. The result shows that children responds childhood cancer experiences in a similar way, regardless of their ethnicity and belongs to different cultural groups. The study by (Woodgate & Degner, 2003) shows that children's experience of illness and pain also affected parents, brothers and sisters and the parents' experiences in turn affect the child's experience. The study aimed to describe about symptoms experienced by children with cancer from the perspectives of the children and their families. The study used a longitudinal, qualitative research approach. The study found out that children and families had specific beliefs and expectations about the cancer symptom experiences as a result of suffering.

Cantrell and Matula (2009) believe that “Comfort” is not something big but simple act of caring by nurses give a meaningful comfort to the patient. The purpose of the study was to describe the meaning of being cared for and comforted by pediatric oncology nurses. The researchers used a hermeneutic analysis method in order to describe the meaning of the phenomenon. The result shows that childhood cancer patients consider comfort as their main survival means and the nurse has to take this in account and try to give the best possible support to them and their families. A study by Berrios-Rivera, Rivero-Vergne & Romero (2008) which is a qualitative study with a phenomenological approach aimed at finding the lived experience of children undergoing hospitalization process. The study’s result shows that children as well as families consider hospitals as a save heaven even if they experiences difficulties with the treatment.

Seth (2010) carried out a study about communication in a pediatric palliative care. The aims of the study were to explore parental perceptions of truth telling to their sick child about his/her diagnose and treatment conditions and to evaluate parental views on participation of children’s decision making. The result shows that most parents had a protective attitude towards their child (don’t want the child to be informed). Parents also expressed dissatisfaction on lack of early information.

According to Ow (2003) families have a strong need to receive information about their child’s condition and diagnosis. A questionnaire study has been conducted; parents with children diagnosed with cancer participated. The main aim of the study is to examine the parents coping mechanisms. The result shows that subjective burden is constantly higher that it affects the parents’ psychosocial environment. The research by Björk (2008) have an overall aim of finding family members’ lived experiences and needs during a child’s cancer course and to describe how the illness and its treatment influence the family as a whole. Interviews with the family members and observations were conducted and the interviews were analyzed with a hermeneutic phenomenological approach and the observations with content analysis. The result summarized and presented as themes. The themes are: family importance, an everyday struggle, a swing between worry and relief, striving to gain control, a need for support and a need for a good relation to the professionals.
Woodgate (2005) conducted an interesting research that aimed to find out and describe how childhood cancer shapes a child’s and his or her family’s way of life as depicted in the narratives that they constructed. An interpretive qualitative research design was used to understand the perspectives of children and their families. The findings describe the core description of the families identified as ‘Life is never the same’. The result shows that the family’s life changed in an irreversible way due to the challenge they experienced throughout the child’s hospitalization period.

Fletcher (2010) conducted a study with an objectives of examining the costs associated with caring a child with cancer and the other aim is to show lived experiences of mother caregivers, from diagnose and the time thereafter. An interview with 9 mothers conducted. The result shows that factors that related to cost identified as financial and work issues, health of family, upheaval of family life and a lost life. Dongen-Melman, Van Zuuren and Verhulst (1998) a qualitative research method was used. The aim of this study is to find a description of what it is like to live through childhood cancer in all its aspects. The result indicates that childhood cancer affects the entire family, parents experienced changes of a definite and long-lasting nature as a result of the child's survival; feelings of loss and preservation of problems existed.

2.8 Problem formulation

Nurses are considering cultural competence as a priority due to increase in number of health seeking multiethnic society. Nurses in a multicultural society meet people from other countries representing different cultures heritages than the culture they already accustomed with and it is very clear that nurses like other health care professionals cannot escape the tensions that can be created due to cultural differences and attitudes. According to Campinha-Bacote (2007) increased knowledge regarding treatment of patients from diverse cultural backgrounds is very important. Cultural Competence in caring is important for the characteristics of quality of care. The view about illness, health and suffering is different from culture to culture, does lack of knowledge about others culture can affect the caring relationship between the nurses and the patient? When a nurse cares for a culturally different patient various problems such as culture confrontation or problems related to language, religion, family relationship, education background etc can be created. It is also recognized that the Swedish health care systems intend at ensuring the population's good health care according to the individuals' needs, regardless of their social position, gender, race or ethnicity or cultural differences (SFS 1982:763). Such knowledge is a guide for nurses when she/he meets and care for patients from diverse cultural backgrounds. To understand nurses’ experiences as well as to learn from it, it is imperative to examine the problems that can arise in the care of childhood cancer patients and their families from diverse cultural backgrounds. The nurse has a central role in the care of childhood cancer patients and their families and therefore it is important to examine their experiences in the health care encounter with patients. What are the possible obstacles that can arise in this particular caring situation? Does cultural difference affect the caring relationship? What skills considered important to be culturally competent nurse? What do nurses experiences in the care of children with cancer and their families from diverse cultures?

3. AIM

The aim is to describe what nurses’ experiences in connection with the care of children with cancer and their families from other cultures other than their own.
4. METHODOLOGY

According to Friberg (2006) in a literature-based qualitative study it is the aim and problem area that decides what types of articles will be selected. This section describes the steps, procedures and strategies for gathering and analyzing data in a study. The author has chosen to do a descriptive synthesis. According to Evans (2003) descriptive synthesis is suitable method to describe what has been reported in previous researches. This descriptive synthesis is used to portray the already published research and provides a description of the data with a minimal re-interpretation. The data analysis method needs to be appropriate for the study’s aim and it is important to use the right method. Evans (2003) model for a data analysis consists of four phases. The first phase is to collect articles. In this step unit of analysis would be determined, a search in different databases conducted in order to generate relevant articles and using inclusion and exclusion criteria, those scientific articles that agree with the selection criteria finally selected. The second phase is to read the study several times and identify the key findings of each study. In this step the texts are read and re-read through several times to get a set of key findings each study that meet the objective of the thesis. During the reading process attention has to be given to the details of accounts and to what each study says.

In the third phase similarities and differences between the categorized key findings is being identified through the creation of themes and subthemes. The themes and subthemes that are common are linked together into a whole that requires careful processing and control. From the collected themes, sub-themes are identified that best answered the study’s purpose. The analysis re-examined in order to identify consistencies. In the fourth phase the common findings will be put together to create a new description of the phenomenon. The description shows how well the themes and subthemes are consistent with the original articles. The text is enriched with quotations and examples from the original studies and presented in a clear and readable manner. Finally, a summary of the result presented as a results synthesis.

4.1 Data collection and selection methods

In this thesis qualitative articles have been include. The search for articles for the result part was made on databases CINAHL and PubMed. To widen the scope of the findings even manual search has been used. There were restrictions on year and language; only English language was chosen. The search words such as ‘cultural competence’, ‘nurse’, ‘childhood cancer’, ‘cultur*’ and ‘pediatric oncology’ has been used. In order to meet the study's purpose different inclusion criteria were used. In order to find the different forms of the word even truncation (*) has been used. Summary of the search paths can be seen in table 1.

**Inclusion criteria:**
- qualitative
- Scientific articles that considers nursing perspective
- articles with abstracts
- English language
- Published date from 2004-2010, as an exception two articles from the year 2001 were included.

**Exclusion criteria:**
- Quantitative
- Articles with no abstracts
- Articles written with other languages than English
In order to get 10 articles primarily abstracts of 50 articles were read and then 14 articles were selected and read thoroughly and then analyzed to make sure the articles are suitable for the aim of the thesis. After reading and reviewing these articles, four were removed which were considered not suitable for the whole work. Featured articles are presented as “summary of articles selected to be analyzed” in appendix 2.

Table 1. Summary of search paths of articles to the result part

<table>
<thead>
<tr>
<th>Database</th>
<th>Search word</th>
<th>Number of findings</th>
<th>preselected</th>
<th>Final selected</th>
</tr>
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<tbody>
<tr>
<td>CINHAL@</td>
<td>Cultural competence* AND pediatric oncology</td>
<td>4</td>
<td>2</td>
<td>1A</td>
</tr>
<tr>
<td>CINHAL@</td>
<td>Nurse AND Sweden AND pediatric oncology AND Cultur*</td>
<td>2</td>
<td>2</td>
<td>2A 2B</td>
</tr>
<tr>
<td>CINHAL@</td>
<td>Pediatric AND oncology AND nurse AND cultur*</td>
<td>10</td>
<td>1</td>
<td>3A</td>
</tr>
<tr>
<td>Pub Med@</td>
<td>(transcultural) AND pediatric AND Nurse*</td>
<td>7</td>
<td>2</td>
<td>4A 4B</td>
</tr>
<tr>
<td>CINHAL@</td>
<td>Caring AND Child AND Dying</td>
<td>18</td>
<td>4</td>
<td>5A</td>
</tr>
<tr>
<td>CINHAL@</td>
<td>Nurses AND pediatric oncology AND cultur*</td>
<td>23</td>
<td>2</td>
<td>5B</td>
</tr>
<tr>
<td>Pub Med@</td>
<td>Caring AND Dying AND Cultur* AND Child*</td>
<td>9</td>
<td>3</td>
<td>6A 6B</td>
</tr>
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4.2 Data analysis method

Analysis of the articles was conducted using the stages according to Evans (2003) descriptive synthesis of qualitative research resources. The aim of the analysis was to make a minimum interpretation of the original data.

The first step started with determining the interest area where the whole work should involve and the aim of the study has been set. The aim of the study is to describe what nurses’ experiences in connection with the care of children with cancer and their families from other cultures other than their own. Then delimitation such as inclusion and exclusion criteria has been set; in order to concentrate the area in which the author set to study as well as to give relevancy to the studies purpose. The abstract of each study has been read carefully and then the searches for articles to be analyzed were performed by reading further the result of each
study. At last ten articles have been chose. The unit of analysis was verified using the above mentioned inclusion and exclusion criteria and then the materials that would be included in the analysis were determined. Ten articles were believed to be up to the standard of this work and were selected. See table 1 and appendix 2.

The second step is identifying key findings from those ten articles previously selected according to the aim of the study. The articles were already read in the data selection process and this made the next process easier but the author didn’t stop here instead read the selected articles several times. The author went deeply and read all the contents of the results in each article in order to grasp an understanding about the whole study. In this step a great deal of understanding has been gained furthermore a feeling seeing the study as a whole has been achieved. Those building blockers (key findings) of the result have been identified. At last key findings grouped together and listed in a separate paper.

The third step starts with identifying themes based on the key findings from step two. The differences and similarities between the different studies identified and those matching ones grouped in similar themes. Further, these themes are examined in order to find explanatory texts that later named as sub- themes. Then the themes and sub- themes are inspected again in order to make sure no misinterpretations have been made.

After examining the analysis, three themes and seven subthemes created. In order to identify consistencies and misinterpretations the themes and sub themes were re- examined. In order to give a better understanding how key findings, themes and subthemes are generated. Key findings, themes and sub themes are presented in appendix 1.

In the fourth process the three themes and seven subthemes were presented with examples from the original articles. The three themes were written referring the original material to show the accuracy of the thesis. The themes began with short description of the contents. Each sub theme is supported with quotations from the original articles. At last, the summary of the result is presented as a result synthesis Examples of the various themes and subthemes can be seen in Table 2.

4.3 Ethical considerations
It is true that all research should be carried out in an ethical manner. According to Polit and Beck (2008) when ever human beings are participates in a research it is very important to respect the rights of those participants. It is important to explain where all the information that are going to be used come from and the new result has to depend honestly on those previous articles. Data from different sources should not be distorted and texts from other research results should not be portrayed as self. Medicinska forskningsrådet (2000) formulates that distortion of research material, fabrication of data and misinterpretations of the result in improper way considered fraud and act of dishonesty. Forsberg and Wengström (2008) suggest that it is important to have a neutral stance in carrying out a qualitative study. The author has been careful not to alter the original data and all possible ethical considerations have been made. It is important to respect the ethical principles so that the work will finalized without any ethical dilemmas/problems.

5. RESULT

After analyzing ten scientific articles the outcome presented as a result, which is formulated in three themes and seven sub themes that are relevant to the aim of this thesis. The themes start with short summary prior to respective sub themes. The sub themes on the other hand
described using quotes from the original articles. The result concluded with a result synthesis where the result summarized and presented. The themes and the sub themes are presented in table 3.

Table 2 presentation of themes and sub themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub theme</th>
</tr>
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<tbody>
<tr>
<td>Importance of communication in caring</td>
<td>Language as an important instrument</td>
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<td></td>
<td>Experiences of using interpreters</td>
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<tr>
<td>Hinders to the caring situations</td>
<td>Lack of cultural competence</td>
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<td></td>
<td>Experiences of frustrations due to conflicts</td>
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<tr>
<td></td>
<td>Lack of support and guidelines</td>
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<tr>
<td>Aspiration for further improvement</td>
<td>Desire for more exposure</td>
</tr>
<tr>
<td></td>
<td>Need for further education</td>
</tr>
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</table>

5.1. Importance of communication in caring
Communication is the main tool in delivering care to culturally diverse patients. A communication barrier that exists between the nurse and the patient/family members results in delivering inappropriate care. Communication barriers because of language problems create troubles in exchange of information between the nurse and the patient and family members. The analysis materialized two sub themes that nurses’ experiences most. This theme describes the importance of communication tools such as language and the use of interpreters. Language as an important instrument and experience of using interpreters presented as subthemes.

5.1.1 Language as an important instrument
Nurses admit the importance of language in conveying information and in developing care relationship between the nurse and the sick children and their family members. Language helps to transfer information, such as treatment protocols and other information regarding the patient transmitted. This helps information to be conveyed clearly and without ambiguity to the patient. Nurses asserts that language is very important while transmitting information in cancer treatment to the child and his family from diverse cultural backgrounds (Pergert, Ekbald, Enskär and Björk, 2008b; Munet-Vilaro, 2004). Nurses consider language as an important tool in developing caring relationship between the patient/family and the nurse and they believe that language problem is the main hindrance to caring relationship (Pergert, Ekbald, Enskär and Björk, 2007).

Nurses’ experiences’ that language is the main factor that challenges nurses’ in understanding children with cancer and their families. And also nurses believe that language is the main barrier that has a major impact on their ability to care for a culturally diverse patient and this barrier restricts their relationship with patients’ families. This barrier also affects families’ understanding information that comes from the nurses. This language problem leads to obstacles in sharing information and even impede care and caring relationship (Munet-Vilaro,
The following quotations are taken from the article and presented as follows:

“But it’s the language more than anything else, because when I think about those families that have learnt Swedish, there you get a completely different relationship automatically” (Pergert et al., 2007, p.319).

Nurses expressed that differences in language is the main factor in their involvement with the patient and family members. Families with limited language proficiency can’t have conversation with the nurse and it is also difficult for the nurse to give information regarding the caring process. The family members can’t acquire information about their child’s health status which affects the caring situation and even a family’s experience and expectations could be affected if the patient and the family members subjected to this difficulty and affects the caring process and nurses experiences uneasy relationship with the care seekers due to the mentioned problems (McKinley and Blackford, 2001). Limited or lack of language ability enforces the nurses to spend more time in explaining and informing the patient/family members (Munet-Vilaro, 2004).

“What I think is missing is the close contact, because you can never chat” (Pergert et al., 2007. p.319).

The higher language differences between the nurses and the care receiver, the minimum becomes the caring conversation which can create weak transcultural caring relationship (Pergert et al., 2007).

5.1.2 Experiences of using interpreters

Nurses admit that when they experiences difficulties in understanding the sick child and the families, they are required to find a solution. At such times they forced to use interpreters. Nurses acknowledge that using interpreters is an important solution to solve linguistic differences but also they experiences difficulties in using interpreters (Pergert et al., 2007, Pergert et.al, 2008b). Nurses believe that the importance of interpreters in delivering caring in a culturally competent way is undeniable and proven to be useful in minimizing the gap between the nurses and the sick child and his families, but nurses believe also that the interpreters should trained not only in language but also have knowledge or trained in medical terminologies, the use of appropriate cultural norms and protocols to communicate health care information if it is wished to avoid the above mentioned (Munet-Vilaro, 2004).

“One should have an interpreter for an hour every day or something... that you book an interpreter every day irrespective of whether there is anything... there is always something...” (Pergert et.al., 2008b, p.39).

Nurses argue that interpreter dependency creates a loss of information and can invite misunderstanding. During translation they are forced to give much information at a time and as a result of that information compacting results. In addition to the above mentioned nurses experiences the use of interpreters takes more time than to communicate directly and as a consequence affects the caring relationship. Sometimes interpreters themselves create problems. At this time nurses affected greatly and as a consequence of that kills the precious time that belongs to other patients. The lack of trust towards the interpreter from the child’s family makes the interpreter thrives to build his/her relationship with the family and creates interference with the nurse’s improvement of transcultural caring with the family (Pergert et al., 2007). The flowing is taken from the article:
“...an interpreter who become completely committed to a family and opposed or questioned the doctor and took over. Instead of interpreting, the interpreter started to discuss with the doctor and to have his own opinions...instead of interpreting the conversation” (Pergert et al., 2007, p.320).

Nurses explained obtaining the interpreter at the right time sometimes is a problem and creates difficult circumstance to their work and affects the family members in such a way that they don’t get information at all. This quote explains the above mentioned:

“... the non English speaking family had been in the unit for a great length of time and it was only on the last morning that the interpreter was able to get through to them. And I think that’s where we fail a little” (McKinley and Blackford, 2001, p. 253).

Moreover nurses experiences that incapable interpreters creates further problem on their interaction with the patient and obstructs caring relationship (Pergert et al., 2007).

5.2 Hinders to the caring situations
It is understood that every caring situation has its own problems. Problems related to culture are the main ones that affecting the caring situation. Lack of cultural competence and associated problems were experienced by nurses while they deliver care to children with cancer and their families. This theme describes how nurses experiences obstacles due to different factors. Those factors presented as subthemes. The sub themes are: Lack of cultural competence, experience of frustration due to conflicts and lack of support and guidelines.

5.2.1 Lack of cultural competence
Nurses acknowledges that health beliefs, suffering, acceptance, and coping strategies are culturally unique to a certain cultural groups so it has been expected that nurses need skills to identify and respond to socio-cultural factors influencing families of children with cancer (Munet-Vilaró, 2004). As nurses meet the child’s family members with another cultural background emerges obstacles; these obstacles might be linguistic, cultural and religious obstacles, social obstacles and organizational obstacles and even experiences challenged while providing care to children with cancer and their parents from other cultural background than their own. Differences that arise due to social interactions between the nurses and those receiving treatment as well as their family members lead to obstacles to caring relationships. Nurses understood that different views on gender roles, religions and traditions can cause problems in transcultural care (Pergert et al., 2007).

Nurses’ experiences obstacles to their work while meeting the family members with another cultural background. Not having competency to other cultures hinders the social and professional interaction between the nurses and the patient/family. As the obstacle grows it affects the mutual understanding between the nurses and the patient/family (Pergert et al., 2007). Nurses already understood even if one is competent in one culture it doesn’t mean that he/she is culturally competent in all circumstances.

“I thought she wanted to nurse the child, but she was saying to me that she did not want to nurse him…I encourage her more to hold her child and eventually she did. And while she was holding her child the grandmother stood behind her and said’ Allah says that you are not to let your tears drop when your child dies, or have them fall on the child because that means you will have bad luck during your next life” (McKinley and Blackford 2001, p. 254.).
Nurses expressed that they lack knowledge about other cultures. They didn’t have an opportunity to learn about other religious doctrines and cultural beliefs. They had no formal competence and training in cultural competence and admit that their cultural competence were inadequate. They acknowledge the need to be culturally competent, to ease the stress in situations in which they encounter. Lack of cultural competence will influence not only the quality of care but also the working environment and nurses’ satisfaction with the quality of their work. Even most nurses caring for dying children have inadequate knowledge about the grieving process of the family members and even felt uncomfortable when the family members cried (Berlin, Johansson and Törnkvist, 2006, Linnard-Palmer and Kools, 2005, Morgan, 2009).

5.2.2 Experiences of frustration due to conflicts

Nurses use different strategies to safeguard the professional calm that they need to provide good care for children with cancer and their parents. Many nurses’ experiences difficulty and frustration in delivering care to sick children and their parents due to transcultural encounters. They admit caring for children with cancer is itself a challenge, and to support the parents of the children require sensitivity to their individual needs. Overwhelming emotional expression by the relatives is so threatening that the nurses affected and it becomes a great problem to their professional composure. When parents express strong feelings in a way that the nurses interpret in their own cultural background, it becomes unacceptable to the nurses and sometimes they reach in the verge of losing control. Anger, threats and bad language are some of families’ expressions of frustration. Sometimes the expressions are so high and intimidating that nurses feel their professional composure affected. Such emotional expressions by relatives affect the relationship between the nurses and the child’s family itself (Pergert et.al, 2008a). This can be seen in the following quote: “…they become so furious that, and then pushing, yelling and going on” (Pergert et.al, 2008a, p. 650).

Another type of conflict that emerges between the parents and nurses are when parents refused medical treatment to their child due to religious beliefs. A great problem created when the view of the nurses differs that of the families (Linnard-Palmer and Kools, 2005).

“Well, us older nurses have seen this many times. Sometimes it is just like walking into a black cloud... you know, like a storm, and them trying to navigate the whole thing through.... I don’t think you can get any larger of an ethical dilemma... who knows what really to do and how to think? I think that time heals the tension.... But, meanwhile I just concentrate on the needs of the child, even if the parents are upset, turn their backs on me, stomp out of the room... I just keep my focus on the child” (Linnard-Palmer and Kools, 2005, p. 53).

Nurses explained how difficult to manage the vast number of family members in times when an important information has to transmit to the parents about the sick child. The reason is that the parents often prefer the presence of a wider circle of their members (McKinley and Blackford, 2001). One participant explained like this:

“Every time the doctor wanted to speak to the mother and the father, the whole family would arrive” (McKinley and Blackford, 2001,p. 253).

Nurses’ experiences difficulty in dealing with parents various expectations and problematic backgrounds. Experienced that their practice were in disagreement with that of the families and as a result created discomfort for them. As a result of this nurses prefer avoid the assumed problem family by retreating either by requesting a change in patient assignment or
using other means that would not include the family (Berlin, Johansson and Törnkvist, 2006, Linnard-Palmer and Kools, 2005, McKinley and Blackford, 2001).

“Sometimes I just step back, just to get out for a while, when it, when it gets to be all just too much to handle” (Linnard-Palmer and Kools, 2005, p. 54).

The difference in views between the nurses and the child’s families create a great problem. During this time the nurses chose to continue their work and provide care to the child, but when the crisis never stops expresses their feelings like this:

“You know, I listen . . . I grit my teeth . . . I stay involved but I really wish I knew more about my rights . . . my legal responsibilities . . . whose side am I suppose to be on? Sometimes the nurses do not know how much of their emotions are expressed during their silence with the parents . . . they use silence because they are afraid to say anything that might get them in trouble, you know, with the law and all . . . they just go in and do the treatment and get out . . . unsure of what their legal rights are” (Linnard-Palmer and Kools, 2005, p. 54).

Nurses choose to distance themselves to avoid conflicts. They keep themselves busy in order to avoid the so called a troublesome family member. Nurses experienced that this types of strategies help them to escape conflicting environments (Linnard-Palmer and Kools, 2005).

5.2.3 Lack of support and guidelines
Nurses’ experiences lack of support from their superiors and other health care team members. This lack of support creates stress and affects their professional capability in delivering care to the sick child (Morgan, 2009). Nurses expressed that they were given extra responsibility that normally belonging to other staff members or physicians and due to this they experiences unsupported by others (Papadatou, Martinson and Chung, 2001). A nurse expressed her frustration like this:

“I am too busy to stop and care. There are too many tasks and not enough time to complete them. I am left alone to make complex and difficult decisions about patient care, or perform medical orders without adequate support. I am alone to provide care for several sick children without adequate backup, time even knowledge” (Papadatou, Martinson and Chung, 2001, p.409).

Nurses underline the importance of organization in delivering transcultural caring. The organization is expected to deliver the necessary resource and guidelines to the workers in order to avoid such obstacles related to routines and other factors (Pergert et al, 2007).

Nurses accuse the guidelines when they do not come to an agreement with their colleagues towards a common goal. Nurses in this facility believes that they play a crucial role in communication with the child’s family and even have a valuable insight into the prediction of progress of a disease that the child suffers from. As a result of which they felt unsupported by their colleagues. Those nurses argue the significance of clear instructions as very important in their work (Papadatou, Martinson and Chung, 2001).

Giving care to children suffering from diseases is not easy and needs an understanding between co-workers. Though the sensitivity nurses’ experiences that their feelings were not supported and even understood that other coworkers don’t listen to them. A nurse presented here feelings like this:

18
“the doctors and parents had in a sense stopped listening. I said that it would be good to move the little boy in with the parents, in their bedroom in the last week, but nobody wanted to take on board the fact that the little boy was so poorly and needed to be closer to everyone” (Gray and Smith, 2009, p. 258).

Nurses disagree that culture is not the sole responsible problem in not giving competent care to children with cancer and their families. The health care system itself affects the caring relationship due to lack of specific guidelines. The healthcare systems should be designed to satisfy all patients, this include structural changes that reduces for example waiting hours so in that context prevents anger and racial attitude from the patient side and improves the nurse-patient relationship (Pergert et al, 2008a). Lack of support experienced by the nurses creates a moral and ethical distress, and many nurses forced to change or leave their work environment (Morgan, 2009).

5.3 Aspirations for further improvement
Nurses are willing to make change and progress in their professional encounter with patients and their families. Nurses have a great deal of contacts with the patient and families and having knowledge about others culture is important. This paves the way in becoming cultural competent in delivering care. Having time with patient and family members is also considered very important in understanding the patient and family member’s beliefs, values and cultural norms and helps the nurse in delivering best possible care. This theme presents two subthemes under the sub headlines of: desire for more exposure and need for further education.

5.3.1 Desire for more exposure
Nurses explained the importance of more time with the child patient and his families. Nurses argue that the organization has responsibilities in providing suitable conditions for the nurses to have more time training in order to decrease transcultural problems. Avoiding obstacles to transcultural caring relationship consumes time; believe nurses (Pergert et al., 2007., Pergert et al., 2008b).

“More time ….TIME, time is the key to almost every problem” (Pergert et al., 2008b. p.40).

Nurses experienced limited time that is too short to establish a caring relationship. “Then there is the time aspect, this sitting by the bedside and talking...[with] someone who speaks perhaps just a little, little Swedish...it will take much more time. But if I go in and talk a little with a Swedish family... it’s a smaller project” (Pergert et al., 2007, p. 323).

Developing caring relationship takes more time due to the strength of the existing obstacles. Lack of sufficient time affects the caring outcome in a negative manner.

5.3.2 Need for further education
Nurses’ give weigh for importance of knowledge about cultural competence in order to avoid difficulties that arise due to misunderstanding with the sick child and his/her families. And learning specific religious/cultural information identified by nurses as a main tool in resolving problems (Berlin, Johansson and Törnkvist 2006, Linnard-Palmer and Kools ,2005, 2006, Morgan, 2009, Pergert et al., 2008b). A nurse expressed her frustration like this:

“I think that what is missing is that in nursing training, not just curriculum, but when you go to the hospital, you are not prepared for it... I have always wondered why we didn’t have a better training in terms of culture, religion, and legal stuff...what to say and, what
“to expect, and where I can look stuff up... how can I approach this without a knowledge base?” (Linnard-Palmer and Kools, 2005, p.54).

Nurses believe that cultural knowledge is necessary to improve their interactions with the sick child and the family and help them deal with difficulties that involving their interactions and underline the need for further education (Berlin, Johansson and Törnkvist, 2006).

“More knowlege and being able to understand the cultures and then stilll to be allowed to talk about your prejudices... ” (Pergert et al., 2008b, p.40).

Nurses consider opportunities for cultural learning and further education as an important solution in resolving crises that arise due to cultural differences. This helps them to deliver culturally sensitive health care that addresses the child’s and the family’s culture and values as important aspects (Pergert et al., 2008b).

5.4 Result synthesis
The present findings indicate nurses’ experiences problems that encountered due to difficulties associated with communication. Differences in language proved to be the main factor that creates bad nurse-patient interactions. As an instrument nurses use interpreters to solve those problems that created due to language problems. But even if the use of this instrument is very important nurses’ also experienced difficulties in using interpreters. Obstacles such as lack of cultural competence, frustrations due to difficult relationships with the family members and not having specific guidelines and support also indicated in the result. The result also shows the nurses’ experiences of aspiration for further improvement. Further development is the core of the nursing profession, where nurses meet human beings and care for them. Nurses underlined the importance of more time with clients in order to construct a relationship that is important in the care of patients from diverse cultural backgrounds.

6. DISCUSSION
In this part the method discusses thoroughly. The result discusses using studies and theories from the background. Suggestion for further education, ethics discussion and conclusion are also presented under this part.

6.1 Method discussion
The right choice of methodology was necessary to achieve the goals that set to answer questions the author wants to address. According to Friberg (2006) qualitative studies are the best tool that helps to understand and describe one’s experiences. The aim of this study is to describe what nurses’ experiences in connection with the care of children with cancer and their families from other cultures other than their own. Evans (2003) descriptive synthesis used as a method and is considered suitable method to analyze an already existed material with little adjustments. This method helped to explain the problems the author pointed out and above all the aim of the study is the center in the whole process, supported by relevant facts drawn from those previously available articles, and presented the whole idea in a logical manner. This analysis method thought to give creditability in describing the nurses’ experiences. However if an interview; a semi structured interview, were conducted the method would have been more prominent than the above used. According to Polit and Beck (2008) a semi structured interview is an interview where the respondents can develop their ideas and follow-up questions and further helps the participants speak freely about the various issues.
The primary advantage of this method is the capability to generate key findings from multiple studies and considered strong because it is produced from multiple articles. Evans (2003) acknowledges that despite its repeated use, the validity and its utility of the findings of descriptive synthesis has not been adequately investigated.

The whole work is so restricted or narrowed to a certain area that the author forced to thin the search scope and as a result encountered article shortage. When the work started it was supposed to restrict all articles from the year 2004 to 2010. Since the availability of articles five years and earlier is limited, two articles (6A & 6B) from the year 2001 were included in order to compensate this shortage. This might be considered a problem but it was found out that the two articles were considered important to the whole work. Although shortage of articles encountered, all articles considered very useful for the purpose of the work. The Search for articles were made on three different databases; ELIN® mälardalen, CINAHL and PubMed. The results in those three databases were so similar that it was concluded to concentrate only on two databases, CINAHL and PubMed. One of the factors that may have been contributed to shortage of articles is the restriction on search words. The author restricted the search words in order to get articles that best answer the purpose of the thesis. This might be considered as shortcomings but also helped the author not to consume time. Time has been a very sensitive issue since the whole work has been written alone.

The area of the thesis isn’t studied well and the articles that are available were limited. Restricting the articles only to English language didn’t affect the outcome and believed positive since the author is writing the subject in English and considered suitable. If articles other than English has been used the result might have been different than this. All the articles used are western oriented and written in accordance with western cultures. For example three of the ten articles are authored by researchers from Sweden and this makes the outcome in favor of the Swedish culture. Another factor that can be considered as shortcoming is that three articles by the same author were included. Even if all the three articles have different headings and purposes the researchers might exposed to fever one particular area than others and as a result affects the whole outcome unconsciously.

The author of this paper has already considered Evans (2003) analysis method suitable method to this work and measured a good decision. The analysis method stared with reading the result parts of all articles. Re-reading considered important and the author did that. All the four phases of analysis methods were read explicitly in order to get a good impression of the whole method. Here deeper understandings of articles were gained. Identifying key findings and constructing themes and sub themes were not difficult as the author considers the aim of the study all the time. The process of categorizing the similarities and differences of the key findings hasn’t been difficult either. This method enables to generate multiple information and findings from different studies and believed important in evident- based health care.

6.2 Result discussion
The aim of this literature study is to describe what nurses’ experiences in connection with the care of children with cancer and their families from other cultures other than their own. The result from the analysis did yield new information in some contexts and did also support and strengthen the existing theory. The result shows that nurses consider communication as a main tool in their work. The problem that comes from cultural differences considered huge and affects the profession and the professionals.
6.2.1 Influence of communication in caring

Nurses already recognized the importance of communication. However problems emerge when ever nurses meet patients from different cultural backgrounds. Immigration is the main factor that contributes to these differences as many from developing countries migrate to western homogeneous cultures. According to Giger and Davidhizar (2008) nurses feel powerless if they can’t communicate with client and also if the client can’t understand them. According to Andrews and Boyle (2008) communication and culture acquired simultaneously and it is difficult to separate them. Differences in language are the main barrier that influences caring. The result showed that language is the main factor that affects the caring relationship and considered very important especially when caring for children with cancer and their families from diverse cultural backgrounds. There are many reasons for that but problems such as confusion and misunderstandings that arise due to shortage of language proficiency can be easily diverted if appropriate language usage constructed. According to Ow (2003) families have a strong need to receive information about their child’s condition and diagnosis. In order to fulfill this need nurses use a means of communication as their basic tool. This is supported by Giger and Davidhizar (2008) and explained that barriers to communication include differences in language. Language is one of those tools and is a basic instrument to communication and it shapes and influences cultural perceptions. Leininger (1995) also agrees on the importance of ability of communication in a cultural context and underlined that nurses who are skilled in that are capable in providing culturally competent care.

The result shows that communication problems due to language differences between the sick child and family members cause huge misunderstandings. But perceptions like time, space, distance and other factors influence the outcome in which the nurse and the patient/family members understand each other. Andrews and Boyle (2008) agree that language as an instrument considered a main factor determining the outcome of nurse- patient relationship. As part of communication skill, good language proficiency results in constructing culturally competent care. Hannsen (2007) agrees that communication problems limit patient’s abilities to express his/her attitudes and feelings thus results in misunderstanding between the patient and the nurse; but it is also described that the nurse can decrease the problems using non-verbal communication as an alternate means of communication.

The result showed that the use of interpreters experienced as an alternative to minimize the challenge created due to language difficulties in caring for childhood cancer patients and their families from diverse cultural backgrounds. These are supported by Giger and Davidhizar (2008) and signify that when the nurse and the patient can’t speak the same language it is important to use interpreters. The interpreters expected to be well skilled in order to translate not only the verbal ones but also the non verbal messages that are additional to the formal communication. Even using interpreter has its own shortcomings. Further expressed Giger and Davidhizar their doubt about the use of interpreters as communication through a third person invites lose of messages in action. This creates a problem for nurses. The result showed that in order to avoid problems that created through using interpreters nurses forced to take more time with the patient and make sure all the information are understood by the child or his families. Even though taking more time considered negative it has some advantages in constructing positive relationship with the patient and the nurse. This is supported by Andrews and Boyle (2008) and tells that when using interpreters’ nurses have to expect the time spends with the patient going to be more. This helps to gain better interaction with the sick and the family members and even paves a way for transcultural caring relationship. As described in the result part nurses experiences problems due to interpreter dependency. Problems such as loss information and misunderstandings are some of the problems that encountered while using interpreters. According to Hanssen (2007) using interpreters have
positive and negative sides depending on factors around the interpreters; for example using family members as an interpreter can cause damage to patient-nurse relationship. One reason is that family members usually do not have the ability of interpreting medical words in such a way that the nurses can understand.

6.2.2 Obstacles to culturally oriented nursing care
Culture is the main factor that affects every individual’s behavior towards the health care provider. How the nurse care for patients is also influenced by culture. Not having ability and knowledge to communication and not having an understanding about health care behaviors that influenced by culture are the main obstacles to culturally competent nursing care. Leininger (1995) supports the above mentioned and advice nurses to think about people’s similarities and differences regarding their culture and have to develop different ways to help their clients. As described in the result part the lack of cultural competence is the main hinder in delivering culturally sensitive care. This outcome is supported by Thibodeaux and Deatrick (2007) that a family's cultural background directly influences how they define and manage their child's cancer. Giger and Davidhizar (2008) also reinforces the above mentioned and signify that a nurse who doesn’t accept the importance of culturally appropriate care cannot probably be an effective care giver. Having knowledge about culture is very important. According to Leininger (1995) culture is the values, norms and practices of a particular group that the nurse has to take in considerations. Andrews and Boyle (2008) also states that culture plays a fundamental and critical role in shaping people's values, beliefs, and perceptions and is a blueprint for determining one’s beliefs and practices. Having this in mind nurses have to appreciate other cultures as a means of their expression. Nurses have to know and appreciate their own culture in order to become culturally competent care givers. According to Leininger (1991) the nurse who has knowledge about culture care would plan, make decision and deliver best care to his/her clients.

According to the result when a child is diagnosed with cancer; not only the child but also family members affected. According to Björk (2008) caring for children with cancer is one of the most difficult areas in nursing. The nurse expected to deal with the family members equally to ensure the wellbeing of the whole family; which is important to the health of the sick child. The nurse in this facility cares not only the child with cancer but also expected to give support and provide information to family members. Due to the complex responsibility and the enormous contact with the families nurses experienced difficulties in dealing with families of childhood cancer patients from different cultural backgrounds due to cultural differences. Woodgate (2005) mean that the child’s suffering changes the family’s way of life in an irreversible manner. According to Eriksson (2006) parents of children suffer so much in their child’s suffering. This affects the family’s emotions and attitudes in such a way that they become easily emotional to conflicts. The United Nations convention on the rights of the child (UN, 1989) stated that the child has to receive best possible health care no matter what problem encountered and even Competence description for nurses (Socielstyrelsen, 2005b) depicted that the nurse has to act according to the patient’s needs and necessities.

The result showed that nurses expressed that cultural difference is the main factor that affected their relationship with the sick child and the family members. Nurses acknowledge that cultural differences are the main factor that challenges their responsibility and activity. Giger and Davidhizar (2008) hold true that misunderstanding emerges when nurses practice their own culturally specific values onto the patient and the family members. The result also found out that numerous factors affect the relationship between the nurses and patient- family members. This is supported by Rollins (2005) and Björk (2008) that the sick child and the family members subjected to stressors related to hospitalization.
It is emerged in the result that the child is diagnosed with life threatening illness that the family’s expectation that seen their child survived reaches the lowest limit and resulted in frustration and confrontation. This lived experience by the sick child and family members is resulted in suffering. Eriksson (2006) supports the above mentioned and used different forms of suffering in her theory. The patient experiences all the three types of suffering, suffering that comes from the illness itself, the suffering that experienced from hospitalization and the suffering of life. The families in the other hand experienced the suffering of life as their existence is challenged by their child’s sickness. Furthermore the family members can suffer and affects from hospitalization processes and environment. All the mentioned factors as well as personal factors can affect families’ expectations towards the caring situation and the result become difficult nurses- family members’ relationship. In order to challenge and even eradicate the problems culturally competent care is rigorously evident. This is supported by Campinha-Bacote (2007) that nurses should understand differences that arises through cultural differences and strives to provide best possible care.

6.2.3 Factors that favor cultural competency
Cultural competence is a continuous process where nurses acquire knowledge through education and practice. Knowledge about culturally appropriate care is very essential to develop culturally competent care. According to Giger and Davidhizar (2008) culturally sensitive environments favors and assists nurses in providing culturally appropriate nursing care. The result finds out that different factors affects and further restricts nurse’s capacity to deliver care in a cultural context. The result proved that nurses experienced lack of support and guidelines and affected by that and nurses argue that the leaders in this organization have to asses those problems that can cause barriers and transmits negative messages to the patient/family members. The result also found out that nurses want to learn and have knowledge about other cultures in order to ease the difficulties that arise due to cultural differences. This attitude is supported by Andrews and Boyle (2008) that primarily the nurse itself is responsible for his/her own knowledge development about patient’s culture. But leaders in this facility have to understand and recognize the importance of culturally based administrative practices. The organization has to be adequate in teaching nurses in order to meet the criteria in which patients and families of patients trust the health care given to them and further strengthen a good relationship.

National Board of Health regulations and guidelines on Quality of Health Care (SOSFS 1996:24) states that the nursing profession is required to have plans for skills development and training that answer a good care outcome. The regulation might not exactly discuss which types of trainings have to be included but it should include trainings that focus in cultures. According to Leininger (1995) when nurses challenged the cultural differences and become culturally competent it does mean that the organization also becomes culturally competent organization. Without the whole organization the nurse alone can’t make a significant change. The result showed that nurses’ argue the organization should strive to avoid misunderstanding between the nurses and even try to develop a supportive working environment and further set guidelines that help the best caring outcome. According to Leininger (1995) the organization has to give priority to education where nurses develop cultural knowledge and attitude.

6.3 Suggestions for further research
In the process of this work the author found out that this area is not well developed. Further research should be conducted in this particular area. Having knowledge about what nurses’ experiences in the course of caring can be used as a lesson for further education for other nurses. Many researches emphasizes on patient perspectives these however do not necessarily mean that these are not important but studies having nurse perspective in this particular area
are also very important. An interview research that focuses on the nurses’ experiences with a greater scale is considered very important for this young area. This helps to identify new factors that influence the relationship between the nurse and the patient in a cultural context.

6.4 Ethics discussion
According to Polit and Beck (2008) in every research the one who performs the study has to formulate an ethical guideline and follow it throughout until the work completes. It is important to have a neutral stance and attention has been given to it. Literature study is one of those qualitative studies and it is important that the author should distance itself and analyze the work without ambiguity. In this thesis attention was given to ethical considerations and problems that associated with ethics were not experienced.

6.5 Conclusion
The result in this thesis shows that nurses’ experiences a great deal of problems due to shortage of sufficient knowledge regarding nursing in broader cultural contexts. Too meet all expectations the nurse has to be experienced in identifying the needs of the patients as well as the family members and has to even respond according to it. More over nurses have to work out to widen their scope on cultural knowledge and even strive to attain cultural competency. Nurses have to have desire to learn about others culture and even see their own culture as a starting point in developing their skills. In this multi cultural society nurses expected to be culturally competent. Nurse should gain the possible knowledge about culture through education and attain the competency that today’s nursing care requires.
REFERENCES


## 10. Appendix 1

Presentation of themes and subthemes

<table>
<thead>
<tr>
<th>Code to articles, Page</th>
<th>Key findings</th>
<th>Theme</th>
<th>Sub theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>6A, 157</td>
<td>Nurses identified that communication with families unable to speak English was at times inadequate.</td>
<td>Language as an important instrument</td>
<td>Language as an important instrument</td>
</tr>
<tr>
<td></td>
<td>The higher the linguistic diversity the greater the lack of caring conversation and chatting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1A, 157</td>
<td>Limited or lack of language proficiency by the care receiver require that nurses spend more time and resources to ensure the information is clearly understood</td>
<td>Importance of communication in caring</td>
<td>Experience of using interpreters</td>
</tr>
<tr>
<td>2A, 38</td>
<td>Communication in care is about sharing information, both medical and nursing</td>
<td></td>
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<tr>
<td>2B, 319</td>
<td>The use of an interpreter means that the health care staff lose control over the information that is given to the family</td>
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<tr>
<td>6A, 253</td>
<td>Failure to use interpreter adequately meant the information couldn’t transmit to the family.</td>
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<tr>
<td>Code to articles, Page</td>
<td>Key findings</td>
<td>theme</td>
<td>Sub themes</td>
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<tr>
<td>4B, 164</td>
<td><em>Nurses expressed difficulties in dealing with the parents’ various expectations</em></td>
<td></td>
<td>Lack of cultural competence</td>
</tr>
</tbody>
</table>
| 4A, 650               | *Expression of anger such as raising one’s voice, intonation, screaming and using bad language*  
*Overwhelming emotional expressions by the family members create unfamiliar situation* |       |     |
<p>| 6A, 254               | <em>The nurses’ practices were in conflict with the family practice</em> |       |     |
| 3A, 54                | <em>Nurses experience the need to retreat from their responsibilities due to conflicts with the family</em> |       |     |
| 2B, 321               | <em>Different views on gender roles, religion and tradition causes problems in transcultural care</em> |       |     |
| 5A, 88                | <em>Barriers may occur when health care providers prevented from acting according to their personal values and professional standards</em> |       |     |
| 5B, 258               | <em>Frustration occurs when providers do not share the same perspectives and goals for a patient.</em> |       |     |</p>
<table>
<thead>
<tr>
<th>Code to articles, Page</th>
<th>Key findings</th>
<th>theme</th>
<th>Sub theme</th>
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</thead>
<tbody>
<tr>
<td>6B, 409</td>
<td><em>Nurses reported that they were charged with extra responsibilities that normally belonged to others</em></td>
<td>Lack of support and guidelines</td>
<td></td>
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<tr>
<td>4B, 166</td>
<td>Workloads and lack of guidelines contribute to experience of difficulty</td>
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<tr>
<td>Code to articles, Page</td>
<td>Key findings</td>
<td>theme</td>
<td>Sub theme</td>
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<tr>
<td>2A,40</td>
<td><em>practice is important in decreasing obstacles</em></td>
<td>Aspiration for further improvement</td>
<td>Desire for more exposure</td>
</tr>
<tr>
<td>2B,323</td>
<td><em>Lack of time an obstacle for exposure</em></td>
<td></td>
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<tr>
<td>4B,165</td>
<td><em>Nurses thought training is important</em></td>
<td></td>
<td>Need for further education</td>
</tr>
<tr>
<td>2A,39</td>
<td><em>Transcultural learning is important</em></td>
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<tr>
<td>3A,53</td>
<td><em>Learning cultural information resolves conflict</em></td>
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<tr>
<td>5A,89</td>
<td><em>Nurses reported the need for adequate knowledge</em></td>
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## 11. Appendix 2

Summary of articles selected to be analyzed

<table>
<thead>
<tr>
<th>CODE</th>
<th>ARTICLE</th>
<th>AIM</th>
<th>METHOD</th>
<th>RESULT</th>
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</thead>
<tbody>
<tr>
<td>B</td>
<td>Pergert, P., Ekbald, S., Enskär, K., &amp; Björk, O. (2008b). Bridging obstacles to transcultural caring relationships- Tools discovered through interviews with staff in pediatric oncology care. <em>European Journal of Oncology Nursing</em>, 12(3): 35-43.</td>
<td>The aim is to gain knowledge about how healthcare professionals solve problems that hinder transcultural caring relationship with families of immigrant backgrounds.</td>
<td>A qualitative method with purposive and convenience sampling, three focus group, and five additional individual interviews were conducted.</td>
<td>Their main findings focus on&quot;bridging&quot; [dealing with obstacles to communication and to transcultural caring relationships]. In order to avoid obstacles to transcultural nursing the article presents different tools to overcome the problems. The tools include communicational tools, transcultural tools and organizational tools.</td>
</tr>
<tr>
<td>B</td>
<td>Pergert, P., Ekbald, S., Enskär, K., &amp; Björk, O. (2007). Obstacles to</td>
<td>The aim is to describe the health situation of families</td>
<td>Qualitative study. Grounded Theory. Focus group interviews with</td>
<td>The result shows that linguistic, cultural and religious</td>
</tr>
<tr>
<td>Transcultural Caring Relationships: Experience of Health Care Staff in Pediatric Oncology. <em>Journal of pediatric oncology nursing</em>, 24(6): 314-328.</td>
<td>with an immigrant background from health professionals' perspective.</td>
<td>health professionals and individual interviews with five nurses.</td>
<td>obstacles, social obstacles and organizational obstacles are the main concern of health care professionals.</td>
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<tr>
<td><strong>Linnard-Palmer, L. &amp; Kools, S. (2005).</strong> Parents' refusal of medical treatment for cultural or religious beliefs: an ethnographic study of health care professionals' experiences. <em>Journal of Pediatric Oncology Nursing</em>, 22 (1): 48-57</td>
<td>The purpose of the study is to investigate the experience of nurses working with culturally diverse children patients.</td>
<td>Qualitative study. An ethnographic design. In depth interview with 20 nurses, and field notes used.</td>
<td>The findings of the study uncovered dilemmas surrounding treatment refusal in pediatrics, the impact of the situation on the nurses’ health and stress levels, and functional status also explored.</td>
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<tr>
<td><strong>Pergert, P., Ekbald, S., Enskär, K., &amp; Björk, O. (2008a).</strong> Protecting Professional Composure in Transcultural Pediatric Nursing. <em>Qualitative Health Research</em>. 18(5): 647-657.</td>
<td>The study’s purpose is to acquire knowledge about nurses’ experiences of emotional experiences while caring for families with foreign background.</td>
<td>Qualitative study with exploratory study, grounded theory used.</td>
<td>The study finds out that overwhelming emotional expression by the relatives is so threatening that the nurses affected and it becomes a great problem to their professional composure.</td>
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<tr>
<td><strong>Berlin, A., Johansson, SE. &amp; Törnkvist, L.(2006).</strong> Working conditions and cultural competence when interacting with children and parents of foreign origin--Primary Child Health Nurses'</td>
<td>The study’s aim is to investigate primary child health care (PCHN) nurses regarding their work and cultural competence while encounter with culturally diverse child/families.</td>
<td>A total of 270 PCHN nurses respond to a questionnaire, the outcome variables were analyzed using logistic regression (approach prediction method).</td>
<td>The result shows that many of the nurses are not satisfied with their work due to lack of inadequate working conditions, quality of healthcare they are delivering and due to lack of</td>
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<td></td>
<td>Opinions, Scand J Caring Sci. 20(2):160-8.</td>
<td>The aim of the study is to clarify the needs of dying pediatric patients and their families and to investigate the needs, impacts, interventions of nurses in this facility.</td>
<td>A literature review, clinical workshops, observations, personal nursing experiences.</td>
<td>The study acknowledges how pediatric palliative nursing care is both rewarding and stressful.</td>
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<tr>
<td>5 A</td>
<td>Morgan D (2009). Caring for Dying Children: Assessing the Needs of the Pediatric Palliative Care Nurse. Pediatric Nursing. 35 (2): 86-92</td>
<td>The aim of the study is to clarify the needs of dying pediatric patients and their families and to investigate the needs, impacts, interventions of nurses in this facility.</td>
<td>A literature review, clinical workshops, observations, personal nursing experiences.</td>
<td>The study acknowledges how pediatric palliative nursing care is both rewarding and stressful.</td>
</tr>
<tr>
<td>5 B</td>
<td>Gray, B. &amp; Smith, P. (2009). Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London. Nurse education in practice. 9(4): 253-261.</td>
<td>The aim of the study is to investigate and show emotions of nurses while caring.</td>
<td>Qualitative study, data collected using in depth and semi-structured interviews. Primary care, mental health and children’s oncology nurses participated.</td>
<td>The results show the variety of ways in which nurses expresses their emotions and experiences.</td>
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<td>1. Structural boundarie s 2. Controllin g communic ation 3. Cultural practices in death of a child</td>
</tr>
<tr>
<td>6 B</td>
<td>Papadatou D, Martinson IM, Chung PM. (2001). Caring for dying</td>
<td>The aim of this study is to explore and compare the subjective</td>
<td>Qualitative, descriptive study. Four research questions were</td>
<td>The findings show that nurses experiences a great grief and</td>
</tr>
<tr>
<td>children: a comparative study of nurses' experiences in Greece and Hong Kong. <em>Cancer Nurs</em>; 24(5):402-12</td>
<td>experiences of nurses in pediatric oncology from two different cultures.</td>
<td>distributed to 63 nurses.</td>
<td>sense of helplessness when caring dying childhood cancer patients and also difficulties with the child &amp; families during the last phase of the disease.</td>
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