

Master's thesis

International Social Welfare and Health Policy

November 2019

**Conflicts between nurses and next of kin with ethnic minority
backgrounds: a qualitative study**



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Acknowledgement

After several months of hard work, serious dedication and plenty of frustration, I have come to the point that I have finally finished my master's thesis. Along this road, I did not know if the thesis was going to finish me before I finished the thesis! However, I could not have finished my master's thesis without some help.

I would want thank all the nurses who took from their busy schedule to participate in this master's thesis. I also want to say thank you to the representatives at Pårørendesenteret in Oslo and Pasient- and Brukerombudet for participating in this master's thesis. I also want to thank the next of kins that took the time to talk to me and share their stories. I am grateful that they opened up to me and were willing to share their experiences.

I would like to thank my supervisor Kjetil Wathne from Oslo Metropolitan University for agreeing to be my supervisor and for helping with me with my research. I also really appreciate that he was always available if I had questions or needed some help. Thank you so much for giving me a pep talk whenever I needed it.

I also want to give a big shout out to my friends who were cheering for me. Last but not least, I want to thank my family for supporting me and for their encouragement throughout my studies and while I was conducting my research. Especially, I want to thank my mom who has always been my number one supporter and who has always believed in me.

This master's thesis is dedicated to the memory of my late dad who I know would have been very proud of me.

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Oslo, 2019

Abstract

Background: Through the years, the Norwegian society has gone from being a homogeneous society to being a multicultural society. This means that nurses and other healthcare personnel in Norway are having to deal with patients with ethnic minority backgrounds more often than ever before. When there are patients, there are usually next of kin. This means that nurses and other healthcare personnel are also having to deal with next of kin with ethnic minority backgrounds.

Aim: The aim of this master's thesis is to gain a better understanding of the conflicts that can arise between nurses and next of kin with ethnic minority backgrounds.

Method: This master's thesis is based on semi-structured interviews with nurses and next of kin and two representatives from two organisations. Thematic analysis was used in the data analysis.

Results: Role expectation at Norwegian hospitals and other care institutions caused conflict between nurses and the next of kin with ethnic minority backgrounds. Communication caused conflicts between nurses and the next of kin with ethnic minority backgrounds. Family relations can cause both stress and conflict between nurses and next of kin with ethnic minority backgrounds. The next of kin experienced prejudice. The nurses expected that people who immigrate to Norway should adapt to the Norwegian system but that one should show understanding that people do things differently.

Conclusion: Norway is becoming an increasingly multicultural society, meaning that the nurses will increasingly face both patients and next of kin with ethnic minority backgrounds. It is important to remember to ask the next of kin with ethnic minority backgrounds what is important for them and the patients since the nurses cannot know everything about every culture there is. The conflicts that are identified here do not only apply to nurses, and not every interaction between a nurse and next of kin with ethnic minority backgrounds results in conflict; instead, it is situational and depends on the individuals involved.

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Chapter 1 - Introduction

It can be a challenge for people to immigrate to a new country. People who immigrate to Norway face many expectations and are expected to integrate into the Norwegian society. This means that the person is included into the society, so that person is tied together with the majority group. However, some people expect them to assimilate into the Norwegian society, meaning that they should adopt Norwegian traditions, culture and values. In this way, the majority group wants to reduce the gap and reduce the level of difference between the minority groups and the majority group. Through the years, however, the Norwegian society has gone from being a homogeneous society to being a multicultural society. With the increasing number of patients of an ethnical minority background, nurses and other healthcare personnel must increasingly interact with patients who are not ethnic Norwegians. In many cases, patients come with next of kin. This means that nurses and other healthcare personnel also have to interact with next of kin with ethnic minority backgrounds. This can pose some challenges for the nurses and other healthcare personnel. Challenges that they can meet is the language barrier and the cultural differences, especially since some cultures have a strong collectivistic mindset.

When people interact with each other, they step into different roles. The Canadian sociologist Erving Goffman looks at roles as rights and obligations that are attached to a person's social position, meaning that the next of kin step into the role as a next of kin, and face expectations on how the next of kin should behave at hospitals and other healthcare institutions. As well for the nurses, there is also set of expectations for how a nurse should behave. When these expectations are not met, conflicts can arise.

The next of kin is considered in many ways to be an important resource to the healthcare personnel. The next of kin can help the healthcare personnel to understand the patient, since they have knowledge about the patient's life. Generally, the next of kin wants the best for the patient. They can also provide healthcare personnel with important information about the patient's wishes and what the patient appreciates the most in their life.

During a speech at a conference about next of kin, the Minister of Health Care Services Bent Høie (2018) stated that:

"We, the next of kin know the patient's history - because it is our own story. It makes us a unique resource. It makes us a vulnerable resource. It makes us a resource that is very important to protect." (Helse- og omsorgsdepartementet. 2018).

With this speech he sought to demonstrate that the next of kin are an important resource and that they also carry vital knowledge for the nurses and other healthcare personnel that encounter the next of kin every day at work. In this speech, he also mentioned that next of kin is a resource for the society. Both the next of kin and nurses want the best for the patient. However, sometimes, conflicts can occur as a result of cultural differences and a language barrier. Therefore, the next of kin and nurses can meet challenges when they have to interact with each other. When someone does not understand the language or they do not see the familiar values and norms from their home country, it might create insecurity, which can lead someone to become more conservative in their new country.

My interest for this topic came from my experience as a next of kin and my interest in multiculturalism. As next of kin, one becomes familiar with what is happening 'behind the scenes' and one gains a new understanding of the Norwegian healthcare services. As reported by two of the participants, there is one thing to be a next of kin, but it is another thing to be next of kin with ethnic minority backgrounds. I was curious to see how nurses and next of kin with ethnic minority backgrounds interacted with each other. This is why I have chosen to do research about this topic. It is also important to prevent misunderstandings and resolve conflicts between nurses and next of kin with ethnic minority backgrounds.

1.2 The background of the Norwegian healthcare services

The Norwegian welfare system is based upon the social democratic welfare system. This model is characterised by universality, meaning that the state's goal is to ensure equality. In the social democratic welfare system, most of the welfare benefits are universal. Universal benefits refer to benefits that are not only non-means-tested but also non-contributory, and which are generally financed through taxation (Fitzpatrick et al. 2006). Thus, regardless of culture, religion and belonging, the Norwegian healthcare system should offer equal healthcare services. All hospitals in Norway have a policy of ensuring that everyone is offered equal healthcare services.

The Norwegian healthcare personnel are educated according to the Western healthcare model. The Western healthcare model is based on the understanding of the natural science, where illnesses are diagnosed after certain criteria. Healthcare services in Norway are usually public, but though some aspects of the healthcare services are private.

When a patient comes in contact with the Norwegian healthcare services, it is usually through their family doctor whose responsibility is to coordinate the patient's medical needs. They can also refer someone to a specialist. Even though Norway has a social democratic welfare system, a patient can be referred to privately contracted specialists. A person who is in need of psychiatric can be referred to a district psychiatric center. Psychiatric patients who are sicker can be admitted to an emergency ward at the hospital.

Norwegian healthcare services are divided into different regional health authorities. The different regional health authorities are responsible for the provision of special health services for the population in their region. They also own the region's public hospitals. The different public hospitals in the regions are organised into health enterprises, which are governed by the regional health authorities. For conditions that require admissions, the patients are referred to hospitals, and the patient can choose which hospital they want. The patient can also choose to be treated at a private hospital that has an agreement with the regional health authorities (Helse- og omsorgsdepartementet. 2014).

1.3 Immigration to Norway

As mentioned before, throughout the years, Norway has evolved into a multicultural society, from being a homogeneous society in the early years. Norway experienced emigration to other countries, especially to the United States. However, at the end of the 1960s, the immigration to Norway increased. The immigration to Norway can be grouped into three phases.

The first phase of immigration to Norway occurred in the 1960s which happened due to the need for labor. The increase of immigration to Norway was a consequence of other European countries strict immigration policy. In the first phase of immigration, people who immigrated to Norway were mainly men from Pakistan, Turkey and Morocco. They mainly moved to Norway for labour, so they could provide a better life for their families who were in their home countries.

The second phase of immigration to Norway began in the 1975. However, an immigration stop was introduced. This was due to the Norwegian government wanting to improve the living conditions and integration of the immigrants that already were in the country. In 1981, the immigration stop became permanent, making it more difficult for people to travel to and back from their country of origin, and leading people to moving permanent to Norway and apply for residency for their families.

The third phase of immigration to Norway occurred at the end of 1970s. In this phase, the people who immigrated to Norway were mainly asylum seekers. Today's immigrants consist mainly of refugees and asylum seekers from conflict areas, though there are still many people who immigrate to Norway because of work (Rugkåsa, 2012, pp. 42-43).

1.4 Structure of the Thesis

Chapter one introduces the topic of the master's thesis, outlining the research question, the background, and the aim and objectives of the master's thesis. Previous studies about this topic are presented. In this section, I am also going to say something about previous studies done abroad. I am also going to say something about equal healthcare services and diversity. At the end of chapter one the limitations and challenges of the master's thesis are presented.

Chapter two is devoted to theory and key terms. In this chapter, I will first present the theory that I have employed in this master's thesis before I am defining the key terms that is relevant in this thesis.

In chapter three, the methodology of the thesis is explained. It also includes the process of selection of the participants and the sampling methods that is used in this thesis. I am going to elaborate on the data collection process, the selection criteria and a description of my participants. At the end of this chapter, I am presenting the data analyses that I have done using thematic analysis. At the end I am presenting ethical considerations that have been done prior and during this thesis. I will also discuss how I ensured confidentiality for all of the participants in this master's thesis.

Chapter four is devoted to the results. In this chapter I am presenting the results from the thematic analyses that I have presented in the chapter three.

Chapter five is devoted to the discussion part of the thesis. Here, I discuss the findings from chapter four. At the end of chapter five, I will compare the two topics role exceptions and integration that I identified during the analysis of my research findings.

In chapter six, I am going to provide a summary the master's thesis. Before concluding the master's thesis, I discuss what the Norwegian healthcare services can do to lessen the gap between the Norwegian healthcare service providers and next of kin with ethnic minority backgrounds. I will then conclude my master's thesis with my findings.

1.5. Aims and objectives

The purpose of this master's thesis is to illuminate the conflicts that can emerge when nurses and other healthcare personnel and next of kin with ethnic minority backgrounds have to interact with each other. Norway is gaining more people with different ethnic minority backgrounds which mean that Norway is becoming a multicultural society. Therefore is this an important topic.

The reason why I have chosen this topic as my master's thesis is because sometimes the next of kin are forgotten when the focus is on the patient. Obviously, the patient should be at the centre of focus, but when a person becomes sick, it doesn't only affect the person who is sick, but it also affect the whole family who are the next of kin. When the next of kin meet a large and complex healthcare system, it is very easy to get lost. When the next of kin meet the healthcare system, it is easy for the next of kin to be overlooked and feel that they are left out and not being taken care of as a next of kin (Klæning & Ueland, 2017).

There has been several cases in which the next of kin with ethnic minority backgrounds have been misunderstood by the healthcare personnel. The most known case occurred in 2010, when the emergency services responded to a call in which there was problem of communication between the next of kin and the paramedics, and the paramedics felt threatened by the next of kin, as a result, the next of kin were arrested by the police (Brenna Grivi & Skevik, 2010).

1.6. Equal health services and diversity

As Norway is receiving more people from different religions, ethnicities and cultural backgrounds, it is important to create a society that ensures equality and diversity. Through the years, several strategies have been published to ensure that there will be an equal health services.

In 2013, the Norwegian government published a national strategy on immigrant health. The goal for the government is an inclusive and equal society. The national strategy on immigrant health, the government's goal is to make sure that everyone who lives in Norway will feel included in the Norwegian society regardless of ethnicity, religion, language and cultural background. This is important for the individual and for the society. An equal health and care service is an extremely important part of achieving that goal (Helse- og omsorgsdepartementet, 2013). The national strategy on immigrant health also states that it is fundamental that the healthcare services to ensure that the patient and the next of kin have faith in the system and the people who work within the healthcare services.

Oslo University Hospital (OUS) published a strategy in 2017 in which they account for priority target areas, which are delineated as patients, next of kin, employees, and organisations. Each of those target areas has different sub-goals. In the target areas that are focusing on patients and next of kin, the Oslo University Hospitals wants, among other things, to guarantee the following:

"Religion or life beliefs: Patients and next of kin's religions and beliefs, and spiritual and existential needs, should be addressed as part of a comprehensive patient care, with the resources available.

Interpreter: Communication through a qualified interpreter may be necessary to provide good healthcare and necessary information and guidance to minority language patients and next of kin.

Health information understanding: Communication should be adapted to the health information understanding of the individual patient and next of kin" (OUS, 2017).

An equal health services can create a closer bond between the majority group and the minority groups in Norway. This can also provide the tools in order to create fewer conflicts in care settings between the next of kin with ethnic minority background and nurses. This can also make it easier for next of kin with ethnic minority backgrounds to cooperate with the nurses and other healthcare personnel. However, the question then becomes whether we can achieve equal health services. This is something I am going to discuss in chapter five that is devoted to discussion.

1.7. Literature Review

Patients and next of kin with ethnic minority backgrounds need different types of nursing and care than Norwegian patients and next of kin. A more culturally diverse population challenges the nurses and other healthcare personnel on daily basis because of factors such as language barriers and cultural challenges. Bellow, I am presenting the results of previous studies that have been done about this topic. This literature review is conducted in interest of gaining a better understanding of the sources and of what has already been written about the topic. The sources that I used for this master's thesis included academic books, research studies within the field of my topic. I have also used to articles written about the topic. The sources that have been written about this topic is manly from the recent years.

During my literature search, I found many interesting articles about the subject, including two research studies that are relevant for this master's thesis. When I conducted my literature research about this topic, I did not find many sources that solely focused on next of kin with ethnic minority backgrounds. Most of the sources that I found included both patients and next of kin with ethnic minority backgrounds. However, I did find plenty of previous studies done about next of kin in general. During the literature search I also found sources about nurses and multiculturalism.

The reason for looking at sources about nurses and multiculturalism is because the topic is linked to the research question of this master's thesis. One cannot discuss next of kin with

ethnic minority backgrounds without talking or looking at sources about nurses and multiculturalism or articles written about next of kin in general.

The literature search was done in both Norwegian and English. The reason why some of the literature search is done in Norway is because the research question is about Norwegian care setting. However, studies that are done abroad are also relevant in this study.

The key words are translated from Norwegian to English. The key words were: Next of kin, next of kin with ethnic minority background, challenges next of kin minority background meet, nurses and cultural competence and multiculturalism in healthcare.

There are few studies that solely are focusing on next of kin with ethnic minority backgrounds. When I was searching for previous studies about next of kin with ethnic minority backgrounds, I found many studies that had been done about next of kin in general. There were also many studies done about next of kin of patients of dementia and substance addiction patients. However, I look at the next of kin as whole, a huge group who can have different specific needs and face different challenges.

In the study 'the Significance of Family relations to Informal Careers' Needs in interaction with Health Services' from 2014, Hanssen and Somerset examined the relations between the next of kin and the health services. Hanssen and Sommerst (2014) points out in their study that the next of kin found it difficult to deal with the health services. Even though this study is not about next of kin with ethnic minority backgrounds, the study has given me relevant input, in which is used later in the discussion in chapter five.

Sevald Høye and Elisabeth Severinsson (2009) came to the conclusion in their studies about multicultural family members' experience with nurses and the intensive care context, that multicultural families experienced difficulties with communication when they first met the ICU nurses and tried to speak on the behalf of the patient. Høye and Severinsson came to the conclusion, that the multicultural family members also experienced difficulties with the visi-

ting routines at the hospital. They also found out that some of the family members found the hospital routines and facilities challenging. The study also concluded with that the multicultural family members found family cooperation and the family bond to be very important factors in managing stress and crisis.

Many studies have been conducted about nurses and other healthcare personnel and multicultural competence. I think that this can be explained with that it is the nurses who have the most contact with the patient and the next of kin. When a person is admitted to a hospital, the first person whom they meet is usually a nurse.

Debesay and Tschudi-Madsen's book 'Migration, health and profession' from 2018, discusses different topics within migration and health. The book is broken down in different chapters to look like standalone articles. After reading through the book, I came to the conclusion that one of the chapters in the book was relevant for my masters' thesis. However, only one of the chapters is used in the discussion later in the thesis, and that was the chapter about collectivism and individualism.

The discussion about collectivism and individualism can be found in chapter three, Debesay and Tschudi-Madsen discuss the consequences between expectations and behaviour when health personnel, patients and next of kin meet. They continue to discuss that healthcare personnel in Norway are a product of a western society, which puts emphasis on individualistic characters, and that they also expect that the patients can help themselves and to be autonomous as far as their condition allows them. In a study that Debesay and Tschudi-Madsens mention in their book, showed that there is a need for the next of kin with ethnic minority backgrounds to be close to the family member who is ill and to be there for each other was consistent throughout the study. The study also showed that being around the patient was important for the next of kin with ethnic minority backgrounds in how they coped with the situation. The study showed that it was a big support both practical and emotional.

Sevald Høye and Elisabeth Severinsson (2008) found in their study about intensive care nurses' encounters with multicultural families in Norway, that there were communication challenges between the ICU nurses and the multicultural families, and that sometimes the ICU nurses engaged co-workers as interpreters. They also found out that the ICU nurses were unsure if the multicultural families had understood all of the information that had been given to them. Furthermore, the study also revealed that the ICU nurses discovered that they were lacking knowledge about cultural and religious values.

The study 'Conflicts between healthcare professionals and families of a multi-ethnic patient population during critical care', an ethnographic study by Rose-Lima Van Keer, Reginald Deschepper et.al (2015) was conducted in a hospital in Belgium, in which the researchers came to the conclusion that conflict between the healthcare personnel and the family members of multi-ethnic patients was related to what the participants in the study meant by what good care, which was based on different care approaches. The healthcare personnel who participated in the study saw good care as based on the biomedical care model, while families who participated in the study felt that good care was based on a holistic lifeworld-orientated approach. The study concluded with that conflict between the families of a multi-ethnic patients and healthcare personnel is linked to ethno cultural differences in views of the structural and functional characteristics of crucial care substantially contribute to the development of conflicts.

Hadziabdic, Albin et al. (2014) conducted a study about family members' experiences of the use of interpreters in healthcare. This study is focussed on the experience of family members with multicultural backgrounds in Sweden. The focus of the study is family members' experiences when they are used as an interpreter. The study concluded that experiences were mixed with some of the family members interpreting directly, and other family multicultural backgrounds left out part of the information that had been given from the healthcare personnel due to cultural reasons, and that it was difficult to interpret a tough message to the family member who was sick

1.8. Research question

The purpose of this master's thesis is to explore the Norwegian healthcare services and next of kin with ethnic minority backgrounds. I have chosen to narrow it down from next of kin with minority background to next of kin with ethnic minority background. The research question for this master's thesis is:

What kind of conflicts arise between nurses and next of kin with ethnic minority backgrounds in the context of Norwegian care settings?

In this master's thesis, I want to discuss this problem on a wider scale than only focusing on one group of next of kin with ethnic minority backgrounds. I have chosen not to focus only one specific group, due to the fact that, when focusing on one specific group this might create a stigma towards that group. I want to try to understand the reality of nurses and the next of kin with ethnic minority backgrounds. Throughout this master's thesis I am going try to have to a hospital bed in mind.

1.8.1 Relevance of the research question

It is important to understand the kind of conflicts that can arise when nurses interact with next of kin with ethnic minority background. A social issue is a problem that can influence an individual or/and social group in society. Research questions like this are important because it can contribute to social policies.

1.8.2 'Next of kin with ethnic minority backgrounds'

In this master's thesis, I have chosen to use the term 'next of kin with ethnic minority background' instead of the word 'immigrant'. In this context 'ethnic minority backgrounds' refers to an individual who has immigrated to Norway or has at least one parent with that background. However, the term 'next of kin with ethnic minority backgrounds' was chosen due to

the next of kin who referred to themselves as 'next of kin with ethnic minority backgrounds' or someone with an other 'ethnic background'. Also, the nurses and the representatives from Pårørendesenteret (PIO) and Pasient and Brukerombudet who participated in the thesis used the word ethnic minority background. The representative from Pasient and Brukerombudet motioned that when we think about minority, we usually think about people from Africa, Pakistan, and Syria and so on.

Everyone is an individuals and everyone are human regardless of colour of their skin, their mother tongue, or their religion. However, we operate in a world in which people are categorised and in which ethnicity is an important component of 'classification' (Eriksen Hylland, 2000. pp. 246).

The need to categories people into groups is something new in Norway. It is not the word 'immigrant' itself that is the problem, but it is the associations that the word brings and the attitudes of the person who use the word (Språkrådet, 2008). Therefore, the term 'immigrant' can be for some people associated with something negative. It is more acceptable to use the word 'ethnic minority' than the word 'immigrant' or 'foreign origin' (NRK, 2007). I have also chosen to use 'next of kin with ethnic minority background' because it is easier to use 'ethnic minority backgrounds' because the term 'ethnic minority background' includes all of the next of kin that participated in this thesis.

It is important to point out that I use the "next of kin with ethnic minority background" a common term to describe next of kin with different ethnic background than Norwegian ethnic background. I use to term to describe next of kin who necessary do not share the same culture, religion, traditions and so on.

1.9. Limitations and challenges

The topic of this master's thesis is very broad, and I have therefore narrowed it down to an analysis of the relationship between next of kin with ethnic minority backgrounds and nurses, because it is usually the nurse who has the most contact with the next of kin. I was able to

recruit nurses from a Hospice and nurses who work at a psychiatric ward. I have also managed to recruit representative from two organisations that work for patients and the next of kin. For this master's thesis, I have chosen to recruit nurses that deal with next of kin as part of their everyday workday.

Chapter Two - Theory and clarification of terms

This chapter of the thesis will provide a theoretical framework for the master's thesis. I will also explain the meaning of the different key concepts in this thesis. I have chosen to divide this chapter in two to separate the terms and the theories that I have used in this master's thesis.

In the first part of chapter, I present the theories that are used in my master's thesis. Theories that I have used in this research paper is symbolic interactionism, symbolic understanding of culture, stereotypes and prejudice. I am going to start with Goffman's symbolic interactionism and then I am going to continue with symbolic understanding of culture. After that I am going to present othering, stereotypes and prejudice. At the end of this part of the chapter I am going to say something about identity and social identity.

In the second part of this chapter, I am going to define the key terms in this master's thesis. The key terms that I have used in this thesis are next of kin, nurses and next of kin, cultural relativism and ethnocentrism.

2.1. Theory

2.1.1 Symbolic Interactionism

In sociology, symbolic interactionism is used to explain the relationship amongst the individuals in a society, meaning that symbolic interactionism focuses on how people interact with each other through communication that is exchanged via language and symbols. There are many theorists that have used symbolic interactionism such as the sociologist and psychologist George Herbert Mead (1907-1931), psychologist William James (1842-1910) and sociologist Herbert Blumer (1900 - 1987), but in this master's thesis I focus on Goffman's symbolic interactionist perspective that is referenced to both James and Blumer. Goffman's symbolic interactionist perspective argues that everything that is real depends on the mutual agreement of the situation given by the people who participate in it, where each one of them adopts the other's point of view (Sergre, S. (2014). pp. 150). Communication usually happens through symbolic nature and it has to be understood by the individuals. He continues to argue that the

symbols, meanings and interactions are up for interpretation by the individuals in a given situation (Sergre, S. 2014. pp. 150). This leads us to Goffman's take on roles.

Goffman defines 'role' as the rights and duties that are attached to a person's social position (Carlson, E. 2012 pp. 459). When someone has a family member who is sick then that person adopts the role of the next of kin, and once a nurse starts his or her shift, the nurse will adopt the role of the nurse. When a nurse adopts the role of the nurse, other people such as patients and next of kin have certain expectations of how that nurse should behave. In the same way, when next of kin adopt the role of the next of kin, other people such as nurses and other healthcare personnel have expectations of how they should behave. The expectations and obligations of the nurse's role and the next of kin's role help them to interact with each other. However, since communication happens through symbols, people can modify or change the meaning, the symbols or the interaction on the basis on their own interpretations. Therefore, a conflict between nurses and the next of kin with ethnic minority background can arise when they have to interact with each other because the next of kin might interpret the symbol of family or interaction at the hospital on the basis of their own interpretations.

Later in this master's thesis I am going to use Erving Goffman's symbolic interactionism to explain how conflicts such as role expectations regarding routines at hospitals (and other healthcare institutions) and regarding family relations can arise between the nurses and the next of kin with ethnic minority background in the Norwegian care setting.

2.1.1 Culture - Symbolic understanding of culture

Culture can be defined in different ways by different people. However, when you ask a person what is culture then you will get different answers. If someone is to defined Norwegian culture you will probably get different answers. In a growing multicultural society, knowledge about culture is getting more important. Culture can be divided into three categories.

These are humanistic refinement and elite artistic activities, a way of life of a people or a group, and systems and patterns of shared symbols. These three categories can be understood as aesthetic, ethnographic, and symbolic definitions of culture (Edles, 2002).

This master's thesis focusses on the third category which is the symbolic understanding of culture. The symbolic understanding of culture defines culture as "*systems or patterns of shared symbols and/or meaning*" (Edles, 2002, pp. 6). Also, cultural systems include formalised systems of meaning that range from religion to daily life. If we look at family, family can have different meaning in different cultures. For example, family can have different meaning in different cultures. One of the participants mentioned that those who are from other cultures can have other definitions of family and who is included, meaning that family can symbolise different things in different cultures. Especially in cultures where there is a dominant presence of collectivism. In a culture that has a dominant presence of collectivism, family can symbolise a very strong unity, not only with the immediate family but also extended family.

The symbolic definition of culture is most useful in an understanding of society as divided into three analytically parts: economic, political and cultural realms. In other words, all societies have some kind of economic system, all societies have some kind of political system (for example, monarchy, democracy, or dictatorship), and last, all societies have some kind of cultural (or symbolic) systems through which people make sense of the world (Edles, 2002, pp. 6-7).

2.1.4 Stereotyping

Stereotyping occurs when someone's beliefs and/or expects certain qualities and characteristics in a certain group in the society (Nelson. et al. 1996. pp. 14). Stereotyping can occur in many ways in the society, including background, gender, nationality, religion and/or race. Stereotyping and stereotypes usually have a negative connotation, which place a specific group in the society in a negative light. Stereotyping also leads to overgeneralisation. An overgeneralisation means that someone's beliefs and/or expectation of qualities and characteristics applies to not only one member of a certain group but to all members of the group. This can also lead to judgment of an individual as a fitting stereotype based on of their relationship with their group.

Stereotypes can also lead to the assumption that all of the next of kin and patients with ethnic minority backgrounds are the same. While the patient's or a next of kin's behaviour is sometimes influenced by their cultural background (Understanding Transcultural Nursing. 2005. pp. 14). However, some nurses and other healthcare personnel can assume that one thing that goes of one person with, for example, with a Pakistani background applies to all of the patients' and next of kin that have a Pakistani background. This kind of stereotypes can be harmful to patients' health (University of Southern California, 2015), and it can lead to prejudice towards a certain group.

2.1.5. Prejudices

Prejudice is a negative feeling that one has towards a group and can also be described as a reaction to explicit or implicit challenges to the dominant groups' position. Anti-immigrant attitudes can take the form of negative attitudes such as prejudice. Prejudice is usually an incorrect attitude towards an individual who is member of a specific social group (Hjerm, M. 2009). However, prejudice is not only linked to anti-immigrant attitudes, but can also be linked to a specific group of people. A person can also become prejudiced if they have had a bad experience with an individual from a specific group if they assume that all people who are member of that group are the same.

Many prejudices exist in the Norwegian society against people who have immigrated to Norway, whom some people refer to as 'immigrants'. In particular, an idea exists that people who moved to Norway should be grateful that they have been allowed to stay in Norway. There is also prejudice against people who is regarded as 'immigrants' when it comes to family relations, as many come to visit when one of family members get sick. Prejudices can also come from the fact that family members might not speak Norwegian, or not well. Some healthcare personnel may expect next of kin and patients with ethnic minority backgrounds should speak Norwegian when they have lived in Norway for a certain amount of time (see appendix 1). Prejudices against individuals of a specific social group can lead to othering and stereotyping.

No one is free from prejudices, as even as even unconscious prejudices exist. However, one can have more prejudices towards one ethnic group and less prejudice towards another group.

2.1.5 Othering

Othering is conceived of as a construction of the self or in-group and the other or out-group in mutual and unequal opposition through the identification of some undesirable characteristic that the other/out- group has and the self/in-group lacks. Othering constructs superior self/in-group in contrast to an inferior other/out-group and it is process in which where identity is constructed in an unequal relationship (Brons, 2015)

2.1.7 Individualism and collectivism

The theory about individualism and collectivism was introduced by Geert Hofstede. Individualism and collectivism is two of six models of dimensions of national culture. Seventy-six countries are listed on Hofstede's individualism index score. Most of the countries displaying a strong sense of individualism are developed and Western countries. On the other side, the countries with a strong sense of collectivism tend to be less developed and Eastern countries (Hofstede, 2011).

In individualistic cultures, the ties between individuals are loose, meaning that everyone is expected to look after himself or herself and his or hers immediate family. Individualism is more focussed on the 'I' more than the 'we'. Individualism focuses more on that others are classified as individuals and that a personal opinion are accepted. There is also a strong sense of right of privacy and a strong sense that tasks are important than relationships (Hofstede, 2011. pp. 11). Two of the nurses, who participated in the thesis, mentioned that Norway is an individualistic country, and that in Norway, they tend to talk more about the 'I' instead of the 'we'.

In cultures with a strong sense of collectivism, the 'we' is emphasised over the 'I', and people from the moment they are born, people are integrated into a strong in-groups, usually consisting of family members such as uncles, aunts and grandparents, who protect them in exchange for loyalty and to opposing other in-groups. In-groups are groups with which a person feels that they can identify, while themselves with, and while out-groups with which a person does not identify themselves with. Collectivism stresses on belonging instead of the right of privacy and priorities relationships over tasks (Hofstede, 2011. p. 11).

Since collectivism stresses belonging and focusses more on the 'we' than the 'I', there can be conflict when both Individualism and collectivism meet. For example, in strongly collectivistic cultures, the expectations of what it means to be in the family might entail the family members taking care of the patient even though the patient is in the hospital. This is something that two of my participants mentioned this. Collectivism and individualism can also affect how an individuals identity themselves.

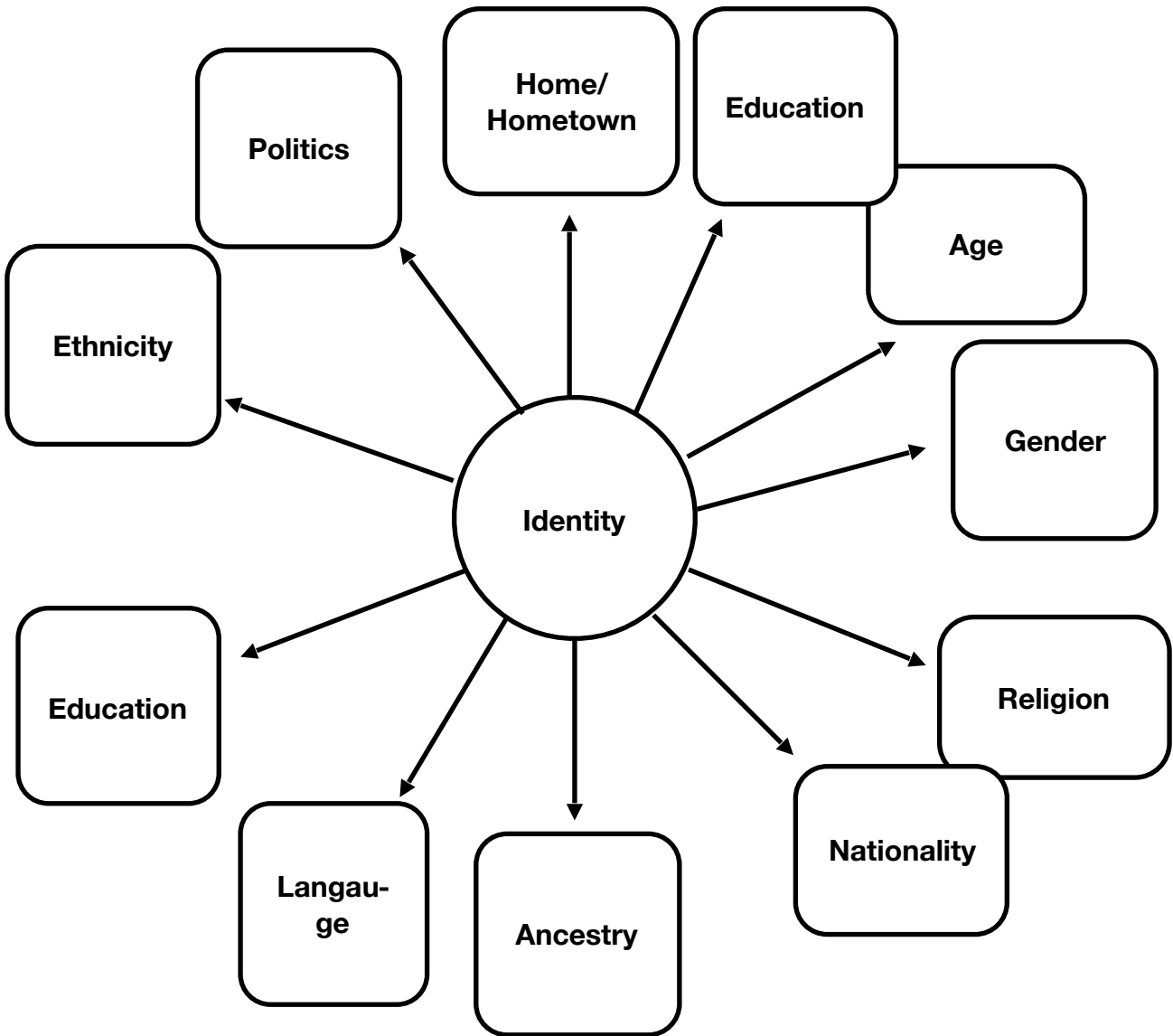
2.1.8. Identity

Identity is what makes a person who they are. There are two different ways a person can identify themselves. A person can identify themselves according to who they are as a person, that is, their personal identity, or they can identify themselves in relation to other groups in the society, that is, their social identity. Identity can create an 'us versus them' mentality. Next of kin with ethnic minority backgrounds can define themselves in different ways.

2.1.8.1 Social identity

Social identity gives a person several options of how a person chooses to identify themselves, and social identity has many different dimensions as illustrated in the Figure 1.0¹ on the following page (Eriksen Hylland, 2000. pp. 242).

¹ The figure was taken from the chapter 'Social identity, ethnic belonging, nationality, place and time' written by Thomas Hylland Eriksen. However, the figure was in Norwegian. Therefore, the figure were translated into English. This chapter is published in the book *Between Heaven and Earth* by Finn Sivert Nielsen and Olaf H. Smedal (red).



Identity can unite some people. For example, a Pakistani person who identifies as Pakistani can feel togetherness or experience a bond with other people who also identify as Pakistani. Identity can also separate people from a person or certain groups. For example, an ethnic Norwegian who identifies him or herself as Norwegian can feel that they cannot identify themselves as Pakistani, so it can separate both of them because they do not ethnicity wise they cannot identify with each other. Identity can also create an 'us versus them' mentality, of which many examples can be found in the world.

However, with social identity, a person can identify ways. A Pakistani or a Moroccan woman and Norwegian woman can identify themselves with each other and create a bond because both of them identify themselves as women. Similarly, two people with higher education might identify with each other, but can create a void between a person with higher education and a person without a higher education, due to the fact they identify themselves differently. How one identifies themselves can also depend on where they are in life. Some identities cannot be changed, such as gender and ancestry. However, identities that can change and sometimes do change, perhaps as a person ages, including politics, nationality, and, indeed, age. One can receive another citizenship, which can make a person identify them less with people whom they once shared the same nationality. A person can change political parties, and as a person ages, the person starts to identify yourself with people close to that age. For example, a person who is 28 year will not identify themselves with someone who is 60 years old, and vice versa.

As mentioned, one can identify with a personal identity, which makes who you are with social identity, but there are several other forms of identity. The different forms of identity include hyphenated identity, clean identity and creole identity. The hyphenated identity is where a person belongs to two different social cultures, for example, Norwegian - Pakistani and Norwegian - Polish. One might say that a person get best of both worlds. The clean identity is

the option that is offered by conservative religious and identity politicians and is based on a contrast, and it is often a conflict or an enemy image to the others.

A person can also identify themselves with a group, which is distinct from a social identity. The difference between a social identity and a group identity is that a social identity, a person identifies him or herself within a social category, while when someone identifies him or herself with a social group.

2.2. Clarification of terms and definitions

In this section of the chapter, I define the key terms that has an important place in the master's thesis. Key terms that I am presenting in this section of the chapter are the different levels of next of kin. After that, I am presenting the relationship between the nurses and next of kin. I am also going to define healthcare personnel. Finally, I am going to present define the terms culture relativism and ethnocentrism.

2.2.1 Next of kin

The term next of kin can be confusing because, in theory, everyone can be next of kin; however, it is the law that defines who is and who is not the next of kin. The law makes it easier for the nurses and the other healthcare personnel to deal with the next of kin and to give information regarding the patient. The Patients and the User Rights law distinguish between who is a next of kin and who is the closest next of kin. A patient can have several next of kin, but not all have the same rights, and only the person who are identified as the closest next of kin that has the right to information. In this master's thesis, I use the definition of next of kin given by the Norwegian Directorate of health.

The Norwegian Directorate of Health (2015) defines next of kin as the person whom the patient has chosen to be their closest next of kin. The patient can choose who should be considered the closest next of kin is because it is not always that the patient's family who has the pa-

tient's best interest by heart. However, if the patient is not capable of choosing who should be considered the closest next of kin, then according to the law, the next of kin should be the person who has permanent and continuous contact with the patient. This is based on a specific order; spouse, registered partner, person living in marriage-like or partnership-like cohabitation with the patient, children over the age of 18, parents or others with parental responsibility, siblings over the age of 18, grandparents and, finally, other family members. However, the person who is appointed by the patient need not to take on the responsibility of the closest next of kin, and the patient can also change their choice of closest next of kin. If a person does not have any family members then the patient can choose a person who is not blood related.

Healthcare is usually given to the patient with their consent, and a patient over the age of 16 can legally consent. The consent is only valid if the patient has received information about their health condition and if the patient is able to understand what consent means. However, there are special circumstances in which the patient cannot give consent. If the patient is under the age of 16 or is unable to give consent due to a mental or psychological condition, dementia, or other health related issues, then the closest next of kin has certain rights to comment on the healthcare or to consent to the healthcare on the behalf of the patient.

2.2.1.1 Nurses and next of kin

Nurses are usually the people who interact most with the next of kin and the patients. The primary role of a nurse is to advocate for the patients. However, the nurses are also supposed to take care of the next of kin. When working as a nurse, the nurse has to follow ethical guidelines. The foundation of all nursing is respect for the individual's life and inherent dignity. Nursing should be based on compassion, care, and respect for human rights. When interacting with next of kin, the nurses are supposed to do the following:

- 1. The nurse contributes to safeguarding the right of next of kin to information.*
- 2. When children are next of kin, the nurse contributes to meeting their special needs.*

3. The nurse interacts with family members and treats their information confidentially.

4. If there is a conflict of interest between the next of kin and the patient, priority shall be given to the patient.

(Norwegian Nurses Organisation)

2.2.2 Healthcare personnel

Healthcare personnel are defined in section 3 first paragraph of the health personnel act as following:

1. personnel with authorisation under section 48a or license under section 49,

2. Personnel in the health and care service or in a pharmacy who performs the actions referred to in the third paragraph;

3. Pupils and students who, in connection with health education, carry out actions as mentioned in the third paragraph.

Several groups can be defined as healthcare personnel. In order to narrow down these groups, I have chosen to focus on nurses in this master's thesis.

2.2.3 Cultural relativism and ethnocentrism

Cultural relativism refers to when a person understands someone's culture and does not judge a person's culture based on their own culture. Instead of judging a person from another culture, in the context of this thesis, a cultural relativist asks questions why people in some cultures come with their whole family to visit someone at the hospital. When a person asks why cultures do what they do, the person can learn something about that culture. In other words, a

cultural relativist tries to learn something about those cultures instead of judging them. The opposite of cultural relativism is ethnocentrism.

The term ethnocentrism was introduced by William Graham Sumner, and this term refers to a person who compares their own culture to another individual's culture, looking at other cultures through the eyes of their own and sees their own culture as better. A person who has an ethnocentric attitude judges other people's cultures based on their own culture. Ethnocentrism can lead to stereotyping and prejudices (Levine, R. 2015).

In her article about how nurses need more multicultural competence, Christine Rødal (2012) explains how ethnocentrism and cultural relativism can affect nurses. In many countries, it is the next of kin who has the responsibility of taking care of the family member who is sick, and some of the patients might feel less safe without their family members, which can lead them to occupy common areas, which in turn can affect the other patients in the unit. From an ethnocentric perspective, a nurse would look at this situation in the context with Norwegian culture, and thinking that in Norway things are done differently, and that the next of kin occupying the common area have to follow the rules and norms of the hospitals in Norway. From a culturally relativistic perspective, a nurse would look at this situation and try to understand why the family is there and respect the reason as part of their culture.

Chapter Three - Methodology

In this chapter I present the research method that is used to gather my data and to answer the research question. First I am going to discuss the epistemology used in this thesis, hermeneutics and what qualitative research is and why I have chosen to do a qualitative research study.

After I have presented the reason why I have chosen to do a qualitative research study, I am presenting the participants. This includes how I recruited the participants in this master's thesis. After that I am going to present the data collection and the interview guide. Later I am going to present how I did my analysis using thematic analysis.

Since ethics are very important when conducting research, I am discussing the ethical considerations I made throughout this master's thesis. Ethical considerations are particularly important to keep in mind throughout the whole process when doing research that revolves around people. In this part of the methodology chapter, I introduce the letter of consent, confidentiality and translations of the interviews. I am also going to say something about objectivity. I will end this chapter with discussing reliability, credibility and transferability. For this thesis, I have used qualitative method in order to answer my research question which is as following:

"What kind of conflicts arise between nurses and next of kin with ethnic minority backgrounds in the context of Norwegian care settings?"

3.1 Methodology Grounds

3.1.1 Epistemology

This master's thesis is based on social constructivism, according to which social phenomena are constructed based on interaction with other people in a group. Thus, nothing is objective since social phenomena are constructed based on intersections with other people and groups (Bryman, 2016. pp. 29). This master's thesis examines the conflicts that can arise between the nurses and the next of kin with ethnic minority backgrounds, and my goal is to get a better understanding of the experiences of both nurses and next of kin, a project that is inherently non-objective.

3.1.2 Hermeneutics

A phenomenon can be interpreted differently. For example, one can interpret the actions of a person or a group of people differently. In qualitative research, a researcher emphasises on interpretations of the data collected. Hermeneutics entails descriptions and interpretation of the meaning of the material such as people's expression, actions, texts, traditions, and institutions. In the hermeneutic tradition, one puts weight on the meaning of the interpretation, argumentation, and language (Karlsen, 2009. pp.12-13). In this master's thesis, in the form of semi-structured interviews, the nurses have related their experiences of meeting next of kin with ethnic minority backgrounds, and the next of kin have related their experiences of meeting nurses and other healthcare personnel. I have interpreted their experiences, as related according to their interpretation, using thematic analysis.

3.1.2 Justification of the choices of methodology

Qualitative research puts an emphasis on words rather than numbers and is thus distinct from research that uses Quantitative methods. Qualitative research is usually used when the researcher wants to conduct research on people. Since this master's thesis examines the relationship between nurses and next of kin with ethnic minority backgrounds, a qualitative method was the best choice. Qualitative research involves collecting data in the form of texts, audio, and images, and it usually emphasises interpretations of the data the researcher has collected through different qualitative research methods such as semi-structured interviews.

When choosing qualitative method to answer the research questions in this master's thesis, it allows me to see through the eyes of the nurses and next of kin with ethnic minority backgrounds. This allows me to see their reality when the nurses and next of kin with ethnic minority backgrounds have to interact. The qualitative research methods that have been chosen in order to collect data to answer my research question are semi-structured interviews. When using semi-structured interview as a research method allowed me to study the participants' behaviour and go further on the topic that was being discussed.

If I would had used quantitative research method, it would not have given me the same opportunity to look through the participants' eyes, and the research question for this master's thesis is a qualitative research questions which seeks to explore and describe what kind of conflicts the nurses and the next of kin with ethnic minority background meet when they interact.

3.2 Selection

Before I started the data collection process, it was necessary for me to determine whom I wanted to recruit to participate in this thesis, and how I wanted to recruit the participants. The selection of participants was influenced by the research question. The participants in this master's thesis can be divided into three groups of participants - nurses, organisations and next of kin.

There are three different groups of participants, but all three groups are relevant to each other. The letter of consent regarding participation in the master's thesis was written in order to fit each group of participants. The nurses who participated worked in different places. Three of the nurses worked at a hospice, while the other four worked at a psychiatric ward. However, the nurses who worked at the psychiatric ward worked in different units within the psychiatric ward.

3.2.1 Criteria for my participants

There were only few criteria for the participants in this master's thesis. However, for the next of kin had to have non-Norwegian, minority backgrounds. They also had to be next of kin to someone who had dealt with the healthcare services and/or had been admitted to the hospital. There were no specific criteria for the nurses, other than they had to be working as an authorised nurse and have experience with working with next of kin with minority backgrounds. All of my participants had to be 18 of age or over in order to participate in the master's thesis.

3.2.2. Recruitment of participants

In order to recruit participants for this master's thesis, I have used purposive sampling. Purposive sampling is a non-probability form of sampling. When using this type of sampling, the selection of the participants in a research study is based on the researcher's judgements and not on random selection of participants. This is also a strategic way of choosing the participants who could help answering the research question in this master's thesis (Bryman Alan, 2016).

The recruitment of next of kin with ethnic minority backgrounds proved to be more difficult than I expected. I contacted various organisations to see if they had possible participants that could fit the criteria. However, many of the organisations said that most of the people who contacted the organisation were ethnic Norwegians or that they did not have any people who could participate in the research study. However, when I contacted Minotek, an organisation that works for issues related to challenges regarding multicultural society in Norway. I was contacted by one participant that wanted to participate in the master's thesis.

The second group of participants, who were recruited for this thesis, was nurses because they had first hand contact with next of kin with ethnic minority backgrounds. Recruiting nurses for my thesis was easier than recruiting next of kin with ethnic minority backgrounds. I contacted the emergency psychiatric ward where I recruited four of the nurses. When contacting the emergency psychiatric ward, later I got in touch with the nursing advisor who deals with these types of inquiries, and later I contacted the different psychiatric units that said that they

had candidates for my master's thesis. I was later contacted by four nurses that had agreed on participating in the master's thesis. There are five units at the emergency psychiatric ward, and all of the nurses were from different units at the emergency psychiatric ward. When I recruited the nurses at the Hospice, I called the Hospice and presented myself and my master's thesis I was told that I should send an email about the master's thesis. I was later contacted by the Hospice. They informed me that they had found nurses that have agreed on participate in the master's thesis.

The third group of participants was people working in organisations working for patients and next of kin. I wanted to interview this group because they could help identifying what kind of challenges faced by next of kin with ethnic minority backgrounds. When it came to recruiting the organisations that I wanted to talk to, I called and sent an email about my research project. I contacted Pårørendesenter in Oslo. PIO is an organisation that works with people who are next of kin to people who specifically deal with mental health issues. They offer support and help to next of kin. I contacted them to ask if they had some people who could participate in interviews. I also contacted Pasient - and Brukerombudet, that is an organisation that aims to help people to make sure they receive the rights according to the Pasient - and Brukerrettigheter law, the Municipal Health Services Act and Specialised Health Services Act

In all, I managed to recruit four next of kin, seven nurse and two representatives from the organisations.

3.2.3 Participant description

As this master's thesis focusses on next of kin with minority backgrounds, the next of kin that participated in this thesis were of all non-Norwegian, minority backgrounds. However, all of the participants were born and raised in Norway. The participants had background from Pakistan, Morocco and Iraq, and they were all about the age of 18. All of the participants were close to the age of 18. Some of the participants had the same educational background.

The nurses who participated in the master's thesis ranged in age from beginning of their 30s to late 60s. Most of the nurses had been working as a nurse for many years, some of them had more than 20 years of experience. Most of my nurses were ethnic Norwegians; however, one of the participants was from a different Scandinavian country. Most of them were females, and only one of the nurse participants was male. I was not purposely recruiting only female nurses for my thesis, but according to a figure from 2018, only 11 % of registered nurses in Oslo were male (Sykepleien, 2018). Therefore, there was a higher chance of recruiting more female nurses than male nurses.

The people was recruited from the organisations that I wanted to talk work either directly n or indirectly with next of kin with ethnic minority backgrounds.

3.3 Collection of data

In this section, I am presenting the data collection methods. First, I am going to discuss the interview guide. After, I present the process of collecting the data. At the end I am going to write about the analysing process.

3.3.1 Interview guide

The interview guide was created with the research questions in mind. I considered what I wanted to know about the next of kin with minority background and the nurses experience when they had to interact with each other. I had to create three different interview guides because I had three different groups of participants. The interview guide for the next of kin was divided into four categories. The four categories were general information, illness and treatment, culture and experience with the Norwegian healthcare services.

The interview guide for the nurses was also divided into two categories. The categories were general information about themselves and multicultural competence. The second category contained questions about the participants' experience with next of kin with ethnic minority backgrounds.

The idea of an interview guide is to have a list of issues to be addressed or questions to be asked in a semi-structured interview. My interview guide did not have a list of issues, but the interview guide included several set questions that I wanted to ask my participants.

When interviewing my participants, semi-structured interviews were used with three groups of participants. Alan Bryman (2016) described semi-structured interviews as interviews that had room for alteration during the interviews, and allowed questions not in the interview guide to be asked depending on the participant's reply to the previous question. A semi-structured interview use opened ended questions and is not strict in the manner of a structured interview. Using semi-structured interview for my master's thesis allowed me to be flexible during the interview. Each of the interviews had standard general questions began with standard general questions, and later on I asked a question depending on the participant's responses. That is one of the advantages of semi-structured interviews, that is, lack of a strict set of questions. Another advantage is the flexibility to change the order of the questions in the interview guide during the interview.

3.3.2 The process of collecting data and the interviews

After creating the interview guide and recruited my participants, I contacted the participants and agreed on a date, time and place for the interview. I told the participants that I would work around their schedule, and I met the next of kin at the coffee shops to conduct the interview.

When interviewing nurses, I was able to meet them at their workplaces to interview them. Most of the interviews were done face to face, and I used a tape recorder to record the interviews. This allowed me to pay attention to the participants instead of trying to write everything down as the participants were speaking. I also thought that it would have made the participants uncomfortable if I was looking down and writing instead of looking at the participants while they were talking.

When interviewing the representatives from the organisation, I was allowed to interview them at in their offices.

However, one of the interviews was conducted via a phone conversation. I asked the participants if we could meet because I felt more comfortable having a face to face conversation instead over the phone. A face to face conversation allowed me to look at the participant and study their body language. Due to conflicting time schedule, the interview was conducted via the phone. The conversation was recorded on the recorder that I had borrowed from the university. Since I was unable to obtain a written consent from the participant, I made sure that I get a clear oral consent and I also informed the participants about my master's thesis. Before conducting the interview via phone, I asked for advice from my supervisor and NSD.

3.4 Analysis

For this master's thesis I have chosen to use a thematic analysis to analyse my data. Thematic analysis is a method used to pinpoint, examine, and record themes within the data the researchers have collected. A theme is a category identified by the analyst through the researcher's data that relates to their research focus, building on codes identified in transcripts or field notes and that provides the researcher with the basis for a rhetorical understanding of their data that can make a theoretical contribution to the literature to the research focus (Bryman Alan, 2016). In this case, I had to identify patterns within the interviews with my participants. Since I had interviewed nurses, next of kin and two representatives from the organisations, I had to identify the themes or patterns from the three sets of data that had been collected.

When doing a thematic analysis, there are some steps that have to be considered. The first step is to become familiar with the data, second step is to coding the data, the third step is to searching for themes, the fourth step is to review the themes and the fifth step is to write up the findings. In this section, I describe the analysing according to the steps mentioned.

3.4.1 Step 1 – Becoming familiar with the data

During the beginning of the analysing process, you have to become familiar with your data, so I first became familiar with the data before starting searching for codes. During the interviews, I got a general overview over my data. However, even though I got a general overview over my data and got to know my data, I need to become more familiar with my data. During the process of transcribing the interviews, my familiarity with the data was maximised.

3.4.2 Step Two - Coding the data

In this second step of the analysing process, I had finished reading through my data and familiarised myself with the data, I started searching for codes. When coding my data, I ended up with producing several codes that I wrote down. To make it easier for me to keep track of the codes, I created one word document for each code. Afterwards, I created a word document for each code. I placed the quotes into the relevant word document with the correct code and with the correct code for the participant. This made it easier for me to keep track. After I was done with searching for codes and coding my data, I went over the interviews to recode interviews to see if I could identify new codes. Each document was one code, so all the quotes that had gotten the code family relations were placed in that document.

3.4.3 Step Three - Searching for themes

The third step of the analysing process was to search for themes. After I had gone through my data for the second time, I started to search for themes. During my search for themes, I made a mind map. When searching for themes, I discovered five themes. However, I was not satisfied with the themes that I had found. I went over my themes. However, I was not satisfied with the themes that I had found, so I decided to repeat the process. However, the second time, I went over the data from the next of kin and the nurse separately. This helped me look at my data from another angle and helped me find two different themes than I had found the first time I analysing my data. The themes that I found after looking the codes and my data from another angle that I had found were:

1. Role expectations

2. Integration

The figure bellow shows examples of the quotes from the participants and the codes that I assigned them. The figure also shows how the quotes and the codes fit into the sub-topics and the topics that I found when I was analysing the data. Since this is just an example, I have only chosen to illustrate with some of the quotes by the participants.

Quote by the participants	Code	Sub-topic	Topic
"It's that they are here all the time and that they are so many. We see that boundaries are constantly overwritten"	Family, Family relations	Family relations can cause stress for nurses and it can also cause conflict between nurses and next of kin with ethnic minority background	Role expectations
"At some hospitals in Spain or Africa, it is the family who does everything expects insert injections and such, but we do not do that in Norway, but some people bring attitudes like that. (..) It can be disturbing for us."	Prevention of the performance of duties	Role expectations at Norwegian hospitals and other care institutions can cause conflict between nurses and next of kin with ethnic minority background	Role expectations

<p>"(..) The patient does not have a mutual language, so it is the family who is the interpreter (...)"</p>	<p>Information to the patient, use of family members as interpreters</p>	<p>Communication can cause conflict between nurses and next of kin ethnic minority background</p>	<p>Role expectations</p>
<p>"I expect immigrants to be able to adapt to the Norwegian system"</p>	<p>Norwegian system, adjusting</p>	<p>Nurses expect people who immigrate to Norway should adapt to the Norwegian system</p>	<p>Integrating into the Norwegian system</p>
<p>"It was that attitude because we were immigrants, and one feel less Norwegian. One feel discriminated and feel that one get another treatment because one have another ethnic background"</p>	<p>Us vs. them, prejudice</p>	<p>Next of kin felt they were met with prejudices</p>	<p>Integrating into the Norwegian system</p>

3.4.4 Step Four - Reviewing the themes

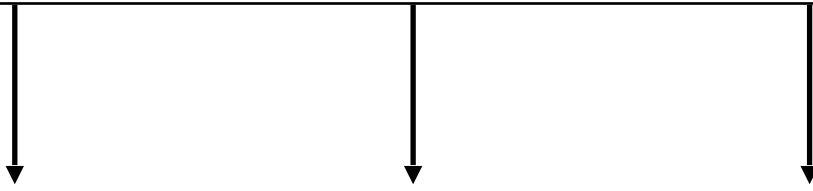
In the fourth step of the thematic analysing process, the researcher has found the themes that the researcher had found when searching for codes. However, in this phase the researcher has to review the themes to see if the themes make sense or not.

I looked over the themes and the codes that I have collected in each of the word documents. After I had looked through the themes that had been collected, I decided which theme made the most sense.

3.4.5 Step Five - Writing up the results

The end of the analysing process is the fifth step. For this fifth step of the analysing process is where the researcher is writing up the results. After I was happy with the analysing process that had been conducted and the themes that had been collected, it was time to write the results. The results of the thematic analysis are presented in next chapter of this master's thesis, where after I provide a discussion based on the results of thematic analysis. After finishing my analyses I found two topics with five subtopics. In the figure on the next page, the reader can see the topics and sub-topics.

Role expectations



Role expectation at Norwegian hospitals and other care institutions can cause conflict between nurses and next of kin

Family relations can causes stress for nurses and it can also cause conflict between nurses and next of kin with ethnic minority background

Communication can cause conflict between nurses and next of kin ethnic minority background

Integrating into the Norwegian system



Next of kin felt they were met with prejudices

Nurses expect people who immigrate to Norway should adapt to the Norwegian system

3.5. Validity and reliability (reliability, credibility, transferability)

In quantitative studies, validity and reliability are used as criteria for quality. However, in qualitative studies, one operates with reliability, credibility, transferability to measure the quality. Since I have used to do qualitative study, I have chosen to use reliability, credibility, transferability.

Data in a qualitative study cannot be measured in the same ways as in a quantitative study. The reliability of a study is important. However, reliability in qualitative studies has little purpose, since there is no quantitative data of which to test the reliability can be checked. Reliability is related to the data that the researcher has collected, including both collection and processing (Johannessen et al. 2011. pp. 229).

Credibility also referred to as validity, can be examined. Credibility concerns how the researcher approached the study and collected the data (Johannessen et al. 2011. pp. 230) In this thesis, I have explained as openly as possible how I conducted my research. I have also explained and justified my decisions. Since this master's thesis is written in English and the interviews with the participants were held in Norwegian, I had to translate the interviews. However, I made sure that I did not alter the meaning of the participants. This is something I am discussing more about later in this master's thesis. This master's thesis is looking at conflicts between nurses and next of kin with ethnic minority backgrounds in the context of Norwegian care setting, and interviewing nurses who work at psychiatric ward and at a hospice and next of kin with ethnic minority backgrounds can strengthen this thesis' credibility.

Transferability refers to the ability of the results of the research study to be transferred to another research study. As a researcher you want your research study can be used in another research study. Results should be transferable to another research study: however, not every research study would produce the same results because what is true in Norway might not apply to Sweden or other Western countries. In this master's thesis, I have recruited next of kin from different ethnic minority groups and nurses from two different healthcare institutions. I have chosen to recruit nurses from the two different healthcare institutions because it can

provide a better understanding of the different challenges the nurses from the different healthcare institution meet when interacting with next of kin with ethnic minority backgrounds. The many different ethnic minority groups in Norway, one cannot be attributed the same traits because they all are individuals, even though people are from the same ethnic background. One of the nurses interviewed said that she has met people from the same ethnic minority group but that it was two different experiences. We cannot conclude that all of the next of kin with ethnic minority backgrounds are difficult, nor that all nurses and other healthcare personnel are difficult, but we can identify the tendencies in the kinds of conflicts that arise from the perspective of both the next of kin with ethnic minority backgrounds and the nurses when they meet and interact.

3.5.1 Objectivity

I have chosen to write about objectivity by itself. This subject is extremely important, because it is important for research not to be motivated by a desire to attack something, for example, the Norwegian healthcare system. I thus wanted to ensure that this master's thesis would be as objective as possible so as to not damage Norwegian healthcare services.

Objectivity in social science focusses on three main demands. The first one is grabbing only onto real objects and real facts. The second demand is driving out values from description and explanation. The third and last demand is using only methods likely to secure true outcomes (Cartwright and Montuschi, 2014, pp. 124 - 125).

To employ more objective research is to use methods that are likely to secure true outcomes. However, a researcher of qualitative research is not able to be 100 % objective, as they might use such, thematic analysis to analyse the data that they have collected. This involves using a subjective position to interpret the data and in order to research.

Nurses and other healthcare personnel are taught to do not harm, and a researcher is also required to do no harm with their research and to strive to be as objective as possible. While maintaining 100 % objectivity is impossible, it was nevertheless extremely important to me to make sure that my research was as objective as possible and that this master's thesis was

not biased against the Norwegian healthcare services. A single situation involving five people will most likely result in five different explanations of the situation. For example, if three next of kin with ethnic minority backgrounds and two nurses stood next to a hospital bed you would likely get five different interpretations of what is happening around that hospital bed.

Therefore, I decided to interview nurses who deal with the next of kin to get the nurses' side because the challenges the nurses face when meeting next of kin with ethnic minority backgrounds can also be challenges that the next of kin also face. There are two different sides to one case.

3.5.2 The researcher's role

As a researcher, it is important to be has to be objective when conducting a study. I have also thought about my role as a researcher and what it means to be researcher. Researchers have a responsibility for the participants and to ensure that the research study is as true as possible, and their own judgement do not cloud the conclusion of the study.

As researcher I have a responsibility to make sure that information about the participants are not misused and that I see through the participant's eyes when I interpret the data. As a researcher, I also have the responsibility not to pressure my participants to answer questions that they do not feel like answering for different reason, and to ensure that they feel welcomed, conformable, and respected during the interview.

3.6 Ethical considerations

Before conducting my research and recruiting participants for this master's thesis I had to apply for approval from the Norwegian Centre for Research Data (in Norwegian: Norsk senter for forskningsdata) (see attachment). Research involves ethical considerations both before and during the study. Just as doctors have the Hippocratic Oath, in which they swear to do no harm, researchers must bear the oath in mind to do no harm, in this case, towards, the Norwegian healthcare services, but simply to raise awareness of what kind of challenges next of kin face when they meet the Norwegian healthcare services. Also, a researcher shall not

harm the participants in a research study, and not to create a stigma towards a specific group. This is why I have not chosen to focus on one specific group in this thesis.

In Alan Bryman (2016) book about social research methods, he outlines four main areas of ethical principles:

1. Whether there is harm done to participants
2. Whether there is lack of informed consent
3. Whether there is an invasion of privacy
4. Whether deception is involved.

The master's thesis was conducted according to Norwegian Social Science Data Service's guidelines. When a researcher wants to research human behaviour or humans, several ethical considerations must be considered, especially when health personnel are involved.

3.6.1 Confidentiality

Confidentiality and the participants' anonymity are extremely important in this master's thesis. Throughout, the research process, I was very strict about confidentiality, particularly when transcribing the interviews. The representatives from the organisations gave me written consent to be named the organisations in the thesis, but the anonymity of the rest of the participants is my responsibility as a researcher and priority, for that reason the participants have received fictional names. Also, I have also used the word 'hospital' instead of the name of the hospitals mentioned in the interviews with the next of kin.

Normally, in a study, the participants are supposed to be anonymous but sometimes that is not possible due to information that might identify the participant. When interviewing the representatives from the organisations, it was possible to indirectly identify the participant due to the fact that the title of the participant and the name of the organisation are mentioned in this master's thesis. Therefore, in the letter of consent the participants from the organisations are

asked if they agreed to that the name of the organisation and their title be mentioned in the master's thesis.

To make it easier for the reader to follow, I have given the participants fictional names.

When it came to the next of kin, I informed the next of kin that since it was only them who had agreed to participate in the thesis, they were not allowed to mention the family members and only their own experience with the Norwegian healthcare services.

The participants who wanted to do a quote check, they were able to do so, which was informed in the information letter and before and after the interview. I also offered the participants to look through their interview after I had transcribed, however, majority of the participants declined the offer.

3.6.2 Letter of consent

All of the participants were asked to sign a letter of consent before the interviews. This letter of consent included information about the master's thesis and its purpose of the thesis. I created a different letter of consent for each group of participants, as I was advised to do so by the NSD. I was also advised by the NSD to ensure that the next of kin understood that their ethnicity was going to be used in this thesis. Therefore, the letter of consent included "I consent to that information such as my ethnic origin is processed until the master's thesis is done".

Ethical concerns, in this thesis, include patient confidentiality law when interviewing the nurses. This concern has been addressed by mentioning in the letter of consent that the nurses were not allowed to mention patients or single cases, and that if they violate the patients confidentiality law, the interview would be stopped immediately. This was also mentioned before the interviewed started. This portion of the consent is aimed to protect me as researcher, and to ensure that the participants who agreed to participate in the interview understood what they have agreed to

However, I unable gain the written consent of one of my participants because the interview was conducted over the telephone. I contacted my supervisor and the NSD asking for advice. I was told that I should inform the participant orally about the master's thesis. I was told by NSD that I also needed to document the consent, when the interview was set up; I asked the participant via text if I could record the phone interview, to which the participant agreed on. During the phone interview, I ensured that I received explicit consent before beginning the interview. I gave all the information to the participant and made sure that the participant understood what the participant agreed on.

Before the interviews started, I informed the participants that if they felt uncomfortable with answering a question they could of course skip that question.

3.6.3. Translation of the data

This master's thesis is written in English but since Norwegian is my first language, all of the interviews were held in Norwegian and transcribed in Norwegian. The analysing portion was also done in Norwegian, but the results of the master's thesis were written in English. However, since the quotes that I have taken from the interviews were transcribed in Norwegian, the quotes that are used in this master's thesis have been translated from Norwegian not English as closely as possible, so the meaning of the quotes did not change.

All of my participants spoke and understood Norwegian very well, except for one nurse who did not speak Norwegian. Therefore, interviewing the participants in English made no sense. One of the nurses that I interviewed was not Norwegian, but the nurse was from another Scandinavian country. She understood Norwegian, so the interview was conducted in Norwegian, but she answered in her native language that was easy to understand.

Chapter Four - Results

Throughout the whole process from recruiting my participants to data analysis, I kept the research question in mind. This has been a long process from finding my participants to presenting my results. The research question is as following:

What kind of conflicts arise between nurses and next of kin with ethnic minority backgrounds in the context of Norwegian care settings?

In this chapter I am presenting the results from the data analysis conducted in chapter three. After I am done with presenting the results, I am discussing the two themes that I have found through my analysis in chapter five. After I am done with discussing my results, I am going to conclude the master's thesis and look at the road head and what can be done to improve the situation so the next of kin and the healthcare personnel are secure enough. After the thematic analysing my data from interviews with my participants, I ended up with two themes with several sub themes. In this chapter I am going present the findings in these two themes:

1. Role exceptions
2. Integrations

In order to ensure it will be easier to separate the participants from each other and make it easier for the reader to follow, I have deiced to give each one of the participants a fictive name. This is to ensure that the identities of my participants remain anonymous. The anonymity of my participants is highly important. The names that the participants have been given is listed in the figure on the next page. However, the names of the organisations will be mentioned, as the representatives from the organisations have given me their consent that the name of the organisations is mentioned in this thesis.

Participants - Group 1	Country
Fatima	Morocco
Aisha	Morocco
Ali	Pakistan
Sunita	Pakistan

Participants - Group 2	Place of Work
Ola	Psychiatric
Kari	Psychiatric
Sara	Psychiatric
Venke	Psychiatric
Trude	Hospice
Gudrun	Hospice
Ruth	Hospice

Participants - Group 3	Code
Pasient and Brukerombudet	PB
Pårørender Senteret i Oslo (PIO)	PIO

In order to reach my results I have used snowball methods and purposive sampling as method. However, the snowball method did not get me the results that I wanted. Therefore, only purposive sampling was used. My results are based on the interviews that were held with three groups of the participants. Those three groups are nurses, next of kin with ethnic minority backgrounds and two organisations that works either indirectly and directly with next of kin.

Some of the participants are quoted more than other participants, and the reason for this is that some of the participants had more to share than others of the participants. The nurses that I interviewed worked at different places that. Three of the nurses worked at a hospice and four of the other nurses worked at psychiatric ward.

4.1 Role expectations between the next of kin with ethnic minority background and nurses

Everyone in the society has different roles that they are supposed to fill. Both the nurses and next of kin have different roles that they are supposed to fulfil with the respect to the patient, but sometimes the roles collide with each other. The interviews with the participants in this master's thesis revealed that there were conflicts between the nurses and next of kin with ethnic minority backgrounds. However, this does not mean that the roles collide constantly when next of kin with ethnic minority backgrounds and nurses meet. The sub-topics I found in the themes that were produced during the thematic analysis.

- 1. Role expectations at Norwegian hospitals and other care institutions can cause conflict between nurses and next of kin with ethnic minority backgrounds**
- 2. Communication can cause conflict between nurses and next of kin ethnic with minority backgrounds**
- 3. Family relations can causes stress for nurses and it can also cause conflict between nurses and next of kin with ethnic minority backgrounds**

4.1.2 Role expectations at Norwegian hospitals and other care institutions can cause conflict between nurses and next of kin with ethnic minority backgrounds

At a hospital, there are rules that nurses and other healthcare personnel expect visitors, in many of the cases are next of kin, to follow. When one do not fill the role that is indirectly 'assigned' to them, conflicts between the nurses and next of kin with ethnic minority backgrounds because the expectations of the roles are not met. When I talked to the nurses, the one thing that stood out was that they felt that sometimes next of kin with ethnic minority backgrounds did not understand how the nurses worked.

Some of the nurses that were interviewed found it challenging to do their job as a nurse and that doing their job sometimes resulted in collision with the next of kin with ethnic minority backgrounds. In Norway, routines at a hospital or other healthcare institutions might be different from those in other parts of the world. Next of kin in the Norwegian system do not have a big role, as they might have elsewhere. Two of the nurses took examples from other parts of the world. Sara explained that:

«We have a good healthcare system where we have expectations that the Norwegian health-care system shall fill a big function. That function does not exist in large parts of the world if we do not include the western part of the world. We have excluded next of kin and the family in context of being ill in Norwegian culture. The next of kin are not supposed to fill a function like that. For example in China there is no food to get. There the next of kin have to serve food themselves. They are there and that is a natural part which we do not have room for here».

Trude, who works at the hospice, mentioned an example of other parts of the world. She mentioned that some of the next of kin with ethnic minority backgrounds wanted to take over. At Norwegian hospitals, the next of kin do not engage in the daily care of a patient.

"At some hospitals in Spain or Africa, it is the family who does everything expect insert injections and such, but we do not do that in Norway, but some people bring attitudes like that. [. . .] It can be disturbing for us. Through care we can spot the patient's development and

see if the patient is starting to develop bedsores. Then we can for example change the mattress".

However, as mentioned the nurses that were interviewed were from different fields within nursing, psychiatric and somatic. In a psychiatric context, the next of kin have a different role than at a hospice. At a hospice, the next of kin are a more natural part of everyday life at a hospice than at a psychiatric ward. Kari, who works at the psychiatric ward, felt it was challenging when the next of kin did not understand how things worked:

"Sometimes, the next of kin do not understand why we do what we are doing, or for example visiting hours or that they cannot bring their own food".

Kari continued with that people can bring their own food but they are not allowed to store their own food at the ward.

To sum up, the next of kin do not have the same role in Norway as in China and in Africa, and the Norwegian healthcare system has excluded the next of kin. The nurses mentioned that it was difficult to do their jobs, when the next of kin with ethnic minority backgrounds wanted to take over and that sometimes the next of kin with ethnic minority background did not understand how things work. However, communication can also cause conflict between nurses and next of kin with ethnic minority background.

4.1.3 Communication can cause conflict between nurses and next of kin ethnic minority backgrounds

According to the professional ethical guidelines according to which the nurses must work with, the nurses must ensure that the patient has understood the information that they receive. The nurses whom I talked to said that they experienced challenges in communication between them and the next of kin with ethnic minority backgrounds. The nurses also said that they had used family members as interpreters. However, both of the representatives from the organisations who participated in this master's thesis, said that nurses and other healthcare personnel have no good practice with organising interpreters and that many people do not know that they have the right to a qualified interpreter. The Patient - and Brukerombudet representative mentioned a case in which a Somali woman lost her son and did not understand why he

had died. The mother and the family had not gotten the boy's medical chart. The mother did not understand anything she had been told at the hospital, nor was she offered an interpreter. She had been too proud to ask for an interpreter. The PIO Center also reported that the healthcare personnel have not been good at finding an interpreter for people who needed an interpreter.

Other challenges can emerge with next of kin with ethnic minority backgrounds. Three of the nurses, who worked at the hospice, reported that the next of kin with ethnic minority background presented challenges because in different cultures, people want to protect the patient who is going to die and children whose parents are going to die. Trude mentioned that at the hospice, they have a clear opinion that children should know that their parents are going to die. This was challenging for the nurses, because they did not know if they had the right to intervene or not. Trude felt torn as to what the right thing to do, and the next of kin would think is right:

"In some cultures children should be protected, and we have a clear opinion that children should be present for the whole process, so that the ones who are being protected and then suddenly mom or dad is dead. They have to be there. It is not easy to know that if we have the right to intervene when we know that it is the best for the child when mom, dad or even grandparents think that it not the best for their child."

This is something that the other nurses at the hospice said during their interviews, and they noted that they faced an ethical dilemma as a nurse because it is the patient that is their patient. Trude said that in some cultures they choose to shield the patient who is going to die.

"Because if there is someone who knows that they are going to die, it is the person who is going to die, and we have experienced that. The patient does not have a mutual language, so it is the family who is the interpreter. We use other interpreters when we need it. But it is the patient who is our patient. That is a challenge."

The primary role of a nurse is to advocate and for care of the patient. If there is a conflict of interest between the nurse and the next of kin, the nurses are supposed to put patient before the next of kin. This is something that can be challenging when the patient does not speak

the same language as the nurse and the nurses have to communicate through the family members of the patient and when the family members are trying to shield the patient.

Ruth said that she felt that it is a huge ethical dilemma next of kin had to be used as an interpreter and when the information did not reach the patient. However, Ruth said that she did not feel that it was done to have control over that person but it was done out of love because it can be hard to tell a loved one how a condition might be.

Ola reported that it was challenging when the one of the closest next of kin is not good in speaking in Norwegian, other family members are used as interpreters in regard to information:

"We use what we get, but sometimes if we have closest next of kin who is not as good in Norwegian, so usually there is at least one person in the family who is. So we use that person regarding information. It can work great but sometimes it can be difficult when the patient do not want information to be given out to that person, so it can be challenging".

This shows that conflict between nurses and next of kin emerges when the nurses' role as an advocate for the patient conflicts with communication with the next of kin and when nurses use next of kin as interpreters. The representatives from the organisations said that Norwegian healthcare personnel do not do enough to ensure that there is a qualified interpreter present. However, the other nurses who also worked at the psychiatric ward but in different units said that they do not wish to use family members as interpreters.

Both Aisha and Sunita, is two of the next of kin, said that they had been used as an interpreter. Sunita also said that the first time she acted as an interpreter, she was 12 years old. Aisha mentioned she usually acts as an interpreter for a family member and she admitted that she sometimes had left things out.

"I: If you do not want to worry the family member, do you leave something out?"

Aisha: Until I get medication and treatment, I don't say anything."

4.1.4 Family relations can causes stress for nurses and it can also cause conflict between nurses and next of kin with ethnic minority backgrounds

Family and family values means different things in different cultures, and the family fills different roles in different cultures. In some cultures, family is a very important factor that creates the 'we' feeling and family members might feel that they have to be with the family all the time. A former study by Høye and Severinsson about multicultural family members' experiences with nurses in intensive care context showed that family members with different ethnic minority backgrounds considered family cooperation and the family bond to be an extremely important factor (Høye and Severinsson, 2008). This can conflict with the nurses who are used dealing with smaller groups of next of kin. This is something that the nurses experienced when they worked with patients with minority backgrounds that there were a large group of next of kin. Trude said that:

"Those who are from other religions and cultures have other relations to family and to be in the family".

Another study showed that situations that produced stress for the nurses were rooms that were crowded with family members, who hindered the nurses from doing their jobs (Høye and Severinsson, 2008). Some of the nurses that I interviewed experienced the same problem. Both the nurses who worked at psychiatric ward and the nurse that worked at the hospice experienced stress regarding the large number of family members at the wards. One of the nurses said that she had experienced that there has been a bus with next of kin.

Some of the nurses experienced that they had to set boundaries, regarding the number of the next of kin inside the patient's room. Ruth reported that this was not a good feeling, because she did not want to be strict in that way:

"It is that they are here all the time and they are so many. We see that boundaries are being overrun all the time." She continued to mention that sometimes they have taken over the whole ward.

When asked if the next of kin had taken it well when the nurses had said that they had to limit the number of next of kin inside the patient's room, the nurses reported mixed responses from the next of kin with ethnic minority backgrounds. Two of the nurses reported that the next of kin had taken it well. However, one of the nurses reported that the next of kin did not take it well. Trude said that they had to limit the next of kin and put them in a room because in some cultures have loud reactions, known as the 'death wailing', a ritual that is usually done at funerals.

"They are many and some people have very loud reactions. We can have 30-40 people in the hallway and it can be very loud. Limiting them and putting them in a room and closing the door and tell them that they have to think about the other patients here (...)"

Gudrun mentioned that in Norway, people tend to be more individualistic and talk more about the 'I' instead of the 'we' and that people from other cultures tend to talk more about and they tend to live closer to their families members. This paints a picture of a stronger family bond in other cultures than in the Norwegian culture, which can create conflicts between nurses and next of kin with ethnic minority backgrounds.

"We are much more individuals and talk a lot about 'I' and 'I' as a person who is important and to set the framework on how I am going to live with other people unlike many of the other people with ethnic minority backgrounds who have the 'we' understanding and live more closer on their families and their network. I find it fascinating to work here (hospice) because when we get patients with ethnic minority backgrounds, they have a huge network around them and have someone around them all the time, which usually is not the case with Norwegian patients".

However, the nurses at the psychiatric ward did not report that they had to limit the number of next of kin. This might be due to the fact that they have different visiting routines and that a unit has one open part and one closed part. However, they sometimes experience stress when it comes to working with next of kin with minority backgrounds. Sara said that that the next of kin with ethnic minority backgrounds sometimes do not understand why there cannot be several people at the time.

"Or in some cultures they wish to have ten next of kin visiting them, but unfortunately it cannot be like that here. It is not always they understand that and that can lead to a cultural crash".

Another nurse expressed that it was challenging when there were many next of kin, because there are many that needed information. Usually, the nurses and other healthcare personnel deal with only the closest next of kin. Ola mentioned that:

"In other cultures there are often large care groups in the family, so there are very many who have a great need of information, and that can be challenging".

However, while the nurses expressed that they found the number of next of kin challenging and a source of stress, some of the next of kin that I interviewed felt that the healthcare personnel hated that there were many people. Ali, who is one of the next of kin, said that he felt that the nurses at the hospital to which the family member were admitted, were on their backs constantly. He also reported that he felt that they just hated that he and his family were so many. He felt that the nurses were either ignorant or lacked cultural understanding.

"There was several times that when we were in the room, several nurses had knocked on the door before the visiting hour was over and said that we had to leave the room. Why? No because we have to do stuff, but the visiting hour is not over. No because we have to give this and that but then I said that listen, we are going to be here, so you can either do it later or do it now when we are sitting here"

This indicated the presence of conflict between the nurses and the next of kin because the nurses might feel that the next of kin are in the way, so that they are prevented from doing their jobs. This is a conflict that is caused by family relations.

Ali also reported that that many family members came to visit the patient. This led to small arguments with the nurses at the hospital. However, he felt that he met more understanding from the nurses who had ethnic minority backgrounds. Ali also mentioned during the interview, that they were called into a meeting in which they were lectured on how one should behave at a hospital:

"We had a meeting with the hospital where they pointed out to us the rules at the hospital on how one is supposed to be at the hospital, and they also lectured us on how one is supposed to behave at a hospital".

4.1.5. Summary of the findings

The nurses reported similar challenges regarding working with next of kin with ethnic minority backgrounds. The majority of the nurses admitted that next of kin had been used as an interpreter between staff and the patient. Some of the nurses had experienced that the patient did not have received the proper information about their current health state, and some of the nurses felt that it was challenging when small children were shielded from what was happening when they felt that it was better for the child to know what was happening. The representatives from the two organisations mentioned that healthcare personnel are not good at acquiring an interpreter for those who needed an interpreter. This is shown in the example from the Pasient - and Brukerombudet of the Somali woman who had lost her son and did not know what the cause of death was (see Appendix 1).

According to ethical guidelines for nurses, the nurses' role is to put the patient first, and if there is a conflict of interest between the next of kin and the nurse, it is the patient's interest that must be prioritised. This can be something that is challenging for the nurses. Others reported that it was a challenge when many family members felt the need for information. To summarise the findings, the nurse experienced stress when working with overcrowded families and that they had to deal with large numbers of next of kin.

4.2. Integrating into the Norwegian system

Integration has long been debated and discussed in Norway. In these sections of the chapter, I present my findings in two sub-themes, namely, expectations to adapt to the Norwegian system and attitudes among healthcare personnel. In the sub-theme, expectation to adapt to the Norwegian system, I present the results from both the nurses and the next of kin. In the sub-theme next of kin felt that they were met with prejudice, the next of kin's stories that are highlighted. The sub-themes are the following:

- **Nurses expect people who immigrate to Norway should adapt to the Norwegian system**
- **Next of kin felt that they were met with prejudices**

4.2.1 Nurses expect people who immigrate to Norway adapt to the Norwegian system

When someone moves to another country, people are expected to integrate into the society and to their new country's system. As mentioned, Norwegian hospitals work from those differently in other parts of the world, which may make it hard to adapt into the Norwegian system.

Some of the nurses said that they expected that people who come to Norway try to adapt to the Norwegian system. The nurses said that they expect next of kin with ethnic minority backgrounds to adapt to the Norwegian system, but the nurses should also have an understanding for the next of kin's culture and religion. Venke, who is one of the nurses, said that:

"We should have understanding that other people do something differently but have in mind that others have expectations that other should adapt to the Norwegian culture. I have expectation that immigrants should adapt to Norwegian system but we should have understanding for each other's culture. For me there is a difference between system and culture".

Sara said that nurses can meet the next of kin in the middle, but as a person who have moved to Norway, one have a responsibility to understand the country one live in but they do not become Norwegian overnight and should be humble towards the country they live in.

«Yes, it has to be the starting point. No one can know every culture there is. It should not be expected that we are going to welcome others with something else that is expected in our society».

However, Ola said that he tries to use his Norwegian 'politeness' but if he sees that is wrong, he will try to change. He continued with that he does not have to do absolutely everything his way, and that he tries to take the culture of the next of kin into account. When he meets people from other cultures, he tries to adapt himself and not force them to adapt.

The next of kin mentioned that they have been lectured on how one should behave at the hospitals, with comments like 'this is how we do it in Norway'. Sunita, one of the next of kin, said that she had been told several times this several times:

"I have not only felt it. I have actually heard them say it. There are some people that do not manage to put their prejudices away. Sometimes it is the body language and sometimes it just slips from their mouth that we do not do that here in Norway. You understand by the context that it was meant and that they just had to say it before they left. . . . [. . .] Yes, I have experienced it several times".

Sunita said that she thinks that it is easier to be a next of kin with ethnic Norwegian background than a next of kin with ethnic minority backgrounds, because one has the language and knows the 'Norwegian codes'. She also said that having another language and the same understanding of healthcare system limits them.

In some cultures one cannot eat certain foods such as pork. Ali recalled an experienced at the hospital in which he asked the nurses not to mix the cutlery but that they continued to mix the cutlery:

"You have probably understood that I am Muslim. You get a slice of bread in the evening around 8 pm. usually it is half a slice with ham and the other half with cheese. There was one nurse who kept mixing cutlery. I told we do not eat pork and it is not okay that they keep mixing the cutlery and if they could stop doing that. We keep asking over and over again. [. . .] When I confronted the specific nurse, the nurse said that she is going to keep mixing cutlery because that is how she had done it for many years".

This is an example of a conflict between a nurse and next of kin in a Norwegian care setting, and this also shows that instead of trying to understand the next of kin and why she should not mix cutlery, she looks at the situation through ethnocentric eyes.

4.2.2 The next of kin with ethnic minority backgrounds felt that they were met with prejudices

When meeting with healthcare personnel, patients and next of kin expect to be met with respect. However, the next of kin in this thesis reported feeling that they were met with prejudice healthcare personnel and felt that they were met with prejudices, especially when it came to people from certain cultures have a large number of family members visit them. Words repeated during interviews with some of the next of kin were 'arrogant' and 'condescending'. Some of the next of kin mentioned doctors instead of nurses, and one of the next of kin said that she did not have issues with the nurse but it was the doctors that were struggling.

Two of the next of kin reported that they were met with the comment 'you are too many in the room'. Sunita said that she had experienced that when the doctor walked into the room, the doctor asked who is who. During the interview, both of the participants said that they knew that doctors were referring to the stereotype that in some cultures, many family members get involved when someone is sick. For both nurses and doctors, it can be a reality that there tends to be a large number of family members visiting, but for the next of kin, they can feel that they are met with prejudices and stereotypes. This is aspect that can create conflict in the Norwegian care setting. Some of the nurses explained that there tend to be many to be many next of kin.

Both Sunita and Ali said that their experience with the Norwegian healthcare services made them feel less Norwegian. Ali, who was born and raised in Norway, said that he felt that:

"I tell people that I am Norwegian, Norwegian - Pakistani, but after what I have experienced and after I have met the people that I have met, have made me feel more like a Pakistani. It is kind of sick because I have always been the person that I have told people that I am born and raised in Norway, but no, I am a Pakistani. It does not matter how much one contributes to the society and how hardworking you are, you will never be to Norwegian for them".

Sunita said that she had no problem with the nurses that she had met, but she described a situation in which she felt that a doctor had talked down to her and her family. She reported that the first thing that the doctor had asked when he walked into the room was why so many in were in the room, and he went around the room to ask who was who. She also said that the doctor at the emergency room had interrupted her when she was translating for a family member. She said that the doctor's attitude made her feel less Norwegian:

"It was that attitude because we were immigrants, and one feel less Norwegian. One feels discriminated and feel that one get another treatment because one have another ethnic background".

However, the doctor's role has been assigned through their status, and they are allowed to ask such questions. This is another example of why healthcare personnel should not allow family members to be an interpreters, because this assigns the next of kin an additional role, and the next of kin can feel that the doctor does not receive their family member's story.

However, Sunita also reported feeling that some doctors and nurses with ethnic minority backgrounds would rather treat people who are ethnically Norwegian, not even talking of next of kin with ethnic minority backgrounds. She also reported seeing doctors with ethnic minority backgrounds in the emergency room not prioritising patients with ethnic minority backgrounds, instead going to take a break. However, Ali felt the opposite. He felt that nurses

with ethnic minority backgrounds were more considerate and understanding than ethnically Norwegian nurses.

Fatima said that some of the doctors she met spoke to her as if she could not understand Norwegian:

"There are some weirdos that do not even talk to you, and who are dismissive and just presume that you do not speak Norwegian and treat you as if you cannot speak Norwegian".

When asked if she felt that she was looked down on, she said yes. Fatima also stated that healthcare personnel should try to understand instead of handling the situation their way with an arrogant attitude because, as many do that. She also stated that many people who expect people are supposed to change because one live in Norway. As mentioned stereotyping occurs as a result when someone's belief and/or expectation of qualities and characteristics of a certain group in the society (Nelson. et al. 1996. pp. 14).

The next of kin felt that the health personnel that they had been in touch with did not have a cultural understanding, and they expressed that they would had wished that the healthcare personnel showed more cultural understanding. Fatima said that:

"Many do not understand how it is to be from abroad. They do not understand the challenges one get. They do not understand the culture".

Most of the nurses in this master's thesis reported that they felt that they need more knowledge about different cultures. Ruth mentioned that when she is unsure, she asks either the patient or next of kin about their culture. She reported that she had received positive feedback from the patients and the next of kin.

4.2.3. Summary of the findings

The results showed that overall; the nurses thought cultural and religious differences should be respected. However, they also expected people who immigrate to Norway, to adapt to the

Norwegian system, because the nurses cannot know everything about every culture and religion. At the same time, the results also showed that some of the next of kin said that they felt that they were met with prejudices, especially when it came to the cultural stereotype of many family members visiting the patients at the hospitals. Many of the next of kin felt that healthcare personnel did not have any cultural understanding. The experiences that the next of kin reported had made them feel less Norwegian.

Chapter Five - Discussion

In this chapter I am going to discuss the findings from chapter four. First, I will start with discussing the theme integration and the sub-themes meeting prejudices in healthcare and the expectations to adapt to the Norwegian system. Later, integration and role expectations will be put up against each other.

In the second section of this chapter, I will discuss role expectations with the sub-themes routines at hospital and other healthcare institutions and family relation causes stress and conflicts for the nurses together because the two sub-themes are highly related. Afterwards, I will discuss communication with an interpreter.

5.1 Meeting prejudices in healthcare and the expectation to adapt to the Norwegian system

The debate about integration into the Norwegian society has raged for several years. Ethnic Norwegians expect those who move to Norway to integrate into the society and adapt to the Norwegian system, and the discussion mainly centres on the manner in which people go about integrating. However, people should not expect people with different ethnic minority backgrounds to put their cultural or religious traditions, values, habits, and customs aside, and some of these habits, customs, values and traditions in a culture usually come with a set of role expectations. Integration is a term with several different meanings. However, integration is defined in sociology as:

"A process that leads to different social units such as individuals, groups, cultures and nations, to unite" (Andersen, H. et al. 1997).

When encountering the healthcare service, people expect to be met with respect. From the time the first phase of immigration in the 1960s, to the third phase of immigration that happened in the 1970s (Rugkåsa, 2012, p. 42-43), Norway has become a country with a multicultural society, meaning that increasing number of patients and next of kin can be expected to have an ethnic minority background. Nurses must thus work with next of kin of ethnic mi-

minority backgrounds, and at present, nurses expect people who immigrate to Norway to adapt to the Norwegian system.

The results showed that most of the nurses that who interviewed expect people with ethnic minority backgrounds to adapt to the Norwegian system, but that nurses should understand that some people do things differently based on different cultures and religions. This leads to the question of whether it is possible to adapt the Norwegian system and for nurses to maintain their cultural understanding. This depends on the people one meets and the setting. One nurse said that nurses and other healthcare personnel and next of kin with ethnic minority backgrounds should meet each other halfway and help each other. Obviously, the nurse and other healthcare personnel should set some boundaries if they conduct that they do not think is acceptable behaviour at the hospital. Instead of see everything ethnocentrically, through Norwegian eyes, the nurse should try to adapt a more cultural relativist position and try to see the next of kin's perspective. The nurses who work with next of kin with ethnic minority backgrounds should be culturally sensitive and be aware of cultural similarities and differences between people without adding values that is either positive or negative. This is important to remember, but it does not mean that if the next of kin overwhelm the area and overcrowd the patient's room that the nurses should turn a blind eye.

An ethnocentric view can lead to stereotyping, which in turn, can lead to prejudices against an individual who is a member of a specific group. This can also lead to othering which sets up a superior self/in-group in contrast to an inferior other/out-group. Othering is a process in which identity is set up in an unequal relationship (Brons, 2015).

The results showed that the next of kin in the study had mixed experiences with nurses and other healthcare personnel. However, the one thing they had in common was that they felt that they were met with prejudices when it came to the stereotypes of the entire family being involved. Some of the next of kin felt were made feel less Norwegian. One of the next of kin even said that he could never ever become Norwegian enough despite how much he worked to fit into the society. When people meet prejudices repeatedly because of their ethnic background, they can be made to feel, which again can lead people to not want to integrate into the Norwegian society because they feel that whatever they do, they will never be sufficiently

Norwegian for the society. When people are left with feeling less Norwegian, they will not identify as Norwegian and instead they will rather identify themselves with people from their own social group. Over time, person's social identity changes. Social identity has several dimensions on how a person chooses to identify themselves (*see chapter 2.3.1 about social identity*). When someone feels less Norwegian, they do not identify with the Norwegian majority group, in which, can hinder the integration into the Norwegian society.

However, one of the next of kin experienced nurses differently than she experienced the doctors. This shows that it is not only nurses who can come in conflict with next of kin with ethnic minority backgrounds and that it is more based on the individual and not necessarily on the role of nurse. Everyone has prejudices, either directly or indirectly. However, this can become a problem when a person acts on their prejudices, as occurred with some of the next of kin in this master's thesis. When nurses or other healthcare personnel act on their prejudices, then conflicts with next of kin with ethnic minority background can arise. Two of the next of kin said that they felt that the only reason, they were treated the way they were because of their ethnic minority background.

Integrating into a society with different traditions in terms of, for example, hospitals and other healthcare institutions can be difficult, because of different expectations to the next of kin. In a country in Africa next of kin might be associated with a different set of role expectations than people have in Norway. In the study by Hanssen and Sommerset that is about the relations between next of kin and the health services. Hanssen and Sommerst (2014) points out that the next of kin find it difficult to deal with the health services. There were no indication in this study of the specific ethnic background the next of kin, who participated, had. However, two of the next of kin, who participated in this master's thesis, reported that while it is difficult to be a next of kin, it is even more difficult to be a next of kin with ethnic minority background.

5.1.2 - Role expectation versus. Integration

The majority group in a society usually expects the minority groups to integrate and to participate in the society in the same manner as the majority group. Norwegian nurses demonstrated this expectation of the next of kin by expecting them to be considerate of the other patients and of routines at hostel and other healthcare institutions. This included visiting hours, the number of people in the patients' room at a time, and so on. As mentioned, the nurses expected next of kin with ethnic minority backgrounds to adapt to the Norwegian system. At the same time, the next of kin with ethnic minority backgrounds were expected by the patient to be present. As mentioned, next of kin can be anybody, whom the next of kin consider the closest next of kin and can thus be many people.

Roles are associated with set of rights and obligations attached to an individual's social position, and all roles comes with a set of expectations. However, the roles that one is assigned through interaction in society might be different across societies. The roles of the nurse and the next of kin helps the two groups to interact with each other, but communication occurs through symbols whose meanings can change on the basis of the next of kin interpretations. This means that the next of kin can interpret, for example, the norms at a hospital differently and that nurse-family interactions might be differently than either party is used to.

It is not that a person should not integrate into a society, but if the person feels pressured and if they are not allowed to act out their role, they might not feel that they can identify themselves with the majority group. Since roles come with different obligations and rights, and the next of kin are not able to act out their role, then there can be conflict between the nurses. In the next sections of the discussion, I discuss role expectations that can cause conflict between nurses and next of kin in the context of the Norwegian care setting.

5.2 Role expectations regarding routines at Norwegian hospitals and other care institutions and family relations cause stress to both nurses and next of kin

When next of kin adopt the role of the next of kin, the nurses and other healthcare personnel have expectations of how the next of kin should behave at the hospital and other healthcare institutions. The expectations and obligations of nurses and of next of kin help both the nurse and the next of kin interact with each other. Sometimes, communication can happen through symbols that can change when the meaning of a symbol is interpreted differently by the next of kin than by the nurse. When expectations and obligations differ, conflict can thus arise.

Imagine a nurse walking into a room that is filled with next of kin with ethnic minority background. The nurse has to struggle to get to the patient's bed, and has to open the window because of the bad air. The nurse says that there cannot be that many people in the room, or that they cannot be at the unit because they have to consider other patients. The next of kin do not take it well because they have the expectations of remaining with their sick family member.

In this case, this case is taken from the results from the interviews with the nurses, portraits a potential conflict between the next of kin with ethnic minority background and the nurses. This conflict can be due to different interpretations of family relation. However, this can also be a role conflict, in which an individual is not able to meet the set expectation that different people or social groups have of them. An individual who experiences being dragged in different directions as they attempt to fulfil the different rights and obligations of that specific role they hold. The next of kin with ethnic minority backgrounds tries to fulfil the different rights and obligations to their role as next of kin how they interpret the role of a next of kin. At the same time, nurses are trying to live up to their expectations as a nurse who advocates of the patient and other patients.

In different healthcare systems, the next of kin have different roles and face different expectations. As one of the nurses mentioned that the Norwegian healthcare system does not have the role that is given to next of kin role in other countries. A healthcare system can symbolise something completely different in other cultures, if we use the symbolic understanding of culture, looking at the healthcare system within the context of culture. For example,

for next of kin in China or countries in Africa that was mentioned by two nurses, the health-care system can symbolise a place where next of kin have to bring food or else the patient will not get food, or that the next of kin do everything expect for the needles.

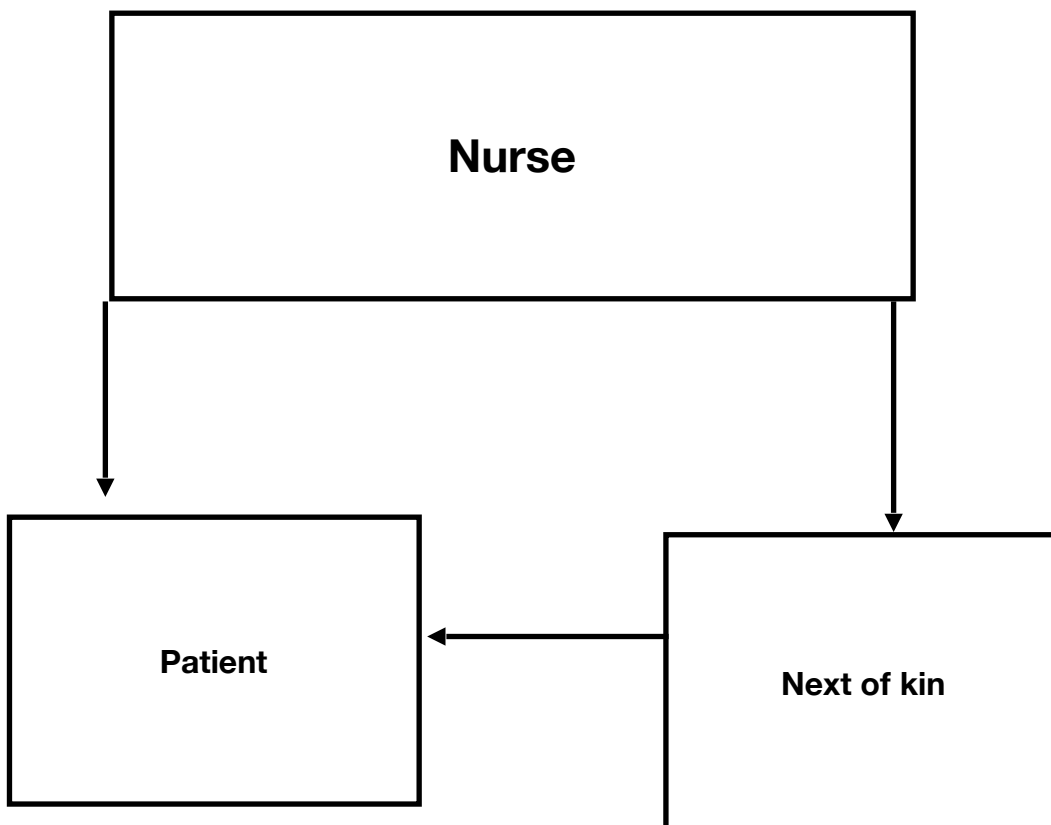
One of the nurses said that some cultures tend to have loud reactions and limiting these limits the ability of the next of kin to culturally express themselves. Some cultures practise the 'death wail'. The 'death wail' is a ritual that is an expression of extreme grief. This ritual is usually performed by women. In the past the women would not only wail and lament, but also scratch at their cheeks, drawing blood, and tearing at their hair (Halevi, 2004).

Some cultures can be considered collectivists centring on the family and the group more than individualistic cultures. Norwegian culture can be considered individualistic; one of the nurses discussed how in Norway, people tend to focus more on the 'I' rather than the 'we', while people from more of a collectivistic culture tend to live closer to their families. This paints a picture of a stronger family bond in other cultures that is considered collectivistic than in the Norwegian culture. According to Hofstede (2011) individualism index score, countries with a strong sense of collectivism tend to be less developed and Eastern countries. When a family member is sick, visitors at the hospitals are usually confined only to immediate family.

Nurses are usually products of a western society that shows individualistic characteristics (Hanssen, 2013). Nurses and other healthcare personnel who are influenced by western theorists usually focus on the individual's need for care (Debesay J. and Tschudi-Madsen, 2018, pp. 51). Debesay and Tschudi-Madsen (2018) mentioned that the reason that are many family members such as uncles, aunts, and grandparents involved when one family member is sick is because it feels natural for the next of kin with ethnic minority backgrounds to be present and participate in the care of the family member who is sick and that it is a cultural obligation to take care of the patient (Debesay Jonas and Tschudi-Madsen, 2018, p. 50). A review study from 2017 found that the next of kin felt the need to be present for the patient, both psychically and emotionally. The study also showed that to be gathered around the patient was im-

portant for how the next of kin coped with the situation and constituted a huge emotional support (Debesay and Tschudi-Madsen, 2018, p. 49).

The nurse responsible for the patient is usually in contact with the family members, friends, and work colleagues. Nursing theorist Dorothea Orem said that the complementary role of nurses and patients also becomes evident through the nurse's contact with the others to represent the patients' wishes and need that is connected to their health situation (Debesay and Tschudi-Madsen, 2018, p. 51). As mentioned, the nurse's primary role is to advocate for the patient. This can also be linked to the next section about communication via an interpreter. One of the nurses who participated in this master's thesis said that it is the patient who is their patient. The table below illustrates what the nursing theorist Dorothea Orem was talking about.



This can create a conflict between the nurse, who is trained within a western healthcare system, and the next of kin, who has a collectivistic mindset; because usually next of kin and the patient are usually considered to be one single inseparable unit in cultures with have a collectivist mindset. When Norway receives people from different parts of the world, then they bring their cultures and attitudes a collectivistic nature.

Each hospital in Norway has its own rules and routines for the next of kin to follow. As the results shows, nurses can be overwhelmed by the number of next of kin who might visit a patient. This causes stress for the nurses, as they feel that they are not able to do their job, and this, in turn can spark a conflict between the nurses and the next of kin with ethnic minority background. As mentioned once before, two of the nurses mentioned that Norwegian healthcare system has excluded the role of the next of kin, who are not supposed to clean or do other tasks that the nurses are supposed to do. One of the nurses said that she had experienced the desire of one next of kin to take over. The nurses are trained to monitor the development of the patient and for example, to see if the patient is developing bed sores, and whether they need from a regular mattress to an air mattress.

Nurses cannot do their job if too many people are gathered inside the room, and nurses tend to be unaccustomed to having 20- 25 people walking around at the unit, and there are also other patients to consider. However, for family members with ethnic minority backgrounds who find family cooperation and the family bond to be important such behaviour can be comforting for both patient and next of kin (Høye and Severinsson, 2008).

One of the next of kin in this study felt that the nurses were constantly on their back and told them to leave the room because they had to give medication and do other things before the visiting hours were over, which led to conflict with the next of kin. However, the Norwegian norm is for the next of kin to leave the room whenever the nurse has to do something (Hansen Ingrid, 2013). The next of kin said that he felt that he was met by more understanding by the nurses who had ethnic minority background than by the nurses who had ethnic Norwegi-

an background, as the former might have more cultural understanding than the latter. In recent years, there has been a focus on immigrant health, and in these strategies, next of kin are also included.

The national strategy on immigrant health was published in 2013 by the Norwegian Government and Oslo University Hospital's strategy of equal healthcare and diversity 2017-2021 is to ensure that those patients with ethnic minority background and next of kin with ethnic minority background is not excluded. The Oslo University Hospital's strategy of equal healthcare and diversity states that focusing on equal and diverse healthcare services is required by national and international law. Both these strategies state that everyone should be made part of Norwegian society regardless of ethnicity, religion, and culture, and an equal healthcare services is an important part of that. No one disagrees that it is important to create equal healthcare services for both the patient and the next of kin, because equal healthcare services should be universal. However, the idea of an equal healthcare services can be difficult to achieve, because, as the nurses have reported, they are unable to do their job because due to the additional stress of overcrowding. Both of the strategies also addressed create an equal healthcare services can be challenging. The national strategy by the government mentioned that the goal of an equal health services is challenged by the language barrier, cultural differences, and the special health problems faced by some individuals with ethnic minority backgrounds. Oslo University Hospital stated realising the goal of being an equal, inclusive, and a diverse hospital can be challenging. However, they maintain that it is important for the personnel working at the hospital to be aware of the hospital's vision and that the individual has a responsibility to be aware of their attitudes, values and behaviour when meeting patients, next of kin, and co-workers (*OUS. 2017*).

Norwegian culture tends to be more individualistic and focus on the 'I' instead of the 'we'. In some, parts of the world, the next of kin have a bigger role, and it can be the next of kin's responsibility to bring food and take care of the patient. This can be challenging for nurses, who are used to a healthcare system in which role of the next of kin is excluded in the sense that the next of kin are not supposed to fill a role, which they do in other parts of the world. This can lead to conflicts between the next of kin with ethnic minority backgrounds and the nurs-

es, and that a national strategy on immigrant health and other kinds of strategies can in theory work, but in real life it can be challenging to realise.

5.3. Communication with an interpreter

When nurses or other healthcare personnel communicate with next of kin who do not speak good Norwegian or any Norwegian, the former must bring in a qualified interpreter, so that they can communicate with the patient and the next of kin. Nurses and other healthcare personnel do use qualified interpreter, but sometimes they use family members to interpret. The Patient and Brukerombudet and PIO mentioned that healthcare personnel in general do not do enough to ensure the use of qualified interpreters, which can create conflict between nurses and next of kin in the context of Norwegian care setting.

The Norwegian Directorate of Health (2011) guidelines for communication with an interpreter states that children or other family members shall not be used as an interpreter, because this places the child in question or the other family member in a difficult situation. It is the healthcare personnel's responsibility to ensure that children or other family members are not used as interpreters, even when the patient wants the next of kin to interpret. The guidelines also state that if a child or other family members are being used as an interpreter instead of a qualified interpreter, can result in important information being held back by the child or other family member. If important information is held back by the family member, the patient is not properly informed about their current state of health. (The Norwegian Directorate of Health, 2011. pp.7).

The Norwegian Directorate of Health's guideline for communication with an interpreter also states that every person who lives in Norway and does not speak or understand Norwegian has the right to a qualified interpreter. This was also mentioned by Patient and Brukerombudet and the PIO Center. However, sometimes the nurses decided to use other family members as interpreters, for various reasons. This can lead to conflict between the next of kin and the nurses in a context of Norwegian care setting.

Some of the nurses who worked at the hospice reported that when the next of kin had to translate some of the information was left out. The nurses also experienced the patient's children out of affairs. These were some of the greatest challenges faced by nurses, because they did not know if they had the right to intervene when the nurses thought that it was better for child to know that one of their parents was going to die. This was, one of the nurses, greatest ethical dilemma that she had faced working at the hospice. However, the nurse said that she did not feel that it was done in order for the family member to have control over that person, but out of love. She mentioned she understands that it is difficult to tell your spouse how bad the situation really is. However, again, it is the patient who is the nurses' responsibility, and they need to know if they are going to die. Until now I have talked about one of the ethical dilemmas some of the nurses had faced when it came to what they think was right and what the next of kin think that is right. Now I am going to discuss more about the use of family members as interpreters, and their additional role as interpreters.

The lack of a common language complicates communication. Sometimes, the nurses are left with few or no resources, and must use whatever they have. One of the nurses said that usually when the closest next of kin cannot speak Norwegian, there are other family members who can speak Norwegian. Using family members as interpreters can be helpful; However, challenges arise when the patient does not want the only person who speaks Norwegian to know about their current state of health. Nurses and other healthcare personnel cannot give out information about the patient without the consent of the patient, as stated in the Patient and User Act (2001) paragraph 3.

"Information about medical conditions as well as other personal information shall be processed in accordance with the applicable rules on confidentiality. The information shall be treated with caution and respect for integrity of the person in question" (Pasient- og brukerrettighetsloven. 2001 paragraph 3-6)².

² Paragraphs 3-6 in the Patient and User Act translated from Norwegian to English https://lovdata.no/dokument/NL/lov/1999-07-02-63/KAPITTEL_3#%C2%A73-5

However, confidentiality is no longer an issue if the patient in question consents to give out the information to their closest next of kin (Patient and User Act, 2001, paragraph 3-6).

In the previous paragraphs in this section, I have talked about nurses using next of kin as interpreters. The rest of this section is going to focus on when next of kin are used as interpreters.

One of the next of kin said that she was used as interpreter when she was 12 years old. According to the guidelines for communication with an interpreter states that children or other family members are not allowed to be used as interpreters. Filling the role of an interpreter can place the child in a difficult spot. Another next of kin admitted that she had left out certain things for the family member for whom she interpreting for.

When next of kin is used as an interpreter instead of a qualified interpreter, next of kin receives an additional role as an interpreter. As Erving Goffman argued, roles that an individual receives through interacting in the society are associated with rights and obligations. If the next of kin receives an additional role as an interpreter, the obligations of their role as an interpreter and the obligations of the role as a next of kin can come in conflict. Previous studies have shown that next of kin feel that serving as an interpreter is a big responsibility and that it was their duty not to transfer all of the information given to the next of kin to interpreter, but to relay it more kindly. This was due to generational and cultural issues from their home countries, where older people are not used to express a message in a direct way that perhaps the nurses and qualified interpreter would. The next of kin also felt that it was emotionally difficult to pass on negative news on to the family members, as it might upset them (Hadziabdic, Albin et al. 2014).

It is therefore important not to use children or other family members as interpreters, because if the family member who holds back the information, the patient will not receive information about their current state of health. This is stated in the Patient and User Act that the patient or the user has the right to information about their current state of health (Pasient- og brukerrettighetsloven. 2001).

"The patient should have the information needed to gain insight into their health and the content of healthcare. The patient should also be informed of possible risks and side effects."³

The nurses have ethical guidelines that they must follow as a nurse, one of which says that they must put the patient first if there is conflict of interest between the next of kin and nurse. The primary role of a nurse is to be advocate for the patient. However, when nurse use next of kin interpreters, the nurse loses the control over the information that is passed to the patient. The nurse has no way of knowing if the patient has received the same information that was given to the next of kin to interpret or if the patient has understood the information the nurses has tried to communicate. As one of the nurses said is that it is the patient who is their patient.

Nurses and other healthcare personnel thus should not use next of kin as interpreters, even though doing so is easier and less time-consuming than waiting for a qualified interpreter. When next of kin is used as an interpreter, they receive a new role and a different set of responsibilities. One of the nurses said that that it is difficult to tell to tell a spouse how bad the situation really is, which is supported in the study about family members' experiences of the use of interpreters in healthcare, which found that the next of kin felt that it was emotionally difficult to pass on negative news to the family members because it might upset them (Hadzi-abdic, Albin et al. 2014). The use of qualified interpreters, rather family members, is also required by law. This one of the conflicts that can emerge between the next of kin and nurses in the Norwegian care setting, while other conflicts include routines at Norwegian hospitals and other care institutions, such as Hospice, and family relations.

³ Paragraphs 3-2 in the Patient and User Act translated from Norwegian to English

Chapter Six - Conclusion

In this chapter, I summarise the master's thesis and present some recommendations for further study and actions regarding next of kin with ethnic minority backgrounds in the context of the Norwegian care setting. At the end of this chapter, I am finally conclude the master's thesis.

6.1. Summary

The Norwegian society has transitioned from a homogeneous society to a more multicultural society, meaning that an increasing number of people with ethnic minority backgrounds are using Norwegian healthcare services and that nurses and other healthcare personnel must interact with patients with ethnic minority background. Wherever there are patients, there are usually next of kin as well, and nurses and other healthcare personnel not only interact with patients but with next of kin with ethnic minority background.

It is thus important to conduct research on patients and next of kin with ethnic minority backgrounds and develop strategies that both patients and next of kin with ethnic minority background feel included, and since next of kin is a sources for all healthcare personnel. In 2013, the Norwegian government published a national strategy on immigrant health, stating that that it is crucial that healthcare services ensures that the patient and the next of kin have faith in the system and the people who work within the healthcare services. In 2017, Oslo University Hospital published a strategy for equal healthcare services, in which the primary focus areas include patients and next of kin.

The purpose of this master's thesis was to illuminate the kinds of conflicts that can emerge when nurses and other healthcare personnel and next of kin with ethnic minority backgrounds have to interact with each other. The research question for this master's thesis was as following:

What kind of conflicts arise between nurses and next of kin with ethnic minority backgrounds in the context of the Norwegian care settings?

To collect data to answer the research questions, semi-structured interviews were used, and the data was analysed using a thematic analysis. The participants consisted of three groups: next of kin who had an ethnic minority background, nurses and representatives from two organisations. Some of the nurses who participated in this master's thesis worked in the psychiatric ward and the other nurses worked at a hospice. Even though the nurses worked in different parts of the healthcare services, they had almost the same experiences with next of kin with ethnic minority background, but in different way. This is due to next of kin have a different role at a psychiatric ward, whereas next of kin is a natural part of a hospice. The next of kin who participated in this master's thesis were of different ethnic origins, all being born in Norway but with parents of various ethnic minority backgrounds. Two topics and sub-topics emerged from the thematic analysis:

Role expectations

1. Role expectation at Norwegian hospitals and other care institutions can cause conflict between nurses and next of kin with ethnic minority background
2. Communication can cause conflict between nurses and next of kin ethnic minority background
3. Family relations can causes stress for nurses and it can also cause conflict between nurses and next of kin with ethnic minority background

Integration

1. Nurses expect people who immigrate to Norway should adapt to the Norwegian system
2. Next of kin felt they were met with prejudices

This master's thesis parented the nurses' perspective, as well as that of the next of kin, though not in depth, though the section on next of kin encountering prejudice in healthcare presented the next of kin's perspective of their experience.

The findings of this master's thesis supports the findings of Sevald Høye and Elisabeth Se-verinsson (2009) study 'multicultural family members' experience with nurses and the inten-sive care context' and their other study 'multicultural family members' experiences with nur-ses and the intensive care context'. The findings in this master's thesis also support the fin-dings of the study done by Hadziabdic et.al. (2014) about family members' experiences with the use of interpreters in healthcare.

6.2.. Recommendations for further study and action

Since Norway is becoming, increasingly multicultural, gaining more knowledge on minority cultures is increasingly important. However, as the nurses said during the interview, they cannot know everything about every culture.

Though many studies that have been done about patients with ethnic minority backgrounds, fewer have specifically examined next of kin with ethnic minority backgrounds. This topic should be taken up by future researcher, so that next of kin with ethnic minority backgrounds can also feel that they are taken care of. Every next of kin should be met individually and ac-cording to their life situation they are in and should be taken seriously. This master's thesis does not insinuate that the nurses do not take next of kin with ethnic minority backgrounds seriously; however, the nurses interviewed in this master's thesis expressed that they would like to know more about the different cultures. Mandatory courses abut multicultural com-munication should be encouraged by the administration at very healthcare institution in Nor-way for nurses and other healthcare personnel. At Oslo University Hospital, the personnel are offered the chance to attend courses that cover diversity, migration health, cultural sensitivity, communication and existing services within equal health services; however, courses like this should be made mandatory.

A questionnaire or other forms should be offered in different languages for the next of kin to provide feedback about the service that they have received during or after a stay. Organisations such as Pasient- and Brukerombudet and Pårørendesenteret (PIO) work for the patient and the next of kin, but people with limited knowledge of Norwegian or of the organisations that works for the patients' or next of kin's rights will feel that they have nowhere to turn.

Further studies should be conducted about using family members as interpreters and how this might affect the next of kin's role placing them in difficult situation of messages. Nurses and other healthcare personnel are trained and through experience know how to convey a difficult messages. The study mentioned in this master's thesis about family members' experiences of the use of interpreters in healthcare was conducted in Sweden, so there should be more research in the Norwegian context about this topic and resources devoted improving the interpreting services in Norway, so nurses or other healthcare personnel do not have to use family members as interpreters.

Finally, the nurses who work with patients or next of kin that have an ethnic minority backgrounds should not be afraid to ask the next of kin or the patient about their culture. One of the nurses at the hospice said that they sometimes ask the next of kin with ethnic minority backgrounds about their cultures and receive positive reactions.

6.3 Conclusion

The nurses who participated in this master's thesis work at the psychiatric ward and the hospice; however, the results show that they encountered the same challenges, but in different ways. The results showed that there are conflicts when nurses and next of kin with ethnic minority backgrounds interact in the context of the Norwegian care setting; these can be due to communication, family relations that caused stressed for nurses and routines at the hospitals and other healthcare institutions. The results also showed that the next of kin experienced prejudice related to family relations.

The results also showed that using family members as interpreters can create conflicts and that the next of kin who are used as interpreters receives additional roles that place them in internal conflict. Furthermore, when using family members as interpreters, nurses lose the control over how much and what information reaches the patient. Nurses and other healthcare personnel must therefore stop using family members as interpreters.

Norway is becoming an increasingly multicultural society, meaning that the nurses will increasingly face both patients and next of kin with ethnic minority backgrounds. It is important to remember to ask the next of kin with ethnic minority backgrounds what is important for them and the patients since the nurses cannot know everything about every culture there is. The conflicts that are identified here do not only apply to nurses, and not every interaction between a nurse and next of kin with ethnic minority backgrounds results in conflict; instead, it is situational and depends on the individuals involved.

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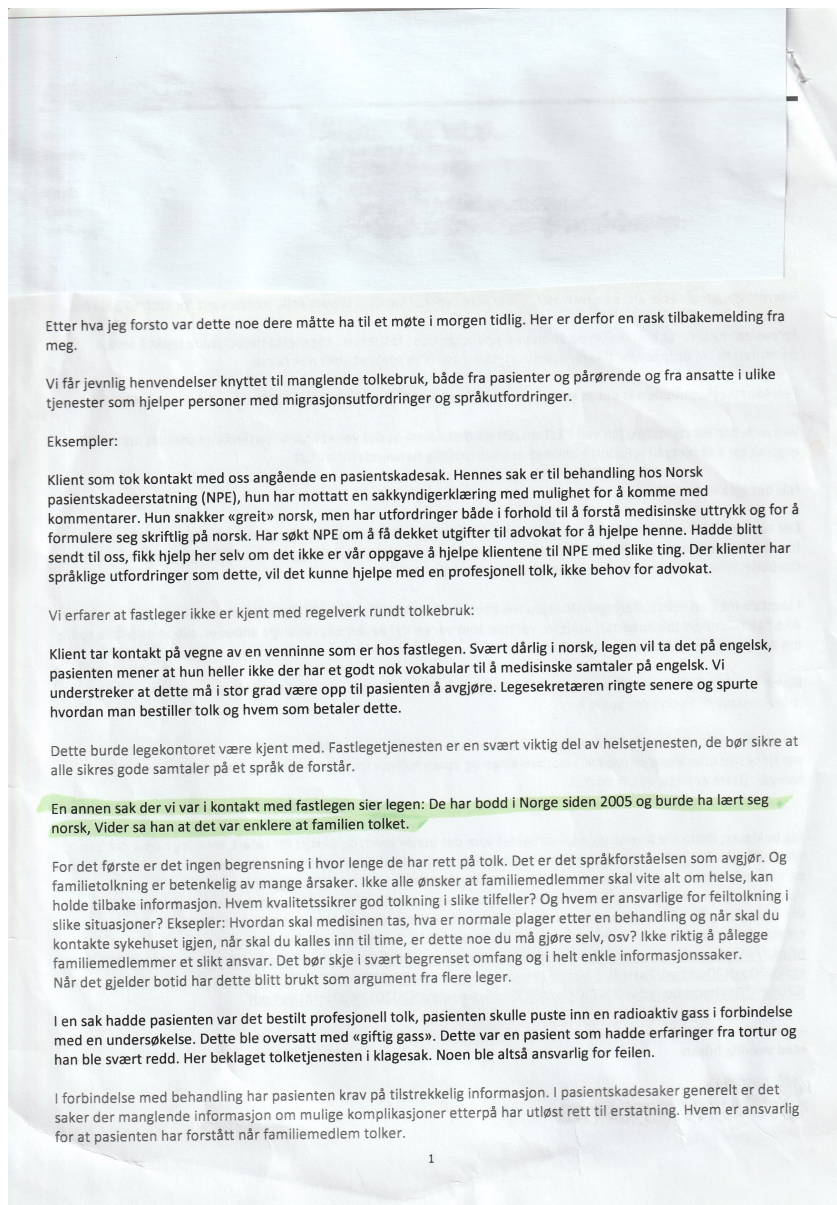
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Appendix 1 - Source (Information given by Pasient- and Brukerombudet)



Vi fikk en henvendelse fra en fastlege med en pasient som legen mente hadde behov for tolk. Pasienten var henvist til undersøkelse hos avtalespesialist. Klinikken pasienten var henvist til ga beskjed om at enten måtte fastlegen bestille tolk eller så måtte pasienten gjøre det. Hvis ikke måtte pasienten henvises til sykehus. Klinikken bestilte ikke tolk og hadde aldri gjort det. De mente det var henvisers oppgave og at de som spesialister hadde andre ting å gjøre.

I denne saken skrev vi til klinikken og fikk svar. Svaret er vedlagt. Vi regner med at de har endret praksis. En klargjøring i regelverk som sier at tjenestestedet som utfører tjenester er pliktig å bestille profesjonell tolk ville sikkert vært greit i dette tilfellet.

En klient ringte oss på vegne av en somalisk familie der sønnen i 20-årene døde på sykehus. De hadde ikke forstått hva sønnen døde av. Heller ikke etter å ha fått utlevert journalen. Guttens mor hadde ikke forstått noe av informasjonen som ble gitt på sykehuset, heller ikke om hun var blitt tilbudt tolk. Hadde vært for stolt til å si i fra.

En pasient fortalte at hun opplevde at en undersøkelse som i fastlegen i utgangspunktet hadde tenkt å sende pasienten til ble droppet fordi legen mente at pasienten ikke snakket godt nok norsk.

I en Akershuskommune var det et krav til deltakerne på frisklivsentralen at de snakket norsk eller engelsk.

Ved avdeling for reproduksjon ved OUS sto det på nettsidene at det var et krav at pasientene snakket norsk eller engelsk for å få hjelp til IVF. Dette ble endret etter skriftlig henvendelse fra oss.

Når det gjelder finansiering:

Det har også blitt oss fortalt at noen, i dette tilfellet fastleger, ikke bruker tolk for de de selv må betale dette først, for så å få refusjon fra HELFO. For det første er dette mer papirarbeid, i tillegg tar det tid før pengene refunderes. Ombudet mener selvfølgelig ikke at dette er et godt argument.

I samtale med en rehabiliteringsinstitusjon med avtale med det offentlige ble det løftet frem som et problem at de ikke fikk refundert tolkeutgifter, at dette var noe som var en del av det opprinnelige tilbudet, slik at de måtte spare inn penger ved å redusere denne kostnaden.

Burde kanskje utgifter til tolk være tatt ut fra øvrige refusjonsordninger slik at tolketjenesten selv sendt refusjonskrav til Helfo eller andre?

Vi har også hatt eksempler der innbyggere ikke har hatt tilstrekkelig språklig kompetanse i møte med bydel til å søke om tjenester eller klage på vedtak. Hvordan klage og innen hvilken frist, samt hvordan klagesaksbehandlingen foregår. Dette er viktig at blir bedre!

Appendix 2 - NSD approval

Det innsendte meldeskjemaet med referansekode 325285 er nå vurdert av NSD. Følgende vurdering er gitt: Det er vår vurdering at behandlingen vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet 07.01.19 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

MELD ENDRINGER Dersom behandlingen av personopplysninger endrer seg, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. På våre nettsider informerer vi om hvilke endringer som må meldes. Vent på svar før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET

Prosjektet vil behandle særlige kategorier av personopplysninger om rasemessig eller etnisk opprinnelse og alminnelige personopplysninger frem til 15.05.19

LOVLIG GRUNNLAG

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 a), jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER

NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen: - om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen - formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål - dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet - lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet.

DE REGISTRERTES RETTIGHETER

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20). NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13. Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER

NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32). For å forsikre dere om at kravene oppfylles, må prosjektansvarlig følge interne retningslinjer/rådføre seg med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET

NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Kontaktperson hos NSD: Silje Fjelberg Opsvik Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Appendix 3- Letter of Consent (Nurses)

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet "hva slags utfordringer pårørende møter med den norske helsetjenesten", og har fått anledning til å stille spørsmål. Jeg har også gjort meg forstått at jeg på bakgrunn av helsepersonelloven kapittel 5 §21, ikke skal nevne enkelt-saker eller pasienter, og at brudd på dette vil medføre at intervjuet blir avsluttet. Jeg samtykker til:

å delta i intervju

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 15.05.2019.

(Signert av prosjektdeltaker, dato)

Appendix 4 - Letter of consent (Next of Kin)

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet "hva slags utfordringer pårørende møter med møte med den norske helsetjenesten", og har fått anledning til å stille spørsmål. Jeg har også gjort meg forstått at jeg ikke skal nevne familie medlemmer som er syke eller andre familie medlemmer som ikke har sagt ja til å delta i prosjekt. Jeg samtykker til:

å delta i intervju

Jeg samtykker til at mine opplysninger som etnisk opprinnelse behandles frem til prosjektet er avsluttet, ca. 15.05.2019.

(Signert av prosjektdeltaker, dato)

Appendix 5 - Letter of consent (Organisations)

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet "hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten", og har fått anledning til å stille spørsmål. Jeg samtykker til:

å delta i intervju

at navnet på organisasjonen og tittel på stilling blir nevnt i avhandlingen

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 15.05.2019.

(Signert av prosjektdeltaker, dato)

Appendix 6 - Letter of information (Healthcare personnel)

Vil du delta i forskningsprosjektet ***”Hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten”?***

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å finne ut av hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten. I dette skrevet gir jeg deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg som velger å delta i prosjektet.

Formål

Jeg er en masterstudent i sosialfag med studieretning internasjonal helsepolitikk og sosial velferd ved OsloMet. Formålet med forskningsprosjektet er å finne ut av hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten.

Hvem er ansvarlig for forskningsprosjektet?

OsloMet - Storbyuniversitet

Hvorfor får du spørsmål om å delta?

Grunnen til at akkurat du blir spurt å delta i studien er fordi dine tanker og erfaringer rundt den norske helsetjenesten er relevant til masteroppgaven som jeg skal skrive. Jeg vil intervju helsepersonell om deres erfaringer og tanker rundt temaet.

Hva innebærer det for deg å delta?

Hvis du velger å delta i prosjektet, innebærer det at du deltar i et intervju hvor du svarer på diverse spørsmål. Dette vil ta ca. en time. Det vil bli gjort lydopptak av intervjuet som deretter blir skrevet ned. Alle informanter kommer til få et pseudonym. Etter at intervjuet har blitt skrevet ned blir opptakene slettet. Selv om deltakerene blir anonymisert er det ikke lov på bakgrunn av helsepersonelloven kapittel 5 §21 "helsepersonell skal hindre at andre får adgang eller kjennskap til opplysninger om folks legems- eller sykdomsforhold eller andre personlige forhold som de får vite om i egenskap av å være helsepersonell," å nevne pasienter og enkeltsaker. Brudd på helsepersonelloven kapittel 5 §21 vil medføre at intervjuet blir avsluttet umiddelbart. Dette vil jeg nevne før intervjuet starter.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta kan du når som helst trekke samtykke tilbake uten å oppgi grunn. Alle opplysninger om deg vil bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Du kan også velge å ikke svare på spørsmål som gjør deg ukomfortabel. Hvis det er ønskelig kan deltakerene be om sitatsjekk. Dette kommer jeg til å nevne før intervjuet.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

For at uvedkommende ikke skal få tilgang til personopplysningene blir opplysningene lagret i separate mapper som får passord. Disse mappene blir lagret på en minnepinne som blir trygt oppbevart. Navn og kontakt opplysningene dine vil jeg erstatte med en kode som lagres på egen navneliste adskilt fra øvrige data. Personene som kommer til å ha tilgang til opplysninger er min veileder Kjetil Wathne og meg selv.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Prosjektet skal etter planen avsluttes 15.05.2019. Personopplysninger og annet informasjon om personene som deltar i studien blir slettet etter at masteroppgaven er levert.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra **OsloMet - Storbyuniversitet** har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- Cathrine Victoria Klosowska Paulsen, på telefon: 93666432 eller på epost: cathrine.-paulsen@yahoo.com
- Kjetil Wathne , på telefon: 46056036 eller på kjetil.wathne@oslomet.no
- Vårt personvernombud ved OsloMet, Ingrid S. Jacobsen, på personvernombud@oslomet.no eller på telefon 67235534

- NSD – Norsk senter for forskningsdata AS, på epost (personvernombudet@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig

Appendix 7 - Letter of information (Next of Kin)

Vil du delta i forskningsprosjektet ***”Hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten”?***

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å finne ut av hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten. I dette skrivet gir jeg deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg som velger å delta i prosjektet.

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Hvem er ansvarlig for forskningsprosjektet?

OsloMet - Storbyuniversitet

Hvorfor får du spørsmål om å delta?

Grunnen til at akkurat du blir spurt å delta i studien er fordi dine tanker og erfaringer rundt den norske helsetjenesten er relevant til masteroppgaven som jeg skal skrive.

Hva innebærer det for deg å delta?

Hvis du velger å delta i prosjektet, innebærer det at du deltar i et intervju hvor du svarer på diverse spørsmål. Dette vil ta ca. en time. Det vil bli gjort opptak av intervjuet som deretter blir skrevet ned. Alle informanter som velger å delta i forskningsprosjekt kommer til å bli anonymisert. Etter at intervjuet har blitt skrevet ned blir opptakene slettet. Selv om informantene blir anonymisert er det viktig å ikke nevne navn eller andre personopplysninger om familiemedlem som er syke eller andre som ikke har sagt ja til å delta i forskningsprosjektet under intervjuet. Dette kommer jeg til å nevne før intervjuet starter. Da temaet for forskningsprosjektet er pårørende med minoritetsbakgrunn vil opplysninger som etnisk opprinnelse bli behandlet i forskningsprosjekt.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta kan du når som helst trekke samtykke tilbake uten å oppgi grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Du kan også velge å ikke svare på spørsmål som gjør deg ukomfortabel.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

For at uvedkommende ikke skal få tilgang til personopplysningene blir opplysningene lagret i separate mapper som får passord. Disse mappene blir lagret på en minnepinne som blir oppbevart på et sikkert sted. Navn og kontakt opplysningene dine vil jeg erstatte med en kode som lagres på egen navneliste adskilt fra øvrige data. Personene som kommer til å ha tilgang til opplysninger er min veileder Kjetil Wathne og meg selv.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Prosjektet skal etter planen avsluttes 15.05.2019. Personopplysninger og annet informasjon om personene som deltar i studien blir slettet etter at masteroppgaven er levert.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra **OsloMet - Storbyuniversitet** har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- Cathrine Victoria Klosowska Paulsen, på telefon: 93666432 eller på epost: cathrine.-paulsen@yahoo.com
- Kjetil Wathne , på telefon: 46056036 eller på kjetil.wathne@oslomet.no
- Vårt personvernombud ved OsloMet, Ingrid S. Jacobsen, på personvernombud@oslomet.no eller på telefon 67235534
- NSD – Norsk senter for forskningsdata AS, på epost (personvernombudet@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig

Appendix 8 - Letter of information (Organisations)

Vil du delta i forskningsprosjektet

”Hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten”?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å finne ut av hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten. I dette skrivet gir jeg deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg som velger å delta i prosjektet.

Formål

Jeg er en masterstudent i sosialfag med studieretning internasjonal helsepolitikk og sosial velferd ved OsloMet. Formålet med forskningsprosjektet er å finne ut av hva slags utfordringer pårørende med minoritetsbakgrunn møter når de møter den norske helsetjenesten.

Hvem er ansvarlig for forskningsprosjektet?

OsloMet - Storbyuniversitet

Hvorfor får du spørsmål om å delta?

Grunnen til at akkurat du blir spurt å delta i studien er fordi dine tanker og erfaringer rundt den norske helsetjenesten er relevant til masteroppgaven som jeg skal skrive. Jeg vil intervju helsepersonell om deres erfaringer og tanker rundt temaet.

Hva innebærer det for deg å delta?

Hvis du velger å delta i prosjektet, innebærer det at du deltar i et intervju hvor du svarer på diverse spørsmål. Dette vil ta ca. en time. Det vil bli gjort lydopptak av intervjuet som deretter blir skrevet ned. Etter at intervjuet har blitt skrevet ned blir opptakene slettet. Det er normalt at informantene blir anonymisert i en avhandling men det er dessverre ikke alltid mulig å anonymisere informanten helt.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta kan du når som helst trekke samtykke tilbake uten å oppgi grunn. Det vil ikke ha noen negative konsekvenser for deg hvis du

ikke vil delta eller senere velger å trekke deg. Du kan også velge å ikke svare på spørsmål som gjør deg ukomfortabel. Hvis det er ønskelig kan informantene be om sitatsjekk. Dette kommer jeg til å nevne før intervjuet

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

For at uvedkommende ikke skal få tilgang til personopplysningene blir opplysningene lagret i separate mapper som får passord. Disse mappene blir lagret på en minnepinne som blir trykt oppbevart. Navn og kontakt opplysningene dine vil jeg erstatte med en kode som lagres på egen navneliste adskilt fra øvrige data. Personene som kommer til å ha tilgang til opplysninger er min veileder Kjetil Wathne og meg selv.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Prosjektet skal etter planen avsluttes 15.05.2019. Personopplysninger og annet informasjon om personene som deltar i studien blir slettet etter at masteroppgaven er levert.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

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- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra **OsloMet - Storbyuniversitet** har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

Cathrine Victoria Klosowska Paulsen, på telefon: 93666432 eller på epost:
cathrine.paulsen@yahoo.com

Kjetil Wathne , på telefon: 46056036 eller på kjetil.wathne@oslomet.no

Vårt personvernombud ved OsloMet, Ingrid S. Jacobsen, på personvernombud@oslomet.no eller på telefon 67235534

NSD – Norsk senter for forskningsdata AS, på e-post (personvernombudet@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig -----

Appendix 9 - Interview guide (Next of Kin)

Generelt

Hvor gammel er du?

Hvilket land kommer du fra?

Hvor lenge har du bodd i Norge?

Hva slags inntektsgrunnlag har du?

Hva slags utdanningsbakgrunn har du?

Sykdom og behandling

Hvor lenge har det vært sykdom i familien?

Hva slags erfaring har du/dere med behandling?

Kultur

Hva er kultur for deg?

Merker du noe forskjell mellom din kultur og den norske kulturen?

Hva legger du i kulturell kompetanse?

Norske helsevesenet

Hva slags opplevelse har du som pårørende med det norske helsevesenet?

Har du/dere opplevd utfordringer når det kommer til møte med helsepersonell? Hvis ja, hva slags utfordringer har dere møtt på? Hvis nei, forklar

Føler du blir hørt? Hvis nei, på hvilken måte føler du at du ikke blir hørt?

Norsk helsepersonell er utdannet etter en vestlig helsemodell, og bygger på naturvitenskaplig forståelse, med diagnostisering av sykdom etter gitte kriterier. Føler du at Norge har et monokulturelt helsevesen? (Norske helsevesen har bare en måte se sykdom på).

Hva du/dere hadde muligheten til å forandre en ting ved den norske helsetjenesten, hva ville det ha vært?

Trekk fram noe positivt med helsetjenesten i Norge.

Appendix 10 - Interview guide (Nurses)

Generelt

Hvor gammel er du?

Hvor lenge har du jobbet som sykepleier?

Hva slags ansvarsoppgaver har du?

Hva er det mest utfordrende å jobbe som sykepleier?

Multikulturell kompetanse

- Hva legger du i begrepet "det flerkulturelle"?
- Hva er det mest utfordrende å jobbe med pårørende med minoritetsbakgrunn?
- Hva slags etiske dilemmaer har du som sykepleier møtt i møte med pasienter og pårørende med en annen kulturell bakgrunn?
- Synes du at helsepersonell har for lite kunnskap om minoritets kulturer? Hvis ja, hva tror du er den beste måten å forbedre kunnskapen om minoritets kulturer?
- Hva er kultur for deg?
- Hvordan ville du beskrive norsk kultur?
- Hva legger du i kulturell kompetanse?
- Hva er kulturell omsorg for deg?
- «Grunnlaget for all sykepleie skal være respekten for det enkelte menneskets liv og iboende verdighet. Sykepleie skal bygge på barmhjertighet, omsorg og respekt for menneskerettighetene, og være kunnskapsbasert» (1). Noen nordmenn mener at innvandrere til Norge må tilpasse seg norsk kultur. Ifølge yrkesetiske retningslinjer for sykepleiere skal vi behandle alle mennesker med respekt og verdighet. Skal sykepleieren møte pasienten og pårørende med en annen etnisk bakgrunn med den "norske" formen for høflighet?
- Norsk helsepersonell er utdannet etter en vestlig helsemodell, og bygger på naturvitenskaplig forståelse, med diagnostisering av sykdom etter gitte kriterier. **Påstand:** Norge har en ensrettet måte å tenke på helse, sykdom og behandling. Er du enig i den påstanden og

føler du at Norge har et monokulturelt helsevesen? (Norske helsevesen har bare en måte se sykdom på).

- Hva kan helsepersonell gjøre for å fremme god kommunikasjon med pårørende med minoritetsbakgrunn?
- Tror du at økt innvandring og mangfold øker behovet for kulturell kompetanse i helsevesenet, eller skal man fokusere mer på fagkompetanse? Begrunn svaret.
- Tror du at pårørende med minoritetsbakgrunn i psykiatrien møter andre utfordringer enn det de gjør i somatikken?

Appendix 11 - Interview guide (Organisations)

- Fortell litt om deres organisasjon og hva dere driver med?
- Hva er hovedformålet med organisasjonen?
- Hvem er det som henvender seg til dere?
- Hvem er pårørende?
- Hva slags rettigheter har pårørende?
- Hvordan kommer pasienter og pårørende i kontakt med dere?
- Er det mange med minoritetsbakgrunn som henvender seg til dere? Hvis nei, hvorfor tror du/dere grunnen til at de ikke henvender seg til dere?
- Hva slags utfordringer møter folk, som kontakter dere, med den norske helsetjenesten?
- Hva slags utfordringer tror du/dere det de fleste med minoritetsbakgrunn møter når de møter den norske helsetjenesten?
- Når man snakker om pårørende så snakker man generelt om en veldig stor gruppe med mange forskjellige grupper, som for eksempel, pårørende med minoritetsbakgrunn. Tror dere at pårørende med minoritetsbakgrunn har et annet behov enn pårørende med etnisk norsk bakgrunn?
- Hva legger du/dere i kulturell kompetanse?
- Synes du/dere at den norske helsetjenesten mangler multikulturell kompetanse?
- Hva tror du/dere den norske helsetjenesten burde gjøre for å få bedre multikulturell kompetanse for å møte pårørende med minoritetsbakgrunn?
- Synes dere at Norge har et monokulturelt helsevesen?

Tilleggs spørsmål

- Overfor helsepersonell fungerer senteret som et kompetansesenter for pårørendes erfaringer. Hva slags erfaringer er helsepersonell ute etter når de ønsker å høre om pårørendes erfaringer?
- Hvilken gruppe helsepersonell kontakter senteret?