Recognising Cultural Diversity in Children’s Hospitals: Managers, Staff and Families

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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or part, for a degree at this or any other institution.

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Signature
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### Abbreviations

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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AAWCH</td>
<td>Australian Association for the Welfare of Child Health</td>
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<tr>
<td>ACHS</td>
<td>Australian Council on Healthcare Standards</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<tr>
<td>CHW</td>
<td>Children’s Hospital at Westmead</td>
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<tr>
<td>CRC</td>
<td>Community Relations Commission for a Multicultural NSW</td>
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<tr>
<td>EAPS</td>
<td>Ethnic Affairs Priority Statement</td>
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<td>EQuIP</td>
<td>Evaluation and Quality Improvement Program</td>
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<tr>
<td>DoCs</td>
<td>Department of Community Services</td>
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<tr>
<td>ISLHN</td>
<td>Illawarra Shoalhaven Local Health Network</td>
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<tr>
<td>LOTE</td>
<td>Languages Other Than English</td>
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<td>LHD</td>
<td>Local Health District</td>
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<td>MPF</td>
<td>Multicultural Planning Framework of the CRC</td>
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<tr>
<td>NESB</td>
<td>Non-English Speaking Background</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>NHS</td>
<td>National Health Strategy</td>
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<tr>
<td>MPSP</td>
<td>Multicultural Policies and Services Program</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>SCH</td>
<td>Sydney Children’s Hospital</td>
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<tr>
<td>SESIAHS</td>
<td>South Eastern Sydney and Illawarra Health Service</td>
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<tr>
<td>SESLHN</td>
<td>South Eastern Sydney Local Health Network</td>
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<tr>
<td>SSWAHS</td>
<td>Sydney South West Area Health Service</td>
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<td>SWAHS</td>
<td>Sydney West Area Health Service</td>
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<td>UK</td>
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Abstract

This research examines how staff at two children’s hospitals in metropolitan Sydney NSW negotiate cultural diversity with child patients and their families from culturally and linguistically diverse (CALD) backgrounds. It specifically investigates the impact of systemic constraints, health and multicultural policies and organisational, professional and individual cultures on the practice of hospital staff. In this research approach, the limitations of ‘politics of recognition’ theory are critically reviewed, as it focuses on difference and ethnic identity rather than on the way mainstream institutions can address disadvantage.

The study involved hospital personnel across all levels and professional categories in a qualitative approach to analyse the discourses of working with cultural diversity. The approach consisted of structured surveys, in-depth interviews, focus groups and participant observation over a period of 22 months. This analysis was augmented by in-depth interviews with three multi-disciplinary health teams with responsibility for the care of children with chronic illness, within both hospitals.

The interviews with hospital managers reveal that cultural diversity is peripheral to daily practice, as efficiency and evidence-based medicine are a priority. Mainstream Australian and western biomedical ways of working with patients and families are the norm, and systemic processes to identify and meet the needs of families from CALD backgrounds appear inadequate. There is also inadequate provision of institutional support for staff working with cultural diversity. One of the ways managers assist families from CALD backgrounds is through the use of culturally diverse staff; however, there is a lack of organisational systems in place to support the use of their skills.
The way that doctors and nurses care for families demonstrates the effect of professional cultures of biomedicine and liberalism which operate to treat all families the same, and in an individualised way. These staff tried to accommodate cultural differences if, and when, they became unavoidable but in those situations they were reliant mostly on allied health staff.

While staff lacked formal support, informal practices assisted staff in working with families from CALD backgrounds. Some managers and staff recognised the culturally different behaviour of families as normal for their background, applying a form of cultural relativism which made non-mainstream behaviour non-problematic. Allied health staff also recognised when families were disadvantaged in relation to the dominant institutional values and needed extra material support.

My argument is that current health care practice for families from CALD backgrounds does not adequately take into consideration the broader social context of health care and multiculturalism in Australia, and this in turn influences the organisational and professional cultures of working with diversity, where cultural difference is outside mainstream health practice. Staff appeared to lack systemic support and this reduced their capacity to accommodate cultural diversity. They addressed inequities as an afterthought, rather than as core business of the organisation.
The aim of earlier research that has focused on the culture of CALD patients has been to ensure effective health care rather than focusing on the impact of the cultural context of health care, and how it can be negotiated by staff. This thesis takes a multidimensional approach to address the systemic, organisational and professional constraints to working with cultural diversity. It uses ‘politics of recognition’ theory as a starting point to understand how staff recognise cultural diversity, and argues that this theory is limited because it focuses on recognising ethnic identity outside institutions rather than examining how these institutions can address disadvantage. This thesis applies discourse analysis to examine how staff discourse is related to a broader context of health care and multiculturalism.

Chapter 2 reviews the impact of multicultural and health policies since the 1970s on health care practice for staff working with patients from CALD backgrounds. It highlights the shifts in the understanding of ‘culture’ in the literature and the parallel structural changes in the way that health services have historically been provided to patients from CALD backgrounds. Multicultural concerns have been on the periphery of health practice, where there is a biomedical evidence-based focus. Critical medical and nursing literature has reviewed the impact of organisational and professional cultures on health practice, but this has not had a major impact on practice.

Chapter 3 provides an analysis of the direction and leadership that managers provide to staff in the context of an increasingly diverse constituency. Findings reveal that the dominant priorities of ensuring adequate patient flow, time efficiency and evidence-based medical practices were inconsistent
with the complexity of fully meeting the needs of families. Secondly, organisational data collection that might identify the needs of families from CALD backgrounds is inadequate. Lastly, mainstream Australian and biomedical patient relations were the unacknowledged social norm. However, the way some managers spoke about the different behaviour of some parents emphasised cultural relativism which served to normalise this behaviour. The allied health managers working in chronic care also recognised the cultural disadvantage faced by some families from CALD backgrounds.

**Chapter 4** analyses how managers and staff understand the roles of culturally diverse staff in assisting patients from CALD backgrounds, and the organisational systems in place to support staff in this role. While NSW government policy acknowledges the benefits of employing diverse staff in terms of their language and cultural skills, this chapter demonstrates there is a lack of guidelines on the appropriate application of these skills, and a lack of support given to these staff when using these skills. While several medical and nursing managers said that they had asked staff from the same cultural backgrounds as the patients to provide cultural information, the staff from CALD backgrounds revealed that in many cases their own ethnicity did not actually have to match that of the families for the staff to draw on their own knowledge, skills and migration experience to assist families.

**Chapter 5** examines how systemic constraints, professional backgrounds, departmental priorities and personal values influence the way health staff work with families from CALD backgrounds. One of the ways acute medical staff spoke about diversity emphasised applying non-discriminatory biomedical principles to treating patients the same regardless of their background. However this approach depoliticises difference, so when
difference becomes apparent, staff often see it as a problem. In nursing, the influence of liberalism was reflected in staff focusing on interpersonal relationships, not structural factors. This chapter highlights the implications of current policies requiring staff to be sensitive to the cultural backgrounds of patients (and their families), where staff need a range of skills to effectively negotiate internal and external factors. Interviews demonstrate doctors and nurses are constrained in their ability to negotiate these factors. However, allied health staff such as social workers helped mediate the needs of families with the medical and nursing staff.

Chapter 6 examines the processes of cultural negotiation between staff and three families of children with chronic illness. Findings illustrate how the constraints outlined above placed limits on the degree to which staff could meet the needs of families from CALD backgrounds. These factors combined to create an expectation of compliance, as evidenced by staff labelling these three families as ‘good’, ‘difficult’ or ‘chaotic’ according to how cooperative they were. In order to address the disadvantages that families face, staff are dependent on the advocacy of someone in the health team to reflect on the inequities of care. In the case of the family labelled as ‘good’, allied health workers recognised that the family was disadvantaged. There was less engagement with the families labelled difficult or chaotic; staff were overwhelmed and the benefits of family centred care were not addressed.

Chapter 7 concludes the thesis by outlining how staff lacked systemic, organisational, professional and individual support to engage with cultural diversity. The dominant culture in the hospital of evidence-based medicine leads to the marginalisation of cultural diversity outside mainstream practice. In some instances, diversity became problematic and this could have negative implications for practice. It was usually allied health staff and
staff from CALD backgrounds who advocated and reflected on how families were disadvantaged, rather than all staff having the skills and competence to work effectively with cultural diversity. Staff engaged in protective practices such as cultural relativism, status recognition and relational positioning to assist families. Resources are needed to fully achieve status recognition but are lacking in the current health environment of economic efficiency and reform.
1. Introduction

People state that it is important [to recognise cultural diversity] but at the end of the day I feel that patients have to comply with our hospital standards or they miss out on optimal care. (speech pathologist, CHW Survey, 2005)

This statement encapsulates the dilemmas that staff at children’s hospitals face in trying to ensure appropriate service provision for patients and families from culturally and linguistically diverse (CALD) backgrounds.¹

This speech pathologist acknowledges that recognising cultural diversity is important, but feels it is the families that have to change to fit the system. However, it is difficult for these families to comply if they do not have the knowledge about the Australian health system, lack English language skills and have different beliefs or practices to those held by mainstream Australians². At the same time staff work in a public hospital system

¹ The term ‘people from Culturally and Linguistically Diverse (CALD) backgrounds’ is used in this thesis to refer to people whose culture and/or language is different to those born in Australia from English speaking backgrounds (Garrett et al 2010). CALD was introduced in 1996 as a term to replace ‘Non-English speaking background’ (NESB) (Commonwealth of Australia 1999). Use of the term is discussed more in Chapter 2.

² I use the term ‘mainstream Australian’ to refer to the dominant values and assumptions held by staff and families in the hospitals. These views could relate to parenting practices and the position of women in Australian society and had a major influence on the way staff worked with families. Other
described as being burdened with workforce shortages, a lack of funding and increased chronic health care demands from patients (NSW Government 2008a). Staff have accustomed ways of working which may be incompatible with the needs of patients and their families. As the statement above reveals, there is an emphasis on patients fitting into the system rather than the system accommodating the needs of patients. This may mean patients receive inequitable care.

This study explores how staff at two Sydney children’s hospitals, Sydney Children’s Hospital (SCH) and the Children’s Hospital at Westmead (CHW), respond to the needs of families from CALD backgrounds. It examines the range of factors affecting this process including policies, systemic constraints, organisational and professional cultures, and the dynamic of staff-family relations. It considers how staff recognise and address cultural difference, and how they negotiate the institutional constraints. It concludes that there is a lack of systemic and institutional support for staff working with cultural diversity, and they must instead rely on allied health staff and staff from CALD backgrounds to take a proactive advocacy approach to address inequities in care. Working with cultural diversity is outside the core business of the hospitals with their emphasis on western biomedical

authors have used the term ‘Anglo-European’ and ‘Anglo-Celtic’ to refer to the cultural specificity of these values (Chalmers and Allon 2002).
practice, and where mainstream Australian conceptions of parenting are the norm.

This introductory chapter begins with a background to the research problem and then provides a brief discussion of the reasons and significance behind examining how staff negotiate cultural diversity in children’s hospitals, which leads to the research problem and questions. Section 1.4 outlines the multidimensional approach employed in this research. Section 1.5 describes the key terms for the thesis. Section 1.6 discusses the theoretical constructs used in my analysis. Section 1.7 provides a summary of the diversity of families and staff, and examines the research process. Section 1.8 provides an overview of the thesis.

1.1 Background to the research problem

This study recommends a shift from merely focusing on the cultural diversity of patients to a broader focus on the impact of the institutional context of the health system on service provision. Staff face challenges working with families from CALD backgrounds, but they themselves have entrenched belief systems and ways of working which are influenced by their profession, the organisation, their own cultural background and the wider social, political and economic context in Australia. This myriad of factors affects health care provision for a diverse constituency of patients and their families.

3 ‘Western biomedical’ refers to the dominant way that health care is provided in western health services (Kagawa-Singer and Kassim-Lakha 2003).
There has been an increase in the cultural diversity of migrants coming to Australia since World War II. The arrival of post-war refugees, and changes in immigration policies encouraged migration from Europe (in contrast to the previously predominant stream of Anglo-Irish immigration). In the 1970s, the official end of the White Australia policy opened the way for immigrants from a wider range of backgrounds, including those from Asian countries who had beliefs and practices different from the mainstream Australian culture at the time (Castles, et al. 1988; Collins 1988).

In Australia, the population from CALD backgrounds continues to increase and diversify. In 2006, people living in Australia who were born overseas represented 22.2% of the population; this was a 13% increase compared to figures in 1996 (ABS 2006: 35). The increased diversification is reflected in the proportion of people who speak a language other than English at home, for example the figure of 15.8% in 2006 is an increase of 10% from 2001 figures (CRC 2006). Over the past decades there has also been a rise in the proportion of people from Asian and Middle Eastern regions and in the population practising non-Christian religions, such as Buddhism, Islam and Hinduism (ABS 2006).

In New South Wales in the last decade, the percentage of the population who were overseas born has consistently increased from 23.1% in 1996 to 23.8% in 2006 (CRC 2006). Likewise, the proportion of people who speak a language other than English at home has increased from 18.2% in 1996 to 20.1% in 2006. This linguistic and religious diversity is represented in the backgrounds of patients and their families, as well as of staff at the two hospitals in this study (see Section 1.7.1).
The increase in diversity makes it difficult for health institutions in Australia to plan appropriate health services. 2006 figures outline migrants come from over 200 countries (ABS 2006). Staff therefore have to be culturally competent\(^4\) to care for patients from so many backgrounds.

Globalisation and the constant movement of people worldwide mean there are many different beliefs and practices of migrants (Morrissey 1997). Patients who are recent immigrants from non-western countries may be unfamiliar with the health care system in western countries (Anderson 1986). Some may have beliefs about illness and treatment that are unfamiliar to health staff and incompatible with the western treatment regime (Manderson and Reid 1994; NHS 1993; Parsons 1990). For example, some patients have more confidence in herbal medicines or use them in tandem with western treatment practices (Lewith 2000; Nguyen, et al. 1994; Sullivan 2005). Patients from CALD backgrounds may also be used to a more holistic model of health than the western model (CDTU 1997). Communication difficulties are a major factor affecting the use of health services by migrant patients from non-English speaking backgrounds (Garrett, et al. 2008a; Johnstone and Kanitsaki 2006; NHS 1993).

Staff in children’s health care face the extra challenge of working not only with child-patients, but with whole families (children, their parents/carers and sometimes extended families) (Shelton and Stepanek 1994). Families from CALD backgrounds may bring with them family dynamics and parenting practices which are different from the predominant cultural

\(^4\) I provide an analysis of ‘cultural competence’ in Chapter 2 as part of my historical overview of how health staff have worked with patients from CALD backgrounds.
framework of the hospital and the wider Australian society. The standard procedures of staff may be based on unacknowledged dominant cultural assumptions about the appropriate roles of parents and care-givers. Research in children’s health care has outlined how the mismatch of beliefs and attitudes can lead to ineffective treatment and collaboration between providers and families (Anderson 1986; Brunnquell and Kurachek 2003; Chalmers and Rosso-Buckton 2008; Flores, et al. 2002; Harmsen, et al. 2003), as well as result in patient non-compliance (Anderson 1986). Immigrant families may also be unfamiliar with the dominant ideologies and expectations in health care (Anderson 1986). A study conducted at SCH has illustrated the mismatches between the expectations of CALD families and the responses of staff for whom mainstream Australian and western patient-staff relations are the norm (Chalmers and Allon 2002). These factors had a negative impact on the quality of care for families.

In response to the recognition that migrants’ linguistic and cultural differences can have a detrimental impact on their access to care and its quality (Galbally 1978:166; Henderson 1975; NHS 1993), Federal and State governments and health institutions since the 1970s have introduced a range of policies that encourage service providers to provide interpreters, equal access to services, and services that are culturally appropriate (CRC 2000; NSW Health 2005b; NSW Health 2006b). To date these approaches have not been fully effective as health inequities in access, health outcomes and quality of care still exist (Chalmers and Rosso-Buckton 2008; Garrett, et al. 2008c; Johnstone and Kanitsaki 2006; Johnstone and Kanitsaki 2007). While progress has been made, there is still difficulty in ensuring that cultural diversity concerns are dealt with as core business of the organisation (Klinken Whelan 2009) and of health care practice (Garrett, et al. 2010).
An area that has not been sufficiently addressed is the impact of the institutional context of health care on service provision. While multicultural policies, reports, research and training in Australia have focused on the provider understanding the culture of the patient, social critics state there has been insufficient regard for the impact of the institutional context of health services on staff attitudes and service delivery (Garrett and Lin 1990; Hong 2001; Mitchell 1989; NHS 1993). International research has indicated that the attitudes of staff towards patients from different cultural and linguistic backgrounds could detrimentally affect health outcomes (Flores, et al. 2002; Institute of Medicine 2003). There may be provider bias.

There is a need to recognize the impact of organisational and professional cultures in health care as they reflect the broader social, economic and political conditions (Culley 1996; Gustafson 2005) which determine how structures and policies are realised in practice (Hong 2001) and how resources are distributed (Culhane-Pera, et al. 2003). Mainstream cultures within health are based on a western biomedical model of health care (Baer 2001; Kagawa-Singer and Kassim-Lakha 2003; Lewith 2000).

Approaches to working with cultural diversity in health care tend to focus on access issues, not on changing the way the health system operates, and they do not address how the needs of patients can be met to improve health outcomes (Jayasuriya 2003; Mitchell 1989). These approaches have also been critiqued as focusing on the cultural competence of individual staff (Hong 2001) rather than examining the impact of broader systemic and structural issues on service provision which can reinforce existing inequities in care (Gustafson 2005; Kagawa-Singer and Kassim-Lakha 2003; Taylor 2003; Wear 2003). However, more recent guidelines state that staff need structures in place at the systemic, organisational, professional and individual level to
ensure that they have the capacity to work with cultural diversity (Australian Government 2005; NSW Health 2007).

In the current environment of health reform, the cultural diversity of patients presents challenges to health services (Migliorino 2010). Health professionals are faced with increased complexity in public hospitals flowing from the impact of a need to reduce health inequities (NSW Health 2004; Schon 1991; WHO 1998), an ageing population, higher rates of chronic disease (Australian Government 2009) and the rising cost and complexity of medical technology (Vissers 2002). In an economic rationalist environment, there are more demands placed on health professionals to be “more efficient, effective and accountable” (Southon and Braithwaite 1998: 26). This may make it difficult to prioritise meeting the needs of patients disadvantaged in the health system (Anderson, et al. 2003a; Southon and Braithwaite 1998; Sweeney and Mannion 2002), including those from CALD backgrounds (Migliorino 2010; Morris 2010). In the context of these competing political, social and economic issues, cultural diversity continues to be on the periphery of health policy, practice and research (Garrett, et al. 2010; Morris 2009), as was the case in the 1990s (Garrett and Lin 1990; Jayasuriya 2003; Mitchell 1989). This thesis explores how various staff deal with these competing pressures in negotiating the needs of families from CALD backgrounds.

1.2 Why study how staff negotiate cultural diversity in children’s hospitals?

Previous approaches to working with cultural diversity in health care focus on the culture of patients, not on the impact of the dominant cultural frameworks operating within health care organisations themselves

Furthermore, these approaches do not examine how staff negotiate diversity in practice (CCHCP 1999; Fitzgerald, et al. 1997a; Fuller 2003; Morrissey 1997; Taylor 2003). How to negotiate cultural difference in the public sphere is a major political problem facing democracies and it has not been dealt with adequately (Ang 2001; Benhabib 1996; Gould 1996; Taylor 1994). The ‘politics of recognition’ theoretical literature focuses on recognising cultural difference on the periphery (Gould 1996; Modood 2005), not on how dominant institutions negotiate difference and address the disadvantages that people from CALD backgrounds may face (Fraser 2002).

In children’s hospitals, the negotiation of treatment decisions for seriously ill children is complex as there are various players involved. Staff and family members have claims to authority in treating a child who is too young to make informed decisions about their care. Health professionals have to consider the best interests of the child but must also consider the views of the child’s parents, and how these may affect other patients. Of course, all these considerations are constrained by the time and resources available. Research has explored some of the implications of the dominant cultural frameworks around parenting values that exist in children’s health care (Chalmers and Allon 2002; Chalmers and Rosso-Buckton 2008; Chalmers 2006b), but has not fully explored the way staff work within multidisciplinary teams to address the cultural disadvantage families from CALD backgrounds may face.
Findings of this study are significant as they reveal the constraints encountered by health staff and the skills they need in negotiating the meshing of cultural frameworks with the needs of families. It examines the broader context of multicultural and health care policies which determine the way the health system operates, which in turn constrains the capacity of hospital staff to negotiate with patients and families from CALD backgrounds. In Chapter 6 of this thesis, I will specifically examine three case studies of how staff worked with children with chronic illness and their families: Connor, with HIV; Zahra, with kidney failure; and Joshua, with brain injury. The case study of Connor explores the impact of the dominant cultural context in the hospital on service provision, where the medical staff’s expectations of parental compliance and responsibility do not match the needs of Connor’s family, and this results in the family’s dissatisfaction. Zahra’s family’s experience demonstrates the protective capacity of the social workers in advocating for the family in consideration of their refugee experience. These staff also discuss the difficulty that arises from treating all families the same, and the benefits of providing an ethnic health worker to address a family’s different needs. In the third case study of Joshua, the occupational therapists reflected on how the institutional and professional cultures in the hospital put the family at a disadvantage. I explore how staff negotiate these constraints when addressing the needs of this family.

1.3 Research aims

The purpose of this research was to investigate the ways staff negotiate cultural diversity with families at two children’s hospitals, particularly in relation to:
• The impact of health care and multicultural policies on the way the health system provides support to staff to work with diversity;

• The impact of organisational, professional and individual cultural frameworks in the hospitals on working with cultural diversity; and

• How staff recognise and negotiate the cultural diversity of patients and their families in consideration of the above factors.

1.4 Multidimensional approach

I use a multi-dimensional approach to explore the range of forces which intersect to affect the way that staff negotiate with child patients from CALD backgrounds and their families. The major dimensions include the influence of systemic issues, organisational and professional cultures, the cultural background of staff, patients and families, and personal factors. The National Health and Medical Research Council (NHMRC) cultural competency guidelines discuss the importance of systemic, organisational, professional and individual factors that determine cultural competence in the health sector (Australian Government 2005). Staff do not just need awareness, knowledge and skills, they also need systemic and organisational support, i.e. the ‘capacity to act’ to provide a culturally appropriate service backed by adequate resources (Australian Government 2005; Cultural Perspectives and Judith Miralles & Associates 2005; Miralles and Migliorino 2005). I also discuss how systemic, organisational, professional and individual health practice operates in a broader social, economic and political context which reflects the dominant values in Australia.

In this study ‘systemic’ refers to health system policies and procedures which determine the way services are provided to CALD patients. The way the
system operates relates to the broader context of multiculturalism and health care in Australia as will be discussed in Chapter 2. The health system is defined as “that aggregate of commitments and resources (human, cultural, political, and material) any society devotes to, or sets aside for, or invests into the ‘health’ concern” (Field 1973: 764). The Australian Government highlights the systemic dimension of cultural competence where “effective policies and procedures, mechanisms for monitoring and sufficient resources are fundamental to fostering culturally competent behaviour at the other levels” (Australian Government 2005: 30). Factors occurring within the health system affect the behaviour of staff in relation to working with cultural diversity. These include the availability of interpreters and translated material, the time constraints of staff, the layout of the hospital, power structures and the availability of beds. At SCH, for example, staff acknowledged they should use interpreters but the ‘system’ in relation to busy hospital regimes and limited availability of interpreters did not encourage their use. This resulted in an organisational culture where interpreters were only used when absolutely necessary (Chalmers and Allon 2002: 27).

Organisational culture relates to “the pattern of beliefs, values and learned ways of coping with experience that have developed during the course of an organisation’s history” (Brown 1998: 9). Fong and Gibbs (1995: 2) outline how organisational cultural frameworks around working with diversity are based on staff values, assumptions, dynamics and modes of dealing with culturally diverse clients. The NHMRC (Australian Government 2005: 30) describes the organisational dimension of cultural competence as a situation in which:
… the skills and resources required by client diversity are in place. A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels.

Organisational processes determine the capacity of health professionals to work in a culturally competent way.

The organisational culture of working with diversity in the hospital operates within the broader social context in Australia. Fraser (2002) explains that the dominant cultural values in society are institutionalized at the organisational level. For example, in Australian society there is an expectation that mothers are the primary carers of a child, rather than grandmothers (as is the case in some other countries), and this would affect staff attitudes and practices in the hospital.

The professional culture influences professional understandings of illness, as well as how the profession works with cultural diversity. The NHMRC outlines the importance of professional education and development in enabling health professionals to develop skills to work with cultural diversity (Australian Government 2005: 30). There are also cultures specific to departments and particular health teams which influence practice (such as the rehabilitation team in Chapter 6).

On the individual level, Hong (2001:4) outlines how health staff form their own personal “idiosyncratically transformed variations” of collective cultures. Staff apply these variations in their interactions with patients and their families who in turn have selectively perceived and transformed collective cultures of which they are part. The culture of the provider is
related to their natal culture and professionalisation (Kagawa-Singer and Kassim-Lakha 2003). The cultural background of staff, patients and families may also determine practice according to a range of variables including their age, gender, class, sexuality, ethnicity and religion.

Understandings of cultural diversity contained in multicultural and health policies, and values from the broader society, are institutionalised in the organisation, in professional behaviour and in individual staff members’ practice. Staff behaviour reflects the dominant culture and structures in Australia, and may lead to patients from CALD backgrounds being positioned as lacking, or ‘other’. For instance, research conducted at SCH highlighted that the parenting practices staff expected were “premised on Anglo Australian values and ideals” (Chalmers 2008: 5). The type of care given in a health care setting is also based on the mainstream culture in society and western biomedical models (Kagawa-Singer and Kassim-Lakha 2003).

1.5 Defining key terms

1.5.1 Culture

Various disciplines have interpreted the concept of ‘culture’, from anthropology to politics, critical theory, literature and sociology (Barker 2003; Couldry 2000b; Galbally 1978; Geertz 1973). A common understanding of culture is the shared meanings and practices of people (Barker 2003: 8; Couldry 2000b; Williams 1981).

In the interviews with hospital staff, it emerged they understood culture as belonging to the patients rather than to themselves. There was also a tendency to reify culture as a closed unchanging unit. This understanding
runs the risk of misrepresenting people and making essentialist assumptions about them.

Couldry (2000a: 93) addresses the problems with the concept of ‘culture’ being understood as “stable, coherent, localised ‘units’” linked to a shared place, group of people and particular time. This model does not fit the current movement of people in globalisation but is influenced by classical anthropological perspectives. In contrast, he contends:

> Our primary data are not so much particular meanings, which we imagine to be shared, as patterns of flow and the structural forces which shape them (Couldry 2000:103).

This understanding highlights the changing nature of culture as “shifting entities” (UNESCO 2009: 4) and not as a fixed feature of a group (Ang 1993; Couldry 2000b; Hall 1996). Frow and Morris (1993: xx) similarly discuss the changing nature of culture as:

> ... a contested and conflictual set of practices of representation bound up with the processes of formation and reformation of social groups.

Culture is contested as a consequence of an “uneven distribution of meaning” in a group of people (Couldry 2000b: 101).

Individual variables such as class, age, gender, profession, institution, hierarchical position and power inequalities contribute to the variation and areas of commonality among meanings. Groups then converge for certain reasons.

Culture is related to the broader social, political and economic context of a situation. Barker (2003: 50) suggests taking a:
… multidimensional and multiperspectival approach to the understanding of culture which would seek to grasp the connections between the economic, political, social and cultural dimensions without reducing social phenomena to any one level.

This understanding of culture takes into account how structures affect practice (Bourdieu 1995; Chan 1997). Kemmis (2009) outlines how histories, social connections, discourses and material-economic relations are implied in the way practice is constructed. In this thesis I will be examining how the social, political, and economic context, in particular multicultural and health policies, have affected the shared meanings and practices of staff.

The term ‘culture’ in this thesis will refer to the dynamic patterns of shared meanings and practices of staff, and in some cases of family members, as conditioned by broader political, historical, economic and social processes and the variables outlined above.

1.5.2 Cultural diversity

‘Cultural diversity’ denotes the existence of different ‘cultural groups’ or different aspects of a person’s identity (NSW Government 2009: 1). Both these forms of diversity will be referred to in this thesis.

‘Cultural diversity’ has been synonymous with the term ‘multiculturalism’ in Australian Government rhetoric:

The adjective ‘multicultural’ is frequently used to mean ‘multi-ethnic’ or ‘culturally diverse’ (Commonwealth of Australia 1999: 3).
In a descriptive sense, multicultural is simply a term which describes the cultural and ethnic diversity of contemporary Australia (Commonwealth of Australia 1989: 1).

Understanding of the term ‘cultural diversity’ is then closely related to the idea of different cultural groups and is reflected in Australian multicultural policies. As highlighted by Stratton and Ang (1998: 138), the term multiculturalism “is associated with an official recognition of the existence of different ethnic groups”.

Rather than just focusing on the ethnic and linguistic aspects of cultural heterogeneity (UNESCO 2009), UNESCO discusses cultural diversity as including different forms of identity in their Universal Declaration on Cultural Diversity:

Culture takes diverse forms across time and space. This diversity is embodied in the uniqueness and plurality of the identities of the groups and societies making up humankind (Article 1) (UNESCO 2001: 1).

The NSW Government’s use of the term ‘cultural diversity’ includes a broad notion of diversity in relation to:

… language, race, ethnicity, dress, values, religion and religious practices, social and community responsibilities, family and family responsibilities, and political views (NSW Government 2009).

In this study, although most hospital staff referred to cultural diversity as relating to ethnicity and religion of the patients, there were some who referred to cultural diversity in a broader sense in relation to work cultures. As explained by a dietician:
Cultural diversity for me is more than ethnicity … it can also be described as socio-economic status … It can be geographical … ‘Cultural’ has also got to do with the profession or work environment. (Casey, dietician, S4)

In this thesis ‘cultural diversity’ is used to refer to the values, beliefs, ethnicity, language, gender and socio-economic position of staff, patients and parents in the hospitals.

1.6 Theoretical framework: recognising and engaging with cultural diversity

The theoretical frameworks of ‘othering’ and the ‘politics of recognition’ are used to explain how staff work with families from CALD backgrounds and recognise their cultural difference relative to the dominant cultural norms in the hospital. I will outline these theories and how they apply to the way staff negotiate cultural diversity within the dominant cultural frameworks in health care. I will then discuss how the theories of ‘status recognition’, ‘productive diversity’ and ‘relational positioning’ could be used to build on the recognition theories. These latter theories are examined to understand how hospitals could move beyond just recognising cultural difference in society at large, and ensure they engage with the needs of families and provide appropriate resources.

1.6.1 Cultural diversity as ‘other’ in health care

The approach staff take to working with cultural diversity in the hospitals is to focus on the ‘other’, as something separate to core activities. The ‘other’ are people from CALD backgrounds who are different from the western norm in health care. The dominant culture of the health system is seen as a
given, with no cultural specificity or bias. The term ‘other’ has been discussed in the literature of feminism, multiculturalism and multicultural health.

Davies and Gannon (2005: 318) explain how binaries such as male/female and heterosexual/homosexual can be used to describe how relations of power are:

... constructed and maintained by granting normality, rationality and naturalness to the dominant half of any binary, and in contrast, how the subordinate term is marked as ‘other’, as lacking, as not rational.

When the dominant group treats the minority group as ‘other’, this representation of deviance can be used to justify alienation and discrimination (Young 1990).

Science is conceived as being apolitical because it is based on “true” knowledge, ignoring the fact that scientific practice is shaped by economic, historical, political and cultural forces (Browne 2001: 120). For instance, medical anthropologist Taylor (2003: 557) observes that the institution of medicine sees itself as scientifically based, rational and culturally neutral, in comparison to “other cultural groups” such as migrant groups.

The binarism of ‘othering’ has been applied to cultural diversity, where difference, in comparison to the dominant norm, is given a lower status (Sarup 1996; Schaefer 1993; West 2002). Ang and St Louis (2005: 292) state:

Difference is conceived in terms of an opposition between the same and the different, where the different is purely negatively defined as that which is not-same. In this sense, difference tends culturally and socially to be associated with the inferior, the deviant, the backward,
thus positioned at the bottom end within a system of domination and hierarchy.

The process of defining cultural diversity as difference from the norm has power implications (Sarup 1996; West 2002). In health care, providing services based on the norm may mean culturally diverse groups may receive inequitable care.

Health systems in Australia predominantly reflect ‘Anglo-Australian’ mainstream culture (Bryan and Batch 2002), where staff see cultural diversity on the periphery of practice (Garrett and Lin 1990; Mitchell 1989). While ethnic minority Australians may be thought to have different cultural understandings of illness and its treatment, mainstream Australians see themselves as ‘culture free’ and their actions are ‘biomedically sound’ (Bryan and Batch 2002: 25).

In the course of my research, instances were found where medical and nursing staff ‘othered’ families from CALD backgrounds, particularly the parents. Staff saw some as deviant and ‘difficult’, as opposed to ‘good’ when they conformed to the dominant culture. These staff often passed on issues of cultural diversity to social workers or colleagues from CALD backgrounds. Cultural diversity was made separate to their core concern with clinical practices.

1.6.2 Politics of recognition

Many staff in this study tried to recognise the cultural difference of patients. The theory of a ‘politics of recognition’ (Taylor 1994) can be used as a starting point for understanding how staff recognised the culturally different needs of families from CALD backgrounds.
Taylor’s (1994) ‘politics of recognition’ advocates recognising the equal value of different cultures. This literature has limitations for understanding practice as it is focused on the other, not addressing how dominant institutions could change to address difference. Fraser (2002) argues it is focused on recognising a person’s culturally different identity, not how they are also disadvantaged in terms of institutional social interactions where they may need a redistribution of resources.

Taylor’s influential work (1994) highlights the need to recognise the cultural identities of minority\(^5\) groups in the public sphere. He discusses individuals as having two rights: universal and particular rights.

With the politics of equal dignity, what is established is meant to be universally the same, an identical basket of rights and immunities; with the politics of difference, what we are asked to recognize is the unique identity of this individual or group, their distinctiveness from everyone else (Taylor 1994: 38).

The politics of universalism is based on the equal dignity of all citizens. However, Taylor points out that this discourse can exclude people because it is based on liberalism’s notion of sameness. He then states that recognition of difference may be needed to affirm the uniqueness of identity for self-fulfilment. Liberalism could give minority cultures a presumption of worth in the public sphere through a politics of equal respect of difference. He asserts a different type of liberalism (from the one he first describes) where

\(^5\) The term ‘minority’ is used to refer to groups that are subordinate as they lack power and opportunities compared to majority groups (Schaefer 1993).
people have an equal entitlement to universal rights, as well as to express their cultural identity.

Taylor (1994) acknowledges but does not address the claim from radical supporters of the politics of difference that liberalism is hegemonic and can override other people’s values.

The charge levelled by the most radical forms of the politics of difference is that “blind” liberalisms are themselves the reflection of particular cultures (1994: 44).

Taylor’s theory of recognising difference represents a form of cultural relativism. He discusses Herder’s notion of people having their own ‘measure’ of ‘being human’, and being true to themselves and their culture. Parekh (2006: 71) has further examined Herder’s understanding of cultural relativism where other cultures should be understood ”in their own terms” (Parekh 2006: 71), according to what is normal for them.

This idea of a presumption of worth is contained in multicultural policy in NSW (NSW Government 2009a), under which staff in the hospitals in my study are required to respect parents’ different behaviour. However, this respect was not always shown, and is outweighed by the expectation that patients would act in accordance with the dominant culture in the hospital where mainstream Australian values were the norm. When families did not meet these expectations some staff were judgmental and viewed difference in a negative way, especially when respecting difference involved committing extra resources.
The difficulty with recognising difference is that it may be essentialised (Benhabib 1996; Fraser 2002), which has implications for practice. Essentialism is based on “the characteristics of the dominant subset of a group or a society being attributed to all members of the group or other societies either by over-generalisations or by unstated references” (Atabaki 2003: 6). The multicultural approach of the 1970s and 1980s tended to essentialise the culture of ethnic groups (Morrissey 1997; Singer, et al. 1986), instead of exploring the fluid and changing nature of cultural identities in different contexts.

Fraser (2002) critiques the ‘politics of recognition’ for its reliance on identity which has the tendency to reify and separate difference. Benhabib (1996: 10) similarly critiques this literature as not addressing the fact that identity is contextual; people have “multiple, complex and heterogeneous allegiances”. Both theorists state it is sometimes not important for people to have their cultural differences recognised, but the nature of group recognition is such that there is often identity essentialism.

Essentialising difference also has advantages, as outlined by Spivak (1990) who uses the term ‘strategic essentialism’ to refer to marginalised groups ‘essentialising’ their own needs in order to gain access to resources (Noble and Tabar 2002).

In my study, staff often essentialised the needs of families from CALD backgrounds, but this was sometimes a starting point for negotiation. A negative implication of essentialism in health care is that the needs of families may be misrepresented, as seen in the case study of Joshua (see Chapter 6).
Taylor (1994) is criticised for equating “recognition with separation as opposed to a more progressively moderated interaction” where relations of power are discussed (Milstein 2003: 3). However, Taylor (1994: 70) disagrees with the view that “all judgments of worth are based on standards that are ultimately imposed by and further entrench structures of power”.

Modood (2005) discusses how the process of inclusion cannot be neutral: dominant cultures and structures would have to change in order to be truly inclusive. Ang (2001: 180) similarly examines how dealing with difference often just means containment in the dominant culture, forgetting the historical processes of colonialism, imperialism and nationalism (Ang 2001: 192).

Another issue concerns how the dominant group can meet the needs of the culturally diverse. Gould (1996: 180) goes further than Taylor (1994) in describing how justice should include “not the same conditions for each one but rather equivalent conditions determined by differentiated needs”. This requires changes to political, economic and social institutions. Equal treatment would then be “inherently responsive to and defined by difference” (Gould 1996: 180). West (2002) discusses how the process of negotiation should move beyond mere compromise and critically engage with differences in power.

In the context of health care, recognition is focused on the ‘other’, without recognising the power and impact of the dominant culture on service provision. But also in health care there are unequal power positions between provider and patient. A realistic goal in health care, to address structures of
domination, is equal outcomes for all patients regardless of cultural background (Jayasuriya 1993).

A further practical issue is how staff can recognise difference, and what this means in practice. When there are limited resources in the hospital system, staff face the challenge of reconciling the universal with particular cultural values that may not be valued in the public sphere.

*Limits to recognising cultural difference*

In the recognition of cultural difference literature, there is discussion of limits to this recognition in terms of values in society, structural change, systemic resources, and the individual’s rights. These were some of the limits to recognising cultural difference in the hospitals in this study.

Taylor (1994) acknowledges there would be limits to recognising difference in terms of compromising the values, rights and principles of the dominant culture. But he does not discuss these limits in terms of a redistribution of resources or of structural change.

    The challenge is to deal with their sense of marginalisation without compromising our basic political principles (Taylor 1994: 63)

Government policy outlines the expectation that Australians should respect each other’s culture and beliefs, but that migrants also have a civic duty to support the basic structures and principles of Australian society (Commonwealth of Australia 2010; Jayasuriya 2003).

The literature in Australia on multiculturalism discusses the limited recognition of cultural diversity as resulting from it not being dealt with publicly, and there not being enough structural and institutional change in
order to address the social disadvantage that migrants face (see Castles and Vasta 1996; Collins 1988; Sestito 1982). Multiculturalism studies applied to health argue that cultural diversity policy implementation has been on the periphery of practice, not affecting the mainstream culture and service provision, and has been dealt with privately (Garrett, et al. 2010; Garrett and Lin 1990; Jayasuriya 2003; Mitchell 1989).

In this study, it is acknowledged that staff were constrained systemically, institutionally, and professionally in recognising and engaging with cultural difference. In acute care, staff were often professionally obliged to focus on the physical health of the child to the exclusion of other concerns. Outside crisis situations, some staff expressed negative judgments of parenting values and practices that diverged from mainstream values, where there was also a lack of resources to address these differences. An example is involving the extended family in treatment plans for the child patient when the hospital did not have the resources to adequately meet these needs (see the case study of Connor in Chapter 6).

Recognition of cultural difference in a children’s hospital raises dilemmas around who is being recognised, as it can limit the rights of another. Recognising the cultural identity of one person may conflict with that of another. For example, should staff recognise the needs of the parent(s)/carers or the (child) patient? These instances of recognition may conflict with each other depending on the needs of different family members. Jayasuriya (2003) outlines the conflict of dealing both with universalism (in terms of equal rights for everyone) and with difference, where the equal rights of people may be compromised through the expression of this difference. For example in this study, staff recognising the particular rights of parents to express their cultural difference may limit the universal rights of the child to health care.
1.6.3 Status recognition: recognising the impact of the dominant culture

Fraser’s (2002: 24) concept of ‘status recognition’ highlights the impact of “institutionalized patterns of cultural value for their effects on the relative standing of social actors”. Fraser (2002) refers to status recognition to understand how public institutions recognise cultural difference, as well as the material impact of institutionalised values in terms of subordinating the status of some individuals. People may be disadvantaged according to these institutionalised values so there may need to be a redistribution of resources. This theoretical approach recognises the power of dominant institutions.

The concept of status recognition moves beyond the focus on the recognition of the cultural identity of the patient, to examine the impact of the dominant cultural context on care and the nature of social interaction in institutions. I use it to understand how dominant social values were reflected in daily practice of hospital staff, in particular values around western notions of parenting and providing treatment. It assists in understanding how staff members tried to negotiate the professional and organisational cultures with the cultures of the patients.

Fraser (2003) argues that the concept of status recognition attempts to move away from recognition as reifying culture and difference, as Taylor (1994) and Honneth (1995) outline, by to focus on recognition of injustice so parties can be equal partners in social interaction. It also tries to avoid making judgements of the worth of cultural and religious practices (2002: 34). Fraser (2002: 24) explains:

What requires recognition is not group specific identity but rather the status of group members as full partners in social interaction.
'Status recognition’, as a way to rectify injustice, is based on recognition of difference and a redistribution of resources. Fraser (2002: 25) explains this as follows:

... claims for recognition in the status model seek to establish the subordinated party as a full partner in social life, able to interact with others as a peer. They aim, that is, to de-institutionalise patterns of cultural value that impede parity of participation and to replace them with patterns that foster it.

In the context of the hospital, dominant institutionalised cultural values may impede the ability of patients and their families to interact properly with staff. An example may be found in the provision of sleeping quarters for parents. There may be a lack of status recognition for a Muslim mother who may not want to sleep next to men. In the hospital, a redistribution of resources may be achieved by providing separate sleeping quarters for men and women.

It would be hard to achieve a parity of participation in interactions between health providers and families, because of the realities of this unequal relationship (Lupton 1994). A more realistic aim is for patients to receive ‘a parity of care’ (or equal provision of care) relative to their needs, so no patient is more disadvantaged than another in negotiating the health system. The focus would be on achieving equal health outcomes for all patients.

There are constraints to the application of status recognition in the health system, especially by doctors and nurses in acute care, as they tend to be focused on the physical condition of the sick child. My research shows that in the hospital system staff also lacked resources needed to achieve parity of participation such as extra time, staff and interpreters. Nurses particularly
lacked resources and power in the health system, which had implications where extra resources were needed for working with diversity (see Chapter 5). This highlights the need for systemic support for health professionals in working with diversity. My research found that it was mainly allied health staff and some staff from CALD backgrounds who recognised difference and reflected on how the institutionalised cultural values of the hospital could disadvantage some families.

As outlined, in children’s health care there is a question of whose parity of participation should be enhanced, where recognising the parent/s’ needs for equality may produce inequality for someone else. Fraser (2002) contends that the move to achieve status recognition does not work if it disadvantages other people. For example, staff satisfying a father’s cultural need to interpret for the mother may deny the mother the right to participate in the health care of her child.

While the NHMRC Guidelines (Australian Government 2005) outline the need for a multilevel approach to enable individual health providers to provide culturally appropriate care, what happens when there are not the resources for staff to assist patients and families with status recognition? The Guidelines focus on the staff member being reflective of their own individual culture, not on how to address the systemic constraints of working with difference. This study demonstrates that in the absence of institutional support, it is up to certain staff members to identify how a family is disadvantaged. This would then involve them in advocacy in trying to redistribute resources.
1.6.4 Multiplicity of difference both inside and outside the organisation

Although the theory of status recognition acknowledges the impact of the dominant culture on those less dominant, in terms of power and resources, it still relegates diversity to the periphery. It defines diversity in opposition to the dominant culture. The thesis explores the idea that there is a multiplicity of differences in an organisation which allows staff to relate to patients and families on a number of levels, while also recognising ‘systems of domination’ (Friedman 1998: 48). The concepts of ‘productive diversity’ and ‘relational positioning’ help explain how staff can relate to difference within the organisation and in relation to axes of differentiation beyond just ethnicity.

*Productive diversity*

The sociological concept of ‘productive diversity’ is useful in recognising the benefits of cultural diversity within the organisation. Cope and Kalantzis (1997) describe productive diversity as the recognition by the organisation of its internal differences in a positive way. Management values “the range of language skills, communication styles, international networks, country knowledge and life experience that people bring to organisations” (Cope and Kalantzis 1997: x). It moves ‘difference’ from the periphery towards being accepted as central and integral to the organisation.

It is based on the organisation being flexible enough to recognise internal differences where:

… people develop and use multiple layers of identity and multiple ways of communicating. This is a process of shunting backwards and
forwards across and between cultures, but always in order to find points of common ground (Cope and Kalantzis 1997: 170).

This concept recognises the multi-faceted nature of people’s lives. It can be used to reflect on the culture of the hospital, especially with respect to the heterogeneity of staff members’ identities. Diversity is not just related to the ‘other’, it is part and parcel of the mainstream culture.

In this study, the hospitals could not always rely on CALD staff to look after CALD patients and their families, so staff from non-migrant backgrounds also had to assist families from CALD backgrounds. This is where the concept of productive diversity is useful, as all staff in hospitals need to have the competence to be able to work effectively with families from CALD backgrounds (Cope and Kalantzis 1997; Morrissey 1997; NLLiA CWCC 1994; Shaw 2005). The staff at SCH and CHW came from a range of linguistic and cultural backgrounds, and had a range of skills and experience, which is representative of productive diversity.

While Cope and Kalantzis (1997) discuss the uses and roles of diverse staff, they do not discuss their rights (Sawer 1997). If organisations benefit from the different skills of staff, the staff also need support (Hage 1998) in the form of policies, training and role delineation. This is discussed in Chapter 4.

*Relational positioning*

The conceptual understanding of being inclusive of diversity in interpersonal relations does not have to mean that the positions of power held by the dominant culture are forgotten. Rather, it means recognising the various axes of differentiation and the power relations between them, instead of reflecting on a binary of difference (Ang 2001).
Friedman’s (1998) idea of ‘relational positioning’ has been used in critical nursing to understand how patients may be disadvantaged by multiple factors. The term is based on the idea that “identity is situationally constructed and defined and at the crossroads of different systems of alterity and stratification” (Friedman 1998: 47). It is a construct for “a multiplicity of fluid identities defined and acting situationally” (Friedman 1998: 47). Identities change depending on the context. This implies moving beyond “prioritizing race and ethnicity (or any type of discrimination) as the most important issues in oppression” (Abrums and Leppa 2001: 271).

Relational positioning enables us to understand how staff can relate to patients beyond the white/’other’ binary, where nurses increase their awareness beyond just the impact of ethnocentrism to various systems of oppression in health care (Abrums and Leppa 2001). This process is part of staff gaining cultural competence as they ‘become aware of their position’ in relation to their patients (Abrums and Leppa 1999). Staff then need to:

… be able to locate themselves in relation to others and recognise the shifting confinements and privileges of multiple positions in various situations (Abrums and Leppa 2001: 272)

Abrums and Leppa (2001) state staff need to analyse the impact that holding a different position to the patient can have on practice and what needs to occur to shift imbalances of power to help build a connection with patients who are disadvantaged.

In Chapter 4, I describe how several staff from CALD backgrounds were able to relate to patients on a number of levels, beyond just having similar ethnicities, to include both having a migrant background and practising a non-dominant religion. Because they came from a migrant background
themselves, some of these staff were able to recognise how dominant institutional structures disadvantaged some families.

1.7  Research process

1.7.1  The setting: two children’s hospitals in Sydney

This study examined how staff negotiate cultural diversity with patients and their families/carers from CALD backgrounds at two children’s hospitals in Sydney – the Sydney Children’s Hospital and the Children’s Hospital at Westmead. Both are major tertiary hospitals where staff treat patients referred from across the State, as well as provide acute care to the residents of the district.

The CHW is located in Western Sydney, with nearly half of the patients coming from Western Sydney, and nearly a quarter from South Western Sydney (CHW 2007). The 2006 census indicates that 29% of the people from Western Sydney Area Health Service (WSAHS) spoke a language other than English (LOTE) at home (WSAHS 2007), and 39% of people from South Western Sydney Area Health Service (SWSAHS) spoke a LOTE (SWSAHS 2007), compared to 20% for the State (CRC 2006). People from these areas require extensive language support; Fairfield, Canterbury, Bankstown and Liverpool in the SWSAHS have the greatest proportion of people in NSW

6 This Area Health Service has become Western Sydney Local Health District as part of National and State health reform (Australian Government 2010; NSW Government 2011).

7 This Area Health Service has become Sydney Local Health District and South Western Sydney Local Health District.
who speak English ‘not well’ or ‘not at all’, followed by Parramatta, Blacktown and Auburn in the Western Sydney area (CRC 2006: 112).

The SCH is located in Randwick, in Eastern Sydney. The hospital is a major resource for the people of the region served by the South Eastern Sydney Illawarra Area Health Service (SESIAHS). According to the 2006 Census, 22% of people living in this area spoke a language other than English, compared with 20% of the State (ABS 2007; Broadley, et al. 2009).

At both hospitals the major language groups which access the interpreter services are Arabic, Vietnamese, Mandarin and Cantonese (CHW 2007; HCIS, SCH 2010; HCIS, SCH 2006/7). At SCH 9% of patients were non-English speaking (SCH 2006/7), compared to 11% at CHW (CHW 2007). These figures do not reveal the full extent of diversity of the families as the hospitals do not collect the country of birth and preferred language of the parents, only details of the child patient. This data collection process was being reviewed at the time of this study to reflect a more accurate picture of the cultural diversity of families.

The cultural diversity in NSW was reflected in the ethnic and linguistic diversity not only of the patients and families, but also of the staff. In 2007, the percentage of staff who were from minority groups or whose first language was not English at CHW was approximately 24-25% (CHW 2007).

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This Area Health Service is now South Eastern Sydney Local Health District and Illawarra Shoalhaven Local Health District.

Where the children are too young to speak for themselves, the cultural background refers to that of the parents/carers (Diversity Health Coordinator, SCH, email dated 14 March 2008).
while at SCH it was approximately 16%\textsuperscript{10}. However, these figures are also misleading as there is no obligation for staff from either hospital to give details of their cultural background\textsuperscript{11}.

Both hospitals are tertiary institutions and so have various employment links with other countries as well as exchange programs. In NSW, at the time of the study, there was a shortage of doctors and nurses (Birrell 2004; Brooks, et al. 2003; Frankum 2006), so many were being recruited from overseas (Phimister 2003; Pollard 2006). At SCH 50\% of Junior Medical Officers were overseas trained, whereas at CHW there were 30\% overseas trained doctors (Chalmers and Rosso-Buckton 2008). At SCH 60\% of nursing staff were overseas trained, while at the CHW 4\% were overseas trained. The proximity of the former to beaches contributes strongly to the difference in these figures as SCH employs a significant number of foreign nurses in Australia on working holiday visas (Chalmers and Rosso-Buckton 2008).

1.7.2 Relationship between my PhD and the broader ARC Linkage project

My PhD was part of a larger project entitled *Negotiating the challenge of cultural diversity in children’s health care: the Australian context* which was coordinated by Dr Sharon Chalmers and Amanda Rosso-Buckton at the

\textsuperscript{10} The figure is based on information provided by the Workforce Development unit at SCH June 2011. The response rate of staff was 80\% to the question of whether their first language was English.

\textsuperscript{11} Based on information provided by the Diversity Health Coordinator at SCH June 2008 and Staff Services Department at CHW February 2009. I reviewed this information again in March 2011.
Centre for Cultural Research (CCR). This project received funding from the Australian Research Council (ARC) (as a Linkage Grant) for three years which included funding of my PhD scholarship. It had several components which used a range of methods including:

- surveys and follow-up interviews with staff and patients at both hospitals (see Chalmers & Allon (2002) for the SCH component);

- Interviews with senior hospital staff at SCH and CHW in relation to policy and training when working with diversity health issues;

- interviews, focus groups and observation with seven child patients with chronic illnesses, their parents/carers and their health staff over a six month period; and

- 269 multilingual telephone surveys conducted with the primary carer for a child hospitalised at CHW and SCH between 2003-2006 (Chalmers and Rosso-Buckton 2008);

While my research focused on the hospital staff’s perspectives of cultural diversity and children’s health care, the other investigators focused on the children and patients/carers’ experiences. Although we worked on different components of the project, we shared an overall research objective of seeking to develop a more systematic approach to understanding and addressing the challenges that service providers face due to the increasing cultural diversity of patients. The data for my PhD was gathered in collaboration with the ARC chief investigators (Chalmers and Rosso-Buckton 2008).

1.7.3 Methodology

This study explores the experiences of health professionals in recognising and engaging with cultural diversity. It used a qualitative mixed method approach to “inductively and holistically understand human experiences.
and constructed meanings in context-specific settings” (Patton 2002: 69). This qualitative approach is concerned with generating new ideas and understandings rather than testing predetermined hypotheses (Glesne and Peshkin 1992; Minichiello, et al. 1990). Due to the complexity of the interactions between staff, patients and families in the hospital, such an approach was chosen to understand the meanings that staff gave to their experiences of working with families from CALD backgrounds. Unlike quantitative research, it did not measure predetermined variables or examine their direct effect on outcomes. The research aimed at understanding the multiple factors that affect practice in the hospital, and why practice occurred. Methods included interviews, focus groups and participant observation with health professionals at SCH and CHW. Surveys were also undertaken at the beginning of the study to provide a background to the themes that were further explored in the interviews.

As funding for this project was through an Australian Research Council (ARC) Linkage Grant, the data was gathered in collaboration with the ARC chief investigators (Chalmers and Rosso-Buckton 2008).

**Surveys and interviews with staff at CHW**

The first stage of the project involved my gathering data in relation to staff’s experiences of working with cultural diversity. Between September 2005 and February 2006 the ARC researchers (including myself) undertook 149 surveys and then 22 in-depth semi-structured interviews with staff from a range of departments and professions at CHW\textsuperscript{12}. The results for CHW were

\textsuperscript{12}I conducted these interviews with the ARC Chief Investigator Dr Sharon Chalmers and Project Coordinator Amanda Rosso-Buckton.
compared with a report conducted earlier with staff at SCH (Chalmers and Allon 2002). This data is analysed in Chapter 5.

All the staff in the hospital were invited to take part in the surveys to understand how they engage with families from CALD backgrounds. Surveys were chosen to understand attitudes, values and beliefs (Quine 1998c). The aim was to understand social processes of staff in more detail, not to make generalisations to a larger population not involved in the research (Kuzel 1999; Quine 1993). For this reason, staff from all departments were purposefully selected to be involved. Probability and statistical analysis was not undertaken as the selection of the sample was not random. The size of the sample was determined through ensuring all staff were given the opportunity to participate and that a range of opinions were explored.

In order to conduct the staff survey, in September 2005 the Executive sent a memo to all departments at CHW informing them about the research and inviting them to participate. Department heads then could express an interest in being involved. The areas which participated were Adolescent Medicine, the Child Protection Unit, Clubbe Ward, Commercial Travellers Ward, Dentistry, Emergency Department, Food Services, Hunter Baillie Ward, Nutrition and Dietetics, Outpatients, Patient Administration, Physiotherapy, Social Work and Speech Pathology (Chalmers and Rosso-Buckton 2007). We visited their department meetings and explained the details of the study while distributing information sheets. Staff then had the opportunity to volunteer to participate after filling out a consent form. These staff then filled in the survey (Appendix 1) and returned them at the end of the meeting. Staff from a range of professional groups participated in the survey including medicine, nursing, clinical management, clinical education, social work, occupational therapy, psychology, nutrition, speech pathology,
arts coordination, secretarial, administration, food services and hospital assistants (Chalmers and Rosso-Buckton 2007). The questionnaires were completed between September and November 2005.

The staff had the option of indicating on the consent form if they would also like to be interviewed. The interviews aimed to gather more in-depth information on the topics explored in the survey. Interviews were used to encourage people to answer questions accurately, freely, openly and in detail (Stewart and Cash 1991). Answers could also be clarified if unclear and explained further. The interviews were conducted during November 2005 and February 2006. They took up to one hour to complete and were conducted in private areas such as staff offices and clinical rooms. The interviews were conducted during work time and were recorded using a minidisk player. They were then transcribed and de-identified for any personal details. See Appendix 2 for the interview questions. Doctors, nurses, social workers and physiotherapists, dieticians, speech pathologists and food services assistants were interviewed.

*Interviews with managers at CHW and SCH*

From October to December 2006 we undertook interviews again but with managers from both hospitals. The main purpose of these interviews was to ascertain their understanding of organisational and professional cultures of working with cultural diversity, and how they saw policies guiding action (see Appendices 3-4). The interviews sought to evaluate the effectiveness of policies including the extent to which they emanate from the ‘top down’ compared with the everyday health practices undertaken by staff. Management interviews are discussed in Chapters 3 and 4.
To commence this phase of the research, the executive of both hospitals sent a letter about the research to a selected group of managers. A cross-section of managers included those in key positions such as the chief executive officers, directors of medicine, directors of nursing, heads of a range of clinical programs/directorates, and managers from allied health, workforce development and corporate services (see Appendix 4). It should be noted that staff often had dual roles as managers and clinical practitioners. The investigators also sent these managers an information sheet. Follow up calls were then made with the managers to encourage participation.

*Interviews, focus groups and observation with three health teams*

During 2007 I conducted interviews, focus groups and observations with three multidisciplinary health teams caring for children who required ongoing hospital care. Staff involved included doctors, nurses, physiotherapists, occupational therapists and social workers. This research was conducted over a period of six months.

The ARC investigators approached the health teams in different clinical areas and in principle support was given before families were recruited. These teams then identified potential families who were then given information about the project. Once families gave consent, health teams then formally gave support. I worked with three health teams looking after families out of a total of seven as part of the broader project (see Chapter 6).

Semi-structured open-ended interviews were conducted so staff could reflect on their experience of working in a team and on their practices in relation to working with a child and family from a CALD background (see Appendix 5).
All health team members were invited to take part in a focus group. We conducted focus groups with the health teams to understand the dynamics between health professionals when discussing cultural diversity issues (see Appendix 6). Approximately six staff members attended. The importance of focus groups is to examine “the group interaction … that would be less accessible without the interaction found in a group” (Morgan 1988: 12). It allowed us to examine how professions relate to each other and discuss the wellbeing of the child. It also enabled us to gather a range of views on a topic in a short period of time (Quine 1998a). Only one focus group was conducted with each of the health teams, due to the workload of the health professionals concerned.

Observations of clinical staff meetings and meetings between staff and family members/carers looking after the child allowed me to document information that may be “beyond the selective perception” of the research participants (Patton 1987: 73). Glesne (1999) discusses how observation reveals patterns of behaviour of participants in the research setting. It provides a ‘holistic description’ of what is being studied and records normal activity which is usually taken for granted (Bogdewic 1999: 49).

Observation permitted me to observe how different health professionals interact together and with the family. Observations are meant to be descriptive, non-judgmental and as objective as possible (Quine 1998b). They were geared towards analysing how staff behaviour related to organisational and professional cultures in the hospital and the cultural backgrounds of the patients and families. After the observations were conducted, I compared my notes with the other investigators to ensure we had similar material.

\[13\] The third health care team did not participate due to time constraints.
In the cases of formal meetings between staff and those between health professionals and the family, this process involved me sitting as a silent observer in the meetings for no more than an hour. When I was observing carers or health professionals looking after their child patient, I asked some questions about what was happening. Minimal notes were taken so as to not interfere with hospital procedures and treatment. These notes were expanded as soon as possible afterwards. My role was to remain independent but I feel I did have an impact during staff and family meetings. This may have made the staff take more of an interest in the needs of the family, but this impact is unable to be tested. Observations with the staff also made me realise how tolerant the staff are with families and children, and the range of strategies they used to assist the families in their transition to looking after a child with chronic health needs. Observations only occurred with the consent of the staff and families.

Observations with the child and carers in the hospital setting allowed me to compare the way patients were being cared for with how the staff suggested they were. I examined the multiple factors affecting how a child was treated. For example, with the case study of Joshua, while the staff said the grandmother did not need assistance in caring for the boy, our observations showed that the grandmother was struggling in spending long periods by herself feeding and lifting him. Discrepancies like these were examined in interviews with staff and the family. In the above case, staff were unable to assist the grandmother due to occupational health and safety issues and lack of appropriate equipment at the time.

I also had access to transcripts of the interviews the ARC project team conducted with the children and parents in the study about their experiences using health services (Chalmers and Rosso-Buckton 2008). Overall two to
three interviews were undertaken with carer(s). Each child was interviewed twice with the exception of Joshua who was unable to participate due to his brain injury.

Reliability and validity

The validity of the research was considered in terms of measuring what is meant to be measured (Borkan 1999; Burns 1990: 271; O’Leary 2004). In the case of this research, I was concerned with accurately exploring the meanings of people’s experiences and understandings. The validity was considered through using multiple methods such as surveys, interviews, observation and focus groups so that factors such as bias could be minimised. I conducted the first few health staff interviews with the other investigators then completed them by myself. We also worked together in conducting observations and focus groups. Our findings were then workshopped and discussed.

The reliability of research refers to the ability for it to be repeated and for the same results to be gained from different researchers (Borkan 1999; Burns 1990: 270; O’Leary 2004). This was considered by using consistent questions and methods which were agreed with before the commencement of the research. The Steering Committee for the project reviewed the questions and findings. The other investigators and I also discussed the themes early in the research. I then developed my own understanding specifically to do with my research questions. As qualitative research is not conducted in a controlled environment, the exact results could not be achieved again.

To increase the credibility of the research we aimed for saturation of results (O’Leary 2004). The number of surveys, interviews, focus groups and observations were determined by ensuring that no new findings were generated. Prolonged engagement also assists with the credibility of the
research (Burns 1990; O’Leary 2004). This was demonstrated by conducting the research over 22 months.

The wide selection of staff who participated in the research also added to the credibility of the research (O’Leary 2004). Staff from a broad selection of occupations were included in the surveys, staff interviews, health team interviews and focus groups and observations.

*Ethical issues and role of researcher*

This research tried to accurately understand how staff negotiate cultural diversity with child patients families from CALD backgrounds. This goal had to be weighed against also protecting the rights and the welfare of the research participants. Participants needed to fully understand the nature and the risks of the research and that it was voluntary before they consented to take part (NHMRC 1999). I submitted ethics applications to the Human Research Ethics Committees at SCH, CHW and University of Western Sydney. In accordance with ethics requirements, the names of staff who were interviewed have been changed to ensure anonymity.

Reflexivity was considered as the influence my values had on the results of the study (Borkan 1999). The nature of the research with families from diverse backgrounds meant there were some instances when I had to question my own values towards parenting so I was not judgemental of those parents in the study. These issues were discussed in the team meetings and with my supervisors to ensure they did not have an impact on the analysis of results. With the examples given in the thesis, I applied careful attention to ensure the multiple perspectives of the parents/carers and staff (and where possible children) were considered.
My presence during staff and family meetings may have sensitised staff to the need to consider the cultural background and other needs of patients and families. Questioning the staff may have also made them consider the needs of the families in the future. We did notice that with the case studies the staff’s attitude changed from frustration to acceptance the longer we worked with the staff and families. This was an unintended consequence and something we could not control.

*Analysis of data: coding and discourse analysis*

The surveys, interviews, focus groups and observation notes were transcribed and then coded to identify common themes and topics (Ezzy 2002: 86). Themes that arose were initially those that related to the research questions and multi-dimensional aspects of the research such as systemic constraints, professional and organisational cultures, and understandings of cultural diversity. I used the computer software package N-Vivo (qualitative research software) to assist with coding and discourse analysis.

N-Vivo assisted me to electronically code the transcripts according to large central themes. For instance, the themes for the interviews with health staff at CHW were: cultures in the hospital; the influence of the health system; types of interpreting; clinical areas; types of staff and patient interactions; workforce issues; understandings of cultural diversity; interviewees’ personal background; staff from CALD backgrounds; and patient cultural beliefs and practices. These themes were then broken into sub-themes. For example, the theme of ‘cultures in the hospital’ was subdivided into: organisational; professional; children’s health culture; medical; Anglo; covert discussions; inappropriate use of facilities; departmental; geographic; and individual.
Discourse analysis was employed to understand the broader social significance of what the staff and managers said about working with cultural diversity. Lupton (1998: 491) explains that discourse analysis is a “method of interpreting the meaning and social context of textual material”. For example, this study explored the historical, political and cultural context of staff members’ experiences with cultural diversity. In this regard, I associated what they said to multicultural and health policies, and understandings of organisational and professional cultures.

Van Dijk (1997) provides a summary of concepts commonly used when describing socio-cultural discourse analysis such as context, action, power and ideology.

- ‘Context’ is the institutional and societal arrangements behind the discourse. What staff and managers said about working with families from CALD backgrounds was understood in a broader socio-cultural framework and then compared. Child patient and carer experiences in the hospital were also understood in a broader social context.

- ‘Action’ is the implications of using a particular discourse on practice (Fairclough 1992; Gustafson 2005). Lupton (1994: 29) discusses the impact of discourse in producing practice, which then reinforces discourse. The impact of the discourses of managers and staff are analysed in this thesis as influencing the behaviour of themselves, other staff, child patients and families. In Chapter 5, implications of discourse was demonstrated in the nurses stating that the way they viewed the behaviour of some families from CALD backgrounds as problematic did have a negative impact on their practice.
Foucault (1981) and Fairclough (2001) agree that discourse is constitutive of social structures as well as reaffirming these structures. However, Fairclough (1997) has a different view from Foucault, saying that discourse can not only maintain practice, but can challenge it, and thereby create social change. While analysing staff and managers’ data, I examined how some individuals might have created social change in the organisation. For example, in an interview with a senior social worker, this person highlighted the impact their position can have in team meetings in making staff consider the social needs of a family beyond just their biomedical needs.

• ‘Power’ is observed in discourse as the form of control one group has over another in being able to make them think and act in a certain way due to access to material and symbolic resources (such as knowledge and education) (Van Dijk 1997). The powerful can control the parameters of discourse and how others are portrayed. Power can also be based on different variables such as a person’s position, ethnicity, gender and class. I analysed the impact of what managers and staff said on how staff and families act and are described. For example, Chapter 3 highlights the way managers use the discourses of efficiency and evidence based practice to make staff act in certain ways in the hospital.

• ‘Ideology’ is the ideas and beliefs that are shared by a dominant group to maintain their position of power (Van Dijk 1997). These beliefs are accepted as natural, a process by which dominant groups reproduce their power (Browne 2001). We analysed staff and managers’ interviews to identify examples of ideology and pervading ways that
staff understood situations. Ideology was observed in the way staff spoke about the qualities of certain groups of people. An example was the way a doctor referred to the actions of the mother of Casey in Chapter 6 as detrimental to the wellbeing of the child. This demonstrated the impact of the ideology of individualism in the hospital and the view that the mother should take responsibility for her adolescent son instead of exploring the family’s social situation.

Fairclough (2001) discusses how ‘ideology’ can maintain the role of ‘power’ in discourse. Discourse is determined by ‘orders of discourse’ which are ”sets of conventions associated with social institutions” which embody power relations (Fairclough 2001: 14). For example, there are the conventions in a hospital of how a health professional speaks to a patient. Ideology sustains these power relations, producing rule by consent. A patient may acknowledge their subordinate position vis-à-vis the doctor according to the dominant medical ideology of compliance.

Organisational discourse analysis explores “the relationship between everyday organisational talk, and larger issues of social structure and meaning” (Mumby and Clair 1997: 181). I used this analysis model to explore whether the discourses within the two children’s hospitals are reflective of broader organisational cultures (Iedema, et al. 2003; Mumby and Clair 1997).

Organisations do not exist in a vacuum, therefore the discourses that were examined were varied and sometimes contradictory. Following the understanding of Clegg (1990), staff in organisations have competing values, and different powers, influences and interests according to their position, profession, and beliefs. These influences highlight the post-modern nature of organisations, operating not as closed structures, but affected by outside
forces (Clegg 1990). The competing and sometimes contradictory forces that affected the way managers and staff spoke and acted were examined in this thesis. This analysis of discourses around cultural diversity as they apply to children’s health care is a contribution to organisational discourse literature.

1.8 Conclusion

This chapter has established a rationale for investigating how hospital staff negotiate cultural diversity in general, and with child patients and families in particular. Previous approaches to working with cultural diversity in health care have focused on CALD patients’ ‘culture’ rather than examining the cultural context of health care and how it can be negotiated. This dominant approach in health care resonates with the ‘politics of recognition’ theory, which centres on ethnic identity outside institutions, rather than examining how these institutions can address disadvantage. I offer the alternate theories of ‘status recognition’, ‘productive diversity’ and ‘relational positioning’ to address these concerns.

This thesis takes a qualitative approach, using surveys, interviews, focus groups and participate observation to examine how staff negotiate diversity within their health care practice. These data are analysed with discourse analysis to relate what staff have said to a broader context of health care and multiculturalism.

The next chapter reviews how Australian multicultural and health policies since the 1970s have affected the ways that the health system has addressed cultural diversity. This provides a background to the policies impacting on health staff practices in the two hospitals.
2. Historical approaches to working with cultural diversity in health care

This chapter investigates the impact that multicultural and health policies have had, and continue to have, on hospital staff practice in NSW. It is based on the understanding of practice as being determined by the broader social, economic and political context (Chan 1997; Kemmis 2009). Attention is drawn to the shifts in the language around culture and the parallel structural changes in the way that health services have historically been provided to patients from CALD backgrounds. While some health workers have tended to equate the culture of patients with their ethnicity (Morrissey 1997), others have tried to include ‘culture’ within a range of other factors that influence patients’ access and response to health services such as socio-economic background, gender, age, and education (Manderson and Reid 1994).

A more recent response in health organisations has been for them to aim for the development of ‘cultural competence’\(^\text{14}\) – the ability to work effectively with patients from culturally diverse backgrounds (NCCC 2004b). Literature has critiqued these approaches to working with cultural diversity as not having a wide enough conception of culture, including the impact of professional and organisational health cultures on service provision (Hong 2001; Kagawa-Singer and Kassim-Lakha 2003; Mitchell 1989). The more

\(^{14}\) For purposes of clarification, I have used ‘cultural competence’ as an umbrella term to refer to the outcome of a capacity. ‘Cultural competency’ is used in a more narrow sense as it refers to a skill in a particular area (see Stewart 2006).
critical approaches of cultural competence and cultural safety move some way towards examining the impact of the dominant culture on health services provision.

The focus on the cultural context of health care has been marginalised to the periphery of health service policy, research and provision (Garrett, et al. 2010; Garrett and Lin 1990; Mitchell 1989). This has been the case because of the continued focus on biomedicine, and later evidence-based medicine and efficiency in healthcare, where the unacknowledged social context of health is based on mainstream Australian social norms and western biomedical models of care. Nor has there been enough attention paid to the need for systemic support to give staff the capacity to work with patients from CALD backgrounds (Australian Government 2005).

Approaches to working with cultural diversity in health care in Australia have changed since the early 1970s when the Federal Government’s policy of ‘multiculturalism’ was first legislated through the Labor (1972-1975) and later Liberal governments (1975-1983). This period was a turning point in that migrants acquired a right to express their cultural difference (Castles 1999). Three major shifts are identified in Federal and State multicultural policies since the 1970s which have affected the way that staff in the NSW health system have engaged with patients from CALD backgrounds. My analysis draws on a range of texts that have informed practice including: government multicultural and health policies, training materials and academic textbooks for health professionals.

Distinguishing the three major periods and corresponding approaches is mainly influenced by Castles’ (1999) analysis of the evolution of multiculturalism through different Federal governments, as well as other
analyses of the changes that have occurred in Australian health services (Baum 2008; Garrett and Lin 1990). The three periods are:

• **Phase 1: Period of essentialising cultural difference (1970s-early 1980s).** This period was characterised by the tendency to essentialise cultural characteristics of ethnic groups, in general (Castles 1999), and in health care (Bottomley and de Lepervanche 1990; Morrissey 1997).

• **Phase 2: Period of equity of access (early 1980s-1990s).** This was a social justice period in Australian politics (Baum 2008; Castles 1999), where health organisations are influenced by equity of access principles and the nature of multicultural policies not addressing difference (Jayasuriya 1993; Mitchell 1989).

• **Phase 3: Period of cultural competence (1990s-present).** There was a rise of conservatism in multicultural politics (Castles 1999), while in health there was the need for evidence-based inventions (Baum 2008) and the need to demonstrate cultural competence (Stewart 2006).

For reasons of simplicity, the titles of the following sections correspond to these three periods. But the titles do not describe the complexity of sometimes competing discourses that have co-existed, as will be outlined below.

Following analysis of these periods, I will discuss some of the considerations of the impact of different ‘cultures’ from within health services on how staff work with patients from CALD backgrounds including the culture of medicine, nursing and allied health care. These have occurred on the periphery of health practice (Whitcomb 2003).
2.1 Phase 1: Essentialising cultural difference (1970s-early 1980s)

The adoption of multicultural policy by the Federal Government during the 1970s had a significant impact on how health providers worked with patients from immigrant backgrounds. While health professionals were more sensitised to the ethnic differences between patients, and extra services were provided to assist patients from immigrant backgrounds, the focus was on understanding the culture of migrant groups, not changing the way that health services were provided.

There have been different terms to describe this approach in health care including it being a ‘culturalist’ (Culley 1996), ‘checklist’ (Chalmers and Rosso-Buckton 2007), or an ‘ethnic sensitivity’ approach (Culley 1996). These terms refer to a common element of ‘cultural essentialism’, where “ethnicities are conceived as absolute categories” (Culley 1996: 567). Although this approach “equates ethnicity with culture” and could lead to stereotypes (Garrett and Lin 1990: 361), it did make cultural difference less problematic and more acceptable, as staff were becoming more familiar with different beliefs and practices.

There was little examination of the impact of the culture of medicine on service provision as health care was entirely based on biomedical approaches. During this period, it was mainly changes that occurred in multicultural politics, not in health politics, that influenced health service provision for patients from immigrant backgrounds (Garrett and Lin 1990). As a result, policies for treating patients from immigrant backgrounds developed on the margins of general health policy (Garrett and Lin 1990).
During this period multiculturalism mainly referred to immigrant cultures with the term ‘ethnic’ referring to immigrants from non-Anglo backgrounds (AEAC 1977; Martin 1978: 3), or minority groups (Encel 1981; Eriksen 1993). This ignored the fact that people from Anglo backgrounds also have an ethnicity according to the definition of ‘ethnicity’ as groups who are distinctive based on “a common ancestry” (Bottomley 1997: 45), language or religion (Encel 1981; Glazer and Moynihan 1975).

2.1.1 Changes in public health

Health policy was slow to address the needs of immigrants. In Australia and internationally during this period, there were moves to encompass a broader, more holistic notion of health than just the physical. This meant the social well-being of all patients was considered, including migrants.

The World Health Organisation conference in 1978 resulted in the Alma Ata Declaration which reaffirmed:

… health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity … whose realization requires the action of many other social and economic sectors in addition to the health sector (WHO 1978).

This definition highlighted the need for different sectors to work together to achieve good population health. The conference also asserted the need for health equity where it recognised that some people were unduly disadvantaged.

At the same time there also emerged the focus on behavioural approaches to health where governments and disease specific organisations felt that individuals could personally change their health status by changing their
lifestyle. This approach was criticised as not considering how health is socially determined (Baum 2008). For instance, the Black Report in England acknowledged the importance of healthy lifestyle, but proposed that social inequalities were the main reason for different health statuses (Baum 2008; UK DHSS 1980).

In 1973 the Whitlam government had introduced the Community Health Program where there were “multidisciplinary health centres responsible for the health of a given area” (Baum 2008: 44). This encompassed the idea of providing children’s health services (Wraith and Murphy 2000). Baum (2008) concedes that there was only piecemeal change in the mentality of health services towards a focus on community health, where a biomedical culture prevailed in mainstream health services.

There was some progress in 1971 when the NSW Health Department introduced language-specific migrant health education programs in Baby Health Centres in metropolitan Sydney (Chesher and Moess 1977; Martin 1978). These educators also acted as interpreters when needed. This initiative lead to the Hospital Interpreter Service being established in 1974 in a children’s hospital in Sydney and eventually the Health Care Interpreter Service in 1977 and Health Translation Service in 1980 (Chesher 1997).

The debates within the area of health did not directly address the disadvantages that immigrants faced, but rather these considerations emerged within the multicultural political arena (Garrett and Lin 1990; Jayasuriya 1993; Mitchell 1989), especially through key reports such as the Galbally report (1978).
2.1.2 Emergence of multicultural policies and reports

The Federal government’s policy of multiculturalism in the 1970s was partly in response to the mass entry of immigrants from European countries (Castles 1999), and later from Asia. This cohort of immigrants lacked the Anglo-Irish heritage of earlier ones and could not be expected to assimilate quickly. Castles (1999) highlights that migrants were often streamed into menial occupations and residential disadvantage which gave rise to disenchantment and fuelled ethnic politics. The Labor government came to power in 1972 through harnessing the ethnic vote (Sestito 1982). Multiculturalism was thereafter proclaimed as an expression of people’s “right to be different” (Castles 1999: 34). This approach continued with the Coalition government from 1975 to 1983. In 1977, the first official definition of multiculturalism was framed, as a policy to promote social cohesion and equality while also enshrining the individual’s right to express their cultural identity (AEAC 1977; Galligan and Roberts 2003).

During the 1970s service providers needed assistance to work with an increasing number and diversity of immigrants (EAC of NSW 1978: 37). Previously, where health professionals saw immigrants having trouble accessing health services, the problems were ascribed to immigrants themselves — as products of their migration experience or cultural attributes, not as a problem of the health institution (Martin 1978). According to the policy of assimilation migrants were expected to fit into the mainstream Australian culture (Garrett and Lin 1990). Multiculturalism allowed migrants to maintain their culture without discrimination (Galbally 1978; Morrissey 1997). Government reports from this period, such as the report from the Commission of Inquiry into Poverty in 1975 (Henderson Report) and the Review of post-arrival programs and services to migrants in 1978 (Galbally Report),
recognised that migrants needed more assistance in their settlement in Australia (Galbally 1978; Garrett and Lin 1990: 345, 350). The Galbally Report revealed that migrants were disadvantaged in areas such as lack of access to health information in their language and lack of familiarity with the complexity of the health system (Galbally 1978). The response of the government was to provide special assistance to migrants by increasing the number of interpreters in hospitals and community health centres (DIEA 1986) and the expansion of the Telephone Interpreting Service first established in 1973 (DIMIA 2003). These reports also encouraged more bilingual health professionals to be employed, and for them to upgrade their language skills. In the interim though, the government recommended that Ethnic Health Workers be employed, with the dual task of assisting new migrants and educating health professionals about the health practices and beliefs of migrant patients.

While the Galbally Report was recognized as a ‘turning point’ in ethnic health policy (Garrett and Lin 1990; Mitchell 1989), critics have said it did not go far enough as it focused too much on a patient’s ethnicity. It pointed to access as the major focus of disadvantage rather than also the quality of care (NHS 1993), and did not pay attention to the social disadvantages that migrants were facing (Garrett and Lin 1990). Recommendations related to providing interpreters and ethnic health workers rather than addressing the “more fundamental cultural and structural barriers to access” (Garrett and Lin 1990: 356). Critiques of multiculturalism at this time discuss its limitations, in that there was not enough structural change implemented in institutions to address the social, political and economic needs of migrants (Castles, et al. 1988; Martin 1978; Sestito 1982). The focus was on allowing migrants to express their cultural identity privately (Collins 1988), rather than publicly, where it could have an impact on service provision.
In NSW the *Report of the Ethnic Affairs Commission of New South Wales on Participation* (1978) had an impact on improving health service provision for migrants. The NSW Government had established the Ethnic Affairs Commission (EAC) in 1977 to review the provision of services for migrants, which resulted in this report. The Participation Report asserted that migrants should not only be able to express their cultural identity, but also participate in the political and social systems. It also considered that the major factor affecting access to health services was communication, and the integration of mainstream with specific services:

> Health care services often do not work in a co-ordinated fashion with other community services - particularly in the welfare and counselling areas - and with interpreters and other multi-lingual professionals. This results in inefficient use of existing resources. (EAC of NSW 1978: 238).

The report also stated that special provisions should be made for children from non-English speaking backgrounds in hospital due to cultural and linguistic barriers to appropriate services. In accordance with this, it acknowledged the progress made in NSW through its Health Care Policy relating to Children and their Families, which was endorsed by the Health Commission of NSW in 1975 and NHMRC in 1978 (AWCH 1999).

### 2.1.3 Understandings of culture in the 1970s

Such reports on multiculturalism had a direct influence on health service provision through the use of notions of ‘culture’ based on early anthropological research (Castles 1999). For instance, the Galbally Report (1978: 104) used a definition of culture from the nineteenth century anthropologist Tylor, which linked culture to a particular location and a set
of collective practices. According to such static notions of culture, it was assumed that migrants brought their culture with them from an historic past and simply continued to live the same way, just in a different geographical location. It implied culture did not change, whether in their country of birth, or in the post-arrival period in Australia (Morrissey 1997). In a report by the Australian Ethnic Affairs Council, whose role was to advise the Federal government on the integration of migrants into Australian society, migrants’ cultural identity was referred to as being based on their ‘historic’ experiences:

Cultural identity is the sense of belonging and attachment to a particular way of living associated with the historical experience of a particular group of people (1977: 4).

In other government reports, cultural difference was conflated with ethnic difference. Under this oversimplified understanding, each ethnic group had its own distinctive culture (Morrissey 1997: 93). Multiculturalism was therefore based on the model of:

Differentiation by cultural communities. Ethnic communities are the carriers of different cultures … (AEAC 1977: 5).

The emphasis on ethnicity when describing a person’s culture assumed that migrants belonged to distinct groups. This could mean that providers made presumptions about how a patient from a certain background would act.

The way that the government distributed services to migrants in the late 1970s also encouraged migrants to align themselves to ethnic specific groups (Castles 1999: 34). The more vocal ethnic specific groups were rewarded by having Ethnic Health Workers employed to assist them within health care services (Galbally 1978). The appeal of this approach for government was
that it was easy to work with specific community representatives and organisations. However, it did not acknowledge the diversity of identifications and needs that existed within ethnic groups according to their class, religion, gender, language ability, region and length of time in Australia (Bottomley and de Lepervanche 1990; Castles 1999; Morrissey 1997).

2.1.4 Essentialist approach to understanding migrant patients’ culture in health

The dominant approach to cultural diversity training in health during this period was to focus on understanding the cultural traits of different ethnic groups (Culley 1996; Culley 2000; Garrett and Lin 1990; Krefting 1991; Wear 2003). Health service provision in Australia was influenced by the ethnic specific cultural awareness courses that were offered to health professionals. The Galbally Report recommended cultural awareness courses should be offered to government professionals so they might gain a better understanding of cultural differences, including the differing roles of the family and child-rearing practices (Galbally 1978; SCAE 1984; STC 1980: v, 18). Although there were different levels of interest in such training across government, the main participants were teaching and medical personnel (Lee 1980).

While some of these courses encouraged health professionals to avoid stereotyping immigrant patients (Jakubowicz 1984; Lee 1984), universal generalisations about particular migrant communities continued to dominate training and education (Garrett and Lin 1990). For instance, health professionals wanting to know how to work with children in a family originally from Lebanon, were given the following information about family life in Lebanon:
Boys are usually dressed in blue when babies and later great care is taken to dress them appropriate to their sex. Fathers and other male members of the family often make comments about the boy’s penis, such as “What’s that for”? The boy is sometimes grabbed by it, amid much laughter and comments about how masculine his is. Little boys are expected to be aggressive, to attack fathers and uncles in aggressive play, and to put up with rough-housing (Semaan and Stambouliah 1980: 90).

Such a description reveals essentialising and homogenising assumptions about people originally from Lebanon and tends to generalise the behaviour of people based on their ethnicity alone. The courses did not look at the contextual nature of a person’s cultural identity. There are a range of variables in addition to ethnicity which intersect to determine identity formation in different health contexts including age, class, gender, and sexuality, and patient and carer positions. Theorists such as Ang (2001; 1998) and Hall (1996; 1990) discuss how a person’s identity is always shaped by situation, time and place. This understanding highlights how identity formation is both self-ascribed and ascribed by others. Indeed, recent Australian research demonstrates that many health consumers from CALD backgrounds within hospitals are at pains to be treated the same as ‘any other Australian’ (Chalmers and Allon 2002: 14; O’Callaghan 2000). For instance, some do not want to be associated as patients with ethnic specific group, while in other contexts the same person may be proud to demonstrate certain facets of their cultural background.

Cultural awareness courses such as these have been critiqued as being counterproductive in strengthening the stereotypes of minority groups (Garrett and Lin 1990; Singer, et al. 1986; Stubbs, et al. 1996). The emphasis
on ‘other cultures’ means that the impact that the Australian culture and/or organisational cultures might have on the level of access and content of health service provision is not explored (Garrett and Lin 1990). An important part of training is having a balanced approach; as a later review of training states:

… information provision, in conjunction with self-reflection/exploration and skills learning has the potential to be effective … the focus should not be solely on cultural difference (Trenerry, et al. 2010: 40).

Although there was mention in these courses that health professionals, as well as patients, interpret tasks according to their own cultural background (Jakubowicz 1984; Lee 1984; Stein 1980), there was little practical advice on how health services should actually change (Morrissey 1997). This type of approach has also been discredited in critical health literature in the United States (US) and United Kingdom (UK) as promoting stereotypes (Krefting 1991), and not addressing the provider culture or structures of disadvantage and inequality for migrant patients (Culley 1996; Wear 2003).

2.1.5 Normalising difference in health care

Although the approach described above essentialised culture, it did have the benefit of allowing health providers to become more familiar with difference so it became less problematic. Health professionals were requested to be sensitive and tolerant to different practices. For example, a journal article from the time described a situation where if a health professional had contact with a child from South East Asia with cigarette-like burns on their body, it should not be assumed to be child abuse, as it could be a result of therapeutic burning by folk healers for a previous illness (Feldman 1984). Recognition of
this difference was therefore important in normalising difference instead of making Eurocentric assumptions of poor parenting. It highlighted to staff that western values are not universal but culture-bound (Marcus and Fischer 1986). This gives patients a presumption of worth as Taylor (1994) outlines, in line with the principle of cultural relativism, and the politics of recognition.

2.2 Phase 2: Equity of access (early 1980s-1990s)

In the period from the early 1980s to 1990s, the focus in government policies shifted to access and equity (Castles 1999), which had a major impact on health service provision for patients from migrant backgrounds. During this period there was a change of government to Labor from 1983-1996. In health there was Federal policy development specifically in relation to ensuring equitable access for immigrant patients, as part of the 1993 National Health Strategy. However, there has been continued criticism within the area of multicultural politics (Castles 1999), and ethnic health (Garrett and Lin 1990; Jayasuriya 1993; Mitchell 1989), of there being a lot of policy rhetoric but little change in the structure and culture of institutions to reflect the diversity of people in the country (Castles 1999; Mitchell 1989). In particular, multicultural policies and practice in health focused on equity of access and not equity of outcomes (Jayasuriya 1993), nor did they specifically address the needs of people from migrant backgrounds. As stated by Mitchell (1989: 209-210), “the policy of multiculturalism has not succeeded in addressing the relationship between ethnic health consumers and public health services, or brought significant changes to these services so as to reflect those attitudes, values and unstated assumptions held by these consumers”. This statement reflects the critique of multicultural policies as not bringing about change in mainstream institutions (Jayasuriya 2001).
2.2.1 Changes in multicultural policies: access and equity

The focus on access and equity principles in Federal and State multicultural policies in the 1980s and 1990s incorporated a move towards mainstreaming - a requirement on government departments to demonstrate that they could provide mainstream services that were appropriate and accessible for people from diverse backgrounds (Duffield 1997; Garrett and Lin 1990). For example, from 1985 Commonwealth agencies (including all health agencies) were required to prepare Access and Equity plans to demonstrate how barriers to access were being removed (DPMC 1989). In 1989 the government’s multicultural policy, *National Agenda for a Multicultural Australia*, strengthened the government’s Access and Equity Strategy to reduce the barriers of language and culture. Castles (1999: 35) highlights that during this period there was a change in multiculturalism from an ‘ethnic group’ to ‘citizenship’ model where everyone had rights and obligations. People had the right to express their cultural identity and receive equal treatment, but also the obligation to accept the structures of Australian society.

It was during this period that the term ‘non-English speaking background’ (NESB) was used to refer to patients who may be disadvantaged in accessing services (Garrett, et al. 2010). The problem with this term was that it tended to reduce all these people’s experiences to the same category (Commonwealth of Australia 1999). It assumed that people who came from predominantly non-English speaking countries could not speak English or were disadvantaged, which was not always the case (Duffield 1997; MacGregor 1997).

There was also a focus on economic efficiency in this period and a change in immigration policies to favouring migrants with needed skills (Castles 1999).
The emphasis was on competitiveness and efficiency in economic policy (Quiggin 1997), while the notion of ‘productive diversity’ put a positive economic spin on employing migrants. There were also the trends of globalisation, deregulation and economic restructuring. The notion of economic efficiency was contained in the *National Agenda for a Multicultural Australia*, with its emphasis on “the need to maintain, develop and utilize effectively the skills and talents of all Australians, regardless of background” (Commonwealth of Australia 1989).

### 2.2.2 Access and equity in health

Within health services, there was some indirect consideration of factors affecting the health of migrants through international developments in the area of public health. Public health is defined as “the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society” (Nutbeam 1998: 3). The World Health Organisation’s Ottawa Charter in 1986 shifted the direction of public health as it emphasised not only lifestyle but public policy change to improve a person’s health. Baum (2008) contends that this Charter was the essence of the international movement to a New Public Health with an emphasis on equity and a more holistic notion of health through considering the impact of one’s social economic position, employment status, ethnicity, gender, age and location, as well as supportive social environments. However as Mitchell (1989) contends, discussions about health inequities in government policies did not embrace migrant health considerations.

There were some milestones in the area of improving people’s access to services in Australia which benefited all Australians (including migrants) such as universal health care (Medicare) in 1983, the formation of
organisations such as the Australian Community Health Association in 1984, the Better Health Commission in 1985, and policy development such as the National Women’s Health Policy in 1989.

Federal health policies considered the needs of immigrant patients through the principles of access and equity. In 1988 the Office of Multicultural Affairs released the Access and Equity Plan for the Department of Community Services and Health. In 1989 the *National Agenda for a Multicultural Australia* policy recommended that the Department of Health, Housing and Community Services and the Australian Institute of Health conduct research into the health needs of people from non-English speaking backgrounds (DPMC 1989).

Although health policies were beginning to specifically address the needs of immigrant patients, critics have said the impact of multicultural politics on health in the early 1990s was insignificant (Lin and Garrett 1990). The 1993 National Health Strategy (NHS) released its report specifically in relation to the linguistic and cultural barriers to service delivery facing NESB patients. It concludes, “the limited response by all levels of the health system has resulted in poor access to services and reduced quality of care for people from non-English speaking backgrounds” (NHS 1993: 12).

For instance, the report stated that tertiary institutions “produce a workforce with a Westernised, biomedical culture” (NHS 1993: 10). This means “there is often a mismatch between the culture of the health care system … and the needs and expectations of people from non-English speaking backgrounds” (NHS 1993:19). This assertion was supported by research conducted in hospitals which showed that doctors and nurses were not supportive of patients’ cultural beliefs and values. It also outlines that “hospitals and
general practitioners do not utilise interpreters to their fullest potential” (NHS 1993: 10), including that they are not always available and are not used appropriately. Research into health issues effecting migrant communities was also not a priority for funding bodies which meant “data collections are ad hoc and unsystematic” (NHS 1993: 11). In response to these findings the NHS report recommended a coordinated response in the area of policy, programs, research and training by government, mainstream health services, accrediting bodies, tertiary institutions and professional bodies.

In NSW there was some progress when, as early as 1983, the Ethnic Affairs Commission instituted a system of Ethnic Affairs Policy Statements (EAPS), to be submitted annually by all government organisations (CRC 2007). This legislation affected hospitals as they had to demonstrate how they were addressing the needs of their culturally diverse constituency. Hospital services were no longer focused solely on the expected behaviour of patients from different ethnic groups, they now had to ensure that their services were appropriate for all their clientele. Both Sydney children’s hospitals in this study prepare EAPS reports (now the Multicultural Policies and Services Program - MPSP) annually (CRC 2009).

In 1983 the NSW Government also developed health guidelines to improve the accessibility and appropriateness of hospital services to patients from NESB. These guidelines were based on the following principles:

- The right of equality of access to health services regardless of ethnic origin or linguistic skill; and
- The responsibility of the health system to respond appropriately to the specific needs of different groups in the community, including ethnic minority groups (NSW Health Commission 1983).
This policy (upgraded to a Policy Directive in 2005) is still used today (NSW Health 2005b). The critique below outlines it was mainly the principle of equity of access that was promoted, not equity of outcome, which made it difficult for health services to meet the second principle of responding appropriately to difference.

2.2.3 Equity of access not equity of outcome

Discussions about access and equity initiated debate within health about the types of equity that could be realistically achieved. While equality was about sameness, equity was about fair treatment (Baum 2008) which acknowledges there are limited resources available and not everyone can have the health care they need or want (Mooney 1983). ‘Equity’ involves a “focus on the distributional impact of health policies and programs on different individuals and families” (McClelland 1991: 1). Health resources may then need to be redistributed to improve the health of disadvantaged people rather than those who are more economically self-sufficient.

Different meanings of the concept of equity were understood in health care, with a distinction being made between ‘equity of access’ and ‘equity of outcomes’ (Whitehead 1990). Health economists argue that it is difficult for health services alone to achieve equity of health outcomes for all people (that is, to equalise everyone’s health status) because of the influence of other social and economic conditions (McClelland 1991). Also, achieving equity of outcomes would be highly expensive. A more realistic aim, promoted by government, would be to try to reduce substantial inequalities in health status between different groups (McClelland 1991), with health services working intersectorally with other organisations to improve the social determinants of health (Harris, et al. 2001; Spencer 2000; Waterston 1995).
'Equity of access' was the main term promoted in Australian health policy. It is based on the idea of equal access for equal need. As a NHS discussion paper outlines, "all people should have the same potential to receive the same health care according to their need for that care" (McClelland 1991: 17). Inequalities in access and use could arise if services are more responsive to some groups than others. For instance, "having little or no skill in English severely limits access to health information and to health and community services" (CDHHS 1994: 12)

The government’s focus on access has been critiqued as dealing inadequately with the health needs of migrants. Mitchell (1989) argues that while there has been discussion about access, there should be more discussion about improving health outcomes. For example, once people reach health services, "there was little or no consideration of how or in what ways the resolution of the health event took place once the consumer had presented" (Mitchell 1989: 206). Mitchell (1989) also outlines that the emphasis on access meant there was little change in health services to reflect the diverse views of the consumers. He contends:

The introduction of multiculturalism has not always been perceived as being linked to public health policies. For many health and medical professionals, this policy is neither related to health policies and services, nor does it underpin their daily work (Mitchell 1989: 210).

Jayasuriya (1993) similarly argues that a focus on access and universalism in policy means that difference was not being addressed. This highlights the difficulty of reconciling universalism with particularism. For instance, while access and equity policies focus on treating people the same under the
principle of universalism, they do not address patients’ specific needs or their differences:

The equality espoused, as evident in the rhetoric of “access and equity” policies of the National Agenda, was linked to *procedural equality*, i.e., equality of treatment, the need to treat all people the same, rather than aggregate outcomes, for *substantive equality of groups* (Jayasuriya 1993: 8).

In order to recognise pluralism, he endorses a redistribution of resources to account for the disadvantages faced by some groups. He further asserts that part of the failure of multiculturalism to effect significant change in health policy and services lay in the form of ‘cultural pluralism’ which was endorsed. It is based on an “ethnic-identity model of multiculturalism” that is “highly privatised” (Jayasuriya 1993: 8) rather than examining how migrants may be structurally disadvantaged. It was one which supposed that people meet on “equal terms” and thus “denies a major political dimension by ignoring the location of groups in the structures of society, and thereby having differential power relations” (Jayasuriya 1993: 7).

2.2.4 Changing understandings of culture in health care

During the early 1990s understandings of a person’s culture in relation to their health came to be further developed in an academic context. Critical social and medical anthropology and gender studies critiqued previous understandings of culture as reductive: not being sensitive to changes over time and place. This discussion occurred on the periphery of mainstream health care (Bottomley and de Lepervanche 1990).
Understandings of culture moved beyond ethnicity in health care to include notions of age and gender, and opened up the discourse to the changing and more fluid nature of culture (Bottomley and de Lepervanche 1990; Krefting 1991). This work was influenced by sociologists, such as Bourdieu (1995), who discuss the structural basis of culture according to different class positions. Bottomley and de Lepervanche (1990: 40) explain, in a multicultural text for health professionals, that:

‘Cultural backgrounds’ of immigrants include predispositions, attitudes and practices related to their specific experiences of class, region and gender, as well as what is more commonly called culture (practices and beliefs such as religion and kinship). More folkloric, and even nationalistic, notions of ethnicity are often perceived as ‘cultures’, but this tends to blur important differences within individual ethnic categories.

Social anthropologists also described culture as a process, in the case of migrants, where cultural forms are constructed and renegotiated in new locations (Bottomley and de Lepervanche 1990: 63).

These more recent understandings took the health professionals’ focus off ethnic cultural difference as the sole definition by which diversity is understood. Some key ethnic health literature published in the early 1990s discussed the socio-cultural context of health (Waddell and Peterson 1994; Trompf and Reid 1990). Manderson and Reid (1994) argue that the culture of a patient is important to the conception of health but is sometimes over-emphasised at the expense of other factors such as class, gender, education, and age and the type of services provided. They asserted that culture should
be conceptualized within a broader context of social, economic and political factors that affect the level of access and equity achieved.

Medical anthropology was also influential in highlighting how culture affects all people’s understandings of health and illness, not just migrant patients. It discussed the biomedical nature of western medicine compared to that of non-western societies (Ferguson and Browne 1991; Helman 1984; Kleinman, et al. 1978; Parsons 1990). However, while medical anthropology questioned western models of care, it stopped short of discussing “how the health system should respond” to diverse understandings of health and illness (Morrissey 1997: 102).

2.2.5 Multiple factors affecting children’s health care

In children’s health care recognition was increasingly given to the impact of social factors on the health behaviour of families. Wraith and Murphy in the *NSW Health Bulletin* (2000: 73-4), suggest that:

> Children’s health problems experienced by today’s children reflect a complex interaction between children, their family, and their socioeconomic, political and cultural environments.

In the early 1990s there were the first national health policies for children and young people which aimed to reduce the incidence and impact of disease, as well as enhance ‘family and social functioning’ (CDHHS 1995; Department of Health 1992; Wraith and Murphy 2000). Good health encompassed health partnerships with public and community based services to address the social determinants of health (Wraith and Murphy 2000). Within multicultural health, there also emerged understandings of culture in children’s health care beyond the ethnicity of the patients to include the social, emotional and
economic effects of a family’s migration (Fernandez 1991; Krefting 1991), including the experiences of being a refugee child and dealing with post-traumatic stress (Fox, et al. 1994; Johnson, et al. 1989; Lee 1988). Discussions of diverse family structures (Sparling 1991), different child rearing practices and developmental stages introduced notions of cultural relativism (Fernandez 1991), and reinforced the need for health providers to respect difference through becoming more familiar with it. This meant universal concepts could not always be applied to families from diverse backgrounds, as these concepts could be biased (Fernandez 1991).

The impact of the cultural background of the provider and the cultural values of their profession on service provision were also beginning to be examined in children’s health (Fernandez 1991; Krefting 1991; Meadows 1991). Tharp (1991) discusses research in the US where there was a high withdrawal of child patients from culturally diverse backgrounds in psychological treatment programs. This indicated that, although patients were all able to access services, offering the same service to all might not be responsive to the different needs of patients. Tharp (1991: 800) concludes “identical is not necessarily equal”. This raises the distinction between access and ‘utilisation’, where there may be a supply of services, but they may not be utilised because they are culturally unacceptable for some groups (Gulliford, et al. 2002). Utilisation rates would then have implications for unequal health outcomes.

### 2.3 Phase 3: Cultural competence (1990s-present)

During the period from the 1990s to the present, there has been more emphasis on examining the cultural competence of health organizations (Fitzgerald, et al. 1997b; Lee 2005; NCCC 2004b; NHMRC 2005; Stewart 2006).
This emerged in a political environment influenced by economic rationalist principles and evidence-based medicine (Garrett, et al. 2010). From the 1990s there was a focus on increased efficiency and measurement of the impact of factors on health outcomes. This has encouraged a growing body of literature presenting evidence of differences in the quality of health care for populations from CALD backgrounds (Institute of Medicine 2003; Johnstone and Kanitsaki 2006; Johnstone and Kanitsaki 2007), and the corresponding evidence that cultural competency interventions have some impact on health outcomes.

While there was more reflection on the impact of the organizational and professional culture within health systemic constraints (Australian Government 2005; CCHCP 1999), this was outside mainstream health service practice. There was little discussion of how staff are to negotiate the needs of patients and families in practice (Fitzgerald, et al. 1997a; Morrissey 1997).

The year 1996 was a turning point in multicultural policies in Australia with a conservative government coming to power offering less funding for multicultural affairs (Castles 1999) and a more mainstream approach in multicultural health (Allotey, et al. 2002). This lack of commitment to multicultural health was demonstrated in the priorities of health reform in Australia (Australian Government 2009) and NSW (NSW Government 2008a) which has been critiqued as not adequately addressing the needs of patients from CALD backgrounds (Migliorino 2010).

2.3.1 Shift in multiculturalism

There was a new conservatism in Australian multicultural politics with a Coalition government from 1996. The rise of Anglo Australian sentiment and nationalism was initiated by the anti-immigration stance of political parties
such as Pauline Hanson’s One Nation. This sentiment was also related to a fear of terrorism in the public that was linked with immigration. The shift towards mainstream values was reflected in the dropping of the word ‘multicultural’ from the title of the Department of Immigration and Citizenship in 2007 (Klinken Whelan 2009).

The Coalition government also took a conservative approach in social policy. This was demonstrated by the government cutting welfare services for migrants and dismantling institutions such as the Office of Multicultural Affairs (Castles 1999). Castles (1999) argues this new conservatism was linked to globalisation and changes in economic policy such as deregulation and economic rationalism. As previously outlined, economic rationalism emerged in the Labour era of Australian politics but with the change of government in 1996, the government placed more emphasis on it and less on social justice (Castles 1999). Economic rationalism is defined as “a government’s free-market approach to economic management, typically reflected in the adoption of privatization, deregulation, user pays, and low government spending as indicators of economic success” (APOD 2007: 1). Whitwell (1998: 4) contends that efficiency is “a sacred goal” of economic rationalism “where resources need to be allocated as efficiently as possible”. Quiggin (1997) has noted that the rise of economic rationalism has increased inequality in service provision. The conservatism in social policy was reflected in a reduction of funding for research into the needs of CALD patients (Allotey, et al. 2002).

During the period after 1996 there was a change of terminology in multiculturalism from ‘NESB’ to ‘people from culturally and linguistically diverse (CALD)’ backgrounds. Although technically the term ‘people from CALD backgrounds’ could refer to people of any descent including Anglo
descent (Sawrikar and Katz 2008), it mainly referred to people whose cultural and linguistic background was different to Anglo Australians (Garrett, et al. 2010).

There has not been a dramatic change in the direction of multicultural politics after the Labor party was returned to office in 2007 and then negotiated parliamentary support for a minority government following the 2010 election. However, there was renewed commitment to multiculturalism when the Federal government released *The People of Australia: Australia’s Multicultural Policy* (Commonwealth of Australia 2011) after an absence of active policy directions since the last policy was released (Commonwealth of Australia 2003).

### 2.3.2 Economic rationalism in health care

Health services since the 1990s were affected by economic rationalist principles of cost cutting public expenditure (Choucair and Ridoutt 1993; Klinken and Noble 2000) and market reform (Reid 1993). These reinforced existing trends towards scarcer resources in public health due to an ageing population, more chronic disease (Australian Government 2009), and the rising cost and complexity of medical technology (Vissers 2002). All these factors stimulated a greater emphasis on private health care where the ‘user pays’. The Howard government introduced a 30% rebate on premiums via the tax system for those who took out private health care insurance. The promotion of private health care in the area of elective surgery and the reduction in bulk billing have pressured public hospitals to take on more of the emergency workload (NSW Health 2003a). These increased demands on health care have made meeting the needs of CALD patients more difficult.
There has also been less funding for community health. In 1997 the Council of Australian Governments’ reform agenda aimed to introduce more cost efficiency in health and community services (Baum 2008). This was accompanied by less expenditure on procedures having an undocumented impact on health outcomes.

2.3.3 Evidence-based medicine

In this cost-cutting and reform environment, organisations needed to measure the impact of interventions on health outcomes (Baum 2008). Evidence-based medicine emerged based on “the conscientious, explicit and judicious use of current best evidence” in health care (Visser 2002: 128). Interventions need to be effective and efficient as resources are scarce and there is an increased demand for health services (Boldy 2002). Providers have to demonstrate the positive benefit of funding certain interventions (Baum 2008).

Evidence-based medicine is supposed to integrate clinical research with ”individual clinical expertise”, as well as meet the expectations of the patients (Visser 2002: 128). However, this may be difficult when the expectations of the patient do not match the clinical views. Evidence-based principles in health care are more geared towards scientifically rigorous, quantitative measures such as Randomized Controlled Trials (RCTs) which are regarded as the gold standard (Learmonth and Harding 2006). Methods of measuring the impact of a range of factors on health care such as class, ethnicity and gender or policies are more difficult to devise, and not conducive to positivist methods such as RCTs. This raises issues of what is valued as relevant knowledge in health care (Goodman 2003), and has encouraged researchers to call for better evidence to address health
inequalities (Redman 2008). However, even when there is reasonable evidence, it may not be recognized as it does not fit the current political agenda, and may not influence policy (Redman 2008). The Federal government funding of State hospitals is based on funding easily measurable outputs (O’ Reilly, et al. 2003), which tends to favour treating uncomplicated conditions and getting patients through the health system quickly (Cameron and Campbell 2003).

Improving the quality and safety of health services emerged in the late 1990s as a prioritised outcome due to recognition of the extent of medical errors and inefficiency in health care (CHW 2006; PSCQP 2005; Redman 2008; Rubin and Leeder 2005; Wilson, et al. 1995). In 2007 there was a series of incidents publicized in the media which outlined a crisis in hospitals labelled as ‘unsafe’ due to medical incompetence, increasing numbers of people in emergency departments, a lack of funding, and an understaffing of senior doctors in hospitals (Australian Broadcasting Commission 2007). This initiated Federal and State commissions of inquiry into health care (Australian Government 2009; NSW Government 2008a; NSW Health 2011). Funding is now more tied to evidence of providing a quality and safe service (Rubin and Leeder 2005) and there is now a major process of Federal and State health reform underway (Australian Government 2009; Australian Government 2010a; NSW Government 2011). This process has been critiqued as not dealing with inequities and multicultural concerns (Migliorino 2010; Morris 2010). More promising is health reform in NSW where patient experiences are part of quality measures (NSW Government 2008a) so that
inequities may be detected. The issue is how these are being analysed and addressed.

2.3.4 Influence of evidence-based medicine and mainstreaming in multicultural health

In an economic rationalist political environment in the early 1990s, there were fears that the interests of CALD populations would continue to be on the periphery of health care (Choucair and Ridoutt 1993; Reid 1993). This was reflected in the lack of multicultural health research being conducted (Kagawa-Singer and Kassim-Lakha 2003; NHS 1993). This is still the case; as a recent review of the coverage of multicultural health issues in mainstream Australian health journals outlines, “multicultural health research and evidence required for equity in policy, services, interventions and implementation is limited and uneven” (Garrett, et al. 2010: 1). A review of Federal health reform outlines the lack of discussion about the needs of patients from CALD backgrounds (Morris 2009). This was demonstrated by the continued mainstreaming of health services and less emphasis on providing ethnic specific services (Allotey, et al. 2002; Messimeri 2009). For instance there has been the removal of ethnic specific positions and the introduction of generalist Multicultural Health Workers (Travaglia and Degrassi 1996).

The corollary of the emphasis on evidence-based medicine is an impetus to measure the impact of linguistic and cultural difference on health outcomes.

15 At CHW, patients who speak a language other than English reported a lower than average rating on almost all the core dimensions of care (NSW Health 2009).
But this is difficult to do, as there are multiple factors involved. However, there are research findings since the 2000s in the US, and now Australia, which demonstrate how a patient’s ethnicity and language can have an impact on health outcomes and quality of care (ACSQHC and NICS 2004; Chandrika, et al. 2007; Garrett, et al. 2008b; Hayes-Bautista 2003; Institute of Medicine 2003; Johnstone and Kanitsaki 2006). There has also been evidence that provider bias, staff prejudice and stereotyping may contribute to differences in care for patients from diverse backgrounds (Institute of Medicine 2002). This data is based on studies comparing patient populations with the same income levels, and ‘other related access factors’ which show the impact of the patient’s ethnicity on how health professionals provide care (Institute of Medicine 2002). This research concludes that patients from ‘racial and ethnicity minorities’ receive lower quality care and lower rates of appropriate medical procedures (Institute of Medicine 2002). This type of research has been labelled ‘health disparity’ literature in the US.

### 2.3.5 Cultural competence

Within health organisations at the national level in Australia and in NSW there has been a move to develop the cultural competence of the staff and the organisation when working with cultural diversity (Australian Government 2005). The trend now is to demonstrate the effectiveness of cultural competency measures (Betancourt, et al. 2003), as will be outlined in Section 2.3.7. Research and discussions of cultural competence emerged in the early 1990s in Australia when the Mayer Committee outlined ‘cultural understanding’ as a key competency based outcome in education (Cope and Kalantzis 1997; NLLiA CWCC 1994). It has a longer history in the US since the 1980s where it has been used to assist staff in human services working with culturally diverse clients (Neufeld, et al. 2002). This approach has been
adopted by specific departments within both of the children’s hospitals in this study, such as the NSW Centre for the Advancement of Adolescent Health at the CHW (Bennett, et al. 2005) and the Multicultural Health Unit overseeing care at SCH (2002).

The meaning of cultural competence has shifted since it was first introduced. While earlier definitions focused on the skills and knowledge of a health professional or the services of an organisation, more recent definitions take an overall systems approach. The definition by Cross et al. (1989) has been referred to most frequently, and is used by the National Center for Cultural Competence (NCCC) in the US:

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (NCCC 2004b: 1).

Of considerable importance to this research project is the contention that there is a range of factors which enable culturally competent practice. In 2005 the NHMRC in Australia developed a four-dimensional model for creating and supporting cultural competence at the systemic, organisational, professional and individual levels (Australian Government 2005) to ensure that health professionals have the capacity to provide culturally competent care.

The policy of cultural competence has been critiqued within critical nursing and medical literature. A range of authors argue that cultural competency approaches over-emphasise developing skills to improve inter-personal interactions rather than taking a more systemic approach (Hayes-Bautista 2003; Hong 2001). Other literature argues for a more critical approach of
considering the impact of personal, professional and organisational cultures on service provision (CCHCP 1999), as well as the impact of the dominant culture and systems of disadvantage (Culley 1996; Hong 2001; Kagawa-Singer and Kassim-Lakha 2003).

The Cross Cultural Health Care Program (CCHCP) in the US encourages health professionals to reflect on the impact of the cultural context of health care when working with diversity in their definition of cultural competence:

Cultural competence involves recognition and respect for differences among patients in terms of their values, expectations, and experiences with health care, while at the same time recognizing the culture-based practices and dictates of organized medicine, and the values, expectations, and experiences of the providers who practice it. Culturally competent care becomes possible only with the skillful management of the interplay between these elements which make up a medical encounter, and determine the points of access or barrier at the institutional level (CCHCP 1999: 1).

Health professionals then have to negotiate the cultural context in health with the needs of patients. This strategy has the potential for health professionals to reflect on the impact of the dominant culture on service provision.

Other terms similar to cultural competence have emerged such as ‘cultural safety’. Cultural safety emerged within nursing in New Zealand in the early 1990s in response to the recognition of the health disparities for the Maori population (Papps and Ramsden 1996; Polascheck 1998; Ramsden 1993) and is part of the Nursing Council of New Zealand curriculum (NCNZ 2005). The Council defines the term as being characterised by:
... the effective nursing practice of a person or family from another culture, and is determined by that person or family ... The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (NCNZ 2005: 4).

This concept is useful as the provider undertakes a process of reflection on the impact of their culture and assumptions on practice (Papps and Ramsden 1996); providing the same service to patients, when there are cultural differences, can lead to inappropriate care (Anderson, et al. 2003a; Phiri, et al. 2009; Ramsden 1993). The provider also recognises the power relations between the dominant culture and minority groups (NCNZ 2005; Polascheck 1998).

The usefulness of the term ‘cultural safety’ is that it incorporates a dominant discourse used in health about ‘quality’ and ‘safety’ and combines it with a focus on cultural diversity. This may mean cultural diversity concerns receive more public recognition. Research in Victoria has recommended that cultural safety and cultural competency approaches be aligned with quality and safety initiatives to improve health professionals’ knowledge of these concepts (Johnstone and Kanitsaki 2007).

As the criteria for cultural safety are patient-focused, the literature has identified that there should be systems and infrastructure in place to enable the patient to participate in health interactions appropriately (Johnstone and Kanitsaki 2009; Polascheck 1998; Ramsden 1993). Research has identified that
the model of patient participation can be determined by a range of factors such as age, “mainstream social-cultural values of the resident country” and the nature of the health problem (Johnstone and Kanitsaki 2009: 3). The impact of the power of the dominant institutional culture also needs to be taken into account, as this may cause patients from CALD backgrounds to feel disempowered and reluctant to express their opinions (Chalmers and Allon 2002; Garrett, et al. 2008b; O’Callaghan 2006).

Critiques of cultural safety argue it is focused on the individual provider reflecting on practice, not on how patients may be structurally disadvantaged. For instance Polascheck (1998: 454) argues:

… effective change on a large scale cannot follow from purely personal changes in outlook. I would suggest that the focus on the individual nurse needs to be complemented by attention to collective issues such as general nursing policies, the nursing settings in which care is provided, and the broader health care structures of which nursing is part.

This is where the concept of cultural safety is useful in combination with cultural competence as the former focuses on the individual patient and health provider, and the latter examines the capacity of the health professional to provide effective services. As stated, this capacity is contingent on systemic, organisational and professional support (Australian Government 2005). The complementary nature of the two terms is reflected in guidelines produced by the Royal Australian College of Physicians (RACP) and the Australian Indigenous Doctors Association (AIDA) to guide the practice of doctors working with Australian indigenous patients (AIDA and RACP 2004). It is now a requirement that Aboriginal health is a core
component of the Australian Medical Council’s curriculum for medical training (AMC 2006).

2.3.6 Models of cultural competence

Some of the approaches to building cultural competence in an organisation focus on developing models and performance indicators. The NHMRC cultural competency guidelines in Australia acknowledge the need for systemic and organisational support for culturally competent practice at professional and individual levels (Australian Government 2005: 30).

In NSW from 1998 the Ethnic Affairs Commission’s EAPS incorporated a Standards Framework which required organisations to assess their performance in the areas of planning and evaluation, program and service delivery, staffing, communication, and funded services (CRC 2007). In 2000 the Ethnic Affairs Commission changed it’s name to the Community Relations Commission of New South Wales under the Community Relations Commission and Principles of Multiculturalism Act 2000 (NSW Government 2000). Agencies had to demonstrate how they addressed the principles of the Act in EAPS. One of the principles of this Act, which applies to health care, is that “all individuals and institutions should respect and make provision for the culture, language and religion of others within an Australian legal and institutional framework where English is the common language” (NSW Government 2000: 1).

In 2009 the CRC’s reporting process, EAPS, was reviewed (Klinken Whelan 2009), and the Multicultural Policies and Services Program (MPSP) replaced EAPS. The Standards Framework is now more focused on strategic planning rather then just reporting on achievements (CRC 2009). It is trying to make
cultural diversity concerns a core issue of organisations by integrating them into mainstream activities.

### 2.3.7 Evidence of cultural competence

There has been debate about whether measuring cultural competence is a suitable objective as it assumes the existence of a definite outcome, namely being competent (Cope and Kalantzis 1997; Kleinman and Benson 2006; Stewart 2006). This is where alternative terms such as cultural humility have been used to position the quest for competence as a life long ongoing process, so health workers do not become complacent (Tervalon and Murray-Garcia 1998).

As cultural competency measures are publicly funded interventions, they are subject to scrutiny for evidence of making a measurable impact on the health care of patients. Hayes-Bautista (2003) states if cultural competency interventions are to be taken seriously, especially by the medical profession, then there needs to be a greater link between them and health outcomes. However, there is difficulty in proving the impact of cultural competency measures on health outcomes (Anderson, et al. 2003b). This is because interventions have not been developed enough to provide exact guidance on how to work with diversity (Brach and Fraser 2008). Moreover, the impact depends on how it is assessed. Measuring the impact of cultural competency inventions is the subject of research at the University of NSW in collaboration with NSW Health. Cultural competency measures are being linked to health outcomes in the form of Results Based Accountability (RBA) (Eisenbruch, et al. 2005). This tool can develop “performance measures and results indicators which can be used to monitor and guide” the provision of health services to CALD patients (Eisenbruch, et al. 2005: 8).
Betancourt, et al. (2003) state that cultural competency interventions need to occur on organisational, structural and clinical levels in order to reduce health disparities. Those barriers that create disparities need to be addressed through interventions such as recruitment of professionals from culturally diverse backgrounds, better interpreter services and appropriate cross-cultural training. There is now growing international evidence that interpreters and bilingual staff can reduce disparities in the quality of care provided (Betancourt, et al. 2003) but “health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly” (Brach and Fraser 2008: 181).

Chin (2003) states there needs to be better measurement of competencies. For cultural competency interventions to have an impact on the daily work of health staff there needs to be more accountability from organisations that they are occurring. These cultural competency measures then have to be linked to the core measurement instruments in the organisation (Eisenbruch, et al. 2005). Even if there is evidence of cultural competency measures improving outcomes, they may not be core practice as they are outside the mainstream quality review process. There have been repeated moves by the Community Relations Commission to make organisations more accountable in terms of “observing the principles of multiculturalism in the conduct of their affairs” (New South Wales Government 2004). In 1996 it became a NSW statutory requirement that the CRC prepare a report in relation to multicultural affairs at all organisations (compiled on the basis of EAPS reports) to be tabled by NSW Parliament (Klinken Whelan 2009). In 1997 organisations were also required to discuss EAPS in their Annual Reports (Klinken Whelan 2009). While this reporting process in NSW is progressive compared to other States, the recent review highlighted that the CRC needs to assist organisations more in meeting multicultural objectives (Klinken
Whelan 2009). For instance, the CRC is negotiating contracts with government agencies to ensure they improve their standards. NSW Health and the CRC now require organisations to reach minimum standards of achievement (Anderson 2008). One of the outcomes of the Planning and Evaluation standard in the MPSP is that “Multicultural policy goals are integrated into the overall corporate and business planning, as well as the review mechanisms of the agency” (CRC and NSW Government 2009: 3). Requirements in the CRC’s MPSP reports are also being tied to mainstream health care accreditation processes such as the Australian Council on Healthcare Standards’ (2010) Evaluation and Quality Improvement Program (EQuIP).

In Victoria in 2009, the Department of Health released the Cultural Responsiveness Framework (Department of Health 2009). This was developed to give health agencies clearer standards and benchmarks to measure the degree to which they are responsive to the needs of patients from CALD backgrounds. Similar to NSW, Victorian agencies then have to submit plans and report on achievements. However, such health specific benchmarks as developed in Victoria do not exist in NSW where health organisations have to adapt the MPSP framework.

2.4 Impact of different ‘cultures’ within health services on working with diversity

Critiques of approaches to cultural competence from medicine, nursing and allied health sectors state there should be more emphasis on the impact of organisational and professional cultures on service provision (Culley 2000; Fitzgerald, et al. 1997a; Gustafson 2005; Hong 2001; Kagawa-Singer and Kassim-Lakha 2003; Taylor 2003). I examine the literature on working with
cultural diversity, particularly in children’s health care and the literature around the impact of organisational and professional cultures on health care.

Figure 1: Interaction of hospital cultural context with the child and family cultural context

Figure 1 above illustrates the types of interactions that may occur in a hospital in consideration of the different ‘cultures’ to be found there. For instance, it shows the interaction of the hospital cultural context with the cultural context of the child and family, and that both of these are contained within the broader Australian political, social and economic context of the
provider and patient interaction. This figure is used as a descriptive/heuristic device to understand the impact of different cultures on service provision.

### 2.4.1 Broader context of working with cultural diversity

There is a small amount of literature which specifically deals with how service providers work with clients from culturally diverse backgrounds. Fong and Gibbs (1995: 2) outline organisational cultural frameworks around working with diversity that are based on staff values, assumptions, dynamics and modes of dealing with culturally diverse clients. In interactions between service providers and clients, there are often mismatches between cultural assumptions and behavioural patterns which can lead to confusion and communication problems (Fong and Gibbs 1995: 11). The literature on managing diversity in the US (Cox 1993, Prasad and Mills 1997), and the literature on productive diversity in Australia (Cope and Kalantzis 1997) argue there should be a positive culture of valuing diversity in the organisation which will have benefits to clients. This will be discussed further in Chapter 4.

Moves to improve the cultural competence of an organisation do not necessarily mean that competence is achieved; this may be hampered by the relationship of an institution’s culture with broader social, economic and political conditions. Fong and Gibbs (1995) outline that even when staff from diverse backgrounds are employed, a culture that impedes working with cultural diversity may persist, reflecting broader views in Australian society. For example, moves to employ women within the police force have not changed the male dominated culture, as this behaviour is related to forces outside the police force (Chan 1997). Chan discusses how top down reform does not necessarily result in cultural change as staff need to have the
capacity to change. Practice is determined by the broader context and the
dominant ideology in the organisation. Research conducted in Canadian
hospitals has highlighted that even after mandatory cross-cultural training,
staff were resentful of the push to be more culturally competent. The
researcher argues that the organisation needs more diversity planning
support or more leadership from management so that staff can be receptive
to change (Srivastava 2008). This example demonstrates that training may
not achieve direct outcomes in practice where other factors are involved.

*Children's health care context*

There has been a lack of research in children’s health care on the cultural
frameworks of working with diverse patients. The literature that does exist
highlights different cultural understandings around appropriate treatment
and parenting practices that have arisen between staff and patients at SCH
(Chalmers and Allon 2002; Chalmers 2006b). Different values around
parenting relate to broader values in Australia. The authors discuss how staff
approach the health encounter with their own set of cultural assumptions
which have an impact on service provision. Chalmers (2006b: 16) observes
that “the rules surrounding Anglo-Australian parenting practices are
invisible or assumed as ‘known’ and ‘knowable’ for staff”, and so may not be
questioned when interacting with parents from diverse backgrounds.

### 2.4.2 Understandings of organisational culture

Understandings of organisational culture have mainly been discussed in the
area of management studies (Peters and Waterman 1982; Trice and Beyer
1994), and to a lesser degree in health management studies (Haber and
Organisational culture has been defined as:
... the pattern of beliefs, values and learned ways of coping with experience that have developed during the course of an organisation’s history, and which tend to be manifested in its material arrangements and in the behaviours of its members (Brown 1998: 9).

In health care, culture shapes “health-related beliefs, behaviours, and values” (Kleinman and Benson 2006: 1673). Qualitative health studies have analysed the impact that organisational cultures can have on the quality of services, in general (Haber and Ashkanasy 1998), and in relation to clients from CALD backgrounds (Hong 2001).

The understanding of organisational culture in health management studies has been critiqued as being limited as it positions ‘culture’ as static (Johnstone and Kanitsaki 2006). Some of this literature identifies culture as an independent variable that management can use to achieve organisational goals (Hudelson 2004: 345), for example hospital managers trying to change the teamwork culture of staff to achieve better patient satisfaction (Meterko, et al. 2004). Haber and Ashkanasy (1998) similarly examine the effect of organisational culture and communication on the quality of patient care at two hospitals in Australia. These approaches are geared towards being able to measure culture’s impact (Learmonth and Harding 2006). By contrast, Hudelson (2004) advocates taking a qualitative anthropological approach to understanding organisational culture as a dynamic and socially constructed reality. Sociological literature acknowledges that managers cannot impose certain values on an organisation, as culture reflects actual social interactions within the organisation (Davies, et al. 2000; Hudelson 2004; Iedema 2007). In order to promote certain cultural values, health service literature acknowledges that structural support is needed (Bloor 1999). Davies, et al. (2000: 116) indicate that:
... organisational culture cannot be tackled in isolation from such issues as the organisational structure, financial arrangements, lines of control and accountability, strategy formulation, or human resource management initiatives.

Post-modern understandings of organisational cultures see them as reflective of broader social and political factors (Clegg and Hardy 1999), such as public policy and economic reform (Clegg 1990), where boundaries of organizational culture are permeable (Martin, et al. 2006). For instance, multicultural and health policies affect the cultures of hospitals and the way health services are provided (as shown earlier in this chapter). Organisational cultures are also influenced by the cultures of different professions as will be outlined below. Social relations are also affected by ethnicity, age, gender and language of staff (Clegg and Hardy 1999). This highlights that there is likely to be not one organisational culture (Bloor 1999), but many subcultures influenced by many factors.

2.4.3 Cultures of health professions

The way a health professional relates to patients may be influenced not only by organisational cultures but also by cultures of different health professions. For example, professions such as doctors and nurses have “their own values, concepts, theories of disease and rules of behaviour” (Helman 2001: 61). Hong (2001: 6) describes how professional culture is practice “organised around a body of specialised knowledge, shared by a group of qualified practitioners”. The staff may also be linked to professional associations that function within particular theoretical disciplines. Each profession may have guidelines for working with patients from CALD backgrounds.
The Sydney Children’s Hospital’s Diversity Business Plan discusses the impact of professional culture on health care delivery:

A culturally competent practitioner is one who recognises, and understands the impact of their own cultural and professionals beliefs on their behaviour, and work practices (SCH 2002: 4).

Health professions have been influenced by critical theory and feminism to be reflective of the values and ideologies underpinning their practice (Browne 2001). The literature below has examined the impact of these ideologies on meeting the needs of patients in general, and those from CALD backgrounds. In particular, the way the professions work with diversity is shaped by the broader multicultural context, and by the current economic and political environment of health care in Australia. The cultures of medicine, nursing and allied health will be discussed as they are the main professional disciplines considered in this thesis.

*Culture of medicine*

While medicine is supposed to be objective and based on pure science (Taylor 2003), its cultural basis in terms of the values underpinning its knowledge and practice is not neutral. The culture of medicine is characterised as being based in reductionism and positivism (Helman 2001; Miller and Crabtree 2000; Sweeney 2006). Sweeney (2006) uses the word reductionism to characterise the way medicine reduces a whole body to its parts, and thereby ignores social complexity. Positivism is based on the assumption that one is able to objectively measure and predict outcomes. Medicine is also characterised as being focused on treating individuals rather than the whole family (Helman 2001).
The position of doctors has undergone change in the past few decades. Doctors have historically been in a position of dominance in hospitals, and when working with other professionals such as nurses (Freidson 1970b; Illich, et al. 1977). A more recent understanding of the position of medicine outlines how it has evolved through changes in the broader macro environment, including the increasing role of government and economic rationalism. Reforms in health mean doctors have to be more accountable to the state and management as they measure the extent of error in health care (Cruess, et al. 2002; Jorm, et al. 2007). This is a trend which may impact on the ability of doctors to meet the needs of patients, regardless of the patient’s background.

The impact of the culture of medicine on those working with cultural diversity has been discussed on the periphery of medical literature (Whitcomb 2003). Taylor (2003: 55) comments that institutional medicine “sees itself as a ‘culture of no culture’ … which systemically tends to foster static and essentialist conceptions of ‘culture’ as applied to patients”. He outlines how it is hard to move beyond this understanding of true objectivity as it is the basis of doctors’ own competence. Wear (2003) also argues that medicine may reinforce stereotypes through its reductionism.

There have been attempts to examine the impact of the doctor’s personal values and cultural biases in medicine (Irvine, et al. 2002; RACP 2009). For instance, the Australian Medical Association code of ethics outlines that doctors should have respect and tell their patient if they think their opinion may affect treatment (AMA 2006).

Kagawa-Singer and Kassim-Lakha (2003) state that approaches to working with diversity in medicine have been limited by focusing on doctors
understanding the individual rather than examining how patients may be disadvantaged in the health system. Other literature states medicine should address the socio-economic status of patients (Kai, et al. 1999). Wear (2003) similarly outlines medicine should examine the impact of structures, institutions and government policies on service provision rather than focusing on understanding patient attributes.

While cultural competency training for doctors has raised awareness about cultural differences, there have been fewer guidelines on interventions and practical skills for doctors. There is a need for ongoing professional development in this area after doctors have left medical school (Eisenbruch and Eisenbruch 2010). Cultural competency training commands a low priority in the hospital system due to a lack of time, resources (Park, et al. 2005), and evidence of training outcomes (Betancourt, et al. 2003). Also raised in the literature has been the need to examine the impact of the culture of medicine in training (Boutin-Foster, et al. 2008; Taylor 2003). There is no consistent approach to cultural competency training for doctors, although there are moves in Australia (Eisenbruch and Eisenbruch 2010) and the US (NCMEHP 2010) to standardise the medical curriculum. As outlined in Section 2.3.5, there has been some development in the area of doctors’ cultural competence when working with Aboriginal patients which may be of benefit to doctors when working with patients from CALD backgrounds.

*Culture of nursing*

According to Browne, nursing has become reflective of the influence of liberalism on the profession which is characterised by the nurse being centred on the individual patient, viewing society as equitable, and as “politically neutral” (Browne 2001: 1). Individuals are conceptualised as “essentially separate, rational agents who can be abstracted from their social,
economic and political or historical context” (Browne 2001: 121). In the literature there is argument for a more critical approach to be taken by nurses to tackle disadvantage and inequalities in health care (Drevdahl, et al. 2001).

The pressures of increased efficiency and cost effectiveness in nursing have meant nurses have less time to meet the needs of patients (Baum 2008; Bjornsdottir 1998; Candlin and Candlin 2007). The emphasis on providing evidence-based health care is outlined in the Australian National Competency Standards for nurses (ANMC 2006). The focus on efficiency in health care has also resulted in replacing regulated nursing with cheaper unregulated nursing (ANF 2004; George and Davies 2000), which may have put increased pressures on nurses to meet the needs of patients.

Nurses have traditionally been valued less in relation to the dominant medical ideology in hospitals. This has been because of the gendered nature of the profession and because of the limited autonomy they enjoy, particularly on the wards (Baum 2008). Literature on the experiences of nurses documents low morale, poor job satisfaction and increased pressures on workload (Baum 2008). These conditions could have implications for the capacity of nurses to provide quality health care in general, and for their work with patients from CALD backgrounds who may need extra assistance. However, changes such as the promotion of multidisciplinary teams and the professionalisation of nursing have made nurse relations with doctors more egalitarian (Candlin and Candlin 2007).

As in medicine, while cultural competency training programs in nursing raise awareness, they are less focused on building actual skills (Rutledge, et al. 2004). A national review of multicultural nursing education found it to be
narrowly focused and lacking an agreed framework among the academic, professional and clinical stakeholders (Eisenbruch 2001: 1). Recommendations call for more critical reflection from within nursing, and an awareness of the “social, political and economic context of culture and health” (Eisenbruch 2001: 2).

Within the more critical nursing literature, Culley (1996) argues that cultural competence is based on a multicultural model that assumes that health professionals’ cultural insensitivity can be remedied by education rather than political processes. It is based on the assumption that communication can solve all problems and skirts the issues arising from the power differentials between health providers and patients (including systems of oppression, discrimination and racism). Nursing has also been critiqued as contenting itself with checklists and essentialised notions of ethnicity rather than exploring other forms of disadvantage such as socio-economic status and gender (Abrums and Leppa: 2001). Approaches such as transcultural nursing are based on cultural relativism and focused on the ‘other’ (Eisenbruch 2001). Gustafson (2005) similarly argues approaches do not deal with systems of disadvantage but focus on the liberal idea of negotiating cultural difference interpersonally. In response to these criticisms, there are programs which encourage health professionals to reflect on the culture of Anglo western values in health care (Abrums and Leppa 2001; Blackford and Street 2002), while Culley (1996) and Omeri (2004) call for institutional and individual change. Although this literature emphasises the systemic disadvantages that patients face, it does not propose procedures to enable nurses to deal with these issues.
Culture of allied health care

In the area of allied health, professions such as social work and occupational therapy deal with the more social aspects of a patient’s life. These are the two professions that were instrumental in advocating the rights of families from CALD backgrounds (see Chapter 6).

Social workers address the disadvantages that clients face, and advocacy is part of their practice. In Australia social workers are supposed to address the impact of systemic issues on the individual, as well as forms of injustice (AASW 2003). Social workers also need to negotiate with other disciplines in the provision of care. There have been reports in the literature on the difficulties that social workers face in an evidence-based environment such as health, where they have to justify the use of scarce resources when implementing any intervention (Giles, et al. 2007). Social workers are confronted with the difficult task of trying to meet the social needs of patients as well as achieve organisational goals of moving patients through the health system (Schlesinger 1985).

The Australian Association of Social Workers’ Code of Ethics discusses the impact of the social worker’s own racial and cultural identity on practice (AASW 2002) but there is no discussion of the impact of the culture of their profession. By contrast, the National Association of Social Workers in the US has developed Standards for Cultural Competence in Social Work Practice (NASW 2001) which encourage social workers to reflect on professional views. It also encourages them to advocate against any negative views of difference that other staff members may hold in organisations. They also discuss the impact of power relations in institutions and how this may disadvantage clients.
Within occupational therapy, a profession concerned with enabling people to participate in everyday activities (AAOT 2003), research has discussed the impact of professional and personal values on culturally competent practice and successful interaction with patients (Fitzgerald, et al. 1997a). Occupational health literature has examined how understandings of appropriate body movements in therapy are reflective of western cultural values such as expected independence when performing tasks, which may not be appropriate to some patients who value achieving shared goals with others (Rudman and Dennhardt 2008).

2.4.4 Team culture

Multidisciplinary teams are increasingly being promoted in government policies (NSW Government 2008a), with the aim of bringing health professionals such as doctors, nurses and allied health workers together to meet the goals of the patient. The push to work in teams is both welcomed and unsettling for health professionals (Candlin and Candlin 2007). This is because doctors, nurses and allied health professionals are trained separately and have different information systems, yet are expected to work together effectively in multidisciplinary teams (ABC Radio National 2005; Pollard 2005). There has been a lack of discussion of how staff work together in a team to meet the needs of patients from CALD backgrounds.

2.5 Conclusion: negotiating cultures

This chapter has presented three approaches that have been taken within NSW Health since the 1970s in attempts to engage with cultural diversity. It has examined the degree to which Federal and State health and multicultural government policies have influenced service provision for patients from CALD backgrounds. While these policies have encouraged health
professionals to be familiar with cultural difference, and consider equity of access, there has been little examination of the impact of organisational, professional and individual cultures on providing services. These health cultures reflect the broader political, social and economic environment of health care and multiculturalism.

Health care is influenced by the culture of the organisation and professions (Bloor and Dawson 1994: 287), the dominant cultural norms of a society (Taylor 2003), broader health and multicultural policies as well as the cultural background (experience, ethnicity, language skills, gender, age) of the health providers, child patient and family. Effective health care for patients and families from CALD backgrounds is dependent on the successful negotiation of these forces by the health professional, and on their capacity to act at the systemic, organisational and professional levels.
3. Managers and cultural diversity

I don’t think that people have it [cultural diversity] very high up on their agendas. The issues that we’re dealing with, particularly at the moment, are much more fundamental. Where do we get the resources to provide the service that we think we should be providing, regardless of whom we’ve got to provide it to? (Terry, medical manager, M9)

This medical manager, working in chronic care, explains the current state of affairs in the hospital where cultural diversity concerns are not a high priority and are outside core practice. The current major concerns of managers are with adequate resource provision for patient flow. In this Chapter I examine manager views at two children’s hospitals in Sydney in relation to how staff work with families from CALD backgrounds16.

Cultural competence exists at an organisational level when it is “valued as integral to core business and consequently supported and evaluated” (Australian Government 2005: 30). The interviews with managers demonstrate limited cultural competency at the organisational level, confirming a widely held critique that multicultural concerns in health are peripheral to core business (Garrett, et al. 2010; Garrett and Lin 1990; Jayasuriya 1993; Mitchell 1989). The discrepancy between the idealised situation, where cultural difference is taken into account in all health encounters, and the current state of play can be explained by a number of

16 The discussion of manager interviews is supplemented by staff comments to illustrate a point of discussion.
Firstly, there is a dominant organisational culture focused on evidence-based medical interventions to ensure overall efficiency of the health system (Baum 2008; Sweeney 2006). Secondly, organisational data processes that might identify the needs of families from CALD backgrounds are inadequate. Lastly, mainstream Australian and biomedical patient relations are the unacknowledged social norm (Chalmers and Allon 2002; Kagawa-Singer and Kassim-Lakha 2003). These factors meant managers responded to difficulties with families from CALD backgrounds in an ad hoc way each time as they arose, rather than systemically, ensuring that they were met within everyday routines. The use of policy was predominantly reactive, relied on after the event. This situation meant providing institutional support and training for staff to work with cultural diversity was also not prioritised. Managers mainly relied on a single diversity health coordinator in the hospital and staff from CALD backgrounds to assist them working with culturally different families (staff from CALD backgrounds will be discussed in Chapter 4).

Managers face practical difficulties in meeting the policy and funding requirements dictated by Federal and State health and multicultural policies (Garrett and Lin 1990; NSW Health 2003b; NSW Health 2005b; NSW Health 2006b; NSW Health 2009). As part of these imperatives, they are required to “improve the health and well-being of children and their families” (SCH 2007: 1), therefore there was not one organisational culture, but a range of different, simultaneous discourses at play. Weedon (1997) discusses how discourses hold different weights, where the dominant discourse reflects the values of the existing structures and institutions in society. The dominant concerns of managers in the hospitals were with efficiency and evidence-based medicine, so they perceived meeting the different needs of families from CALD backgrounds as difficult.
Despite this situation, managers did engage in some protective practices that sought to ensure that cultural diversity was recognised and addressed. The way managers spoke about the behaviour of CALD parents emphasised cultural relativism, which served to normalise the latter’s behaviour so it was not considered a problem. For example, it can explain the aggressive behaviour of a father as being normal for his cultural background. Several managers from chronic care also recognised the cultural disadvantage some families faced. These practices can be seen as moving towards Fraser’s (2002: 24) notion of ‘status recognition’, in acknowledging that families were disadvantaged in line with ‘institutionalized patterns of cultural value’ in the hospital. In some instances, these managers went on to discuss how resources could be redistributed through providing extra time to families or employing bilingual workers to assist in the provision of care; this is in accordance with what Fraser calls ‘parity of participation’.

I begin by highlighting the cultural diversity policies outlined by managers. I then discuss how the managers recognised the needs of families from CALD backgrounds, and the types of institutional support provided.

3.1 Management and cultural diversity policies

The main policies that managers could recall in relation to cultural diversity were the use of interpreters (NSW Health 2006b), equity of access (NSW Health 2005b) and equal employment opportunity (EEO) (NSW Government 1998). These policies will be discussed in more detail below, with the exception of EEO policy which will be discussed in Chapter 4. Several managers also discussed the Ethnic Affairs Priority Statement, now the Multicultural Policies and Services Program (MPSP) (CRC 2009). This is the
main policy where health organisations are held accountable for cultural diversity practice in NSW.

The interviews indicated that the use of policy was predominantly reactive. Managers did not proactively endorse policies around cultural diversity but referred to them when issues arose. This finding is consistent with literature that states policy is often used as a guide for action when there are problems (Colebatch 1998). A manager working with children with chronic illness outlined the difficulty in implementing cultural diversity policies when there is no training and it is up to staff to read the policies which are on the intranet.

There are probably a number of policies around … So probably we would … deal with them in the same way that we would deal with a complaint … assuming that we recognised … because we may not recognise some of the cultural diversity issues because those people are not going to be the ones that complain … (Terry, medical manager, M9)

The concerns of families to do with cultural diversity are under-estimated, as families from CALD backgrounds may not complain (Department of Health 2009; Garrett, et al. 2008b). The quote indicates that cultural diversity issues are not a core concern within the hospital.

3.1.1 Communication: language, culture and working with interpreters

When the managers were asked about cultural diversity policies that impacted on their practice, the majority discussed the use of interpreters. Staff access the NSW Health Care Interpreter Service through the Area
Health Services\textsuperscript{17} which provide on site interpreters (NSW Health 2001). Interpreting services can also be accessed over the phone by using the Translating and Interpreting Service (TIS) 24 hours, 7 days a week (Australian Government 2010b) but this is not a preferred method as a fee is charged. Current NSW Health policy, \textit{Standard Procedures for Working with Health Care Interpreters} (NSW Health 2006b), states:

It is [mandatory] NSW Government policy that professional health care interpreters be used to facilitate communication between people who are not fluent in English … and the staff of the NSW public health system. The use of professional interpreters allows health professionals to fulfil their duty of care, including obtaining valid consent (NSW Health 2006).

\textit{Minimal use of interpreters}

Despite the above policy, this study indicates that interpreters were not used all the time. This finding confirms recent research in Sydney which states that “only a third of patients with limited English proficiency had used a professional interpreter in hospital” (Garrett, et al. 2008a: 755). Some of the reasons that managers stated for their non-use included that interpreters were not always available, it was impossible to use them all the time, and families do not always want to use them. There was also an organisational culture of interpreter use not being considered essential compared to clinical practices which were prioritised. Managers and staff acknowledged occasionally relying on informal interpreting, which involved using people who were untrained to interpret, such as family members and bilingual staff.

\textsuperscript{17} Now Local Health Districts.
The managers and staff noted the difficulties that families from CALD backgrounds face in communicating with health professionals as the most significant impact of cultural diversity on the hospital. This finding was consistent with previous research conducted at SCH (Chalmers and Allon 2002), which mainly revolved around the use of interpreters.

Managers from a range of backgrounds acknowledged the need to address the inconsistent use of interpreters and to take the issue more seriously, whether or not clinical issues demand priority. As stated by a medical manager:

If you don’t deal with this at a very high level and you don’t think about it constantly, and you’re very much overwhelmed by clinical pressures, it’s not surprising that you can underestimate the interpretation, the impact … the time, the patience, the expertise required in communicating and interpreting and supporting and understanding where people are coming from … all the surveys we’ve done are reminders that good intentions are not enough. There’s a lot more required, and that includes training, that includes day-to-day implementation of those issues and not overlooking them, as it’s so easy to do. (Pat, medical manager, MI2)

A nursing manager reflected on the Child-Friendly Healthcare Standards research undertaken at the hospital. These standards were developed by a range of international agencies in accordance with the UN Convention on the Rights of the Child to ensure health care considers the child’s “physical, psychological and emotional well-being” (Southhall, et al. 2007). The hospital chose to review the most problematic healthcare standard - communication. This manager outlined the need for improvement:
As we started to peel away the layers you can imagine we found lots of room for improvement … they cited a lack of information for culturally diverse families, lack of printed information, and the lack of interpreters when they wanted them. (Rickie, nursing manager, M3)

Health research has revealed the costs incurred to the organisation in not using a trained interpreter are such that it can lead to medical complications, poor patient outcomes and legal action which may be costly to health organisations (Chandrika, et al. 2007; Flores 2005; Heaney and Moreham 2002). Literature highlights that use of informal interpreting may be due to a lack of knowledge on how to use an interpreter (Heaney and Moreham 2002). However, the managers noted the difficulties in busy staff attending non-mandatory training (see Section 3.3.2 later in this chapter).

There was a general acceptance that some interpreting would suffice rather than a lot. As explained by the following staff:

It’s a big strain if you’re going to be seeing someone to have an interpreter every single time, so I try to do it every second or third time so we can talk through what’s been going on. (Ali, speech therapist, S5)

Phone interpreters we use readily. It’s just not the same as doing it in person, but if you’ve got to, you’ve got to, so if it’s got to be done, it’s done. If you can get by, I think most people would try to avoid using one because of time constraints. (Carmen, doctor, S1)

When children are in hospital for a long time with a chronic illness, it may be difficult trying to access an interpreter whenever there are interactions between staff and families. In an emergency situation it may also be difficult
to get an interpreter straight away. Chalmers and Allon (2002) have highlighted the need for more guidelines for staff in these grey areas.

Access was difficult, especially to small communities and high demand interpreters. It was also difficult in emergency situations, so staff said they used a family member to do the interpreting. A nurse explained the current culture of not using an interpreter all the time is not fair on some families, as communication is condensed to a small amount of time. Care for these families would therefore be inequitable compared to others.

We give a very basic level of care rather than an optimal level, and interpreters are hard work. For example, getting an interpreter it might be three days before you have access to a face-to-face interpreter … Even if you make one outpatient appointment, you’ve got to find an interpreter to be there, and that does become an issue, so they do miss out, a lot of families that need interpreters. I feel desperately sorry for them. We might talk to Gary’s grandmother, who’s Korean, once a week. She gets a two-hour opportunity to talk, and it’s not enough. (Ally, nurse unit manager, S11)

Use of untrained interpreters

Care was usually taken to meet the legislative requirements for using interpreting, such as when securing informed consent for operations, and for medical instructions (NSW Health 2006b). However, it was less clear in the legislation and to staff whether interpreters should be called for simple instructions, so staff often used a family or staff member. An allied health manager states:
We try very hard not to [use informal interpreting], because it’s not fair on the children. It’s often the children, or the aunty. But sometimes, especially in an inpatient situation, you can’t have an interpreter there all the time, so sometimes it’s a staff member [who is called on to interpret]. (Leslie, allied health manager, M11)

The results of a survey of families using the hospitals in this study also revealed that, of those families who had used an interpreter, 51% also had family or friends interpret medical information for them (Chalmers and Rosso-Buckton 2008). Colebatch (1998) highlights how the implementation of policy objectives may be thwarted by entrenched practice. In the case of these hospitals, continually making do without a trained interpreter has endorsed it as a norm. A further problem with using informal interpreting is that management may form an unrealistic estimate of the need for interpreters (Chalmers and Rosso-Buckton 2008).

Some staff agreed that it was appropriate to use family or staff for casual conversation:

If it’s an innocuous conversation like “Can you please come back?”, or “Can you take these clothes?”, most people would be happy to use the sister or the cousin or whoever is actually bringing them. (Carmen, doctor, S1)

The use of informal interpreters could have benefits in helping care for the family. Use of untrained interpreters is practised worldwide, not just in Australia (Heaney and Moreham 2002). There were a few instances in this study when a senior manager thought using a neighbour or family friend actually helped the family situation by getting other people involved in treatment. A study in Sydney has also outlined that reliance on family to
assist with communication is useful as they can act as advocates in a health system lacking resources (Whelan (Klinken), et al. 2000a: 42).

The practice of staff not using an interpreter was reinforced by some parents not wanting to use one either. Health policy acknowledges the reluctance of some patients to use an interpreter:

The practitioner should ... encourage the use of a professional interpreter by exploring the reasons with the patient/client for their refusal (NSW Health 2006: 10).

Research has indicated that refusal may be related to families not wanting to be seen as asking for an extra service or for staff to see them as a problem (Chalmers and Allon 2002; Garrett, et al. 2008a).

Use of bilingual staff

Although several managers mentioned using available staff to interpret, it is against NSW Health policy (2006c). Using bilingual staff to interpret was considered a breach of the staff member’s “legal duty of care”, although “bilingual staff members may use their community language in the provision of direct patient/client care in the normal course of their work” (NSW Health 2006b: 15). The interviews indicate there was confusion in this area.

A staff member on the ward who spoke the language of the family was used on one occasion to assist with a verbal exchange, but they were not actually looking after the family. As explained by a nurse:

It’s not part of their job, but it makes things a lot easier. We had a father last week who had no English whatsoever, but we had a nurse who spoke the same language, so we communicated through her,
which made things easier for us. But she didn’t interpret for the doctors. Just for the nurses. (Jessie, nurse, S17)

Several nursing staff said they get bilingual staff to interpret simple things, especially if there is no interpreter available. One nurse stated they ask staff first before using phone interpreters:

Staff will interpret for patients. Like, a Cantonese-speaking staff member will interpret, “What has your baby had to eat?”, “This is where the nappies are. Let the nurse know how many nappies you’ve changed.” (Lauren, nurse, S16)

This was not consistent practice; another staff member said she was asked to interpret but refused, as she was not directly looking after the patient:

For my direct patients, yes, but I don’t do it for other patients. Like, if someone was seeing someone on the ward and said, “Oh, we can’t get an Arabic interpreter, will you do it?”, I won’t do it. But when I’m treating my own patients, yes, I will. (Ali, speech therapist, S5)

Health research in Sydney has indicated that staff were confused over the use of bilingual staff as interpreters. For instance, health staff stated they have ‘interpreted’ when they have not (Whelan (Klinken), et al. 2000b). This is a reason appropriate use of language by bilingual staff is an area that needs to be further developed through guidelines. In particular, the researchers state that there could be more discussion of using bilingual staff and families to act as ‘communication facilitators’ rather than ‘interpreters’ for everyday language. This would assist patients when interpreters are not available, or for casual conversations.
Communication as separate from clinical procedures

The interviews with medical managers indicated that communicating with patients was understood as separate from clinical procedures. Communication encompassed all the non-medical cultural and personal issues which arise when treating a patient (Johnstone and Kanitsaki 2006; Manderson and Reid 1994). In areas such as cancer treatment, a medical manager saw a division between clinical treatment and communication. This manager was quite definite in saying that cultural diversity affects how you communicate, not the way you treat someone:

I can’t claim, and I’ve never suggested, that the content of the clinical care … changes, but how it’s communicated, and sometimes how it’s couched. While you don’t change the content of clinical care you may make allowances for sensitivities, and postpone or delay, or involve different people in the discussions. Ultimately care is evidence-based, and that evidence is totally objective, at least in the best of circumstances, and it’s supposed to be driven by good scientific information, but having said that, if it’s not accepted and not adhered to, then it’s a waste of time. So the clinical content is not what is affected. It’s the capacity to negotiate that and make it palatable and acceptable and understandable by all participants. (Bernie, executive medical manager, M2)

This highlights the manager’s understanding that there is a difference between the nature of evidence-based clinical medicine and communication on improving health. Medicine is seen as totally objective, as having no culture (Taylor 2003). In contrast, communication issues are not scientifically based for this manager. Cultural diversity is relegated to the area of
communication, a less scientific area. It is a separate discourse competing with a more dominant one (Weedon 1997), around efficiency and evidence-based medicine. The work of communicating in health care has been referred to as ‘immaterial labour’ as it is hard to measure (Iedema 2007).

But what are the health benefits of providing good communication? Current research in the US is presenting evidence of the detrimental impact of linguistic barriers on the quality of health outcomes (Chandrika, et al. 2007; Flores 2005; Johnstone and Kanitsaki 2006). Despite this evidence, communication is still seen as separate to the dominant clinical ideology in the hospital.

3.1.2 Equity of access

A quarter of the managers interviewed referred to ‘equity of access’ as a major policy affecting practice. Equity of access is currently outlined in the Policy Directive: Non-English Speaking Background - Standard Procedures - Improved Access Area/Public Health Services (NSW Health 2005b: 2), which states that patients should have “the right to equality of access to health care services regardless of cultural origin or linguistic skills”. An executive medical manager explained the importance of equity of access:

The most important policy is absolute commitment to equity and access. Now, access is a manifestation of equity, but we highlight it because it applies not only to cultural barriers but to geographic and social and economic barriers … So, wherever you are, whoever you are, whatever your background, whatever your social and economic background, or cultural, religious, ethnic background, [you] have absolutely equal access to the best that we can provide … That’s probably the most relevant domain when it comes to diversity … and
in terms of staff, well, it’s the easiest thing to sell to them. (Bernie, medical manager, M2)

As this manager said, it is “the easiest thing to sell” to staff and a first priority. However, as outlined in the previous chapter, principles of access do not specify what happens once patients get to the hospital, and the type of services provided (Mitchell 1989). The focus on equity of access has been critiqued as not addressing the way that services can structurally meet the different needs of patients from CALD backgrounds (Jayasuriya 1993; Jayasuriya 2003). Principles of access and equity have mainly been concerned with universalism, rather than ensuring equity of outcomes through adequately addressing difference (Jayasuriya 1993). Once people can access services they may need a redistribution of resources to meet their particular needs (Fraser 2002; Jayasuriya 2003).

The later part of the Policy Directive referred to above states that it is “the responsibility of the health system to respond appropriately to its target population, which includes people of non-English speaking background” (NSW Health 2005b: 2). This addresses difference to a certain extent. However, the emphasis is on ‘responding’ instead of proactively planning to meet their needs. There is also a difficulty in ‘responding appropriately’ to cultural difference where patients from CALD backgrounds may not complain. Observations follow below (in Section 3.4) from several managers working in the area of chronic health, who recognised when families from CALD backgrounds had different needs and required additional assistance.

18 The use of the term ‘non-English speaking background’, combined with outdated demographics, highlights the need for this policy to be updated.
3.2 Recognising the needs of patients and families from CALD backgrounds

The interviews with managers reveal a lack of effective mechanisms for managers to recognise the needs of patients and families from CALD backgrounds, or ways to plan appropriate services strategically. In particular, the interviews indicated the demographic data analysis and reporting processes could be improved. The managers detailed the obstacles to working effectively with cultural diversity considering the dominant ideology in the hospital relating to efficiency and patient flow. This research underlines the need for managers and staff to have more systemic support so that they have the capacity to meet the needs of patients and families. Cultural diversity was conceived as something less tangible, less rational and measurable compared to other, more quantifiable key indicators (Taylor 2003). Although children’s hospitals are supposed to be family-orientated, there are systemic, organisational and ideological restrictions on the extent to which the needs of families from CALD backgrounds can be met. These circumstances sometimes meant that senior managers working in acute care and the wards focused on the physical health of the child patient rather than the social needs of the family. This could have implications for the health outcomes for the child.

3.2.1 Hierarchy of priorities

My data suggests that the emphasis within the health system on efficiency and evidence-based medicine (Anderson, et al. 2003a; Bjornsdottir 1998; Choucair and Ridoutt 1993; Reid 1993; Sweeney and Mannion 2002) had a negative impact on managers’ focus on cultural diversity. The current Multicultural Planning Framework states that “multicultural policy goals are
integrated into the overall corporate and business planning” (NSW Government 2009a: 5). However, the interviews indicated that the managers saw multicultural policies and concerns as less urgent and more vague than other priorities in the hospital.

A medical manager explained that the day-to-day priorities were to meet Key Performance Indicators (NSW Health 2003b), something that could be objectively measured, while meeting culturally diverse needs was a vaguer requirement that was more difficult to measure:

> At the moment – it’s much worse at the moment, but even before that, our main issue is that because we’re driven by the Department of Health requirement for Key Performance Indicators, and a lot of them are numbers that have to be worked on each week, and so whereas the Department of Health is likely to say, “Oh, we want a policy on this,” or something like that, which is a much more longer term and vaguer thing which is, I’m afraid, where cultural diversity might fit in. So because we’re all running so fast keeping in the same place, I don’t think we’ve got time or energy to look specifically at these issues other than the fact that we deal with them every day because families are coming through. (Terry, medical manager, M9)

Key Performance Indicators include a range of measures such as waiting times, length of stay and discharge rates of hospital patients (NSW Health 2003a). Meeting certain targets was a means of ensuring the efficient flow of patients through emergency and in-patient areas so they can be discharged. Efficiency in ‘patient flow’ is needed due to increasing emergency hospital admissions and political pressures. NSW Health provides financial incentives to hospitals and other health services in order to meet a range of
performance indicators and outcomes (NSW Health 2003a: 21). This funding arrangement highlights the influence of economic rationalism which emerged in the 1980s and 1990s, where funding is increasingly linked to ‘measurable outputs’ (O’Reilly, et al. 2003), and evidence-based practice. Although there was a need for hospitals to meet these measurable targets, this manager still acknowledged the importance of cultural diversity as something that staff see every day with families. The reporting mechanisms on patients moving through the hospital system are more definite and rationalist, whereas dealing with the complexity of people’s lives is inevitably more uncertain (Sweeney 2006).

A manager working in the area of adolescent health described how issues to do with families from CALD backgrounds are not a priority:

I’ve been on the Ethnic Access Committee which concerns itself with how people access services here and how well they’re managed and it’s always seemed like a bit of a struggle to have that become a priority issue. I believe that it’s underrated as an issue. I don’t think it receives the importance that it deserves … it’s too easy to take a cookie cutter approach to dealing with people. (Bailey, doctor in adolescent medicine, S21)

A mental health manager concurs that more effort needs to go into providing evidence of the impact of linguistic and cultural difference on health care outcomes to make them a priority:

I mean the last 10 years, there’s been money to develop multiculturalism in health, out of political imperative really. Whereas now there is a shift in the tone to saying [everything] has to be evidence-based, to prove that there is a special need, that money
going into it is going to improve outcomes, so that’s actually put a huge burden on the system to demonstrate the need … (Dominique, mental health manager, M14)

A nursing manager describes the pressures from the Department of Health to provide evidence about waiting lists and times as opposed to ensuring that families are getting good quality care:

[The Health Department is] micromanaging the most ridiculous stuff, which is political things, so they have a daily meeting with the Executive Directors on how many patients are in your ED [Emergency Department] and what your waiting times are, and what your waiting lists for theatre are … It’s just ridiculous, and the reason that’s the case is because the press can get hold of it and it’s something they can measure, as opposed to whether or not people are getting good care, which is very hard to measure … (Gale, nursing manager, M8)

She refers to a focus on measuring quantifiable outcomes (Cameron and Campbell 2003; O’Reilly, et al. 2003) as opposed to the more difficult task of measuring qualitative outcomes such as quality of care and inequities (Redman 2008).

3.2.2 Planning and reporting on cultural diversity

The interviews indicated managers lacked resources, support and practical guidelines on how to address the needs of families from CALD backgrounds. The main issues were being strategic and having better data on families’ cultural backgrounds so they could identify and plan for the needs of families.
An obligation to meet the needs of patients and families is enshrined in the NSW Multiculturalism Act 2000, which provides that “institutions should respect and make provision for the culture, language and religion of others” (NSW Government 2000: 1). NSW Health policy also requires “that the full range of mainstream health services [must] be accessible and appropriate to ethnic communities” (NSW Health 2005b: 2). However, managers felt there were inadequate mechanisms in place to identify the demographic diversity or needs of families from CALD backgrounds. This effectively made cultural diversity issues peripheral, as there was no evidence for the need to focus on it. The nature of the accountability process for families from CALD backgrounds was based on a one-off reporting process by departments. Policy-makers did not see addressing specific needs of CALD families as a core concern. This process was contained in the Multicultural Planning Framework (MPF), a tool used to assist government agencies “plan for and demonstrate their achievements” (CRC and NSW Government 2009: 3). Organisations have to report their activity in seven outcome areas: consultation and feedback; leadership; human resources; access and equity; communication; social and economic development. However, there were no clear incentives for managers to engage in strategic planning to reach the highest standard of reporting, although in 2008 NSW Health directed that health organisations have to reach a minimum level of self reported achievement (Anderson 2008).

Identifying diverse needs

One way to review the needs of families from CALD backgrounds is through demographic data analysis to see if they are disadvantaged in their access and health outcomes. The activity area of Planning and Evaluation in the MPSP states that “analysis, planning, program development and monitoring
are informed by client data from relevant program areas and business units, ABS, and other sources” (NSW Government 2009a: 5). The interviews revealed there were inadequate processes for analysing demographic data. For instance, a nursing manager admitted that the hospital did not do enough strategic planning for its diverse clientele:

We do need to look at our case mix, our demographics, and then looking at what are the needs around that. And I would say that I don’t personally think that we do that to that degree, but I also don’t think that we are ignoring those things … I actually think that we are aware of it, but are we being strategic about it? I think that’s something we possibly don’t do. Not to the degree we should. (Pat, nursing manager, M12)

This situation may change for the better: Pat explained that, due to the restructure in NSW Health, there will be a specific senior manager position set aside for planning, which may mean proactive change in the area of assessing the needs of their diverse clientele.

The process of being strategic was hampered by inadequate mechanisms at the hospitals to analyse the cultural background of child patients and their families. An administrative manager explained:

We have really inadequate systems for identifying people who come through the door [who are from] diverse backgrounds. Our system here actually captures country of birth [of the child], so if you look at our statistics for country of birth, 99% of people are born in Australia … (Shea, administrative manager, M7)
This data-gathering measure was not an adequate reflection of the diversity of families at the hospital as it only registers the birthplace of the child, not the parents. At the time of doing this research, both hospitals used interpreter statistics and preferred language of families as the main mechanisms to plan for services (SCH 2006; The Children’s Hospital at Westmead 2006).

A mental health manager had a similar problem accessing information on the diversity of patients’ parents, which could affect planning:

> There is a state-wide system for mental health where every contact is recorded exhaustively including the time spent and the diagnosis, level of impairment and change over time. And we have certainly been advocating that; I think it has measures like country of birth, and whether you need an interpreter, and language spoken at home if other than English … But for child mental health, unless you have country of birth of your parent, it doesn’t really tell you anything.

(Dominique, mental health manager, M14)

The difficulty in collecting ethnicity data did not just relate to children’s health care; there were also general difficulties across government agencies in NSW. The recent review of EAPS stated that organisations had “inconsistencies in ethnicity data collection” (Klinken Whelan 2009: 58). A recommendation of this review was that the CRC prepare “a discussion paper on data collection to assist consistent use of data across agencies” (Klinken Whelan 2009: 58). This would allow hospitals to analyse the data more effectively and permit them to identify and act on issues.

A nursing manager explained the need to have data on diversity to ensure appropriate service provision:
How do I know what materials I need to have interpreted when I don’t even know what my population is? You can’t go by the census because our population is from across the whole State. We don’t just have a local catchment area. So it’s really important that we get that information so that I can try to get grants for interpreters, for translations or whatever. (Rickie, nursing manager, M3)

The need for more adequate ethnicity data raises issues of establishing what is sufficient for planning. Social science and epidemiological health literature has identified the difficulties in deciding which dimensions of a person’s identity need to be collected in order to best describe ethnic inequalities in health (Aspinall 2001; Bhopal 1994; Nazroo 1998). Nazroo (1998) discusses the limitation of only using country of birth as an indication of ethnicity. This assumes people born in a country are homogenous regardless of their culture, religion, migration history or socio-economic status, some of which may have more association with determining health outcomes. A range of data may therefore need to be collected to reflect the “fluidity, complexity, and mixture of multiple ethnic, class and gendered identities” of people (Aspinall 2001: 850). Dominique explained that even when data is recorded, it is not systematically reviewed:

It offended me that because they did the NSW mental health survey and they did strengths and difficulties questionnaires (SDQs) of 5,000 families … And they did have a cultural mix but they didn’t analyse the data to see if they were any way disadvantaged or advantaged [in relation to cultural background]… there is a real threat if no one collects the data, then it will slip off the agenda … (Dominique, mental health manager, M14)
This process of analysis described above is hampered by inadequate recording of the diversity of families as it is not a priority. At the Quality Health Care for Culturally Diverse Populations 2008 conference in the US, speakers highlighted the need for CALD issues to be linked to core reporting priorities. For instance, analysing patient flow data according to the demographic background of patients could present a ‘business case’ for the organisation to address difference (Kvasnicka, et al. 2008).

The lack of an adequate process for recording cultural diversity factors may mean inequities are not recognised. One of the strategies recommended by NSW Health which may improve monitoring of fair access is an annual review of emergency and hospital treatment in terms of use by disadvantaged groups (NSW Health 2003b).

*Reporting on diversity*

The main way that managers report on cultural diversity initiatives is to seek information from frontline staff for the EAPS report (now MPSP); however, this reporting process is voluntary for staff. An allied health manager, who has had some involvement with this process, explained that it is not mandatory for activities to be written up in the EAPS report, and not every department is held accountable:

> There are often impressive ... initiatives that individual staff have taken to make a difference, by getting a document translated or running a special information session for families from a different cultural group ... but what we can’t answer is, what departments aren’t making those kinds of initiatives? Or where there are gaps and problems? (Gabriel, allied health manager, M15)
This manager told of the need for a better feedback system on how comprehensively the hospital is meeting the needs of families from CALD backgrounds:

The anecdotal examples of things not working out that well, either from the staff or the families’ point of view, need to see the light of day … if the things we are struggling with, or having difficulty with in terms of cultural mix…if they can somehow be brought forward, surfaced and reviewed. Then I think we will have a better sense of how to move forward. (Gabriel, allied health manager, M15)

Since this reporting process was at twelve-month intervals, there was difficulty in ensuring that the needs of children and their families were being met on a continuing basis. The review of EAPS has noted the problems with just reporting on initiatives and is trying to encourage a more strategic planning approach with mainstream accrediting processes (Klinken Whelan 2009).

Several managers stated that for cultural diversity concerns to become core practice, there would need to be an increase in resources as well as proactive implementation of procedures. In relation to the EAPS plan, an executive medical manager stated it is the implementation of policies that needs development:

There’s a lot more paperwork and bureaucracy and reporting done in this domain than there is action, that’s partly because to do it right requires significant resources … What we don’t lack is policies … what we do lack, and what I’d like to see more of, is hands-on actions and implementations of those policies. (Bernie, medical manager, M2)
3.2.3 Difficulty working with parents from CALD backgrounds

Managers whose primary task was the treatment of critically ill children faced difficulty in addressing the needs of families from CALD backgrounds where they differed from the norm of mainstream Australian familial relations. One medical manager commented, “We would probably find it easier to manage Anglo communities” (M9, 2006). Particular needs of families from CALD backgrounds related to culturally specific accommodation, interpreting needs, religious support, treatment decisions and specific food preferences.

Staff who were focusing on the physical health of the child felt it was the parents who were the bearers of cultural difference, not the child. Research conducted with staff from Early Childhood Community Health Centres in Sydney who are working with families from CALD backgrounds found that child and family community nurses perceived “the physical health of the child and mother were separate from the social and cultural well-being of the family”, including their diverse parenting and religious beliefs and practices (Chalmers 2006a: 8).

Another difficulty managers faced was the different gender roles in some families, which challenged the normal way that the staff would operate. Sometimes it meant the father did not accept the status of female doctors and nurses and this had implications for practice.

Although family centred care was endorsed in the hospital (AWCH 1999), managers found providing this care difficult especially when families from CALD backgrounds required extra services. Moving towards having the family more involved in care is encouraged in both the United States
Family Centred Care is based on:

The understanding that the family is the child’s primary source of strength and support and that the child’s and family’s perspectives and information are important in clinical decision making (American Academy of Pediatrics 2003: 691).

The active involvement of the family was first endorsed in the 1970s in Australia (AWCH 1999; Chalmers 2006b). However, as a manager said, some staff were used to the old model of care where families were not expected to be involved as much in care. For instance, research with paediatric nurses in NSW suggests that they find it difficult to endorse family based care due to a lack of time (Paliadelis, et al. 2005).

Although family centred care was the ideal, in reality it was hard to achieve with families from CALD backgrounds. Ashley, an allied health manager, explained:

It’s a family-centred approach … the child and family are at the centre of care … and then you’ve got all your services around them, so we need to meet their needs for what they require in their care. (Ashley, community health manager, M4)

Contrary to this approach, in some instances, the individual rights of the child to health care took preference over the cultural rights of the family (Schweder 2002). It became difficult to meet all the needs of the family, and so the health staff said they had to focus on the child. The same manager was shocked by parents wanting access to halal food while their child was in hospital. This person thought the focus should be on the child.
We had an issue … where we had several families who were of Turkish background and the parents … made a complaint that they couldn’t access halal food, but it actually wasn’t the children they were worried about. It was that they couldn’t access halal food, and we don’t provide food to the parents. We don’t. We can’t do that. We feed the kids, but we can’t feed the parents. However, we had a vegetarian menu, we had a non-pork menu … but they were concerned that they couldn’t access it. So following that, we actually looked at the whole halal issue … We now get food from St George [hospital] for halal menus for children … then there became the issue … how do the parents access it? So what we put together in each ward was a folder of local menus around here, and Coles sells frozen halal meals … (Ashley, community health manager, MI4)

For this manager, the child’s physical health was distinct from cultural needs of the parents. Through the complaints procedure, the managers recognised the needs of not only the children but the parents, although this manager first perceived the parents’ needs as being extraneous or a challenge to the dominant way that services were provided. In this case, the dominant cultural values around food provision had initially disadvantaged the family. This staff member recognised the needs of the family through changing the dominant culture so it became more inclusive of difference.

The systemic and institutional barriers to fully meeting the needs of families from CALD backgrounds were evident with the establishment of a clinic for refugee children at CHW in 2005 (Sheikh-Mohammed, et al. 2006). A clinical staff member’s comments indicate the difficulty staff had with assisting the whole family:
The refugee clinic is a new thing. I don’t think we’ve got that right yet … It’s really family-based care, but we’re only supposed to be dealing with the children. We’re looking at extending it to the family, but then really is that our job? (Frances, clinical manager, M10)

The aim of this clinic is to provide screening, treatment and vaccinations for infections in children, as well as provide referral to specialist services in the hospital. A similar clinic was established at SCH in 2007 (Woodland, et al. 2010).

Working in a paradigm of family based care is challenging for staff when families from CALD backgrounds hold beliefs and views that are contrary to the dominant parenting values held in Australia. The managers spoke about the parents being the main holders of culturally diverse beliefs and practices, not the children. As a manager explained:

Often dealing with the children is not the problem. It’s the extended family that is difficult for staff because that’s where your language problems are, that’s where the cultural differences are more notable, where the behaviours, particularly of male and female relationships, are very different sometimes to what Australians are familiar with and what we’re culturally comfortable with. (Frances, clinical manager, M10)

This manager saw the child as having a cultural context different from that of the parents. Working with CALD parents involved extra effort compared to the mainstream Australian norms in the hospitals. This was contrary to the principles of family centred care.
3.3 Institutional support

Some managers had difficulty identifying institutional support for staff working with cultural diversity apart from specific diversity positions, but stated ethnic health workers would be useful. When questioned about cross-cultural training (CRC 2009), managers said there could be more; however, there were systemic, organisational, professional and philosophical difficulties with trying to make staff attend it. As described by a nurse:

I’ve reached the stage where I don’t need the support, but I’ve never had it. I mean, there is training … (Ally, nurse, S11)

There was a reliance on social workers and culturally diverse staff when staff were too busy or had to focus on the health of the child. The role of these staff will be explained in the following chapters.

3.3.1 Specific diversity positions

The main sources of structural support for staff working with cultural diversity were the positions of part-time Diversity Health Coordinator (DHC) at SCH and Cross-Cultural Clinical Consultant (CCCC) at CHW. The managers noted that the impact of these positions was compromised due to the requirement that the appointed individual provide support for the whole organisation. While several managers said they wanted to make these positions more integrated with clinical concerns in the organisation, there was a lack of resources. The managers also suggested there could be bilingual staff trained to assist patients from specific ethnic groups in a role similar to ethnic health workers.
Diversity Health Coordinator

The DHC’s role at SCH was to:

identify patient and community needs in order to develop effective and culturally acceptable programs; develop and implement health promotion projects; support diversity education and training; facilitate the development and implementation of policies, procedures and standards of practice that promote culturally competent care; build partnerships within the Health Service and with external agencies; support research projects and initiatives; and facilitate networking and information exchange (SEIAHS 2005).

An administrative manager said that the DHC position was not adequate for assisting all departments:

We have a part-time multicultural officer, and it’s not sufficient. And I think that we probably don’t do it really well for staff. In the real world it would be great to have somebody actually going to each department looking at projects, doing activities … but we don’t. We don’t have those resources at all. (Ashley, community health manager, M4)

A medical manager acknowledged that the specific nature of the DHC position makes cultural diversity concerns peripheral to core business:

That’s the problem with putting a hat on someone, saying: “You’re the person to talk to about cultural diversity.” Might be every time they raise something, people go, “Oh, well, that’s your job.” It takes away the onus on everybody else for it to be their responsibility. (Robin, medical manager, M13)
Another manager noted the criticisms of the DHC and said this position is going to be integrated more into different departments, so cultural diversity is more of a core concern of clinical training.

But my aim is to integrate [this person], not ... so much stand-alone, because I think we will always, rightly or wrongly, prioritise clinical training above diversity training, even though the two go hand-in-hand. We need to marry them at joint presentations, or however that works. (Shea, quality manager, M7)

*Cross Cultural Clinical Consultant*

The role of the CCCC at CHW was “to assist clinicians with the cultural interpretation of health issues” and “reduce barriers for families” in accessing services (CHW 2005). This was a joint program between CHW and NSW Transcultural Mental Health Service. The position was mentioned positively by one of the managers working in the area of mental health; however, none of the other managers at CHW acknowledged its existence.

A benefit of having one specialised person is that others listen to that ‘expert’. As explained by the mental health manager:

I can think of [a] case where the mother was subject to domestic violence and despite giving her all the advice to go and get help and support, it was actually [the CCCC]’s input who much more assertively discussed the situation that transformed the predicament. (Dominique, mental health manager, M14)

Addressing cultural diversity as a core or separate issue does not have to be mutually exclusive. A range of approaches is needed such as leadership and
a flexible mainstream approach, as well as additional support (White and Lord 2008).

*Cultural brokers/ethnic health workers*

Medical and nursing managers raised the idea of staff from CALD backgrounds being trained as cultural brokers to assist families and staff when there were cultural differences. They were unsure how to describe this position but used the model of someone who is representative of an ethnic community or a religion in discussions. This highlights the need for more resources to address the specific needs of families from CALD backgrounds, instead of just providing the same mainstream service to everyone:

I would imagine they would be from some particular, everyone’s from some particular cultural background, but for them to be … seeing things from that other perspective. (Robin, medical manager, M13)

Just like we are encouraged to [use] Aboriginal liaison individuals, we might have a Muslim liaison individual and an Indonesian liaison individual … A point of contact for helping navigate, someone that’s … there, to listen and to help you fit into the system, or have the system fit into you. (Bernie, medical manager, M2)

The danger is that this person may be looked upon as a spokesperson for a community and this may essentialise practice. A nursing manager acknowledges the specific training that would be needed to equip bilingual staff to support families in a non-medical role:

We could probably put some effort into providing training for people from culturally diverse backgrounds to become advocates and leaders and mentors. (Frances, nursing manager, M10)
Whelan (Klinken) et al. (2000c) have also noted the important role that bilingual staff play in supporting the interests of patients and have recommended they be trained in their advocacy role. A nurse similarly said a cultural broker would be useful rather than relying on interpreters:

I’d like to see a resource person that might have expertise ... to have an understanding of families and where they’re from. We have it for religion within the Hospital. We have chaplains that are affiliated with certain religions. It would be really good if we could have someone [who is] culturally understanding ... Because I think that we rely on people that we shouldn’t necessarily be relying on, like interpreters, to give us inroads into something like, “How do you think we should approach this?” And it would be really good to have someone that we could refer back to. Maybe fact sheets about religion so that when Ramadan’s on ... I think that we could do with a lot more support.

(Ally, nurse, S11)

The National Center for Cultural Competence (2004a: vii) defines a cultural broker as a “go-between, one who advocates on behalf of another individual or group” (taken from Jezewski and Sotnik (2001)). Brokering is defined as “a health care intervention through which the professional increasingly uses cultural and health science knowledge and skills to negotiate with the client and the health care system for an effective, beneficial health care plan” (NCCC 2004a: vii).

The model described by managers is reminiscent of ethnic health worker positions which were used in the 1970s to provide health information and education to patients from particular ethnic groups (Lin and Garrett 1990). A review of their role has revealed their use dwindled in the 1990s, but has
since increased. Research has indicated that ethnic health workers play a critical role in assessment, education, review, problem solving, referral, support, advocacy and interpreting (Matthews, et al. 2008). With the case study of Zahra in Chapter 6, a social worker similarly recommends that a staff advocate or ethnic health worker could have assisted this family with their particular needs.

3.3.2 Cross-Cultural Training

While cross-cultural training is recommended in national and state policies (Australian Government 2005; NSW Government 2009a), few staff took part in such training at the hospitals (Chalmers and Rosso-Buckton 2008). In the NHMRC cultural competency guidelines, training is an important concern at an organisational and professional level so that staff have the capacity to work effectively (Australian Government 2005). Similarly, the Multicultural Planning Framework (MPF) in NSW states “the capacity of the agency is enhanced by the employment and training of people with linguistic and cultural expertise” (CRC 2009: 6). Managers from a range of backgrounds acknowledged there could be more cross-cultural training, but stated there were constraints due to a lack of time, and they felt there was a lack of evidence that cross-cultural training improved health care outcomes. This understanding was contrary to research which states there are benefits in

19 There is currently a lack of consensus on the terminology used to describe the training of staff to work with people from CALD backgrounds (Trenerry, et al. 2010). For the purposes of simplicity, I will use the term ‘cross-cultural training’ to refer to any training which addresses how staff should work with patients from CALD backgrounds.
training staff in general (Trenerry, et al. 2010), and in health where there have been positive outcomes for patients (Majumbar, et al. 2004). There was also a lack of consensus among managers about the type and content of this training. These comments demonstrate the lack of consistency, evaluation and development in the area of cross-cultural training nationally and internationally (Trenerry, et al. 2010).

Australian research has demonstrated that training is ineffective in the long term unless there is organisational and systemic support (Bean 2006). An international review of training similarly states, “diversity training is unlikely to have sustained positive effects if implemented in the absence of broader organisational-accountability mechanisms or organisational leadership” (Trenerry, et al. 2010). At the same time managers were constrained as they had to ensure other mandatory training was undertaken.

*Other training priorities*

The managers acknowledged the importance of training but outlined the difficulty in making staff attend cross-cultural training when they are already busy. This highlights how they saw cultural diversity concerns as being conceptually different to clinical care. This type of training was also of lower priority compared to other mandatory training as required by NSW Health. Lee (2005) outlines how the NSW health system is under stress and staff find it difficult to find time to attend any training, let alone cultural competency training. A manager explained the difficulties:

I don’t think enough of the staff have had diversity training to the extent of fully appreciating it. We all have a superficial knowledge, but simply time does not allow. There are so many bits of training, many of which are mandatory, that staff need to undertake, that at the
end of the day there’s just no capacity to do it all. (Bernie, medical manager, M2)

A workforce manager indicated that the more pressing issue for managers was training about Aboriginal affairs and disability. This reflects the fact that the national priorities at present are not with cultural diversity issues:

Cultural diversity is not one that we spend a lot of time on, to be honest … I suppose our focus has often been about disability and Aboriginality. So in terms of looking at our workforce data, cultural diversity and the other EEO groups - women, for example - are the two that have been less prevalent in terms of needing attention.

(Ashton, human resources manager, M16)

The education centre runs cross-cultural courses at CHW, but the people who attend it are those who are told to attend, or those who already have an interest in the area.

Type of training: core or separate concern

Managers from allied health, medicine and nursing acknowledged the need for training to become a more integrated issue rather than staff attending separate training. For example, Gabriel from social work discussed integrating training into actual situations to make it more relevant:

Ultimately I think on the spot timely training is much more effective than going to a course anyway. So if you have got people dealing with an issue, and they are wondering how to deal with the Sudanese family who are booked in for a developmental assessment next Thursday, that’s when the real learning can take place both in the
preparation and the working with that family. (Gabriel, allied health manager, M15)

Integrating this training makes it become part of clinical care. This would involve the cross-cultural training unit being involved in clinical training.

Scenario based training for doctors was already occurring in staff hospital orientation programs. Issues raised included different gender relations in families and the associated impact on a female doctor’s authority:

One of the scenarios, for example, that we use and we talk through is this dominant father dealing with a young junior female medical staff … it’s certainly looked at in a scenario setting, but not for example, there’s not a specific cultural diversity [education] ‘station’ at orientation. (Leigh, medical manager, M6)

Relevance of cross-cultural training (CCT)

In a health system where evidence-based clinical interventions are prioritised, there was inconsistent evidence of the long-term benefits of cross-cultural training, and of the most effective way in which to provide this training (Anderson, et al. 2003b; Bean 2006; Betancourt, et al. 2003; Brach and Fraser 2008; Trenerry, et al. 2010). There was difficulty then in establishing whether or not it should become a core concern. While a national review of cross-cultural training in Australia stated that there was statistically significant evidence that training was of direct benefit to employees, their organisation and their clients, the use of cross-cultural training in different sectors was hindered by a “lack of consistency in cross-cultural training approaches and aims and the absence of clear measures of cultural
competence and practical guidelines for implementing programs” (Bean 2006: 2).

The effectiveness of cross-cultural training depends on systemic support, which was lacking at the hospitals. As Bean (2006: 5) states “at the systemic and organisational levels, cultural competence must be closely linked to policy requirements and organisational values and service delivery objectives and expressed in high levels of political, leadership and managerial support for CCT [cross-cultural training]”.

One of the medical managers questioned whether there was sufficient evidence of the clinical benefits of cross-cultural training. If it could be shown to enhance the safety and quality of care, then it would be more palatable to managers:

I would have to do a risk assessment and look at how I’d allocate very scarce resources … I’ve got to look at it from the point of view of clinical governance, and that’s probably the thing that drives the most – aside from the financial issue … If for example, you could show me that if I increased the awareness of cultural diversity … training, and things like that, it would reduce adverse outcomes by X amount, then you’d have an argument. (Jo, executive member, M17)

Jo’s comments shows how cultural diversity training needs demonstrably to improve the quality and safety of care for patients (ie. clinical governance (Scally and Donaldson 1998: 62) to be considered core business of the organisation. This is a recommendation of cultural competency research (Johnstone and Kanitsaki 2007). The question then is how do health authorities measure health care quality. Is it defined just in terms of reducing adverse outcomes? NSW Health reform has included a measure of patient
satisfaction (NSW Government 2008a). However, as indicated earlier in this chapter, such a measure might not capture the role of the patient’s cultural background in their satisfaction as there are inadequate demographic data measures, especially in children’s health.

Content of training

There have been varied approaches to cross-cultural training in health care in Australia, from a checklist approach based on awareness of other cultures (see Chapter 2), to provision of more generic skills where notions of racism and inequities are explored (Hollinsworth 1992; Singer, et al. 1986). An international review of training approaches has concluded that there is inconsistency in terminology, conventions and content (Trenerry, et al. 2010). This review concludes that training should be reflective of the impact of the health professional’s individual and professional culture on health care, as well as teaching an understanding of the cultures of clients (Bean 2006; Eisenbruch 2001; Trenerry, et al. 2010).

Medical and nursing managers and staff in this study stated they would like information on the specifics of different cultures. For example, a nurse manager recommended:

Teach us about how a particular culture feels about X. That would be of interest. Thirty minutes is what I’m talking about. There are lots of things you could do. (Rickie, nursing manager, M3)

Nurses were the main staff group who wanted more training and information on different cultures and religions:
It would be good to have people to come in to talk about different cultures, the way the families are structured … Even something like a simple fact sheet. (Ally, nurse, S11)

Even if the different ethnic groups sent out leaflets or had some sort of information that they had available, it would be good. But we don’t have anything available. (Taylor, nurse, S15)

These comments reflect the predominant approach in the 1970s in Australia, which is still common today, especially in nursing (Culley 1996), where staff want a concise description of different cultures. As indicated in Chapter 2, this has been critiqued as potentially leading to stereotypes (Singer, et al. 1986), especially if training is just focused on the Other, and not self reflective of the potential bias of the provider (Trenerry, et al. 2010).

A manager from a social work background reflected on the dangers of having expectations about how a family from a particular cultural background would behave, as it may create stereotypes when dealing with new families. Staff expectations may be more rigid when contained as a checklist. As explained by an allied health manager:

One of the discussions going on at the moment is … ‘Well, I’ve got a pretty good understanding of … Lebanese people, I don’t really understand some other culture,’ … and, ‘I would like some sort of reference or book or handout, that I could go to … understand those groups’. And that then gets into a discussion about putting together information about different cultures, and that is inevitably flawed because it’s always static, and out of date, and stereotypes people, and people are often offended by what is actually written about that
culture. So … it’s difficult to meet the clinician’s needs in a way that is really going to be effective. (Gabriel, allied health manager, M15)

A quality manager from a nursing background reflected on the difficulty in having specific cultural information formally provided as staff may take it too literally:

I think that we rewrote our “care of the body after death” policy, and we included in the back of it some generalisations, admittedly, about different cultural views about what gets done to the body after death … The difficulty is people taking us literally, so that if you put in that Jewish people have these particular views, then all of a sudden, “Oh, they’re Jewish, they have to do…” … So we’ve tried to [emphasise] that these are generalisations to guide you, and what you actually have to do is have a conversation with people, just to raise the level of awareness, that if you’re dealing with a strict Jewish family, these may be considerations. (Shea, quality manager, M7)

While having some understanding of different cultural traits is important in making cultural diversity less problematic, the difficulty is relying on this information to direct care. As the manager above stated, health providers should also have a conversation with patients about their beliefs and values. Health researchers similarly argue that “health services would be assisted by materials on ethnic cultural factors that avoided stereotyping and emphasised asking questions” (Allotey, et al. 2002: 29). Reviews of training have outlined there are some benefits in raising awareness about different cultures in reducing uncertainty and personalising others, but programs must also raise awareness of discrimination and power structures in society (Trenerry, et al. 2010).
Reflecting on the impact of the culture of health care is important. A social worker explained there should be more training, especially of the reflective kind:

I don’t think we do a very good job at training staff. Like, I don’t think that there’s good training for staff around diversity or even things for people to have a chance to debrief about. (Kerry, social worker, S8)

The managers did not discuss the need for a more critical focus in training, where staff reflect on the impact of the culture of their profession, organisation and systemic issues of how patients may be structurally disadvantaged. These approaches focus on examining how power relations are institutionalised (Culley 1996; Hollinsworth 1992; Hollinsworth 2006a; Hollinsworth 2006b). Nevertheless in this study, the way allied health managers discussed how some families were disadvantaged meant they did reflect on the impact of these factors (as shown in the next Section).

3.4 Cultural norms and disadvantage

Some managers spoke about certain cultural norms which tended to affect the behaviour of families from CALD backgrounds. These cultural norms mainly related to parents’ ethnicity, gender and religion. Managers attributed to parents’ ethnicity the way they coped with stress; how they related to the gender and position of health professionals; their different understandings of chronic illness; and the success of certain psychological treatments. Religious background also had an effect on end of life and surgical procedures. NSW legislation requires that health services are accessible, as well as being culturally and linguistically appropriate (NSW Government 2000; NSW Health 2005b; NSW Health 2006c). However, in health services there has been an over-reliance on ethnicity to explain the
behaviour of patients at the expense of other factors such as the effect of education levels, familiarity with health service, socio-economic status, gender, immigration status, and quality of health care (Manderson and Reid 1994). At the same time, ethnic essentialism was part of cultural relativism. This had an important function in normalising the behaviour of families so cultural difference was not seen as a negative. Staff then gave these families’ behaviour the presumption of worth (Taylor 1994).

Several managers working in the area of allied health and chronic care explored the effect of not only ethnicity, but also gender and different health and migration experiences, on how families accessed services. Some also reflected on how families may be disadvantaged in relation to the dominant institutional values in the hospital. Advocacy was important to assist families in negotiating the system. It is useful to apply Fraser’s (2002) notion of ‘status recognition’ to discuss how managers recognised the disadvantages that families faced, and how this led to more time being spent addressing their needs. The behaviour of the managers reflected their awareness of the impact of the dominant cultural values and structures in the hospital. This was in line with the more critical approach to cultural competence and cultural safety outlined in Chapter 2 (CCHCP 1999; Hong 2001; Kagawa-Singer and Kassim-Lakha 2003; Nursing Council of New Zealand 2005) and highlights the importance of reflecting on the dominant power structures in the institution, as outlined in Section 3.3.2 on the review of cross-cultural training.

3.4.1 Parents’ expression of stress

‘Respect’ for cultural difference was one of the values of the hospital that senior managers said was important for all interactions with families. This
was also evidenced on the website of one of the hospitals, “We will respect families and children we look after no matter who they are or where they are from” (CHW 2004). Sometimes as a form of ‘damage control’, managers would use cultural explanations around ethnicity to explain why families from CALD backgrounds treated staff in a problematic way. Managers tried to normalise the behaviour perceived as being a problem by other staff and managers. This was a form of cultural relativism which involved a positive notion of difference. This sometimes involved essentialising the difference (Benhabib 1996; Fraser 2002). A medical manager explained:

Some cultures can be very fussy and difficult … In terms of the stress, some cultures can be quite loud and physically expressive … I’ve got an example of a Middle Eastern background dad who just basically was concerned and stressed about his child, who had gone through a horrible time over several months, but this dad, every now and then, would become quite loud but also a big, muscly guy and would become quite physically intimidating. And we talked about it, and we recognised that that’s just the way he dealt with it. It wasn’t meant to be personally threatening, but it certainly came across [that way] to other people who weren’t used to it. (Leigh, medical manager, M6)

This manager sensitively reflected on the way that some men from CALD backgrounds expressed their stress more explicitly compared to an Anglo Australian norm. The behaviour of a father from a Middle Eastern background was presented as being normal for his background. This manager wanted to de-escalate tensions by using a culturally relativist understanding of physical behaviour, stress, gender and ethnicity.
A nursing manager explained the need to build the cultural competency skills of nurses when they are working under stressful conditions:

We have to teach them a whole different skill set … Education about different cultures … And whilst it’s on protecting yourself and aggression, it’s actually recognising what is aggression and what is just people, how they communicate … we spend a lot of time trying to … educate them on the cultural aspects of various … [behaviours] … and the social workers are really good because if they are called to a family who are in crisis, they come in and invariably they know something about what’s going on and they will educate the ward staff … (Gale, nursing manager, M8)

This quote highlights the need for nurses to be competent in recognising when aggressive behaviour should be deemed ‘normal’ and thus acceptable. Nurses also tended to rely on social workers to assist them working with difference. This will be discussed more in Chapter 5.

3.4.2 Cultural disadvantage

Managers working in chronic care and mental health reflected on the impact of the dominant culture in the hospital. Fraser’s notion of ‘status recognition’ applies in this context, where staff recognise difference and possible disadvantage in terms of the need for a redistribution of resources.

Understandings of chronic health care

Several managers in the area of disability acknowledged that families sometimes had different understandings and experiences of treatment and illness, which in order to address them could mean the provision of an extra service. In some instances, even when an interpreter was provided to
parents, effective communication and understanding was not occurring. They outlined there was more than just a language difference but an understanding of health that is different from ‘the western model’. These different understandings were mainly expressed when discussing children with chronic illnesses. Social anthropology literature has also outlined the different understandings patients may hold about health and illness in comparison to health professionals’ western model (Helman 2001; Parsons 1990).

A medical manager working with dialysis patients gave an example of a pattern she recognised with ‘the Vietnamese’:

They find it very difficult to follow that we’re dealing with a chronic disease where we don’t actually have a cure, … and they tend to come back to the same issues over and over again. (Terry, medical manager, M9)

Some families in developing countries such as Vietnam have had different experiences with the health system. Western pharmaceuticals were only introduced in Vietnam in the 1930s and 1940s, where many saw them as miraculous cures when compared with the traditional and Chinese medicine that had previously been used (Chau, et al. 1993; IWHS 2003; Ladinsky, et al. 1987). Some Vietnamese patients in Australia have therefore “developed a distorted image regarding Western medical practices” (Vo 1995: 5). The education levels of the parents may also determine understandings.

Fraser (2002: 24) suggests that rather than focusing on identity politics there is a need to focus on a person’s social status:
To redress the injustice requires a politics of recognition, to be sure, but this no longer means identity politics. In the status model, rather, it means a politics aimed at overcoming subordination by establishing the misrecognised party as a full member of society, capable of participating on a par with other members.

The staff member’s discussion of patients from Vietnamese backgrounds is not in terms of a ‘damaged identity’ as described by Fraser (2002) but in relation to recognising injustice in the provision of mainstream care. Fraser (2002: 24) critiques the focus on identity:

Construing misrecognition as damaged identity, it emphasizes psychic structure over social institutions and social interactions.

The patient’s lack of understanding of chronic illness is a service provision issue affecting staff, not a self-identity issue.

Terry also discussed a refugee family who had difficulty understanding the management of a chronic illness. The same manager further explained:

We’ve got a little girl from Sudan at the moment, and she’s a real challenge … even with an interpreter … I’m not sure that I’m getting past first base with her mother. I think the problem is … their experience of health is so fundamentally different from my experience of health, and particularly of chronic disease, because you wouldn’t have chronic disease where they come from because everybody dies, so you have acute disease from which you either die or get better, so this concept of chronic disease which we can fix partially but which needs management that involves both child and family, and we don’t just wave a wand and it’s all fixed … (Terry, medical manager, M9)
This manager recognised that the migration experience of being a refugee is a major issue affecting how families understood chronic illness and treatment. She also reflected on the assumption in health care that patients will have an understanding of this. But different understandings have resource implications, requiring the social worker in this case to spend more time with this family. Fraser (2002: 24) outlines that there needs to be recognition as well as redistribution of resources according to the ‘institutionalized patterns of cultural value’. The issues of working with this particular family are further explored in Chapter 6 with the case study of Zahra.

Cultural barriers in accessing disability services

Two other managers in chronic care went on to discuss how families from CALD backgrounds may be more disadvantaged than other families in accessing, and accepting, disability services. They spoke of how the health system does not help families who are not assertive or do not speak English. This aligns with Fraser’s (2002) notion of recognition as being based on injustice and not on damaged identity. The managers’ reflection on difference is based on comparing the values and behaviour of these families to the dominant cultural values in the hospital, and how they may be disadvantaged in health interactions. It is a question of their social status compared to others who may assert themselves more.

In the area of disability services, families have to be strong advocates for their needs. A manager explained:

One of the reasons why the families get particularly stuck is because of the cultural barriers to accessing services and their cultural style in terms of the skills of accessing services … you often come across a
situation where there is a male dominant culture where there is a boy with a disability growing up, and mothers are very accepting of violence, and it’s very difficult to get the mother to engage in the same egalitarian way that we expect of Australian women. I can think of one case where the father has died [leaving] a matriarch … who is not particularly assertive or has language barriers, and particularly with intellectual disabilities, unless you are extremely assertive and persistent, you don’t get anything. (Dominique, mental health manager, M14)

This manager is reflecting on how the health system disadvantages some families from CALD backgrounds where the dominant cultural value is that women assert their rights. It is not just the values of women in the institution disadvantaging some people (Fraser 2002), but the nature of the difficulty that families from CALD backgrounds have in advocating for services when they have a child with a disability (MDAA 2010):

It is the nature of the way the system runs, that if you are not on the phone on a regular basis, you are crossed off from having any needs. Or you have to be an advocate, actively telephoning regularly, making complaints about your needs, and I think that quality cuts across cultures, but it certainly seems to come up more often when there are other cultural issues. (Dominique, mental health manager, M14)

As stated previously, some families may be reluctant to ask for help because of their migrant status, fearing that any request may jeopardise the health care for their children or that staff may view such behaviour negatively (Chalmers 2006a; Chalmers and Allon 2002; Garrett, et al. 2008b). Patients
may also be uncertain of their rights to services (MacIntyre 1994; Pardy 1995).

Another manager from an allied health background, Leslie, working with children with disabilities, explained the difficulty families from certain backgrounds have in accepting a child with a disability:

Many different nationalities come, and we have to be very aware that what our expectations are - are probably very different with the different cultures, and trying to marry that up and making sure that we’re doing the right thing by the family … thinking of children with ongoing disability, some cultures still have real problems in their ability of being able to go out into the community … They want to protect that child, or hide that child away, where in Australia it’s very much the opposite. (Leslie, allied health manager, M11)

This manager reflected on the expectation in the hospital that parents with a disabled child would ask for assistance. Leslie recognised this family was disadvantaged because they did not want to ask for help:

I feel very sorry for one particular family of Vietnamese background. They have a boy with … a muscle disease, and it’s a progressive condition … I think they felt really bad that they were getting the government to help them with the modification of their house…all that bureaucracy was difficult for them, and they kept on changing their minds … I think it was to do with being very proud … But they were shutting themselves away because they couldn’t get out, and I don’t know how much was cultural in that they didn’t want to go out of the house, and how much was because of all the finances, so we’ve had to spend a lot of time reassuring them that we’re not singling
them out, that this is what every Australian family has the right to expect … (Leslie, allied health manager, M11)

Leslie recognised the inequity in service provision for this family and tried to explain to them that they had a right to services just like any family. The redistribution of resources (Fraser 2002) was the extra time spent with this family reassuring them of their rights. They were entitled to the same service as other people, but they were disadvantaged in access. The dominant cultural value in the hospital was that families ask for support, so they were disadvantaged in relation to this.

*Culturally specific mental health treatment*

In areas such as mental health, evidence-based treatments based on mainstream Australian norms did not have the same impact on all patients. A manager working in the area of mental health explained:

> There is a need for research in certain areas because certain treatment models just don’t work so well in certain cultural backgrounds. For example, in the treatment of anorexia nervosa, where we run the best proven treatment for anorexia nervosa, which is probably obviously a model of family therapy, … and yet it seems that, I think both Chinese and Arabic family backgrounds don’t do so well in this program. (Dominique, mental health manager, M14)

This discussion highlights that, although the model of family therapy used is regarded as the best-proven evidence-based treatment, it is culturally based on a western model and not necessarily appropriate for some families from CALD backgrounds. This issue was further explored through bilingual workers being employed:
So we have a project starting up whereby we are going to train some bilingual counsellors in the treatment model and then use their skills and knowledge to look at why some families find it more difficult, while they don’t accept or respond, or why the treatment doesn’t work. And see if we can learn something from it. (Dominique, mental health manager, M14)

This manager is reflecting on the cultural basis of a system of health care. Tharp (1991) highlights that psychological treatments for children should be understood in terms of the family’s belief systems. There may be ethnocentric bias in offering treatment programs which reflect Anglo beliefs and attitudes to patients from CALD backgrounds. There was a need for both recognition and redistribution in terms of different resources provided (Fraser 2002). One approach does not fit all. In this case, resources were redistributed through the employment of bilingual workers.

3.5 Conclusion

This chapter demonstrates how management practices in hospitals reflect the broader social and political contexts of health care and multiculturalism in Australia. Hospital policies that emphasise economic rationalist concerns of evidence based medicine and efficiency tended to take greater precedence in the practice of hospital managers, sometimes at the expense of the cultural and linguistic needs of families. This highlights the dominance of universalist and instrumental discourses over those sensitive to local differences: an approach reflective of perceptions about broader values in society. Health care models discussed in the interviews were predominantly based on mainstream Australian norms of parenting, which made dealing with cultural diversity a separate, problematic, add-on. These findings at the children’s hospitals are in line with the literature that finds that multicultural
policies are premised on ‘equity of access’ rather than ‘equity of outcomes’. Practices tend to be reactive, without addressing difference. For these reasons there was limited cultural competency at an institutional level, as it was not perceived to be core business and was not adequately supported. The interviews indicated there were neither adequate processes in place to identify the needs of families, nor resources to support staff in responding to these needs.

The study did identify some managers who understood that there was not sufficient systemic support for CALD patients. These managers often did engage in protective cross-cultural practices, for example in the areas of chronic care and disability services. They provided cultural relativist understandings of how some CALD families were disadvantaged in using these services and tried to provide families with extra assistance. The institution’s success in addressing inequities was dependent on these health professionals practicing status recognition through reflecting on the values and nature of health care, and understanding how the different needs of families from CALD backgrounds put them at a disadvantage in health care interactions.
4. **Workforce diversity: views of managers and staff**

I think because our workforce is multicultural, that’s actually been useful for all of us, to just appreciate a bit more about other cultures, but also to appreciate what we don’t know about other cultures … Often we will ask somebody, one of the nurses or one of the doctors, to see if they’re happy to either act as interpreter, or even just let us know what it is about this child that’s making this family really upset. It’s not often just the interpretation of the language … we can’t understand what their issues are, what they’re trying to say. (Robin, medical manager, S13)

This interview with a medical manager working in the emergency department throws light on how useful it is to have a diverse workforce, because some staff can interpret and provide an understanding about other cultures. Using the language skills of a health care provider can save staff from the disruption and cost of sourcing a trained interpreter. However, the staff member may not be completely proficient in the language, or the wider competencies of being an interpreter, and therefore may compromise the safety of treatment provided (NSW Health 2006c; Whelan (Klinken), et al. 2000b). It might seem that asking a health provider to sensitise other staff to cultural issues related to a family of the same cultural background may be useful; however, there is a danger with such an approach if it “relies on an ethnic resemblance model of recognition”, which may imply an essentialised understanding of culture and may overshadow other areas of inequity (Shaw 2005: 292). While the staff member can provide a cultural interpretation of the situation, other staff may be tempted to generalise from this information rather than ask family members themselves. Asking a staff member
employed for their medical skills to interpret or provide cultural information may also add to their workload and put pressure on them to act outside their usual role. This chapter argues that there should be proper processes in place at a systemic and organisational level to utilise and support the skills of staff from CALD backgrounds in working with cultural diversity.

In this study, while several medical and nursing managers said that they had asked staff from the same cultural backgrounds as the patients to provide cultural information, in contrast staff themselves said that in many cases their ethnicity did not actually have to match the ethnicity of families for them to draw on knowledge, skills and migration experience to assist the families. Staff practised a broad conception of diversity beyond matching ethnic identity. As indicated in my first chapter, ‘productive diversity’ describes a situation where an organisation values its staff’s different and complementary skills, styles of thinking and languages, where “people develop and use multiple layers of identity and multiple ways of communicating” (Cope and Kalantzis 1997: 170). In the case of the children’s hospitals, staff were able to relate to families on a number of levels such as migration experience, gender and religious position. This resembled Friedman’s (1998: 48) notion of ‘relational positioning’ where:

Individuals are constituted through many group identities and cannot be reduced to one collectivity, they are able to be flexible in dealing with global variation in forms of otherness and contradictory subject positions.

These practices of staff were a step towards Fraser’s (2002) concept of ‘status recognition’ because they recognised how families may be disadvantaged in relation to dominant institutional cultural values in the hospital.
While there would be benefits to the hospital of having a staff profile that reflects the demographics of patients, especially in terms of sharing a language and having similar cultural values (Institute of Medicine 2004), this situation does not exist in the Australian health care system (Eisenbruch 2001; Hawthorne, et al. 2000; Johnson, et al. 1998; Whelan (Klinken), et al. 2000a) or in the US and UK (Institute of Medicine 2004; Eisenbruch 2001). Staff therefore need to be competent in dealing with patients from a range of backgrounds (Cope and Kalantzis 1997; Morrissey 1997; NLLiA CWCC 1994; Shaw 2005) rather than relying on staff from the same ‘culture’ as patients to assist them (Taylor 2003).

While NSW government policy acknowledges the benefits of employing diverse staff in terms of their language and cultural skills (NSW Government 1998; NSW Government 2009a; U.S. Department of Health and Human Services 2007) this chapter demonstrates there is a lack of guidelines on the appropriate use of these skills, and of support given to these staff when using them. There have been calls to develop guidelines on when, where and how it is appropriate for staff from diverse backgrounds to use their language skills in health settings (Whelan (Klinken), et al. 2000b), but there is less discussion on the appropriate use of cultural knowledge. The NHMRC’s cultural competency guidelines recognise the need for ‘diversity management’ as a process of “capitalising on the benefits of diversity and minimising workplace challenges” (Australian Government 2005: 8). While such guidelines exist, there are no mandated government policies for managing diversity in the hospital. The models that do exist have mainly been developed in the United States (Dreachslin, et al. 2004; Weech-Maldonado, et al. 2002) where managing diversity is about “planning and implementing organizational systems and practices” (Cox 1993: 11). The interviews in this study support the literature that argues that there is a lack
of systemic support and organisational processes to assist diverse staff (Eisenbruch 2001; McGrath 2004; Smith, et al. 2006). In particular, in this study, the cross-cultural tensions apparent between staff from different cultural backgrounds demonstrate that there is a lack of inter-staff cross-cultural training and assessment of staff satisfaction, the development of which is recommended in policy (NSW Government 1998). This study demonstrates that a sub-group of staff from CALD backgrounds, overseas-trained staff in particular, need support with their English language communication skills (Eisenbruch 2001), and in working in children’s health care, to enhance their performance and ensure patient safety.

I will now discuss the benefits of using staff from CALD backgrounds, as well as the policies and current literature concerning their employment and use. I then assess the understandings of the managers and staff interviewed in this study. I will then review the literature on managing diversity, and discuss how effectively the hospitals supported staff from CALD backgrounds.

4.1 Benefits of employing diverse staff in the hospitals

Employing diverse staff helps to address the language and cultural barriers faced by patients from CALD backgrounds. Australian multicultural policy in the 1970s first recognised the importance of bilingual health staff as a resource that could assist patients who do not speak English (Galbally 1978). Overseas policy and guidelines also recognise the importance of bilingual staff (HHS ACMH 2009; Institute of Medicine 2004; U.S. Department of Health and Human Services 2007), in recognition of ethnic disparities in health care access and treatment (Betancourt, et al. 2003; Institute of Medicine 2002; Weech-Maldonado, et al. 2002) due to language difficulties, underuse
of interpreters, and ethnocentrism in health service provision (Hawthorne et al. 2000; Shaw 1995: 92). Studies support the proposition that broadening the racial and ethnic diversity of health professionals increases patient satisfaction (Stevens, et al. 2003), improves access to health care for patients from CALD backgrounds and assists with communication (Institute of Medicine 2004; RCCHC, et al. 2003).

The managers discussed the safety benefits of having staff who had the same linguistic backgrounds as patient families. A manager from a nursing background explained:

"I think the value of bilingual staff is just enormous … we see that every day. I think we do have a lot of staff from Asian countries, and that is absolutely brilliant where we have families in, especially with extended families. The children might speak English perfectly well, but perhaps their extended families don’t. It just makes the days so much better and so much safer. (Frances, clinical manager, M10)"

This supports the evidence of the benefits of a health provider and patient sharing a language (Hawthorne, et al. 2000; Snowden, et al. 1995; Stevens, et al. 2003). Language barriers can have detrimental effects on health outcomes and quality of care and can lead to adverse events (Chandrika, et al. 2007; Flores 2005; Johnstone and Kanitsaki 2006; Whelan (Klinken), et al. 2000a).

A health professional who speaks the same language as families can help them to feel supported and to understand the health system and Australian culture. As explained by an Indian nurse who spoke the same language as a family:
Currently we have a patient who I often go to, and the father and I usually try to speak the language when I’m up there to explain why we’re doing things … They speak very good English. That’s not a problem … It’s just understanding the way of life, the Australian way of life! (laughs) (Nanda, nurse, S18)

A doctor used her conversational language skills to make a child feel more comfortable in the hospital:

I don’t make a point of speaking Spanish to them, because I just can’t take a medical history in Spanish… But I can reassure the child in Spanish … I’ve found out that works really well. (Carmen, doctor, S1)

She understood the limitations of her language use, but recognised the benefits of using her language for less technical casual conversation.

A doctor from a Jewish background used his religion to make a family feel more supported:

I’m thinking of a recent case of a Jewish family with a boy who’s suffering the after-effects of a very serious cancer surgery. I became involved in the case as a consultant from this department because of my Jewishness and understanding of their issues. I’ve been working with a non-Jewish colleague but very comfortable to use my knowledge to help them feel understood and supported. (Bailey, doctor, S21)

Staff from CALD backgrounds also assisted with access issues. A medical manager in this study mentioned the informal networks that have developed in the outpatients departments where families may be linked with staff specialists of similar backgrounds:
From this area, there are lot of Jewish doctors on staff. They would get a lot of the Jewish clients, either directly because of personal links and relationships, or through general practitioners … and, again, speaking the language helps. (Leigh, medical manager, M6)

Having a diverse workforce assisted staff in developing cross-cultural skills through working with each other which was then of benefit working with patients (Eisenbruch 2001). As explained by a doctor from a Chinese background:

Your colleagues are the ones who you have a great respect for and who, if they’re from a different background to yourself, then you do discover a lot about that, and their ideas about patient management … I don’t think I’d have any Muslim friends if it wasn’t for being a doctor. (Lee, doctor, S10)

4.2 Policy and practice of employing CALD staff

While policy encourages organisations to employ staff who are representative of the communities served and to foster diversity at all levels of the organisation (NSW Government 2009b), the priorities of managers in this study were to fill staff vacancies based on clinical competence, not necessarily with hiring staff because of their backgrounds. Moreover, inadequate data is collected for managers to know the diversity of their staff and thereby fulfil policy requirements. Trying to provide care based on ethnic and linguistic matching of provider and patient is difficult as there are a range of factors that determine quality health care.
4.2.1 \textbf{Staff representative of communities served}

Equal Employment Opportunity (EEO) principles in NSW recommend that “diversity in the workforce reflects the diversity of the NSW community”. The NSW Government (NSW Government 2008b; 2009b) also specifies that organisations employ 19% of people whose first language is not English but do not specify that the ethnicities of staff have to match the ethnicities of the clientele. However, the Australian NHMRC cultural competency guidelines state a “health organisation: … recognises the benefits of diversity and dialogue across cultures and aims for a workforce that reflects the cultural makeup of the population it serves” (Australian Government 2005: 34).

At the two hospitals the demographic composition of staff did not reflect the communities served but was reflective of the hospital and health professional registration processes used to fill workforce shortages. The demographic composition of doctors was mainly determined by available medical expertise as the hospital has to fill specialist positions which were often sourced from overseas. A manager with a nursing background commented that in her opinion they could have put more effort into making staff more representative of the community:

\begin{quote}
We probably don’t have as representative a workforce as we could have, especially for our location … The figures [indicate that] around a quarter of Australia is going to be from a culturally and linguistically diverse background within 10 years or something, and we certainly don’t have a quarter of our staff representing the right groups. So it’s sometimes very difficult to find staff who want to work with us who have a background that is perhaps different from the masses. Certainly a lot of people come to us from, for example,
\end{quote}
Indonesia and the Philippines, and that’s more about the advantages of life here than it is necessarily about representing their local communities here. So we could probably do more to engage local community groups to work here. (Frances, clinical manager, M10)

In 2005 26% of the Australian physician workforce were overseas trained. The main countries of origin of overseas trained doctors were Britain, India and New Zealand, followed by South Africa (Mullan 2005). At SCH overseas trained staff figures were higher, with 50% of junior medical officers overseas trained, while at CHW 30% were overseas trained (Chalmers and Rosso-Buckton 2008). With nursing, at SCH 60% of nursing staff were overseas trained, while at the CHW there were 4% overseas trained. The reasons for the large figures at SCH were due to the paediatric nursing networks and working visas arrangements established there, as well as the coastal location (Chalmers and Rosso-Buckton 2008).

Hospital recruitment practices and differing standards of health professional registration boards made employment of diverse staff who are reflective of the communities served difficult to achieve (Choucair and Ridoutt 1993; Douglas 2008; McGrath 2004; Robotham and Levett 2007). There was a preference for health professionals educated in western health systems and from English speaking backgrounds (ABC Radio National 1999; Choucair and Ridoutt 1993; Eisenbruch 2001). Managers in this study explained the diversity of staff was skewed, where possible, to countries such as the UK and Ireland, where they have a similar health care system to Australia.

A study conducted at SCH demonstrated that managers had as many concerns over recruiting staff as over meeting the needs of its diverse patient population (Whelan, et al. 2005a). Another report states that targeted
recruitment of bilingual professionals has “never been a high priority within the health system”, as there may not be people from the preferred backgrounds who are appropriately trained (Choucair and Ridoutt 1993: 29).

The current diversity of staff in NSW was not being used effectively as bilingual staff are not being allocated to patients who speak the same language. There was also a tendency to allocate patients to staff based on medical needs rather than language ones. Research conducted in SWSAHS demonstrated that 37% of bilingual staff rarely used their language skills (Whelan (Klinken), et al. 2000a). This relates to a lack of proper processes and policies on the appropriate use of these languages (Choucair and Noble 2001; Johnson, et al. 1998; Whelan (Klinken), et al. 2000a).

Beyond ethnic concordance

The benefits of having diverse staff in health care organizations to match the demographics of patients have led some researchers in the US to examine the model of ‘racial, ethnic and linguistic concordance’. This “refers to the process of matching any or all such characteristics between patients/consumers and clinicians” (RCCHC, et al. 2003: 1). Hawthorne et al. (2000) state the endorsement of bilingual/bicultural care to match the demographics of patients is based on assumptions that there is an adequate supply of staff matching that population, and that staff and patients prefer the match. However, as explained by Johnson et al. (1998: 49), “supply does not directly match community demand” in Australia. This was confirmed in this study, as indicated in the previous section. Although there are obvious benefits of encouraging the employment of diverse staff, there “have been no systematic Australian studies to date of the degree to which NESB patients indeed desire bilingual bicultural nursing care, or consider it superior to
‘mainstream’ service provision” (Hawthorne et al. 2000: 193). While ethnic concordance is not explicit in the policies in NSW, some managers at SCH and CHW enacted a model similar to ethnic concordance in how they sought cultural information from staff of similar ethnic backgrounds to patients.

The impact on health outcomes of cultural and language concordance between the patient and provider, such as whether it has an effect on preventing adverse events, is under-researched (Johnstone and Kanitsaki 2006). Studies that do exist have shown that the main benefit of bilingual and culturally similar care is sharing a language in terms of ensuring clear communication (Hawthorne, et al. 2000; Snowden, et al. 1995; Stevens, et al. 2003). The benefits also depend on the level of the health provider’s professional skills (Hawthorne, et al. 2000; Snowden, et al. 1995; Tharp 1991; Whelan (Klinken), et al. 2000c). Another factor is the type of health care offered, such as whether health care is geared to patients from CALD backgrounds (Snowden, et al. 1995). In one study, access to a ‘culturally similar’ provider led to inferior care, where patients perceived a bicultural nurse was pretending he/she did not know the language of the patient or treated Caucasian patients better (Hawthorne, et al. 2000). Chalmers (2006: 29) has also noted that some patients from CALD backgrounds may not want an ethno-specific nurse, feeling they may “be stereotyped in line with traditional practices with which they have little or no connection”. Findings such as these have led researchers to note that the relationship between a staff member’s “race or ethnicity and patient access, process, and outcome is arguably far more complex than mere demographics” (Dreacslin, et al. 2004: 963). This highlights that staff need to be able to relate to patients from all backgrounds as the ideal situation of ethnic concordance will not always be possible (Jackson and Lopez 1999; Shaw 2005; Tharp 1991).
There may be pressure for staff from immigrant backgrounds to assist patients from similar backgrounds. Of bilingual staff surveyed in a SESIAHS study, while 65% were willing to let others know about their language skills, 31% did not because they felt they were not proficient enough in the language, and to a lesser degree because the extra work related to using these skills was not part of their job (Choucair and Noble 2001). Other research in SWSAHS in Sydney reveals that bilingual staff had positive experiences using their languages but that there were concerns about increased workload, and the blurring of boundaries beyond their primary professional role and their language proficiency (Whelan (Klinken), et al. 2000a). There has been less research about diverse staff providing cultural information related to the patient, although it is noted that staff from migrant backgrounds are often seen as ‘cultural’, so the onus may be put on them to work with patients from similar backgrounds (Taylor 2003).

Ethnic concordance may be difficult to identify between patients and health professionals from CALD backgrounds as they may not have migrated from the same country (Featherstone 1995). There are various aspects of a health professional’s and patient’s cultural background with which they may want to identify such as country of birth, ethnicity or religion. Different aspects of a person’s identity may be relevant in different contexts (Friedman 1998).

The notion of being able to match the cultural background of the provider with that of the patient is problematic in children’s health care as there may not be a simple fit. Should the ethnicity of the provider match that of the child, mother, father or another carer? In research conducted on the benefits of ethnic concordance in children’s health care, one study showed no benefit of matching the ethnicity of the provider with the child (Stevens, et al. 2003).
This study suggests it may be better to try to match the provider’s language to the family.

4.2.2 Diversity at all levels of the organisation

Australian and overseas policy also encourages organisations to have diversity in employment at all levels of the organisation. This ensures diverse staff are in touch with the needs of the patients and the rest of the workforce (Dreachslin 1999; HHS ACMH 2009; RCCHC 1999; Weech-Maldonado, et al. 2002). The Multicultural Planning Framework in NSW promotes the need for minority representation to exist at all levels of the organisation (NSW Government 2009b). The NHMRC’s cultural competency guidelines also state that there should be “cultural and linguistic diversity at all staffing levels” (Australian Government 2005: 30). Similarly, the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in the United States recommend that “health care organisations should implement strategies to recruit, retain, and promote at all levels of the organisation a diverse staff and leadership that are representative of the demographic characteristics of the service area” (U.S. Department of Health and Human Services 2007: 1). This has led to calls to increase the percentage of culturally diverse students enrolling in health professional training in Australia and the US (Abrums and Leppa 2001; Choucair and Ridoutt 1993; Eisenbruch 2001; Institute of Medicine 2004).

The management interviews in this study support research previously conducted at SCH (Whelan, et al. 2005b) which found that there has been little attempt to ensure representation of staff from CALD backgrounds across health professions in the organisation. At both children’s hospitals the
managers spoke about the majority of the Executive\textsuperscript{20} being from Anglo-Australian backgrounds, with only a few from non-English speaking countries. There was also an uneven representation of diversity across the professions and income levels (CHW 2007). As explained by a medical manager:

We’re probably not exactly equitable across the spectrum of what’s in the community, but certainly a very broad spectrum of staff, both medical, nursing … certainly more the [hospitality] services tend to have a different background again. A lot of the more recent migrants without the opportunity for education [are not represented in] the more professional categories. (Bernie, medical manager, M2)

At the hospitals there was also inadequate data analysis on the diversity of staff, which made it difficult for managers to know if they are meeting policy requirements. At SCH, data is collected on country of birth of staff but on a voluntary basis\textsuperscript{21}, while at CHW information on whether English is the first language of staff is collected, but this is also voluntary\textsuperscript{22}. From those who did volunteer data, there were approximately 24-25\% of staff at CHW (CHW

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{20} This term is used in the hospital to refer to senior management.
  \item \textsuperscript{21} Based on correspondence with the Diversity Health Coordinator at SCH, dated June 2008.
  \item \textsuperscript{22} Based on discussion with Ms Williams, staff services department, CHW, February 2009.
\end{itemize}
\end{footnotesize}
2007) and 16% at SCH\textsuperscript{23} who were from CALD backgrounds or whose first language was not English. These figures indicate CHW is meeting EEO targets (NSW Government 2009b) although this diversity is not fully represented across all salary levels (CHW 2007). A staff survey conducted in SESIAHS, where SCH is located, demonstrated that there was a ‘reasonable match’ between the languages of the population and the bilingual staff, but there were more bilingual staff in certain professions such as nursing and allied health (Choucair and Noble 2001; Whelan, et al. 2005a: 15). Again, participation in this study was voluntary for staff so figures may be inaccurate. A recent survey at SCH indicated that only 5.6% of managers review the ethnic demographics of their workforce by ethnicity (Whelan, et al. 2005b).

4.3 Use of culturally diverse staff in the hospitals: managers and staff

This study sought information on the type of cultural assistance provided by staff from CALD backgrounds. While several medical and nursing managers discussed asking staff from the same cultural backgrounds as the patients to provide cultural information, interviews with staff revealed that the ethnicity of staff did not have to match the ethnicity of families for staff to use their knowledge, skills and migration experience to assist families. This supports the benefits of using a range of skills of staff, not necessarily just matching their ethnicity to patients, and demonstrates the benefits of using a broad

\textsuperscript{23} The figure is based on information provided by the workforce development unit at SCH (June 2011). The response rate of staff was 80% to the question of whether their first language was English.
notion of diversity in line with Cope and Kalantzis’ (1997) productive diversity and Friedman’s (1998) relational positioning. Staff could relate to patients on a number of levels including language, culture, religion, migration experience and also years of experience working with various cultures.

4.3.1 Managers’ views on consulting diverse staff

Several medical and nursing managers reported asking staff who they perceived as having similar ethnic backgrounds to patients to assist them by providing cultural information about these families. This process had its benefits as it helped normalise cultural difference and familiarise staff to different practices. Some of the difficulties with this approach were that it could replace asking families themselves, add to the workload of staff, and essentialise practice.

There was a tendency for staff from CALD backgrounds to be singled out to assist families from CALD backgrounds:

Certain people do, I don’t know whether they like it or not, but they do represent certain communities by virtue of being a professional from a certain ethnic background, some more definitely than others. (Dominique, mental health manager, M14)

Asking staff from CALD backgrounds for cultural information was an informal process when staff were unsure what to do. As explained by a medical manager:

People from an Islamic background, I’ve known that there are Middle Eastern workers who you could refer to if there were some particularly sensitive issues … the other time that it comes up … is
end of life issues, and sometimes surgical procedures, and there certainly are some things where … [you] need to be sensitive to cultural backgrounds and what to do in those situations … that’s where [people in the organisation] who are from similar backgrounds, you consult them, rather than there being a formal policy, or a formal process. (Leigh, medical manager, M6)

This approach outlines difficulties staff face in providing appropriate services due to lack of knowledge about patients’ cultural practices (Allotey et al. 2002). The practice described above is similar to the model of ethnic concordance discussed earlier in this chapter.

Anthropological critiques of the model of ethnic concordance argue it is too reductive and limiting. Shaw (2005) argues the idea of matching the ethnicity of provider and patient is based on a reductive and essentialised notion of culture. It is focused on an ‘identity model’ of recognition of the provider’s and patient’s ethnicity which then “homogenises differences between groups” (Shaw 2005: 301). This raises the need for information to be followed up with the family. As the interpreter policy states, interpreters can provide cultural information, but this should not take the place of asking the patients themselves (NSW Health 2006b). The same would apply to using cultural information from ethnically similar staff, especially if they are not directly looking after the patient.

This pattern of asking staff from CALD backgrounds for cultural information was more common with staff from emergency and critical care, where they have less time to work with the family. In these departments, overseas trained doctors have provided in-service training on how to work with
families from similar backgrounds to themselves. A manager from emergency explained the nature of these seminars:

They were just talking about the family relationships and what “family” means to someone from that background … And the guy from the Arabic background was talking about male-female gender issues … (Robin, medical manager, emergency department, M13)

Staff becoming familiar with the culturally different practices of families is important, however the tendency to stereotype when providing training on a particular culture is acknowledged in the literature, as tended to happen in the 1970s in Australia (see Section 2.1.4) (Garrett and Lin 1990; Morrissey 1997; Singer, et al. 1986; Trenerry, et al. 2010). The risk is that such training may endorse an essentialised understanding of culture (Shaw 2005); however, the same manager acknowledges the diversity within language groups:

What I’ve become aware of is, as within ours and within every culture, there are multiple variations, and so just saying that someone is from an Arabic country doesn’t at all mean that they are aware of the cultural sensitivities of a culture group we’re talking to. (Robin, medical manager, emergency department, M13)

While promoting awareness of cultural differences is important, if it is used in isolation, it can have negative effects. Training should contain a balanced focus on “awareness, attitudes and skills” (Trenerry, et al. 2010: 40). There needs to be an unbiased attitude including an “awareness of the self and the processes that contribute to racism and prejudice” in health practice as well as skills training so behaviour can change (Trenerry, et al. 2010).
4.3.2 How diverse staff relate to families

It was beneficial when staff from CALD backgrounds worked with patients and families who spoke their language and came from similar backgrounds. While the managers discussed the approach of utilising staff from the same cultural backgrounds as the patients, staff practice highlighted a broad notion of diversity beyond just matching ethnic identity to being able to relate to patients in various ways to assist them in their health care.

*Utilisation of different experiences and skills of staff: productive diversity*

Staff used their range of skills and experience to relate to patients according to the notion of ‘productive diversity’ as “the range of language skills, communication styles, international networks, country knowledge and life experience that people bring to organisations” (Cope and Kalantzis 1997: x). They acknowledge the difficulty in ensuring that the ethnic background of a service provider always matches that of a patient. As explained by one of the nurses, coming from a different background means “you bring something different to the skill mix and the knowledge base” (S17). As outlined by a doctor:

> I just enjoy the mixing of cultures because I think it’s enriching, personally and professionally. (Bailey, doctor, S21)

A senior nurse explained how a nurse from an Anglo background provided information about the practices of families from Vietnamese backgrounds, as she was married to a man originally from Vietnam. This nurse was able to explain the practice amongst some Vietnamese parents of wrapping up their children who are having a febrile convulsion:
The Anglo-Saxon nurse who’s married to a Vietnamese man is very understanding of the Vietnamese culture and actually can explain that to the nurses. So, that’s very useful in helping us. For example, if you have a child that’s febrile, the Vietnamese way is to wrap the child up in blankets and keep them warm, and so she can quite succinctly explain the philosophy behind that. (Ally, nurse unit manager, S11)

In this case there was no ethnic concordance between provider and patient, but the provider’s depth of knowledge could assist the relationship. Cope and Kalantzis (1997: 142) state in order for staff to be ‘brokers’ of cultural difference there needs to be an openness of boundaries.

*Staff and patients sharing non-dominant cultural backgrounds: relational positioning*

One important form of identification was recognising how families from CALD backgrounds were disadvantaged in the context of the western health care system and where mainstream Australian parent relations were the norm. Several staff from CALD backgrounds were able to use their experiences and skills to reflect on inequities. They recognised that some migrant families may be disadvantaged in different ways in relation to the dominant institutional values around religion and the position of women. They could relate to families using different parts of their identity. This highlights Friedman’s (1998: 47) notion of ‘relational positioning’ where staff could relate to CALD patients based on “different systems of alterity”. Patients and families could be disadvantaged in ways beyond just having a different ethnicity. For example some had beliefs and followed religious practices that were considered different from the implicit norms of the hospital. In some circumstances, staff who were from a CALD background
and have experienced and/or witnessed some forms of discrimination, could empathise with families who were institutionally disadvantaged in particular ways.

This form of relational positioning incorporated status recognition on a number of axes of differentiation, such as believing in a non-dominant religion and being a migrant. Shaw (2005) discusses the need for there to be a different notion of recognition based on Fraser’s (2002) ‘status model’, which encompasses the idea of ‘distributive justice’ and ‘parity of participation’ rather than just recognition based on ethnicity. There were examples where recognition by staff of an imbalance of power was a step towards status recognition. Status recognition is a way of developing a notion of cultural competence which focuses on recognition of the impact of the dominant culture in the hospital, which may disadvantage some families.

A staff member from child protection discussed working with Pacific islander communities, where her migrant background assisted her in relating to families who were also from migrant backgrounds:

> I consider myself to be fairly open-minded, so because I’m aware of all those differences, and because I’m ethnic myself, my sensitivity to the issues is large … I’ve been on the receiving end of nasty stuff when we were kids. The taunts and all that stuff, so I’m fairly patient. (Carmen, doctor, S1)

This doctor was from an European background. A speech pathologist from a migrant background also stated:

> because we’ve gone through the migration … coming to a new country where I didn’t know the language … maybe I have … a little
bit more empathy for other new migrants that are coming here and struggling with the same issues. (Alpha, speech pathologist, S6)

The connection was not ethnic concordance but rather migration concordance, and being from a non-Anglo background. Because both provider and patient were migrants, the provider could reflect on the impact of the dominant culture. At the same time, there is great diversity among people from migrant backgrounds (Friedman 1998). The nature of negotiation as described by Cope and Kalantzis (1997) is where people strive to create some connection based on different aspects of their identity.

There were some nurses and allied health workers from CALD backgrounds who used the way they felt different from the dominant Anglo culture in the hospital to assist families who they felt were marginalised. For example, a speech pathologist with parents from Syria and Lebanon, who was of Christian background, found her experience of mixing socially with people of Middle Eastern background, and her exposure to Al Jazeera television, helped her identify with the specific needs of Muslim mothers in the hospital. There was not so much a similarity of identity between this staff member and family as her having experience working with and associating with Middle Eastern Muslim mothers.

This staff member identified disadvantage based on a family not being able to participate properly in health care interactions. For example, the speech pathologist told of a situation where some staff held negative opinions of a mother labelled as ‘difficult’ when she had to learn to use a feeding machine for her daughter. While staff were upset about the mother using hospital equipment inappropriately, this worker asked about whether the woman
had transport to the hospital. A simple question such as this would have enabled the mother to interact on a more equal level with the staff:

I can think of an example of a little girl … where the nursing staff were just so frustrated with the family, and the family were of Middle Eastern descent … The main issue that was causing the difficulty was that Mum could only commit to … be trained up in the care of her child between, say, eleven and one every day … and part of the contingency for the child going home was that the mother had to be trained to do nasogastric feeds … so the nursing staff were finding it really frustrating as to why she wouldn’t commit to being here for longer, … but I found it really interesting that no-one asked, “Why is it that you’re only here…?” If people asked her she would have said, “Well, I’ve got other kids to look after.” … and so I put it to them, “Well, how does she get here?” And they said, “We don’t know. Maybe someone drops her off.” (Ali, speech pathologist, S5)

Here the speech pathologist explored the particular issues behind the nursing staff labelling this mother as ‘noncompliant’. This example highlights broader systemic issues such as the lack of disability services in the community, meaning some families have to attend the hospital for extended periods of time to gain assistance (Galbally 2010; NPDCC 2009; Wood 2008).

A nurse originally from India, identified as belonging to the Sikh religion, said she provided advice to other staff about families who were not Sikh, but “Muslims and different cultures (where) women are not prominent”. She gave an example of assisting a Muslim family who spoke one of the Indian languages she knew. She said that through knowing the language, and also
through “coming from a different cultural background” similar to the family’s, she was able to assist them when they became upset with staff handling their copy of the Koran, with disrespect. She enacted the ‘status recognition’ model (Fraser 2002: 24), which “aimed at overcoming subordination by establishing the misrecognized party as a full member of society”. The family were at a disadvantage when interacting with staff in relation to their cultural difference. The nurse explained:

The staff weren’t aware, because it was a different language … So I told them, just leave it there, on the side, so we don’t touch it if we have dirty hands or something. (Nanda, nurse, S18)

Through the nurse knowing a language, she could build trust with the family. Recognition of the importance of the Koran for the family was coupled with the nurse’s request for staff not to touch the book.

These examples show the usefulness of Friedman’s (1998) notion of ‘relational positioning’ in understanding how staff and patients can meet along different axes of differentiation. This concept has been used in nursing training to understand how patients can be disadvantaged by multiple factors (Abrums and Leppa 2001). The term is based on the idea that:

… identity is situationally constructed and defined and at the crossroads of different systems of alterity and stratification (Friedman 1998: 47).

It is a construct for:

… a multiplicity of fluid identities defined and acting situationally (Friedman 1998: 47).
In the case above, the staff member was able to relate to the family based on
sharing a non-dominant religion and being a migrant. In other situations she
could relate to families where the mother was in a situation of disadvantage,
as she too had shared this experience. These forms of identification and
negotiation were related to particular situations.

The nurse used advocacy to try and explain to other staff how the family was
disadvantaged as compared to other patients who identified with the
dominant cultures in the hospital. The concept of relational positioning also
acknowledges that the power of the dominant culture should not be
forgotten when there is a plurality of relations between health professional
and parent. As stated by Friedman (1998: 48):

The concept of relational positioning should not be confused with
pluralism, which always runs the risk, as Chandra Talpade Mohanty
points out, of suppressing the analysis of structural power relations
and systems of domination ... scripts of relational positioning still
open the door for dialogue, affiliations, alliances, and coalitions across
racial and ethnic boundaries.

In comparison to the theory outlined above, models of best practice for staff
to work in a culturally competent way outline how staff should reflect on the
impact of structural demands and the culture of health care (CCHCP 1999).
The NHMRC guidelines outline that a culturally competent individual “can
advocate with and/or on behalf of clients and their communities” (Australian
Government 2005: 39). The Victorian Health document on tools to promote
diversity in organisations also outlines that effective cross-cultural training
should include “a focus on the individual, societal and structural
mechanisms pertaining to racism and prejudice” (Trenerry, et al. 2010: 41).
The staff member then recognises how the patient may be disadvantaged according to broader structures. This is similar to Manderson’s (1990) discussion of focusing on the adequacy of health service provision rather than the culture of the patient.

_Diverse staff normalised difference_

Having diverse staff normalised the behaviour of patients and their families from CALD backgrounds. A senior social worker stated that overseas trained doctors are useful as they bring a different perspective to the team when they point out that certain cultural practices of families are not unusual. She stated they made ‘difference OK’, so it was not classed as being a problem. The high status of doctors was important in this affirmation in removing the low status of difference:

> Sometimes in ICU [Intensive Care Unit] we have doctors from overseas and I think what they sometimes bring to a team is another perspective, or someone else saying, “This is very normal in our culture”, and sometimes that is very important … hearing that from a professional person … it actually has a strength in that it [is] another person who’s saying, “Difference is OK and this is quite normal” and actually help our staff in terms of: How do we deal with this issue? How can we be more open to dealing with it? (Kim, senior social worker, S7)
This process of normalising difference was discussed in Chapter 3, where managers de-escalated tensions. An example was doctors saying that ‘coining’\textsuperscript{24} is a common practice in some cultures:

We’ve got Asian doctors here and they often will laugh and say, “Oh, yes, I’ve had coining done”. It’s not actually seen as a child protection issue. It’s seen as a cultural practice that people do. (Sam, nurse, emergency department, S13)

The presence of diverse staff created a general sense, for both staff and families, that difference was respected. A nurse originally from Zimbabwe stated that she had not had the opportunity to work with families from similar backgrounds as yet. But she said that the very presence of staff from diverse backgrounds was a positive affirmation of difference:

I find it very good, because there’s a lot of interaction. Also, it just balances the situation … you find that most of the patients are from a different background as well, so that mixture in the staff helps as well … You … interact easily when you have people from different environments rather than just one background. (Taku, nurse, S19)

As noted by Cope and Kalantzis (1997: 135):

\begin{flushleft}
\footnotesize
\textsuperscript{24} ‘Coining’ is a form of traditional medicine practiced in South East Asia to treat minor illnesses such as colds, coughs and chills (Sullivan 2005). This technique is called \textit{cao gio} in Vietnamese and is used to remove the ‘bad wind’ from the body (Nguen, et al. 1994).
\end{flushleft}
Given that the market potential for a product or service, locally and globally, is invariably diverse, then an organisation has to be just as diverse internally as its clientele and potential clientele are externally.

Cope and Kalantzis (1997) argue that organisation needs to develop an internal culture of flexibility through being able to recognise and negotiate its own internal differences, for example finding different ways to relate to its clients. As stated by Taku, the staff member above, people ‘interact easily’ when there is diversity amongst staff and patients rather than just ‘one background’. It enables multiple ways of interacting.

4.4 Systemic support for a culturally diverse workforce

While policy encourages the employment of bilingual/bicultural staff in recognition of the benefits to patients and of achieving organisational goals (CRC 2007; Institute of Medicine 2004), there is a lack of policies and guidelines that support staff from CALD backgrounds, especially overseas trained health staff (ACHE, et al. 1998; Eisenbruch 2001; Smith, et al. 2006; Wallace 1996). Although literature exists on managing diversity in the US, there has been less development in this area in health organisations in Australia. There is no national approach to integrating overseas trained doctors into the Australian health care system, or assisting them to communicate with patients and health workers (McGrath 2004). There is also a lack of policy development on the use of language by bilingual staff (Whelan (Klinken), et al. 2000b). The interviews indicated diversity was not actively promoted in the hospitals beyond managers and staff mentioning the benefits of language support, and staff from CALD backgrounds providing cultural information. A dominant western health care model
pervaded and several staff from CALD backgrounds stated they did not want to discuss their cultural backgrounds with other staff members.

The literature from the United States discusses the need for policies and for staff to have the skills to work with staff and patients from CALD backgrounds, so the organisation can perform better (Weech-Maldonado, et al. 2002). In consideration of the benefits of a diverse workforce, it promotes implantation of an organisational culture valuing diversity and diverse staff. Cox (1993: 11) defines managing diversity as “planning and implementing organizational systems and practices to manage people so that the potential advantages of diversity are maximized while its potential disadvantages are minimized”. Prasad and Mills (1997) argue managing diversity is also about changing the organisational cultures to ensure an acceptance of diversity. This literature reports that positively acknowledging the diversity of staff has an impact on the way staff in turn work with diversity amongst their clientele (Weech-Maldonado, et al. 2002; Whelan, et al. 2005a) and thereby improve organisational performance. While some management studies assume that managers can simply change workplace culture to promote diversity (Haber and Ashkanasky 1998; Learmonth and Harding 2006), other literature acknowledges that to create culture change structural support is needed (Bloor 1999; Hudelson 2004).

There has been a lack of research on diversity management in health care, as well as on diversity management programs in operation in health organisations (Dreachslin, et al. 2004; Klinken Whelan, et al. 2008; Weech-Maldonado, et al. 2002). Weech-Maldonado et al. (2002) state that diversity management in health care is a way to achieve culturally appropriate or accessible care and involves more than just meeting EEO principles. Dreachslin (1999: 111) has developed a range of performance indicators to
promote diversity leadership, based not just on human resources but also ‘healthcare delivery issues’ with patients. These measures are similar to the NSW CRC’s Multicultural Planning Framework (NSW Government 2009a) as discussed in Chapter 3, with more emphasis on supporting culturally diverse staff. Performance indicators include Planning (and assessment of programs); Stakeholder Satisfaction (including staff evaluation surveys); Organisational Development (including training for all staff on working with a diverse workforce and clientele); Human Resources (including mentoring and support for staff from minority backgrounds); Health Care Delivery (ensuring that services are culturally appropriate and accessible); and Progressiveness (including rewarding change agents involved in cultural diversity initiatives, and mentoring staff to become change agents).

The concept of ‘managing diversity’ is similar to the Australian policy of ‘productive diversity’ which has been in existence since the early 1990s and refers to the “cultural, social and economic dividends arising from the diversity of the population” (Commonwealth of Australia 2003: 6). Diversity management has a longer history in the US than Australia, and is used extensively in business (Bertone, et al. 1998). While the Australian cultural competency guidelines make reference to the need for diversity management (Australian Government 2005: 35), there is no requirement that health managers follow these guidelines. Hage (1998) has critiqued the notion of utilizing staff diversity where there is little support or concrete ideas of how productive diversity would be conceived. Hage (1998) states there is excessive emphasis on people from diverse backgrounds being ‘managed objects’. This critique highlights the need for more support and recognition for staff of diverse backgrounds, especially in light of the positive contribution they can make in enhancing service delivery.
I will now discuss some of the difficulties diverse staff faced in communicating with families and other staff, in becoming familiar with children’s health care and in relating cross-culturally with other staff. I then discuss how some staff from CALD backgrounds did not find it empowering to discuss their cultural backgrounds and skills. The interviews indicated there was a lack of policies and guidelines, both at hospital and national level, to assist managers to address these concerns. In particular there was a lack of support for overseas trained staff with English language skills, with understanding the Australian health care system and with adjusting to a new country (McGrath 2004). These were areas that managers said could be managed better.

4.4.1 Assistance with staff communication skills

Managers and staff outlined that poor communication skills of staff was one of the impacts of a culturally diverse workforce, especially of overseas trained staff. McGrath (2004) recognises that this is an area that needs development. In particular, overseas trained staff needed assistance with English language skills, Australian vernacular, children’s health language and having a social forum in which to practise their language skills.

In the context of the hospital, where staff are trying to explain illnesses to patients, language skills are very important. The very busy environment that usually exists in hospitals was not conducive to staff trying patiently to understand what someone is saying. Communication could affect patient safety (McGrath 2004), especially when staff and family are from different non-English speaking backgrounds. A senior medical manager who had been in hospital with their son explained the communication problems:
I suddenly realised that you’ve got to have really good language skills to work with a child and a family, and if you’ve got somebody who doesn’t speak English well, speaking to a family whose first language isn’t English, then you’ve got a major issue … So I was very concerned. (Jo, executive member, M17)

Occasionally imperfect understanding of the Australian vernacular by overseas trained staff affected how they communicated with each other and with families. These staff needed assistance talking with children about health issues. As explained by a medical manager:

We see the problem of integrating these people for whom Australia is not their culture … and certainly English is not their first language. In order to get a position here again … they have to pass a certain English test. But it’s very different when you’re actually dealing with vernacular Australian, distressed parents, talking about “kiddy” things. Nobody learns “kiddy” Australian, they don’t learn “kiddy” French and words for the “poo” and “wees” … (Robin, medical manager, M13)

It is difficult for these language skills to be enhanced when overseas trained staff do not feel comfortable integrating with other staff and being confident to use the language. As explained by a nursing manager:

If their English is less than pretty bloody good, it’s extremely difficult for them … to interact with the other staff, because I think you are isolated if you haven’t got the language and the vernacular right … there will be almost subgroups of teams and groups that are culturally the same because they’re not comfortable with their language in an urgent situation or in a rapid conversation … I know there are people
who, for example, have walked out of a clinical handover and not understood anything and then gone on to work … But it’s very difficult to tell someone you haven’t understood that. Not from the fact that you can’t understand it from an intellectual point of view, [but] you haven’t understood the conversation … it’s a risk we’re not managing well. (Frances, nursing manager, M10)

This quote shows the difficulty staff from culturally diverse backgrounds have in understanding each other, not because they do not have good English skills, but because their English vernacular at clinical handover is not the same as staff who have grown up in Australia. This manager also discussed the difficulty of telling a professional staff member that their English skills are not acceptable. This discussion needs to happen in a sensitive way. Overseas managing diversity literature for health organisations encourages the provision of English language classes to staff (Whelan, et al. 2005b). Research overseas has also highlighted the need for overseas trained nurses to have training in the language of nursing (Eisenbruch 2001).

There is also a tendency for recent migrants to group together, which means they may not be practising their English skills. Dreachslin (1999) has highlighted the ability of staff to work with other staff from different backgrounds as a performance indicator for managing diversity. Staff socially grouping together according to background may have adverse clinical implications in the context of the hospital, where staff have to be able to relate to peoples of different backgrounds.
4.4.2 Unfamiliarity with Australian children’s health care culture

Managers outlined the difficulty that overseas trained staff had in adjusting to working in children’s health care where families are more involved in treatment. Medical managers also stated some were used to more hierarchical relationships between doctors and nurses, and men and women. The adjustment of overseas staff to the health care system is an area that needs to be addressed institutionally and nationally (Eisenbruch 2001; McGrath 2004). Several staff from CHW recommended that the hospital should provide more assistance to overseas staff in adjusting to a new country.

Medical managers from both hospitals discussed how some overseas trained staff were unfamiliar with the notion of family-centred care where parents and carers are actively involved in treatment decisions and care (American Academy of Pediatrics 2003). A medical manager stated:

The cultural things of how … patients see medical staff … particularly involving the parents in decision-making, is something that isn’t the cultural norm in, a lot of other cultures …

You have a medical or nursing person who comes from a background in which that isn’t the norm, to talk to the families and tell them what’s happening, [they’d] just say, this is what’s going to happen, rather than discuss the options … we’ve identified, that that’s one of our problems with medical staff, … one of our senior medical staff, having helped a few overseas trainee doctors with this, is trying, with them, to put together a list of things they learnt, basically a bit of a cheat sheet. (Robin, medical manager, M13)
The implication of not assisting overseas trained staff with their transition to children’s health care in Australia is that it can affect patient care. For example, an overseas trained staff member’s alleged insensitivity to parents led to a complaint as explained by a medical manager:

Sometimes parents will come into the Emergency Department and they’re very stressed, with a sick kid, and a doctor from India will see them and will miss the sensitivity that we display in Australia towards children and their parents, and will come across as rude or uncaring, and that will lead to a complaint. (Claude, medical manager, M1)

Staff from a range of departments and professions commented on the differing cultural practices of staff from CALD backgrounds in comparison to the dominant culture in the hospital:

I think people from different cultures, like doctors, struggle because of the predominant culture here within our hospital, so the way we practise is probably very different for them … and I think there is - I wouldn’t call it a tension, but I think there is difference and sometimes there needs to be some understanding about how things are done differently. (Kim, social worker, S7)

Some overseas trained staff were not familiar with the specifics of health care in Australia and the social relationship between health professionals. Medical managers from both hospitals recognised that some overseas trained doctors were not used to having egalitarian relationships with nurses and other staff. As outlined by the medical managers:
... things that have potentially caused conflict in the past ... is where you come from a more hierarchical system, both hierarchical in the medical system but also the nurses and allied health workers are well below you, and therefore not treated well, or administrative staff and things. (Leigh, medical manager, M6)

The doctor’s expectations were related to the position of women overseas. This demonstrates how the broader social and political environment in relation to the position of women in other countries and Australia is reflected in staff practice:

We got negative feedback from the nursing staff because those medical staff didn’t perceive how it would be that they’d develop a relationship with the nursing staff. (Robin, medical manager, M13)

Every now and then you will get a male-female, the interaction is poor because some people come from a culture where it’s a paternalistic society, a male-dominant society where they don’t treat women so well. (Leigh, medical manager, M6)

Medical, nursing and human resource managers at CHW maintained there could be better orientation for overseas staff. For example, a nursing manager from CHW stated there was inconsistency in the ethos of the hospital, which is supposed to appreciate overseas trained staff but does not have the proper mechanisms in place to support them:

What was very interesting to see overseas was that ... they’ve started to develop cultural orientation programs about how to adapt to that change ... and we’ve not necessarily done that. Yes, I can see that we have cultural diversity, we look for cultural diversity in our
employees, but we don’t necessarily put the right processes around that. (Pat, nursing manager, M12)

Assistance for staff is devolved to the departments and professions rather than provided on an institutional basis. These findings reflect the lack of current national policy and practice to assist overseas trained staff (McGarth 2004). As explained by a human resource manager:

What we could do is improve the way we look after our overseas staff in terms of socialising them into the hospital community, and the community at large ... It actually falls between the gaps. So I think it is a shared responsibility. At the end of the day, the responsibilities for employees rest with the manager where they work. Our job is to facilitate and support the managers in doing that functional job ... And part of it for overseas nurses, is the transition into Australia, and our culture, and that is something that we don’t do particularly well ... We have formal orientation but not targeted at people from overseas ... (Ashton, human resource manager, M16)

At SCH there is a program where nurses are recruited from Ireland and assistance is given to them in settling into Australia. Overseas trained doctors are also specifically targeted for support:

At orientation we talk a lot [about] the needs of children ... There’s also a specific program for overseas doctors; we spend a lot more time with them. Our handbook’s developed so that they can be aware of the policies and procedure of the Hospital, so we do target that group more specifically. (Claude, medical manager, M1)
4.4.3 Cross-cultural staff relations

The existence of discrimination in organisations is noted (Trenggry, et al. 2010). For instance, studies in Australia (Omeri 2006), the UK (Smith, et al. 2006; Ward 1993) and Canada (Turrattin, et al. 2002) indicate that overseas trained nurses have perceived discrimination from other staff. For overseas trained doctors in Australia, there is a history of distrust and strict entry requirements (Garrett and Lin 1990; Kamien 2007). International diversity management literature acknowledges this concern and promotes staff training in working together, as well as with patients (Dreachslin 1999).

While NSW policy promotes cross-cultural training for staff, it is ‘mainly for client contact’ (CRC 2007) rather than in how staff work together.

While managers and staff spoke of the benefits of having a diverse workforce, the existence of inter-staff cross-cultural tensions demonstrated there was insufficient assistance given to staff from CALD backgrounds. The hospitals in this study lacked any mechanism to assess cross-cultural staff relations other than the complaint process. There was also a lack of active promotion of diversity in the hospital. At the same time, some staff from CALD backgrounds spoke about wanting to adapt to the dominant culture in the hospital rather than expressing their difference.

Insensitivity and intolerance

The interviews with managers and staff revealed insensitivity among staff in relation to cross-cultural issues. Insensitivity was also reflected in complaints where staff from CALD backgrounds have felt discriminated against by other staff. A manager explained the nature of some of these complaints:
They are generally staff to staff: “So and so acted, behaved this way to me, and I didn’t like it, it’s because I’m Indian, Malaysian”, … and things such as people feeling they are treated less favourably because of their race. There is not a huge amount of those, but generally speaking the more complex ones come to us, and the majority of issues would be dealt [with] at the managerial or department level. (Ashton, human resource manager, M16)

This quote suggests how complaints were generally managed at a departmental level, rather than a whole organisational level. This insensitivity of some staff towards others may explain why some overseas trained staff were grouping together:

There are elements of racism within the Hospital, and I think people get very frustrated that people can’t speak English. (Ally, nurse unit manager, S11)

Some staff not only made comments about the cultural differences of overseas trained staff, but also about their different physical appearance. For example, a staff member explained that a nurse called an overseas trained doctor a ‘blackfella’. Although the nurse made this comment in a playful way, the doctor who was victim of this racial identification did not appreciate it. A physiotherapist explained:

One of the nurses said, “They’re waiting to see the blackfella,” and thought that that would be taken as a joke, because we’re very jokey in the back room, but she crossed the line with that one … He’s a very funny man but he did not appreciate that comment. He said, [spoken in an Indian accent], “Do not use that. That’s over the top.” (Adan, physiotherapist, S20)
It was not only staff from Anglo backgrounds who appear to be intolerant of cultural diversity. A senior nurse discussed how staff from migrant backgrounds appear to be sometimes intolerant of other parenting styles:

Some of my staff who are from different ethnic backgrounds, in fact, are the ones who cannot tolerate behaviour in other ethnicities. I’ve got a nurse from China and she is very intolerant of any sort of behaviours, and culturally I believe that’s the way she lives her life. In fact, her child had an appendectomy on this very ward and the girls said that she had him up and out of bed, no sympathy and no understanding … I think that probably my Anglo-Saxon staff, for want of a better expression, are more tolerant and more open. (Ally, senior nurse, S11)

This apparent intolerance highlights that all staff, including overseas trained staff, need cross-cultural training as proposed in the managing diversity literature for health organisations (Weech-Maldonado, et al. 2002). Intolerance is not limited to mainstream Australians, nor is it an intrinsic ‘cultural’ trait necessarily. The concept of relational positioning tries to move beyond the white/other impasse which is ethnocentric and does not acknowledge the nature of global relations where there may be discrimination from people from CALD backgrounds. As described by Friedman (1998: 45):

… the processes of racial and ethnic othering are a worldwide phenomenon, not the exclusive product of Caucasians or the West in dealings with people of color.

The option of training staff to work effectively with each other was not discussed specifically by staff or managers in this study. The importance of this is mentioned in Dreachlin (1999) and in research conducted at SCH
Cope and Kalantzis (1997) argue the promotion of diversity amongst staff has a positive impact on clients, and could mean a positive impact on patients from diverse backgrounds.

A human resource manager stated there could be better feedback services in relation to cross-cultural issues:

I think that is an area we don’t do particularly well. I think most of our policies and procedures and structures are sound if people access them. The question would be whether people from different cultures feel that those systems and processes are accessible to them and they use them. My experience is that they do. So, whether that is true across every ethnic group, I can’t comment. But certainly people don’t seem to be shy about using the structures of complaint, or grievances, or avenues to express themselves to get support … (Ashton, human resource manager, M16)

Should overseas trained staff have more assistance than just in terms of complaints procedures? This person also mentioned that there are not enough feedback mechanisms for staff:

We don’t have a staff survey, a whole of hospital staff survey. We have looked at it a couple of times but it is very costly. So the first thing is we don’t have a mechanism to pick up staff feedback around that point. We do run a lot of individual targeted based surveys but we haven’t done one around cultural diversity. (Ashton, human resource manager, M16).

A staff survey did also not exist at SCH (Whelan, et al. 2005b). EEO Policy states there should be a staff survey in relation to discrimination (NSW
Government 2009b), as reported in the diversity management literature (Dreachslin 1999; Weech-Maldonado, et al. 2002). A report at SCH also highlighted that there was not a mechanism to evaluate employee satisfaction according to ‘ethnic group’ (Whelan, et al. 2005b). In 2008 the situation improved when the review into NSW hospitals recommended that there be staff surveys to improve the safety and quality of health care (NSW Government 2008a; NSW Health 2009). These surveys do not assess cross-cultural relations, nor are the results analysed according to the background of staff.

*Diversity not actively promoted in the organisation*

While the majority of the managers mentioned it was positive to have a culturally diverse workforce, there were some tensions. The productive diversity and managing diversity literature promotes an organisational culture where staff see diversity as a positive (Cope and Kalantzis 1997; Dreacshlin, et al. 2004). However, having a diverse workforce does not necessarily mean that diversity is actively promoted, as the dominant culture in the organisation still exists (Fong and Gibbs 1995). As explained by a dietician, despite the cultural diversity of staff and patients, “the white Aussie culture dominates” in the hospital (Casey, dietician, SI4). Fong and Gibbs (1995: 2) state that “an agency which serves ethnically diverse groups also needs to evaluate its own organisational cultural framework, i.e., its assumptions and values, its staff dynamics, its organisational processes and procedures, its behavioural norms, and its mode of dealing with culturally diverse clients”. Having a dominant culture in the organisation does not mean that diversity can not be promoted. It could mean making changes in the organisation to make the dominant culture inclusive of ‘diversity’ in terms of different views of staff, ways of working, beliefs and behaviours.
This could involve the agency “integrating divergent forms of input from all parts of the community and within the organisation itself” and where staff “participate fully in decision-making, program planning and service delivery” (Fong and Gibbs 1995: 17).

A nursing manager stated the organisation could do more to promote the religious holidays of staff from CALD backgrounds:

We have a poor balance for representing the cultural events of different groups. We have this big focus, especially around kids, at Christmas, and we have very little representation of other groups’ holidays and events of note, … we have a huge Indian component of staff, and around the time of Ramadan we’ll have the afternoon teas on the ward and the party or whatever, and they’re not eating or participating, and people aren’t sensitive to the, “Oh, let’s just take something out for whoever,” because they haven’t come in, because they haven’t [understood] that they don’t want to be faced with food because they’re not supposed to eat it! So there can be some insensitivity just through lack of understanding, and I think we all have room to grow. (Frances, nursing manager, M10)

Promotion of diverse religious events was one of the requirements outlined in the US managing diversity literature for health organisations to promote stakeholder satisfaction (Weech-Maldonado, et al. 2002). In the example above, staff forgot to consider the diverse beliefs of staff from Muslim backgrounds because of the dominant Anglo culture in the hospital.

A social worker’s comments highlight the dominant culture as well as how cultural difference is not tolerated if it is over promoted:
I don’t know how much [cultural differences are] tolerated. I think if people are very overassertive or get too precious about their cultural difference or get too defensive … We’ve got one psychiatrist here who’s Jewish and he gets very obsessional. Like, before Christmas he ran around going, “Why have we got a Christmas tree? We should have a menorah” … The trouble is there’s sometimes an expectation that we will understand all of that. (Kerry, social worker, S8)

The psychiatrist’s religious beliefs may need expression in an appropriate forum through management support so they are not resented by other staff.

Interviews with some staff from migrant backgrounds revealed they did not feel their background was empowering or their experience was important in health care. For these reasons, it seems the tension shown towards staff from migrant backgrounds had an influence on how these staff in turn tried to adjust to the dominant culture in the hospital. Theories discuss how identities can be constituted around how they are represented by others (Hall 1996: 4). As there were negative perceptions of cultural difference, those staff from immigrant backgrounds seemed to want to try to fit into the mainstream dominant culture in the hospital.

A dietician from New Zealand explained that adjusting to the dominant culture was necessary:

You put your head down and you just become very alert to what the social mores are, and you adjust. And you don’t want to make a goof of yourself so you play your cards very carefully, and then as you become more confident and more at home then you show who you are and you laugh at various jokes … I was taking a diet history of a kid with cystic fibrosis and I wanted to ask about fish and chips and I said “fush and
chups” and they hooted and fell off the chair! So the next time you say it, you say “fish and chips” and you notice that they don’t blink so you think, right. I’ve got it right. Because you don’t want to be having your professional work constantly interrupted by the cultural differences … You adapt. And you learn how to do it … (Casey, dietician, S4)

A domestic services staff member from China felt that the way she worked, which was quicker than most other domestic staff, was viewed negatively in the culture of the department:

Sometimes I think it’s not useful. For example, in my country I worked hard, but sometimes I feel I don’t fit into this culture. I think maybe people are against you if you work hard or work quickly … I think maybe we bring a different culture but you can’t see it … Because in China it’s a harder place, a harder situation, everybody since they’re young is aware of competition … (Ming, food service assistant, S22)

Management may perceive working hard as a positive value of this staff member’s background and experience, but it was not positive for her.

This staff member said she did not fully identify with other staff members originally from China, who she perceived to be more traditional. She wanted to try to adapt to the dominant ‘Aussie’ culture in the hospital. Nevertheless, she would identify with people of Chinese origin if a problem arose:

When people treat me unfairly, if I back the Asian people, the Chinese people, I have more support! … But if I feel confident, I don’t need it … Sometimes we need them. Especially when people don’t think we can join the Aussies, we still need [to go] back to them. The Chinese think, oh, you’re not a good Chinese, you want to live somewhere far away,
you want to become Aussie! I know I can’t be, I just try … I’m in the middle, sometimes here, sometimes there. (Ming, food service assistant, S22)

This staff member says she tries to become Australian but she believes she can not. This complexity demonstrates a hybrid potential in people’s identity: she does not feel completely Australian or Chinese, but chooses to affiliate with one or the other ethnicity according to when she feels disenfranchised. This understanding encapsulates Bhabha’s (1992) theory of hybridity as a “third space”, as living between two spaces “without allegiance to any” (Kraidy 1999: 464).

A nurse from Zimbabwe spoke about how she had to adapt to the different health system in Australia:

Because we’ve got a different culture … we talk differently and the way we do things, a different way in perspectives, like the way we think about illness. So, when you come into a different environment altogether, it’s something challenging. You really have to put in a lot of energy and effort just to understand other people, because here things are a bit different from our own country. (Taku, nurse, S19)

In the interview Taku explained that one of the differences between Australia and Zimbabwe is that families do not appear to respect health professionals. When I asked her if she has spoken to other staff about these differences she said:

No. To me, it wasn’t that important to talk to anybody about, it was important for me to get used to the new environment because I’m the one who’s come here … I had to get used to it. I had to get used to
patients and their visitors harassing staff. It’s normal here. (Taku, nurse, S19)

Taku could have used the knowledge of how patients from different countries treat health professionals to inform other staff how some patients from similar health systems may be reluctant to ask questions because of the perceived higher status of health professionals. In this case, however, recognition of cultural difference was not empowering and did not lead to more productive diversity.

These examples demonstrate that although there were staff from diverse backgrounds who brought different strengths in terms of knowledge and skills in working with diversity, several did not find this knowledge and experience empowering or useful. The dominant culture in society was reflected in the organizational and professional culture, therefore CALD staff have to adjust (Taylor 2003).

4.5 Conclusion

This chapter analysed manager and staff understandings of the role of culturally diverse staff in assisting patients from CALD backgrounds, and the organisational support given to staff in this role. The interviews suggest the model of ethnic concordance, of trying to match the ethnicity of a health provider to a patient, is based on a homogenising understanding of culture and ethnicity, overshadowing the heterogeneity of experience of the people involved and the quality of care provided. However, the ethnicity of staff did not have to match the ethnicity of patients for staff to use their knowledge, experience and skills to assist families. Staff from CALD backgrounds could identify with patients through shared experiences of migration or being from a non-dominant background. As in Friedman’s (1998) ‘relational
positioning’, they could relate to each other based on more than just one form of oppression or alterity, depending on the situation. This practice is a move towards ‘productive diversity’, where staff use different skills and experiences to relate better to their clientele. If staff are culturally competent working with a range of patients and recognise when there is a risk that patients may be disadvantaged in relation to dominant cultural institutional values and practices, their ethnicity does not have to be matched exactly with patients in order to provide effective health care.

While many managers recognised the need for the hospital to have better diversity management, in practice the interviews with both managers and staff revealed the situation was lacking and could have implications for patient safety. There was no overall organisational direction for “capitalising on the benefits of diversity and minimising workplace challenges” (Australian Government 2005: 8). This supports the identified need in medical and nursing literature for more policy and guideline development in managing diversity at national and organisational levels, specifically with supporting overseas trained staff to be inducted into hospitals. Without adequate policy, the hospital developed a culture of using overseas and bilingual staff inappropriately, and giving them inadequate respect and support. This lack of promotion of diversity was evidenced by some staff from CALD backgrounds saying they did not want to reveal their different views and experiences. Their silence suggested that their ethnic identity was not empowering for them. This points to the negative impact of the dominant culture in the hospital on staff from CALD backgrounds.
5. Caring for culturally diverse families

The Resident had trouble getting blood from a patient … and people started – nursing staff and everyone, having preconceptions because they were Middle Eastern or whatever, but the parents were very angry and didn’t want that doctor to ever treat their child again. We were just taking bloods, which is a standard thing, and veins can be quite difficult in children. So it can be difficult, and a bit awful when the nursing staff start ganging up against that family … “Oh, that’s that family, they’re the troublemakers of the ward.”… “They’re from that background, that’s why they’re like that”. (Lee, fellow – trainee consultant, S10)

Lee, who is from a Taiwanese-Chinese background, describes a complex cultural situation that arose around a standard procedure of taking blood from a child. In this tense situation the nursing staff attributed the family’s apparent aggressive behaviour to ethnicity, rather than to the junior doctor’s lack of experience or other factors.

The nursing staff comments reflect a reductive and linear way of thinking characteristic of medical settings (Sweeney 2006). The nurses reinforce a stereotype about people from Middle Eastern backgrounds being antagonistic (Poynting, et al. 2004), and defend both the health team and their own professionalism. The staff associate the cultural background of the ‘Middle Eastern’ family with being a problem. In contrast, the doctor later explained that when a similar situation occurs with an “Anglo family that were problematic as well”, the nursing staff did not categorise their responses according to ethnicity or to preconceived collective characteristics. Here, staff associate cultural difference with being negative in comparison to
the dominant norm (Gannon and Davies 2005). This demonstrates how the dominant values in society can be institutionalised in hospitals.

This scenario illustrates how hospitals are not closed structures (Clegg 1990), but are affected by powerful outside forces. In high-pressure hospital environments constrained by time and resources, staff draw on a range of discourses such as treating people the same, essentialising and seeing difference as a problem when working with unpredictable cross-cultural situations. The ‘everyday’ experiences of people are influenced by a range of social and political factors (Bennett and Watson 2002; Kemmis 2009). For hospital workers, these factors include their professional training and affiliations, their department and management, dominant cultural values in Australia, the media and social circles, as well as more formal constraints such as national, state and hospital policies and procedures.

This chapter explores the capacity of staff to negotiate difference when working with families from CALD backgrounds. It highlights the impact on staff practice of dominant values in society, systemic constraints, organisational and professional cultures and individual factors. Policies and guidelines which require staff to provide culturally appropriate services (CRC and NSW Government 2009; NSW Health 2005b) do not address the impact of professional and organisational cultures on health care provision (Hong 2001; Kagawa-Singer and Kassim-Lakha 2003; Taylor 2003; Wear 2003) which can reinforce inequities in care (Gustafson 2005). Nor do they have much to say about daily practice in the hospital, where different categories of staff face different challenges in the care of patients and their families.
I will first detail some of the systemic constraints placed on staff to meet the needs of patients from CALD backgrounds, then discuss how cultural competence depends on there being a capacity in the health system to negotiate difference (Australian Government 2005). The next section examines the influence of the dominant organisational culture of biomedicine which was apparent in acute care. In areas such as emergency and intensive care units, medical staff emphasised treating people the same regardless of background. This approach emphasises the similarities between all people, but depoliticises difference (Frankenburg 1993; Gustafson 2005), so when difference does become apparent, staff often see it as a problem. In nursing, the influence of liberalism was reflected in staff focusing on interpersonal relationships, not structural factors. There were occasions when nursing staff recognised cultural difference in a negative way and this seemed to be related to the call on extra resources and the lack of systemic support. The negative impact of these professional cultures of medicine and nursing on providing culturally competent care meant medical and nursing staff depended on allied health staff such as social workers to engage with the culturally different needs of families.

In general, there were different degrees of engaging with difference, from acquiescence to actively negotiating the professional, organisational and systemic issues which led to a redistribution of resources. When difference was recognised on the wards, it was usually essentialised as a starting point for negotiations. The last section examines how allied health staff had to reconcile the cultural rights of parents with the individual rights of the child, other family members, or other patients on the ward. Applying the principles of ‘intercultural dialogue’ (UNESCO 2009) is useful for understanding how this process occurred.
5.1 Complexity of staff practice in working with cultural difference

With the changes in the professions and in the health care system, staff need increased skills negotiating the constraints and the impact of the culture of health care. I will briefly reassess the nature of the changes and constraints facing health professionals which affect their capacity to work with cultural diversity.

When treating a child, staff work in multi-disciplinary teams of professionals, the main health care workers being doctors, nurses and allied health staff such as occupational therapists, physiotherapists and social workers. Within the professions there are also hierarchies. For example with doctors, there are different levels of seniority from the Consultant at the top, to the Resident at the bottom (CHW 2005). There are also different levels of seniority and responsibility in the nursing team from the Nurse Unit Manager to the enrolled nurse. Each multi-disciplinary health team will be slightly different, depending on the health needs of the child they are treating (CHW 2005). While staff are affiliated with their respective professions, they also spend a lot of time in specialised wards such as emergency, intensive care, burns and brain injury. There are also specialist areas where children can be referred for a consultation (outpatients), but not necessarily to stay in the hospital, including child protection, adolescent health and physiotherapy.

5.1.1 Capacity for cultural competence

Cultural competence is dependent on a range of factors that enable staff to work effectively in cross-cultural situations:
Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (NCCC 2004b).

This definition underlines the need for policies and practices that support systems, agencies and professions to work competently with cultural diversity. Staff need the capacity to act competently. However, in the course of this research, it became clear that in the hospitals being examined, staff had to negotiate a lack of systemic support, organisational and professional cultures and personal views.

Systemic constraints

The NHMRC characterises systemic support as the “effective policies and procedures, mechanisms for monitoring and sufficient resources [which] are fundamental to fostering culturally competent behaviour and practice at other levels” (Australian Government 2005: 30). As demonstrated in Chapters 3 and 4, processes are lacking to identify inequities in care, and moreover proper processes are not in place to assist staff in terms of training and resources. Nor are enough workers being trained in complex cross-cultural issues.

Change in health professions and the capacity to work with difference

A ‘profession’ is defined as an occupational group holding self regulated specialised knowledge for the common good (Abbot 1988; Cruess, et al. 2002; Southon and Braithwaite 1998). Professions have faced increased complexity and uncertainty when working with clients in the past few decades (Schon 1991). Health professions such as medicine which are based on positivism
(Schon 1991; Sweeney 2006) face complexity with the growing inequities in health (NSW Health 2004; WHO 1998), an ageing population, higher rates of chronic disease (Australian Government 2009), and the rising cost and complexity of medical technology (Vissers 2002). While staff are trained to assess the physical health of patients, mounting evidence shows that social determinants of health and the nature of service provision can have a major impact on health outcomes (Harris, et al. 2001; IOM 2002; WHO 1998).

Health care professions face challenges through increased pressures from the State and management. There has been a continual process of health reform, especially in hospitals, aimed at increasing efficiency and accountability which has placed pressures on the professions to meet certain standards (Freidson 1970a; Southon and Braithwaite 1998). The pressures on management were evident in the last two chapters of this thesis. There has been a loss of confidence in the medical profession by the general public because of criticisms of doctors’ self interest (Freidson 1970a), the increased reporting of medical errors, and the rise of the consumer movement questioning medical expertise. These changes have created a shift in the nature of professionalism. For example in medicine, traditionally there was a strong relationship between the doctor and patient (Ham and Alberti 2002), with doctors given power and prestige because of their scientific knowledge. This professional power has been reduced as doctors are controlled more by management and government, as well as having to be more accountable to the patient (Cruess et al. 2002; Southon and Braithwaite 1998). Nurses have also felt the pressure to improve efficiency but there is less time to spend with patients (Bjornsdottir 1998).

All health staff have to deal with increased accountability and efficiency demands such as patients being seen within a certain time. In NSW Health
there are fewer resources due to under-staffing and decreased funding (NSW Government 2008a). With the pressures of health reform, it is difficult for staff to have the capacity to meet the needs of all patients (Southon and Braithwaite 1998). When the family is from a CALD background there is increased uncertainty and complexity around management and treatment decisions if the views or behaviours of family members are different from those favoured by various health professionals. In the current round of health reform, there has been insufficient attention given to CALD patients (Migliorino 2010; Morris 2010).

**Impact of dominant organisational and professional cultures**

The dominant approach by medicine to working with patients is characterised as being reductive and linear, and focused on the physical body of the patient. This understanding does not reflect the complexity of patient’s lives (Sweeney 2006). In nursing the focus is on the well-being of the individual patient, not on systems of disadvantage (Gustafson 2005). As stated in Chapter 2, the Cross Cultural Health Care Program (1999: 1) in the US encourages health professionals to reflect on their professional culture in its definition of cultural competence. This means:

… recognizing the culture-based practices and dictates of organized medicine, and the values, expectations, and experiences of the providers who practice it. Culturally competent care becomes possible only with the skillful management of the interplay between these elements which make up a medical encounter, and determine the points of access or barrier at the institutional level.

Health professionals have to negotiate not only the cultures of biomedicine with the needs of patients, but also their values around parenting which are
based on an ”Anglo-Celtic middle-class family structure” as the norm (Chalmers and Rosso-Buckton 2008: 52). Reflection on these values has not readily been adopted by health professions, and has rather been on the periphery of debate (Hong 2001). This tendency was evidenced in the last chapters. A review of cross-cultural training in Australia also demonstrates that this self reflective emphasis has not been embraced (Bean 2006; Eisenbruch 2001). The focus has rather been on just understanding the culture of clients or on interpersonal relations (Culley 2000).

Provider bias

A health professional’s own personal values may also affect working with cultural diversity. Research has “found evidence that stereotyping, biases and uncertainty on the part of the healthcare provider can all contribute to unequal treatment” (Institute of Medicine 2003: 1). However, professions, by definition, are supposed to be impartial in their appraisal of a client (Cruess, et al. 2002; Freidson 1970a; Southon and Braithwaite 1998). This discrepancy demonstrates the impact of broader views held in society about people from CALD backgrounds.

Approaches to addressing bias range from educational strategies to changes in policy (Institute of Medicine 2003). Critical nursing and medical theorists have critiqued the approach of focusing primarily on individual provider bias as ignoring the link between individual views and institutional values (Culley 1996; Wear 2003). As stated by Gustafson (2005: 8):

Individual prejudice, bias, and discrimination stand in for, and obscure attention to, racism and other forms of oppression, exclusion, and marginalisation. Isolated from the institutional relations that make them explicit, racist, homophobic, and sexist ideology and
action become treatable like a disease with educational programs and consciousness-raising proffered as treatments for individuals who demonstrate aberrant behaviors.

This points to the need to link personal bias to the impact of organisational cultures, and more broadly to Australian multicultural policies and practices. So reflective practice, in order to be effective, needs to go beyond the impact of individual behaviour to the impact of more systemic structures. Adequate resources must also be available to permit staff to act on this awareness.

5.1.2 Team based approaches

One of the constraints that acute care health staff face in meeting the needs of patients and families is the extent to which they are dependent on allied health staff such as social workers to assist them. Multidisciplinary team based approaches to providing patient focused health care have been recommended in reviews of the NSW health system (NSW Government 2008a) and are now part of policy (NSW Health 2009). Literature on multidisciplinary health teams addresses the benefits of health professionals working together, rather than alone (ABC Radio National 2005b; Cott 1998; Opie 1997). This is beneficial providing that members of the team have solid understandings of their respective roles, can integrate their skills to enhance positive outcomes, and have egalitarian relations with each other. However, research demonstrates that these conditions do not always exist (Cott 1998:851). Some of the major obstacles are professional hierarchies and divisions that occur within teams.

This study highlights the need to provide medical and nursing staff with more support and professional skills so they have the capacity to work with difference, rather than just relying on allied health staff. All staff need a skill
set of cultural competence (Australian Government 2005). While there is benefit in allied health workers assisting other staff in a team, some of the implications of nursing and medical practice (as shown in this chapter) are that difference may be recognised negatively which may result in inequities in care for some families. This study demonstrated that social workers were often called in when medical and nursing staff perceived a ‘problem’ with the behaviour of families.

Social workers also need adequate resources to do their jobs properly. To provide extra resources may be difficult considering allied health staff have lower status in health care decisions compared to that enjoyed by the medical profession (Giles, et al. 2007; Keigher 1997), as well as the overall lack of resources in the current health care system.

5.1.3 Bridging ‘health’ and ‘cultural’ needs

In both hospitals there were cases where medical staff saw a tension between the children’s right to health care and their parents’ rights to express their cultural identity. This framing was influenced by staff seeing children as culture free, while their parents asserted ‘cultural’ needs. These views raise broader issues of how respecting the culturally diverse views of some people may violate the human rights of others (Shweder, et al. 2002). In the case of the hospitals, staff felt that by respecting the rights of the parent/s to culturally diverse views they were acting in opposition to the human rights of the child or other patients, and in some cases of the mother of the sick child. The allied health staff had to use a range of skills to accommodate these tensions, within the constraints of the hospital. They had to ensure that the right of the child to appropriate health care was not compromised by the right of the parent/s to express their cultural difference.
In the following sections are examples of the ways that staff spoke about working with families from CALD backgrounds. The staff’s professional and departmental affiliations were strongly reflected in the discourses that they used to describe working with diversity. There was also overlap in the themes between professions and departments, as each staff member often held multiple, and sometimes contradictory views.

5.2 Dominant cultural frameworks and recognising cultural diversity

I think [cultural differences] sometimes get recognised but they sometimes get pushed to the back of everything. (Jessie, nurse in the wards, S17)

It’s more about being aware of what those things are, and maybe reminding yourself to ask, and sometimes that’s easy to overlook. (Jamie, doctor, child protection, S3)

These statements from a doctor and a nurse show how difficult it was for staff to recognise cultural difference in the context of the dominant culture and values in the hospital, and in circumstances where staff were so busy. In general, staff approached families in a non-discriminatory way, in a context where mainstream Australian practices were the norm and biomedical cultural assumptions pervaded negotiations. Staff tried to accommodate cultural differences when they became apparent. Respecting cultural difference was conditional on the health of the child not being detrimentally affected and resources being available. Staff had a sensitivity to the practices of major ethnic groups and religions, which assisted them in trying to meet the needs of families.
I first outline the influence of the dominant medical culture of treating people the same, a culture in which difference is often treated negatively. I then outline the nursing culture where a requirement to redistribute resources sometimes made difference problematic. Finally, I consider essentialism as a starting point for negotiations and examine the complexity of respecting cultural difference.

5.2.1 Influence of dominant medical culture: treating people the same

Medical and nursing staff in acute care spoke about treating all children in the same way. In contexts such as the emergency department, where there are life threatening conditions, this blindness to diversity seemed more appropriate to these staff than in other hospital wards where patients stay for longer periods. It reflects the discourse of biomedicine, focusing on the physical condition of the child. It also endorses the ‘equity of access’ universalist policy approach taken in the 1990s, intended to ensure that all patients, regardless of their background, are given equal access to treatment (see Chapters 2 and 3). However, treating all patients the same, and only dealing with difference when it arises, risks making cultural diversity into a problematic extra concern. Health staff see medicine as being objective and culture free (Taylor 2003). This approach tends to result in services being geared towards a western biomedical model of health care, where families are expected to act in certain ways that are reflective of a western normalised construct of parent relations. Such an insistence on objective and culture free medicine was common in the hospital wards where the emphasis is on treatment of illness. In other areas, such as child protection and adolescent medicine, there was more room to focus on the child and family’s social condition. In these instances, there was more time to explore cultural differences and their significance in the circumstances.
Nature of acute care

The tendency to treat families ‘the same’ was most prevalent amongst the doctors and nurses interviewed in the emergency department. It was in this busy department with its life-threatening situations that the biggest challenges and key dilemmas of working with cultural diversity were most evident. In this context, the need to look at the physical body first is not denied. A nurse from an Anglo-Saxon background explained that it is after the child and parents/carers move to the ward that cultural issues start to arise:

Because we do the initial stuff and it’s full-on for a while. Once they’re sorted, we transfer them to the ward and often it’s after they’re on the ward for a week or whatever, that things start, people seem to think, “Something’s not quite right there”. But while they’re here, if they’re acting appropriately to the situation that is occurring, it’s not usually until later that people seem to pick up that something’s not quite right or something may be amiss. (Chris, nurse in emergency department S14)

Chris’ comment about families ‘acting appropriately’ demonstrates the expectations that staff have that families will conform to the prevailing norms of the hospital.

It is difficult for staff in emergency who are used to positivist thinking (Sweeney 2006), and certainty in health care, to deal with the social aspects of a person’s identity. Emergency staff are also under pressure to ensure the flow of patients through the system and avoid ‘access block’ (when patients are unable to see a doctor within a specified time) (NSW Health 2003a).
**Influence of biomedicine coupled with anti-discrimination principles**

A doctor originally from England, working in the emergency department, offered the view that the culture of medicine enhances an ability to work with diversity because it is based on non-discriminatory principles of treating everyone the equally, regardless of culture:

I see the culture [of medicine] as actually meant to be non-judgemental; it’s meant to be treating people in their best interests ... I think a lot of things about medicine are extremely positive, things within the culture ... because it’s primarily because you focus upon medical problems which happen to everybody, that can, in a sense, transcend culture and ethnicity for me because when people are ill it’s so obvious that human beings are all the same ... Intrinsically, we’ve all got hearts, brains, blood, do you know what I mean? So I think in a sense the medical culture is probably one of the best places to understand that ethnic diversity isn’t quite as much of a serious thing as people believe in. (Cameron, doctor in emergency department, S12)

Cameron invoked the principle of equality of treatment, an impartiality that forms a philosophical basis for the medical profession. As doctors have training in biomedical approaches to working with patients, this doctor uses this medical rhetoric as a way of working with diversity. According to Cameron the culture of medicine is non-judgmental, but he does not acknowledge the inbuilt assumptions and philosophical premises of medicine’s evolution. This approach highlights the philosophy of biomedicine – “the understanding of illness and disease as primarily physical in nature” (Samson 1999: 4). This understanding has existed since the Enlightenment, characterised by a separation of body and mind, where
the body is a material entity detached from the social and emotional aspects of a person’s being (Samson 1999). During medical procedures, the doctor searches objectively for universal signs indicating particular diseases in the patient’s physical body (Helman 2001; Miller and Crabtree 2000). Cameron’s statement highlights a discourse of medicine for which ethnic diversity is irrelevant. Medicine is supposed to be objective and scientific, having ‘no culture’ (Taylor 2003). Biomedicine is focused on the individual patient’s body, not systems of care (Kagawa-Singer and Kassim-Lakha 2003; Wear 2003).

Cameron combines the discourse of biomedicine with the rhetoric of anti-discrimination in defence of treating people the same. Frankenburg (1993: 139) explains that the desire to treat people the same is “partly in response to essentialist racism”: it is better to treat people the same than discriminate against them negatively. According to the Racial Discrimination Act (1975):

> It is unlawful to do any act involving a distinction, exclusion, restriction or preference based on race, colour, descent or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of any human rights or fundamental freedom in the political, economic, social, cultural or any other field of public life (s9: 1).

This universalist approach is in theory helping to bridge differences between people. However, it may well be that one approach does not fit all, and patients may have different needs, even in emergency, as will be discussed below.
Recognising different needs

Although providing equal treatment to everyone is based on a well-meaning anti-discrimination philosophy, it may actually mean providing unequal outcomes or inappropriate care in some contexts. Sometimes people have different needs even in emergency situations (Flores, et al. 2002), so treating people the same may mean these needs are not being addressed, so care can be inequitable (Blackford and Street 2002; Ramsden 1993). Taylor (1994) discusses how the liberal idea of giving people equal respect is necessary, but that not recognizing cultural differences in some contexts could be oppressive. Not providing ‘culturally and linguistically appropriate’ services is also against NSW Health policy (NSW Health 2005b: 3). Frankenburg (1993: 148) highlights that the understanding that “all people are the same under the skin” is a power and colour evasive discourse dominant in the United States:

One concomitant of viewing people in terms of universal sameness overlaid with individual difference is the disinclination to think in terms of social or political aggregates.

Treating patients the same does not recognise the way in which some families may be disadvantaged in the type of care they receive. The interviews with staff from the emergency and intensive care departments revealed that there were cases where families did want to be treated differently, for example in relation to religious beliefs of a child with a terminal illness or the use of traditional medicine. As explained by a medical manager reflecting on the practice of western medicine:

There’s lots of cultural clashes, with the parents saying, “My son doesn’t need an operation. He needs herbal medication. I’m taking
him off to the herbalist.” Particularly from that background …

Chinese families … it can cause clashes because in western medicine we assume everyone’s going to listen to the doctor. The western doctor’s right, that’s how he’s trained, … our practice is to accept what they do, and when it doesn’t happen it can create a lot of unhappiness. (Claude, medical manager, M1)

Here, providing the same care for all would disregard these parents’ views of appropriate treatment, but such views have to be negotiated with the medical staff’s views of the best treatment for the child.

Sometimes when difference arose, staff saw it as being a problem. As Chris, the nurse mentioned earlier in this chapter, discussed:

I think you just need to deal with them as people first and deal with the differences if and when a difficulty arises … Be approachable and sympathetic and it doesn’t matter where the people come from, you’ll make a connection and that’s what you are after. But I think if you try and approach different people differently just because of where they come from you’re setting yourself for a fall. (Chris, nurse, emergency department, S14)

Treating everyone the same and then addressing difference if a ‘difficulty’ arises may mean equating difference with a problem. However if too much recognition is given to someone because of their background it can lead to problems such as stereotyping and discrimination. From this point of view, treating people ‘the same’ is better than treating people negatively based on their cultural difference (Frankenburg 1993; Young 1990).
In line with this understanding of ‘different’ as problematic, research conducted in 2002 with parents/carers from CALD backgrounds at SCH demonstrated several parents wanted their children to be treated ‘the same’ as other children, and felt that staff did not need to know about their cultural practices. Chalmers and Allon (2002: 14) argue that families themselves, like the staff, sometimes construct difference as a negative. Some parents/carers thought that demonstrating that difference would lead to negative repercussions on the standard of care, or being perceived as trouble-makers. This highlights how recognition of cultural difference is not always sought (Fraser 2002). Other Australian research has suggested the notion of the ‘Happy Migrant Effect’ where acute care patients with little or no English “feel ‘happy’ and satisfied, despite problems with their hospital care” (Garrett, et al. 2008b: 1). The authors discuss a range of reasons for this effect including “a fear of reprisals if they spoke out in complaint” (Garrett, et al. 2008b: 1). These comments highlight the relationship between difference and power relations, where working with difference often entails extra work (this will be discussed in Section 5.2.2).

*Influence of dominant western cultural values in the hospital*

The tendency for staff to favour treating all families the same did not just exist in the emergency department, but also on some of the wards. By ‘treating everyone the same’, staff enacted their own, usually unacknowledged, cultural understandings of appropriate treatment, parenting practices, and gender relations, which sometimes did not match those of the parents. Sameness in this context tended to mean accepting the existence of one hegemonic culture (Taylor 1994: 42). Consequently, some families were disadvantaged if they did not fit staff expectations in line with the dominant culture. For example, some staff at SCH judged negatively the
appropriateness of different parenting practices against the cultural norm of a mother’s active involvement in care. Chalmers and Allon (2002) discuss the case of a grandmother, rather than a mother, coming in with a newborn baby. As a manager explained:

There was a woman who had given birth to a child – and I’m not sure if she was Vietnamese or Chinese – but she didn’t come in with the baby, the grandmother did. And people were talking about making DoCS notifications … they thought the mother was neglecting the child … I had a chat with a friend of mine who is a psych nurse, and I just said, “It’s kind of weird, because when you talk to this mother, everything sounds very normal, and she’s actually at home getting stuff ready for the baby, but she’s actually not taking care of it” and she said, “Oh, no, that’s right. She won’t for six weeks. The grandmother will do that.” …What normally happens is the grandmother shows the mother how to handle the newborn… and we accommodated the two of them in hospital, so it actually worked out OK. But it was only in response to something that was perceived as a problem. (manager, quoted in Chalmers and Allon (2002: 31)

This situation occurred because the staff saw Anglo parenting practices as the norm and difference as deviant, as well as the fact that they may not have been familiar with this custom. In this case, staff may have called Department of Community Services (DoCs) to investigate this case as a form of child abuse. However, when the psychiatric nurse explained that the behaviour of the family was normal for their cultural background, then it was no longer seen as a problem. In this case the manager could have reflected on the impact of the dominant norms in the hospital in line with cultural competence and cultural safety (CCHCP 1999; Nursing Council of
New Zealand 2005), to be more inclusive of diversity. At the same time, staff have to be respectful of the rights of the child, and the complexity of this issue will be discussed in Section 5.3.

5.2.2 Challenges nurses face working with families from CALD backgrounds

The interviews revealed that while nurses were generally able to meet the culturally diverse needs of families, some nurses had difficulties. There were several examples of nurses reacting negatively to the practices of families from CALD backgrounds judged to be different from the norm.

Negatively evaluated difference affecting patient care practice

Some nurses saw the dominant cultural values in the hospital and their own personal values as superior to the different values of some families. Dominant cultural values may disadvantage some as different behaviour may be seen as deviant (Fraser 2002; Young 1990). Passing judgement on the behaviour of patients is also contrary to the professionalism required of nursing staff (ANMC 2006; Southon and Braithwaite 1998). This highlights the benefits of training in reflective practices. As explained by one of the nurses, difference is recognised, but sometimes in a negative way:

There’s definitely a recognised difference, and sometimes the recognition is recognised in a derogatory way, and not necessarily (because) they’re just being different … sometimes there are discussions about the parents and the way they bring up their children. For example, the Arabic boys are generally allowed to run amok and do whatever, and never get into trouble. It doesn’t matter what they do. Whereas the girls are much more disciplined … Some
people are very much accepting of different cultures and different ways of life and say, “Well, that’s the way they do it.” And other people are very unaccepting. This is people that I work with on the ward here, I’m just picturing in my mind certain people! (Lauran, nurse, S16)

When asked if this attitude affects practice she replied it did:

Sometimes it does, yes … Probably negative ways for those people that don’t accept the differences as easily. (Lauran, nurse, S16)

Another nurse makes judgements of the behaviour of the parents according to her own values:

There’s a little bit of a difference … mothers from Lebanese background. Sometimes they won’t even stay here with their kids because they’ve got some other roles at home to be carried out, like they’ve got a sick child in hospital but because at home they’ve got a role to cook and wash and clean the house, they still have to leave to go to do that, despite that the husband maybe should be taking care of those things, or should actually be coming into the hospital as well to look after the kid. (Taku, nurse, S19)

Less problematic were families that fitted into the dominant hospital culture. While staff were supposed to be non-judgemental, there were instances of staff favouring families who were compliant. This demonstrates the detrimental impact on service provision if families do not comply. A medical manager explains the behaviour of the staff in her ward:

Sometimes … we do [have] a bit of favouritism, I’m afraid. Some families are more favoured than others … They comply … they’re just
nicer, in a non-specific way. They’ve got nice kids, they do as they’re told, they come on time … they follow their treatment well, they adhere to their treatment regimes. (Terry, medical manager, M9)

Interviews with nursing staff revealed that negative judgements towards difference were not just related to their personal opinion but also to the need to provide extra resources. This demonstrates how provider bias is not just a matter of changing personal values but linked to broader structural issues (Culley 1996). Some nurses reacted behind patients’ backs, or made critical comments in a joking way. For example Lauran, the nurse quoted above, said:

I know there are different cultures out there and I try to respect them as much as I can. We whinge behind closed doors about certain practices and things but I try not to let that influence my face-to-face interactions with people I come into contact with. (Lauran, nurse in the wards, S16)

The views of staff reflect the notion that diversity meant more work and nuisance. Diversity can make one’s work more complicated and time consuming. This was not just in regard to recognising culturally different views of caring for the child, but also views about the status of women and nursing staff. A nurse unit manager explained the resource implications of working with cultural difference, for instance a father’s different understanding of appropriate gender roles which denies authority to women (or nurses):

I’ve actually noticed that a lot of men from certain cultural backgrounds are very dismissive of me and what I have to offer, and it takes ages, sometimes like half an hour, before they will even start
to listen to what I have to say and respect what I have to say, because of my role. ... It’s almost like a barrier that you need to get over. (Ally, nurse unit manager, S11).

Negativity linked to the provision of extra resources

There is a growing body of literature documenting provider bias in health care (IOM 2003). However, studies on the bias of health workers neglect to analyse the effect of structures of inequality affecting the behaviour of providers (Culley 1996).

West (2002) points out that when recognition of difference involves a redistribution of resources, there can be a negative take on diversity. West (2002) cites Bhabha (1999):

Cultural difference is not difficult, if you like, because there are many diverse cultures; it is because there is some particular issue about the redistribution of goods between cultures, or the funding of cultures, or the emergence of minorities or immigrants in a situation of resources – where resource allocation has to go … It is at that point that the problem of cultural difference is produced (Bhabha 1999: 16).

Cultural differences become a problem in the hospital when expression of these differences is perceived as an implicit demand for extra resources. However, as Fraser (2003) observes, if someone who is disadvantaged is misrecognised as a full partner in social interactions, it can represent a form of injustice. To rectify this, resources need to be redistributed to ensure a parity of participation and status recognition. An example could be staff acting on a request from a Muslim mother to be given privacy when breastfeeding. In this case, the dominant cultural value in the hospital is non-
Muslim, as staff of both genders mix and are not separated. Recognising different forms of modesty around gender and religion means providing extra resources such as a more private space for the mother and extra time spent with the patient by the staff member to understand and respond to the situation. Lack of action would mean the mother would be disadvantaged (or there would be a form of injustice). Fraser (2003: 25) explains:

> For practical purposes then, virtually all real-world axes of subordination can be treated as two-dimensional. Virtually all implicate both maldistribution and misrecognition in forms where each of those injustices has some independent weight, whatever its ultimate root.

This explanation highlights that, if there is a form of subordination, two things are needed to rectify the situation: recognition (of subordination) and resource redistribution.

*Systemic constraints in nursing*

Redistribution of resources is difficult for nurses in the current health reform environment. With increased emphasis on efficiency, there is less time to meet the needs of patients (Bjornsdottir 1998; Candlin and Candlin 2007). The previous chapters have also discussed a lack of systemic support for staff. Nurses are reliant on social workers to address the more social aspects of a child’s health. As explained by a nursing manager:

> A lot of the cultural diversity policies actually affect allied health more than they affect nursing, because whilst you have to deal with them with dignity, respect, blah, blah, blah, it’s the other areas, the social areas, which tends to be social workers who come in if you need
assistance … Or if they’re in crisis, they tend to come in, because the nurses are really a bit busy nowadays to sit down for a chat with the patients, or take them for a coffee, that kind of thing. (Gale, nursing manager, M8)

Some of the other systemic demands that nurses face relate to a lack of respite care for disabled children in the community which means families stay longer in the hospital (Galbally 2010; NPDCC 2009):

It takes up an acute bed, and when you’ve got children lined up waiting for beds in Emergency and places like that, it’s very frustrating. Because that’s the culture of our health system! (Lauran, nurse, S16)

They keep bouncing back. With chest infections and aspirations and things, just because they don’t have the services at home to keep them going. (Jessie, nurse, S17)

The managers also spoke about the workforce changes that have occurred in nursing, leading to fewer experienced nurses on the ward:

We’ve noticed two trends that are working against each other. One is that the nurses are younger and less experienced, and the other is that the acuity of our patients is more complex, and the two don’t go together, obviously. (Lin, administrative manager, M5)

This indicates that some nurses are limited in their professional capacity to meet the complex needs of families, especially those from CALD backgrounds whose needs might require extra services.
One of the ways that nursing staff recognised diversity was through asking parents if they had any special requirements such as interpreters and special food, or whether they wanted to perform any specific religious rituals. Several nurses across the wards discussed using their nursing plan to help them accommodate the needs of diverse families. Gustafson (2005) highlights that nurses work with difference on an interpersonal basis through their nursing plan, without challenging the dominant culture of the hospital. Working with diversity on an individual basis can obscure the minority status of some groups (Gustafson 2005: 5):

Appealing to universal subjectivity reasserts the view that we are all just people negotiating interpersonal relations while simultaneously obscuring the power of the very social processes used to organize those engagements.

According to Brown (2001) nursing practice is informed by liberal political ideology, which emphasises individual freedom and ignores systemic inequities. Consequently nurses deal with difference on an individual, case by case basis:

When we need help, we just deal with the situation at the time. If we have a problem with a parent, a specific problem ... say if the mother cannot speak English, we’ll either call a social worker and if we need an interpreter, we’ll just get the interpreter and we’ll deal with that issue at that time. Then because they’re only in the hospital for a short while and then they go home, like, we solved that problem or patched that problem and then they go home and then the problem is solved for that time. Then the next person comes with a different problem.
It’s not like it’s a problem that stays, it’s just a different problem that comes along each time. (Taylor, nurse, S15)

Some nurses did consider how families were disadvantaged systemically but they lacked the resources to assist them. One nurse who was interviewed did recognise injustice but was constrained by what she could do on a professional basis. This nurse, from New Zealand, saw how some parents from CALD backgrounds have difficulty trying to negotiate the system. She gave the example of two children who had similar developmental disabilities, but the child of the parents from a Muslim background did not receive as much support as the other child:

We’ve got a baby who comes in quite frequently whose mother is a Muslim lady, and the father travels quite a lot. She’s got four children, three of which are special needs. They were born with developmental problems, and she’s got no help in the community and she’s on a waiting list to get help at home. And then we have, say, a child who comes in with an acute brain injury and … the child is similar developmentally, has the same needs, and they immediately get everything thrown at them. Like, equipment, services, staff … (Jessie, nurse in wards, S17)

This nurse acknowledged the inequities in care but was constrained in terms of the assistance she could provide. The way that the non-Muslim family got assistance was through the efforts of the doctor involved, in utilising the services available in the hospital:

There are some doctors who will go that extra step and think beyond discharge for a child, and then there are some doctors that don’t, and don’t really maximise the opportunities that are available for some of
these children, and some of the services that are in the hospital. (Jessie, nurse in wards, S17)

This example demonstrates how doctors have more power to assert the needs of the family than the nurses. Jessie also said it would be beneficial if a case manager was employed to assist families that are disadvantaged. Such as provision would highlight their special needs, rather than being treated the same.

5.2.3 Essentialising cultural difference as a starting point for negotiations

As outlined in the previous chapters, one way that staff respected difference was to speak about the practices of families from CALD backgrounds in a way that normalised cultural differences. This involved a positive take on difference as outlined in Taylor’s ‘politics of recognition’ (1994). It took the form of a cultural relativism where other cultures are understood ‘in their own terms’ (Parekh 2006). Relativism is one of the first stages of cultural competence outlined in a model of ethno-sensitivity developed by Borkan and Neher (1991), which is characterised by an acceptance of cultural differences, “but also by a naiveté regarding actual knowledge of specific differences and their implications on providing care” (Office of Minority Health 2002: B4).

Medical and nursing staff commonly said that it would be useful to have information provided on the cultural behaviour of different ethnic groups to assist them in their treatment. This approach has been challenged as potentially leading to essentialism and stereotyping (Singer, et al. 1986). Yet such generalised understandings of cultural traits of ethnic groups were often used as a starting point and background to interactions. For example, a doctor in child protection explained that she has got to know that the
extended family is very important in Islander communities. It was normal for a child to live with an aunt, and have brothers and sisters living away from them. This knowledge meant that it was not necessarily a child protection issue if the mother is not present at the hospital all the time:

Because we’ve got such a huge multicultural catchment area – you recognise certain things based on what you’ve seen before … with the Islander groups … you get to recognise it and so your starting point connecting with that person culturally is much higher than it would have been. So it’s a benefit to the next person you meet to have a bit more understanding of how they function and within what context.

(Carmen, doctor, child protection, S1)

This person said that the child protection department is more accommodating towards families from CALD communities because they may have different understandings of parental responsibility, and may not be familiar with laws in Australia.

The nature of hospital care is that there is less time to build relationships compared to community care. As explained by a doctor:

We try and remain aware of those things [of recognising cultural differences] … we still have a lot to learn. We’ve got a lot of practice issues that stem from that but haven’t probably been fully understood. In my own private practice, I see quite a lot of families from a range of different cultural backgrounds. In some ways it’s a bit easier to manage that … outside the Hospital, because you’ve got more time.

(Jamie, doctor, child protection, S3)
Modood (2007: 92), in explaining the work of Bauman (1996), has stated that it is common practice to categorise people according to their ethnicity and customs as a shorthand way of describing behaviour, but then there needs to be more discussion about the differences within groups. He explains:

People in multi-ethnic locations sometimes speak as if everybody belonged to one or another ethnic group, constituted by their participation in uniform customs and practices with co-ethnics, but at other times they are more savvy and appreciate that there is considerable internal diversity, overlap between members of so-called different groups and that not only do individuals belong to more than one group but different groups will be salient in different contexts (sometimes it might be ethnicity, or colour or youth or neighbourhood, etc.).

The transition from generalisation to recognition of complexity was demonstrated by a nurse unit manager who explained that the problematic behaviour of the caregiver of a child was related to her cultural background, but then went on to describe her actions in accordance with her role as a grandmother, and dealing with a child that is ill. This person moved from an essentialised understanding based on ethnicity and gender to a more complex one based on familial relationships:

Trying to explain to staff why the Grandmother’s doing all these things because this is her role as a woman in Korean society … however, there’s an element of co-dependency there, as well … sometimes that co-dependency is actually quite nicely fostered for the benefit of the carer and they don’t like to see their child or grandchild
being independent. They want to be needed. (Ally, nurse unit manager, S11)

Modood (2007: 102) goes on to explain that essentialism is a form of reductionism which, like all forms of reductionism, needs to be explored to reveal its complexity:

For all such generalities will at best approximate and typically crudify real situations. For what is wrong with essentialism is wrong with all theoretical homogenization, abstraction and reductionism. They miss out on the diversity, complexity and open-endedness of social phenomena.

As explained by Ally, the nurse above, there are problems if you predict certain behaviour based on ethnicity:

If you’re not careful you do actually say, “Oh, here we go again. This, this and this is going to happen,” and it’s trying to understand everybody and why they do things … (Ally, nurse unit manager, S11)

A doctor in child protection explains the complexities:

It’s trying to be aware of what might be important within that family … because it isn’t easy even to assume that because they’re from some background, you can’t necessarily even impose the general cultural understanding from a community level to a particular family … It doesn’t really apply because you don’t know where they’ve come from … they’ve been in Iraq for three years and then they’ve been in Afghanistan for a year, and before they were on a boat to somewhere else. All those things often don’t even get acknowledged when you’re
trying to deal with the immediate problem. (Jamie, doctor, child
Protection, S3)

Effect on staff of families’ culturally different practices

Staff did acknowledge that there was diversity within diversity as outlined in
Chapter 4, but there was also a need to know about common practices as
they affect staff practice and resource distribution. As explained by a nurse:

As long as you’ve got a basic understanding of, say, the Muslim
culture so that you know that the women cover their heads and only
their husbands see their hair and things like that, that allows you to
practise safely. But you have to be aware that not everybody does
things exactly the same way, because we have Muslim women who
come in and don’t cover their heads. And part of that also comes into
the fact that when we place children or parents if we’ve got a Muslim
woman who’s staying with her baby and she covers herself, we have
to be aware, if there’s a father staying in that same room she won’t
undress and she won’t sleep at night. (Jessie, nurse, S17)

A nurse outlines the possible resource implications of different religious
beliefs:

You’ve got to think about that if a child dies, because you’ve got to
think about the religious beliefs … finding out if families want
pastoral support, so if they need a priest to come in, are they Catholic,
do they need last rites, … I know that Jews and Muslims have special
things, like you’ve got to bury them by sundown…so that can create
problems sometimes if people aren’t aware, although usually the
family will tell you … (Sam, nurse in emergency, S13)
Staff also need a sensitivity to migration experiences such as torture and trauma. A doctor explained:

[I was working] with this particular man to name some photos, and one of the photos was a knife, so I was going like this, and showing him to cut, and then I don’t know what possessed me, but he just wasn’t able to understand what I was doing, and I went “like this” and my supervisor said, “Oh, gosh! He’s a torture and trauma person!” So I think I traumatised him even further when I did that! So it’s more awareness … it’s taught me to be more sensitive to other people’s backgrounds and views. (Carmen, doctor, child protection, S1)

Several nurses explained that they needed to have a good knowledge of cultural norms as sometimes patients may not offer information and this may relate to families trying to fit into the dominant culture.

Most of them are very quiet when we ask, because it’s kind of a touchy question to ask … if they’re on a special diet and they’ll say no, and if there are foods excluded from the diet and they’ll say no, but then it will turn out that they don’t eat pork. That comes up quite a bit. Or they’ll say, “No, we don’t want an interpreter,” but then when you converse with them further you realise that they really do need an interpreter. But otherwise we get most things, I think. (Jessie, nurse, S17)

5.2.4 Complexity of respecting cultural diversity

There were different degrees to which health professionals accommodated cultural diversity, from acquiescence to changing behaviour and providing
extra resources in respect of difference. Staff have developed various informal tactics and techniques as ways of accommodating common situations of dealing with diversity, especially in relation to different gender roles in the family. In other situations staff had to have skills in negotiating systemic, organisational and professional constraints and personal values with the needs of different family members, although they were mainly reliant on allied health for this form of negotiation.

In some cases working with diversity simply required passive tolerance of difference. For example, a nurse said that she noticed that Chinese parents liked carrying their children everywhere. As this did not affect daily professional practice, these families were not adversely affected by the dominant hospital culture.

Working with diversity when families had needs which deviated from the dominant institutional culture meant redistributing resources in terms of time, extra staff and hospital resources. For one staff member, allowing families to do what they wanted involved advocacy of cultural difference:

It’s allowing the family to take over the ward, we ended up with about twelve or thirteen relatives … but that advocacy is a really important part of that, and not allowing the staff to waste energy on not being able to change someone’s longstanding beliefs … primarily the child is of the major concern, obviously … but also focusing on the family and the way they also live their lives, and if it’s not impeding the child’s progress or recovery then I think there should be an allowance for, a certain amount of understanding and consideration.

(Ally, nurse unit manager, S11)
Redistributing resources sometimes involved extra staff being available to cater for the different gender relations in the family. For example, a physiotherapist spoke about being sensitive to the cultural norms of different families, although he said there was diversity within cultures. For example he said about different gender relations in ‘Arabic culture’:

It’s like basic knowledge. Like, Arabic culture where the man is more the control figure and calls the shots of the lady, but the lady, the mother, is usually the one who does all the work but is quieter and less outspoken in the presence of the man. (Adan, physiotherapist, S20)

By using this conception of gender relations amongst Arabic speaking families, he was sensitive to an ‘Arabic girl’ who fulfilled these gender expectations when she seemed uncomfortable showing her knee in front of him. If a doctor had to look at the knee, he said he would leave the room. However, if he had to assess the knee himself, he said that he made sure that another person was in the room. Fraser (2003) outlines how recognition of cultural difference has resource implications if justice is to be done. In this case, extra staff members were needed in recognition of different gender values. The child would have been disadvantaged if the physiotherapist had not called in extra staff members to assist in the procedure.

Meeting the needs of families could also benefit staff in terms of assisting them to perform their job. For example staff would get a male or female doctor or interpreter depending on which family member they wanted to influence. As explained by a nurse:

It depends what we need to do. If we need to convince the father that his child needs a graft, we’ll get a male interpreter. We’ll actually try
and get a male doctor as well, rather than a female. (Ally, nurse unit manager, S11)

Sometimes bringing in a community leader will help staff negotiate a significant cultural difference dilemma. A doctor in Child Protection gave the example of getting a community leader who is sympathetic and can assist with compliance:

I was actually in ICU [Intensive Care Unit] and there’s a child there that has a lethal condition … For whatever reason, this child ended up in an ICU intubator with some respiratory condition. The family’s Muslim. We couldn’t get the baby off the ventilator even though that’s the only reason he was alive. They brought the Imam in again, the religious elder. And you try and select one that you know is going to be empathetic … (Carmen, doctor, child protection, S1)

According to the more critical understandings of cultural competence (CCHCP 1999), staff needed to reflect upon the impact of their own culture:

You grow up with certain experiences and it’s very easy to forget that other people haven’t grown up with those until you have an epiphany somewhere along the line and it hits home. So I wouldn’t say that it’s a big issue, because I’ve learned over the years to be aware of that, but particularly when you’re stressed or busy, that’s when you’re more likely to overlook some of those really important fundamentals, because you’re rushing something, and sometimes people can’t be rushed. And if you don’t understand those issues you can easily get the whole thing upside-down … (Jamie, doctor, child protection, S3)

The complexity that may flow from assisting parents with their requests was
highlighted by a senior nurse in the Burns Unit where the rights of the child to health care had to be negotiated with the cultural needs of the parents. This situation occurred in a context of systemic constraints to do with time, professional roles and the health care needs of children. When the staff requested that the child be given pain relief, the father disagreed for a range of reasons, as explained by a senior nurse:

We had a child, the mother was Serbian, and the dad was Croatian and their belief was that he had ‘to be man’. If he took morphine, he was a drug addict. He had a 65% burn and they didn’t want him to have pain relief but they wouldn’t let us move him because it would hurt him. Over there, you very rarely would have morphine ... That was all tied in with drug addiction, and being a man. Dad had lost a leg and he didn’t have any morphine at all. We actually in the end agreed to disagree ... We didn’t actually have to make that patient a ward of the state, or bring them under the control of DoCS but we have had to do this in the past for life saving surgery and procedures ... They would allow us to do what we wanted but if they didn’t want to be in the room at the time then that was fair enough. For example, they wouldn’t let us try to rehabilitate him. [His] mum would spend four hours doing his dressings. And that was allowed to happen in terms of caring for the child before he came here. We couldn’t allow the child to have a four hour dressing on the ward so we had to talk to her about that. In the end we actually asked them if they would leave so we could get on with the dressings because we were getting absolutely nowhere. (Ally, senior nurse, S11)

In this situation, there was not a simple relation between the father’s ethnicity and his expected behaviour. There were a number of issues
involved in this family’s decision to refuse pain relief. Firstly, there was the issue of the father’s notion of masculinity. Secondly, this refusal was related to the father’s own experiences of war in the former Yugoslavia and not being given any pain relief. Thirdly, the father associated morphine use with drug use and addiction.

The staff in the ward, on the other hand, were in a difficult situation as they could not give appropriate health care and ensure the right of the child to pain relief. They were also constrained by the issue of time. The mother could only be allowed to dress the burns under nurse supervision, and to stretch the procedure over four hours was not practicable in the hospital context, as it would divert nurses from looking after other children. As explained by the nurse:

> Unfortunately, we’re all about fairness and equity, as well, so that’s some of the problems, or issues that we have. We’re happy as long as we’re seen to be fair and equitable with all our families. (Ally, senior nurse, S11)

This situation highlights the professional and systemic constraints to being ‘culturally competent’, as staff have to have the capacity and resources to act. In this case the doctors and nursing staff were operating within a biomedical framework but were trying different options to accommodate the parents. The parents’ beliefs were not compatible with the normal procedures for the Burns Unit to do with resources and time, nor, in their view, were they in the best interest of the child and other children. This type of cultural competence, being able to negotiate contested issues, is different from simple acquiescence where the mother could be allowed to continue to do the dressings over four hours.
Multicultural policies in NSW state it is important to provide culturally and linguistically appropriate care (CRC 2007; NSW Health 2005b), but do not discuss the implications of this for staff (Morrissey 1997), or how to work with the constraints. The skills of negotiation have been discussed only briefly in the cultural competency literature (Office of Minority Health 2002). This literature does not discuss the skills needed in negotiating the personal and professional values of the staff with the needs of the families, in a context where there are multiple demands, and limited resources.

The nurse identified the family as needing particular attention precisely because they were refugees:

I think there were big cultural issues there … they were a refugee family … that’s a whole new ball game for us, in a sense, and often we’ve asked parents … and they’ve said, “Look, I’ve seen people with their heads blown off. Don’t worry about me.” And they are the people we’re worried about, because they’ve not seen their own family with major burns … Refugees are becoming more and more an issue. (Ally, senior nurse, S11)

This situation may have worked better if the staff had identified the family as refugees earlier, and therefore needing special assistance, such as more time, interpreters and other resources, or the use of a cultural broker. Staff could have also had specific training in working with refugees. As explained by the nurse:

I can now make sure that we double-check where these families come from, particularly if they don’t speak English very well and they’ve only been here for three months. (Ally, senior nurse, S11)
The difficulty working with refugee families and the need for different services is discussed in the case study of Zahra in Chapter 6.

5.3 Social work negotiating challenges

In general, staff tried to accommodate the needs of families as long as those did not affect the well-being of the child. However, there were some instances in acute care and psychological medicine where medical staff felt trying to meet the needs of parents for culturally appropriate care detracted from their ability to look after the physical health of the child. For example, too many relatives by the bedside of a sick child can present a problem. In situations such as this, social workers played a critical role in brokering the needs of clinical staff in ensuring the health of the child and the cultural needs of the parents. In other instances, trying to respect the rights of a parent to culturally appropriate care infringed on the needs of other staff members or family members.

This negotiation highlights the limits to recognising the cultural difference of parents without compromising the values and rights of the dominant culture (Taylor 1994). Australian multicultural policy (Commonwealth of Australia 2010: 5) outlines:

> The Australian Government celebrates and values the benefits of cultural diversity for all Australians, within the broader aims of national unity, community harmony and maintenance of our democratic values.

This is where patients had to respect dominant values in institutions such as the hospital.
In some cases, staff invoked the notion that the human rights of the child were being compromised by the cultural beliefs of the parents. Staff mobilised “the discourse of international human rights” against “traditional cultural practices”. As described by Shweder, et al. (2002: 12):

More is involved with conflicts over cultural practices than just domestic constitutions and laws. International law and the discourse of international human rights increasingly offer resources for people to mobilize against traditional cultural practices. Others then face decisions about whether to join or resist the importation of international human rights language in assessments of tensions over cultural practices.

The Universal Declaration of Cultural Diversity states that “no one may invoke cultural diversity to infringe upon human rights guaranteed by international law, nor to limit their scope” (UNESCO 2001). However, the UNESCO World Report *Investing in Cultural Diversity and Intercultural Dialogue* (UNESCO 2009) argues that cultural and human rights do not have to be in opposition if human rights are inclusive of cultural rights. As the Report (UNESCO 2009: 27) states: “a set of standards protecting human rights is best incorporated in a cultural context through dialogue and communication”. A number of theorists similarly argue for universal rights or citizenship rights to include both human and cultural rights (Castles 1999; Jayasuriya 2003).

I will now give some examples of where tensions arose between the professional roles of staff and the cultural needs of the parents.
5.3.1 Physical health of the child and cultural needs of parents

In several instances in acute care and psychological medicine, medical staff felt the cultural needs of a parent were in conflict with the health of the child. While staff are treating children, they also have ethical and professional responsibilities to respect the rights of the child. One doctor in emergency expressed concern that parents were imposing their cultural beliefs and practices on the child patients, to the child’s detriment:

I find the difficulty in paediatrics is if people’s cultural or religious beliefs are exerted onto the child when in fact they haven’t had the chance to make up their mind. So I believe that if children can understand the concepts then they should be allowed to make their own decisions, when possible, yet sometimes they can’t make their own decisions … It’s a bit more tricky because your patient is the child, so you have to protect them to a certain extent, within reason. (Cameron, doctor in emergency, S12)

In this interview the doctor sees children as being subjected to their parents’ cultural and religious beliefs. He is sympathetic to the children, who he sees as needing his protection.

During the interview, the doctor discussed the Chinese medical practice of cupping as an example of a potential child protection issue where parents impose their views upon their child. This practice involves placing a heated glass on the body to draw away unwanted illnesses (Soo 1986). This doctor had difficulty with parents exercising a cultural practice with which he is not familiar, and which is different to the western norm in the hospital. This was in tension with the principle of family centred care based on the family being involved in clinical decision making (American Academy of Pediatrics 2003;
AWCH 1999; Institute for Medicine 2001). At the same time, the doctor had a legal responsibility to identify any signs of harm (NSW Health 2006a). After some discussion he said he was supportive of any practices that do not cause harm. This situation outlines how working with cultural diversity is impacted by the professional values and roles of staff, so they need skills in negotiation.

Social workers and allied health staff often act as mediators, brokering the needs of the parents and the professional needs of the staff in treating the physical health of the child. A social worker who had worked in the Intensive Care Unit (ICU) explained that her role was to “broker an understanding between the medical and cultural”. For health staff, ‘the cultural’ was sometimes manifest as difference from the normal way that parents were expected to behave. This worker gave an example from an occasion when she was requested to assist a family in an ICU:

The flyaway comment that might happen is, “We’ve got too many relatives. You need to come here and do traffic controlling, because we don’t have time for this. We need to focus on the child”… I think my role is very much mediating between the needs of the medical and the needs of the family. (Kim, social worker, S7)

Kim indicates a division of labour in the acute care sections of the hospital where dealing with cultural diversity was relegated to the social workers.

These days the practice of cupping has become more familiar to health services, so it is no longer a potential child protection issue.
She gave an example of meeting the medical and cultural needs by finding alternative solutions:

It’s important for a family to wail and do all the culturally appropriate things but maybe it’s detrimental to the child’s health for that to happen in that room, so sometimes social work is about helping each understand each other’s needs, and sometimes it’s about trying to find alternatives, trying to find a quiet room where they can wail away from the bedside … (Kim, social worker, S7)

In line with the principles of ‘intercultural dialogue’ (UNESCO 2009), the human rights of the child are dealt with in a culturally appropriate way for the parents and extended family. This is conditional on there being a spare room available. These are some of the systemic constraints to cultural rights in the public health system.

The tension between cultural needs of families and the professional roles of the medical staff has necessitated that the hospital develop new guidelines for dealing with these ethical issues. It is important for such guidelines to establish that recognising cultural difference has limits if it infringes on the human rights of someone. Social workers trying to meet the needs of both health professionals and parents also had to meet the needs of other child patients. Here, the philosophical principle is relevant, that group rights should be protected so long as they do not affect other people’s fundamental rights (Taylor 1994; Thompson 2006: 57). Fraser (2002) also states that recognition of someone’s unequal status should not occur if it affects other people detrimentally.

When health care moved into areas such as child protection and mental health, Kerry, a social worker, sometimes saw parents using their cultural
background as an excuse for acts that were potentially harmful for the child. This worker had to identify whether the parent’s behaviour was normal for their cultural background or there were other factors involved such as mental illness. As explained by the social worker:

I don’t have a problem with different cultural practices as long as they’re not disrespectful of the basic human rights … You need to respect people’s cultures but you also need to put the rights of the child, their health and safety, first. (Kerry, social worker, S8)

Kerry explained that in some cases “parents blame their culture when in fact a pathology is to blame”. Kerry discussed a case where a mother originally from Indonesia had an obsessive compulsive disorder about cleanliness but said that it was part of her Indonesian culture that children are clean all the time.

In child protection, staff were respectful of cultural difference but laws against child abuse effectively place limits on the exercise of that respect. Some new refugee communities were not aware of this so staff sometimes brought in community leaders:

We’ve assessed a child here at the Unit who had obvious signs of corporal punishment and that’s still accepted, because we spoke to Sudanese elders and got a little bit of input. Corporal punishment is still an accepted way of disciplining children as long as you don’t draw blood … although this elder was happy to accept that that’s not the way we do things here. He was saying, “Well, what else do we do?” … So they were happy to accept that that’s not the way to do it, and it was great in that he was asking for alternatives at a community level. (Carmen, doctor, S1)
This example highlights the importance of community engagement to negotiate the norms in Australian society, the rights of the child and community needs.

5.3.2 Fathers’ cultural rights challenging female staff rights

Several staff spoke about trying to accommodate families when the father did not accept the authority of a female staff member. This applied mostly to families from Middle Eastern backgrounds, but it was not limited to these families. For instance, staff call in male authority figures regularly to help the families deal with issues, especially if the staff wanted families to accept the treatment recommendations. As explained by a female doctor from a Spanish background:

If you have a lot of Muslim families, you often wonder how that’s going to affect the whole interaction, so we’re very conscious of that and if there is a difficult father, you can try and have a male present. Not for security reasons, but to actually give weight to what we’re saying (Carmen, doctor, S1)

Arranging for a male member of staff to intervene sometimes challenged the professional and human rights views of female health professionals. There were some staff who did not like to accept the gender dynamics in the family as these were contrary to their views of egalitarian relationships in families. Chalmers and Rosso-Buckton (2007) argue that to use a male member of staff can reinforce gender hierarchies in the workplace and undermine female authority. In this case staff may see cultural diversity as infringing upon their human rights (UNESCO 2001), where the different views of the father infringe upon the rights of the female staff member. However, the view of some staff was that they were not going to change beliefs and practices held
over a long period of time in the family, so they pragmatically accommodated the family’s views.

5.3.3 Negotiating fathers’ cultural rights with staff professional needs

Sometimes staff encountered situations in relation to gender issues in the family which challenged their personal and professional views of the rights of the mother, which they thought should be negotiated.

For instance, staff found it confronting if a mother was not involved in treatment decisions as this was against the professionalism of ensuring the informed consent of both parents (NSW Health 2005a). In a few instances allied health staff spoke about trying to involve the mother. As explained by Kim, the social worker:

Sometimes a father will say, “Mum doesn’t need to be part of a meeting to discuss these issues,” in terms of protecting her, and then we as health care professionals, myself included, really struggle, because if you believe in principles that are really dear to us in health about informing patients or their parents about their child’s health, and that one parent is actually keeping information from another, do you accept that as cultural difference, or do you actually say, “You need to be informing that parent” and are you actually seen as not doing your duty? Because in heath care, informing parents about the risks of surgery, all of that, is very important. If one parent is saying, “You need to tell me that and not tell my wife these risks,” where are we placed legally? (Kim, social worker, S7)

As discussed by Kim, informing both parents so they can both give consent to treatment is a professional ethics issue. This dilemma again relates to
individual human rights overriding cultural rights. In particular, the individual rights of the mother, to have a say in the health care of their child, were given precedence over the cultural rights of the father. The social worker’s personal values relate to broader values in Australia about the rights of women. This is where the personal mixed with the professional, as outlined by Kim:

I think practice is impacted by our values, and at this point in time, in our predominant culture we value that women have a say, that women are seen as equal to men and they’re just as important in decision-making as men or whatever. That is a value and I suppose I hold that value professionally but I hold it personally. (Kim, social worker, S7)

This demonstrates how the principles of cultural recognition can be in tension with western democratic principles (Shweder, et al. 2002) and feminist principles, which perceive that the cultural rights of the father may infringe upon the democratic rights of the mother.

But is trying to involve the mother in discussions imposing liberal white feminist politics onto the family? Blackford and Street (2002: 665) discuss how nurses are “influenced by the social, economic and political climate in which they are located” and use a liberal feminist discourse when working with NESB women. They discuss how nurses think the women should be liberated, but do not consider how gender interacts with class and ethnicity. They try to treat all women the same using an Anglo construct. Blackford and Street (2002) suggest that the nature of the hospital situation where families are extremely stressed and highly anxious may not be the time or place to discuss gender relations in the family. However, in the context of the
example given, staff still had a legal responsibility to get informed consent from the mother, but also wanted to respect the views of the father. This is where the UNESCO (2009) document states human rights should be discussed in a culturally appropriate way. What Kim did was fulfil her legal obligations and then give options to the family. As explained by Kim:

Sometimes what I’ve done is, if there’s a family meeting and the dad has said to me, “I don’t want my wife to come,” the compromise might be that he allows me, with an interpreter, to invite her to the meeting and let her know what the meeting’s going to be about, and for her to then make a choice about whether she comes or not, and so she is aware that this is a process. (Kim, social worker, S7)

Kim tried to assist the medical staff in getting informed consent from both parents about the medical/family meeting, then let the family discuss privately which members would come to the meeting.

Another allied health worker, a speech therapist from a NESB background, had a similar attitude when working with the mother:

“Go home, talk to your husband about it, talk to your mother or whoever, your support network, and then call me and tell me what you want to do,” because often I’ve found, often it’s not the mother’s ultimate decision about what she wants that dictates what actually ends up happening, so often I’ll try to get it right from the beginning and make sure everybody’s on board before we start. (Ali, speech therapist, S5)

These examples demonstrate the difficulty of applying cultural competence in a hospital setting, where it is more than just understanding the cultural
norms and beliefs of parents. It is about negotiating the professional needs of staff, the rights of the child to appropriate treatment, the right of the parents to informed consent, and being culturally sensitive. This whole process of negotiation consumes extra resources in the form of the time of the social worker and other hospital staff.

5.4 Conclusion

This chapter examined the complexity involved in staff having to negotiate systemic constraints, as well as the dominant organisational and professional cultural frameworks in the hospital, with the needs of the families. Medical and nursing staff were constrained in their ability to address the ways in which families were disadvantaged by the dominant culture in the hospital, where western medical care and mainstream Anglo parenting values were accepted as norms. These staff were focused on the physical aspects of health care. As a result, they sometimes saw difference as a problem, with implications for inequitable health care. Cultural relativism and essentialism played important roles in normalising difference as staff tried to understand the different needs of families. More difficult negotiation was required when the culturally diverse views of parents conflicted with the rights of the child to health care or with the individual rights of other family members. Allied health staff often play a crucial role in reconciling both the system’s need to gain informed consent with the needs of the parents, which had implications for the conduct of service provision. At the same time, all staff need the skills to work with difference rather than just relying on social workers so that practice is not problematic and equitable care is ensured.
6. **Negotiating diversity: three case studies of children with chronic illness**

People’s concept of time, and appointments, and what they need, can be very different to the way our hospital is set up to function efficiently … sometimes [with] hospitals it can either be “this or that” and sometimes there are lots of shades of grey in between, and actually helping to broker that, that’s really hard when you’re busy. (Kim, social worker, S7)

This social worker outlines the difficulty with trying to meet the needs of families who have different views to those held predominantly in the hospital. As discussed in the last chapter, allied health workers play a critical part in brokering the social needs of the family with the professional roles of medical and nursing staff, within the systemic constraints outlined. The dominant organisational culture in the hospital prevents staff from engaging too much with the specific needs of families.

This chapter explores the practicalities of recognising and engaging with cultural diversity as staff work together in a team. It specifically examines how staff negotiated cultural difference with three families of children with chronic illness: Connor from a Maori/New Zealand background who has HIV; Zahra from a Sudanese/Egyptian background who has kidney failure; and Joshua from a Chinese background who has a brain injury. Children with chronic illness were chosen so we could observe and analyse the family and staff interactions over a six month period.

Findings from these case studies demonstrate that a dominant biomedical culture, systemic constraints and mainstream Australian and western staff-
patient relations in the hospital placed limits on the degree to which staff could meet the needs of families from CALD backgrounds. Within the hospital there was an expectation of compliance, as evidenced by staff labelling these three families as ‘good’, ‘difficult’ or ‘chaotic’ according to how cooperative they were. For example, there was more negotiation with Joshua’s family who were labelled ‘good’ as they complied with the unspoken rules of the hospital system despite their cultural difference. The staff had more difficulty trying to meet the needs of Connor’s and Zahra’s families. In order to address the disadvantages that families face, staff are dependent on the advocacy of someone in the health team to reflect on the inequities of care. Levels of engagement of staff are also dependent on the involvement of families.

*Constraints to working with cultural diversity*

Medical and nursing staff were not always able to respect the needs of parents as their main focus was to ensure the physical health of the child. The nature of the intensive treatment regimes for the children in the case studies, namely dialysis, brain injury rehabilitation and HIV anti-viral treatment, meant a very strong biomedical culture of encouraging compliance was enforced for the well-being of the child. This biomedical culture is characterised by scientific positivism and reductionism which manifests itself in the labelling of families. Labelling is reflective of the medical culture of the hospital where there is an ideology of normalisation of patient behaviour and compliance (Anderson 1986). The staff labelled Connor’s and Zahra’s families as ‘chaotic’ and ‘difficult’ because they did not fit the expected norm in the hospital. While this practice can be seen as provider bias (as they are making assumptions based on their values), this chapter will demonstrate that provider bias is connected with broader
institutionalised systems of marginalisation (Gustafson 2005). ‘Normal’ mainstream parenting values prevail in the hospital, where it is assumed the mother will take on most of the parenting (Kolar and Soriano 2000). When families act outside these norms, as in the case studies described below, staff see their behaviour as inappropriate.

*Tolerance versus full acceptance of cultural difference*

I use the term ‘tolerance’ to understand how staff worked with the constraints and limits to fully meeting the needs of families from CALD backgrounds. Hodge and Carroll (2006) explain ‘tolerance’ as having to ‘endure’ something. They state in ‘everyday’ situations there are varying degrees of tolerance to cultural difference. The term ‘tolerance’ encompasses limits.

While respect is better than tolerance, tolerance is better than no tolerance. As explained by Hodge and O’Carroll (2006: 58)

> The last three decades in Australia have shown how far beyond tolerance it is possible to go. It is certainly true that we should not stop at tolerance. But nor should we ever think of rejecting it, or minimising its value.

Respect for, or fully engaging with cultural difference is desired, but is difficult to achieve in some contexts. West (2002: 6) outlines the difference between critically ‘engaging’ with diversity and just ‘tolerating’:

> Critical thinkers convincingly argue that the code words associated with multiculturalism and liberalism – civility, diversity, pluralism, tolerance – have more to do with universally imposing the monocultural and monological ideals of liberalism to heterogenous
situations and less to do with enabling and engaging differences on their own terms.

Critically engaging with difference beyond tolerance has power implications:

Differences are relational, and involve hierarchy and differentials of power that are constantly contested (West 2002: 12).

In the hospital sometimes what was on offer was tolerance rather than fully meeting the needs of families, due to the constraints outlined.

Hodge and O’Carroll (2006) suggest there are varying degrees of tolerance in multiculturalism. They consider some other multicultural theorists as too binary when they judge anything short of complete commitment to cultural difference as racist. For instance, Castles and Vasta (1996: 5) argue that discourses of tolerance “can only be seen as genuine anti-racism if they are matched by a fundamental change in institutions, attitudes and practices”. Similarly, Hage (1998: 90) dismisses tolerance as practices of exclusion and domination disguised as egalitarianism by those in power. By contrast Hodge and O’Carroll (2006: 52) put forward a different concept of tolerance, as a contradictory and changing principle but useful nevertheless:

Behind Hage’s negative judgement lurks a crisp binary logic applied to tolerance: it is either a pure and homogenous essence of tolerance, or it is unworthy of the name. For us, tolerance is a contrary, fuzzy principle, existing as more or less, not a thing in itself. Differences between more and less matter in everyday life … There is a range of positions in between – the fuzzy, complex terrain where life is mostly lived.
Enabling the negotiation of cultural difference

The case studies revealed varying degrees of tolerance and acceptance but not full acceptance of cultural difference. Negotiation was assisted by reflective practice and advocacy skills of allied health staff, duty of care of the health professionals and the involvement of the family.

Advocacy and reflective practice

Reflective practice and advocacy were important in addressing the limits to respecting cultural difference. This has been shown in previous chapters in relation to the role of cultural relativism and status recognition. The benefits of reflective practice have been highlighted (Anderson, et al. 2003a; CCHCP 1999; Gustafson 2005; Kagawa-Singer and Kassim-Lakha 2003; Trenerry, et al. 2010). Findings in this study suggest that staff need to reflect on structures of disadvantage, organisational and professional cultures, and individual values.

Negotiation of cultural difference was enhanced by advocacy. Advocacy is defined as “influencing those who have power on behalf of those who do not” (Teasdale 1998) in (Waterston 2002: 1). An international review of tools to help reduce race-based discrimination and support diversity has highlighted the need for advocacy along with other actions such as organisational development, policy reform, research, evaluation and monitoring (Trenerry, et al. 2010). Given the lack of systemic and organisational support for cultural competence (see Chapters 3 and 4), staff advocacy was an important part of practice.

Advocacy for children, in the form of “speaking out in public and supporting a child or family’s case” (Waterston 2002: 586-7) is essential as a child’s health is dependent on factors outside their direct sphere of influence
Advocacy is also important in the area of chronic illness where patients are often unable to assert their own needs (Tannous 2000). Allied health staff played a key role in advocating the needs of families as this is enshrined in their practice (AASW 2003).

Civic duty and duty of care

Limits to respecting cultural difference were not absolute in the hospital as staff’s professional duty co-existed with civic duty. The nature of professional care, including factors such as duty of care and altruism (Cruess, et al. 2002), meant that staff respected some practices with which they were not entirely comfortable, such as different notions of parenting. There is also a civic duty to tolerate a variety of behaviours in accordance with the policy of multiculturalism (Hodge and O’Carroll 2006).

Involvement of family: reciprocal respect

The interviews revealed that the staff’s levels of respect and tolerance were affected by the amount of involvement and compliance of the families, that is, how well they tried to fit into the ‘system’. When families fitted staff’s expectations, staff were more tolerant. Hodge and O’Carroll (2006: 56) discuss the reciprocal nature of tolerance as implying “reciprocities of rights and duties, between communities or between individuals and governments”. Federal legislation and policy outlines that Australians are supposed to respect each other’s culture and beliefs, but migrants also have a civic duty to support the basic structures and principles of Australian society (Commonwealth of Australia 2003; Jayasuriya 2003). In the case study of Joshua, the respect between the father and staff was reciprocal. In Honneth’s (1995) understanding of reciprocal respect, individuals earn respect through
knowing their obligations to others (Thompson 2006: 49). Respect is not then one-way.

Reciprocal respect could be applied to cultural competence in the hospital, where working with cultural diversity should not be a one-way process of staff trying to understand patients, as staff need families to understand how the health system works in order to assist with negotiations. Other literature has similarly surmised that if the health staff respect a family’s background and beliefs, this may promote family compliance and acceptance of western health care (Eisenbruch and Handelman 1990; Meadows 1991). The benefits to health outcomes of engaging patients in health care treatments have also been noted (Johnstone and Kanitsaki 2009). Engaging families in the treatment of the child also has benefits, as outlined in the family centred care literature (American Academy of Pediatrics 2003; AWCH 1999; The Royal Australasian College of Physicians, et al. 2008).

In the following sections I discuss the three case studies, each preceded by a text box outlining the chronic illness of each child and the most difficult issues staff faced. I first discuss the case study of Connor, where the medical staff’s expectations of parental compliance and responsibility did not match the family’s understanding, which made negotiations difficult. With the case of Zahra, the social worker advocated respect for the mother’s problematic behaviour in relation to her refugee experience and lack of experience with the health system. The judgemental behaviour of the nurses demonstrated the nurses’ lack of support in general, and in relation to working with cultural diversity. Lastly, I use the case study of Joshua to discuss how the staff’s respect for the grandmother’s cultural difference was constrained by the need to focus on Joshua’s physical health. The rehabilitation staff were also constrained by the determination on the part of the hospital executive to
make Joshua leave the hospital. At the same time, staff advocated respect and reflected on how the family was disadvantaged as a consequence of organisational and professional constraints.
6.1 Impact of dominant medical culture: Connor and his family

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<th>Connor and his family</th>
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<tr>
<td>Connor is a fourteen year old boy who is HIV positive. Connor was born in New Zealand. His father was of Maori background while his mother is of Maori/Anglo background. Connor has been HIV positive since birth. His mother was diagnosed with HIV when she was pregnant, shortly after her husband’s diagnosis. Her husband had contracted the HIV virus through complications with a medical procedure, and died about two years after Connor was born. The family left New Zealand when Connor was about seven due to the social stigma associated with the virus.</td>
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<td>Connor lives with his mother, Trish, and has five other siblings. The family is of a low socio economic status and live a long way from the hospital. Trish lacks social support especially with the care of her two youngest children, although Connor does spend a lot of time with an aunt and uncle. Trish’s current partner was not working and was not involved in Connor’s care. Trish said she finds it difficult to travel to the hospital with her young children.</td>
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<td>The main issue staff raised in the interviews was the non-compliance of the family. Connor was reported to have behavioural problems, and had also been suspended from school. During the course of the interviews, he was hospitalised for a range of infections as he became resistant to most of the anti-viral drugs. Trish said she found some of the staff to be judgemental to her management of her son’s illness.</td>
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<td>Full compliance is needed when taking HIV antivirals or the patient can become resistant to the medicine. Even when full compliance is ensured, the antivirals may stop working after a while and the patient needs to change to a stronger antiviral. There are also only a limited number of antivirals available which can treat the virus.</td>
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26 Information provided by the social worker.
In this case study, the family and the hospital staff had different priorities in the treatment of Connor. While the health staff valued full compliance, the family felt the responsibility for compliance was shared across the extended family and local health services as well. This resulted in the staff viewing the family as ‘chaotic’ (ie. negative). The mother on the other hand viewed the hospital care as unsatisfactory.

Advocacy on behalf of the family was limited. There was little defence of the family based on their cultural background or their social situation, which were not overtly discussed with the staff. It was more a private matter for Connor. Nor did the health staff reflect on the impact of the organisational and professional culture of seeing this family as chaotic, which was consistent with the dominant norms in society and the expectations of the medical staff.

This case study demonstrates the difficulty of negotiation. Status recognition did not occur here as, although the mother was disadvantaged, hospital staff did not recognise or support her treatment decisions because their primary focus was on the physical health of Connor. There were also not the resources available to implement the mother’s view of how the illness should be treated.

6.1.1 Medical expectations of parental responsibility and compliance

The staff interviews revealed that they expected that someone in Connor’s family should take sole responsibility for ensuring medical compliance, and that the family should respect medical judgement and knowledge. When these expectations were not fulfilled, the medical staff were critical of Trish’s parenting. They did not accept the family’s notion of responsibility shared
between the mother, Connor himself, the aunt and uncle. Cultural relativism
and status recognition did not feature in the negotiations.

An interview with one of the doctors revealed that the option of Connor
having injectable medication was ruled out because of the perceived lack of
attention that his mother gave him:

He’s going to need an adult to help him, and we’re not confident
there’s any stable adult person in the household who he can rely on to
help him with it. Our experience in the past has shown us that his
mother doesn’t consistently exercise enough responsibility to be relied
upon … her life is obviously pretty chaotic in that she has a child from
a different father every – I think she’s actually had two children by the
same father, so that’s cause for celebration. (Alex, doctor 1)

The doctor is dismissive of non-nuclear families, or shared notions of
responsibility in the family. He and two other staff use the term ‘chaotic’ to
refer to the family’s lifestyle. The doctor explained what was meant by this
term:

She is inconsistent in her care of the children. She has young children
that are obviously occupying her priorities at the moment, and
Connor can’t expect to get from her the attention that he would have
had three or four years ago. She had, even then, relied on other
members of the family to take a lot of the brunt of his care. (Alex,
doctor 1)

The discourse the doctor uses emphasises individual responsibility rather
than acknowledge the social and psychological reasons for the family’s
behaviour (Baum 2008; Kagawa-Singer and Kassim-Lakha 2003; Sawyer and
Aroni 2003). Schon (1991) discusses the difficulty health professionals have in dealing with the complexity of a patient’s life, and they sometimes blame the patient for their own lack of knowledge of the situation. However, there are more contemporary moves, inspired by the consumer movement, for health services to take a role in ensuring compliance beyond blaming the patient for any failures (Sawyer and Aroni 2003).

Humphrey, Weeramanthri and Fitz (2001:1) have reported how non-compliance is often regarded within medical discourse as a ‘scientific problem’ that can be overcome through education. However the promotion of compliance ignores the evidence that only 50% of patients with chronic illness take their medicine as prescribed by their doctor (Sawyer and Aroni 2003). Despite this reality, health professionals still see ‘compliance’ or ‘adherence’ as a dichotomous construct, “in which patients are considered to be either adherent or not” (Sawyer and Aroni 2003). Unfortunately with HIV treatment, adherence must be 100% in order to be effective.

The influence of individualism and neo-liberalism in health care, and in society more broadly, where consumers are expected to take more responsibility for their actions, may also have been influential in the doctor’s assessment of the mother’s lack of responsibility:

The drift of politics in liberal democratic states towards the right since around 1980 has made individual ideologies more influential in the shaping of public policy. Individualism holds individuals totally responsible for their actions and the consequences, including health.

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27 As explained by the social worker in this health team.
In philosophical and ethical terms, its key principle is autonomy (Baum 2008: 74).

Individualism may lead to a process of victim blaming instead of exploring the social and economic causes of health behaviour. In the case of Connor, it was his mother who was held responsible for his non-compliance.

The doctor is probably also influenced by mainstream parenting values in Australia where the mother is expected to take full responsibility of care giving in the family. From recent parenting research in Australia, Kolar and Soriano (2000) reported that it is the norm in mainstream Australia that mothers provide all the care in the family, and they are often blamed when things go wrong. The authors however assert that parenting does not happen in isolation and that social assistance and other resources are required to support parents.

Anderson (1986: 1281) describes how families who do not fit the expected norm of compliance in health care become a ‘problem’ family in the minds of providers:

The family who fails to comply engenders feelings of frustration and impotence in the practitioner hence the family becomes labelled as ‘difficult’ or ‘non-compliant’ or ‘problem patients’.

Connor’s family have different values of parenting to those expected in the hospital and are therefore disadvantaged in interactions. Difference is viewed according to dominant norms and the main ideology in the hospital (Anderson 1986). As outlined by Fraser (2002: 25):

Interaction is regulated by an institutionalized pattern of cultural value that constitutes some categories of social actors as normative
and others as deficient or inferior: straight is normal, gay is perverse; ‘male-headed households’ are proper, ‘female-headed households’ are not; ‘whites’ are law-abiding, ‘blacks’ are dangerous. In each case, the result is to deny some members of society the status of full partners in interaction, capable of participating on a par with the rest.

Fraser (2002: 34) asserts that judgements of cultural and religious practices must be abandoned before parity of participation can be achieved. What needs to be addressed is how people are disadvantaged in the context of ‘institutionalized patterns of cultural values’. In the case study presented above, the doctor made moralistic judgements that the mother’s parenting behaviour was deviant without considering how this family was disadvantaged institutionally and socially.

However, as Fraser (2002) points out, parity of participation can not occur if status recognition disadvantages other people. In this light, staff may have felt they could not support Trish’s views of shared responsibility as that could compromise Connor’s right to health care.

Staff are faced with the dilemma of deciding whether the mother or the child should be accorded parity of care.

Trish had different notions of parental responsibility based on her belief that her son was old enough to take responsibility. In one of the interviews she explained that she did not see her son’s medication as being her sole responsibility, but shared between herself and her son, and with his aunt and uncle as well.

I tell them he hasn’t been compliant, he hasn’t been taking his medication, and they ask me why? I say, “How would I know?” … I
say, “I can only tell you [about] when he’s with me on the weekends.”
And then he’s telling his aunty and uncle that he’s been taking them. I
say, “Well, that’s something that you need to discuss with Connor”…
Because I don’t constantly ask him every day, “Connor, have you
taken your medication?” … Because I think it’s time [for him] to take
responsibility. (Trish, mother)

If the hospital accepted the family’s shared notion of responsibility, this
would have more resource implications in terms of involving the extended
family (aunt and uncle) in the treatment plan.

The health staff did briefly discuss including the extended family but it was
removed from the health care encounter as they did not come into the
hospital.

There’s also a big extended family who we don’t see. We know of
them … but we don’t see [them] in terms of our communication and
health messages … So that’s often been a problem … He’s been
backwards and forwards between his aunt and uncle, to his mother’s
house … I don’t think it’s a custody arrangement, I think it’s just part
of their cultural community … is my understanding, that’s what I’ve
been told. (Kennedy, doctor 2)

This doctor seems to have had the role of Connor’s extended family
explained to her as being related to their cultural background. This form of
cultural relativism is protective and gives the family the benefit of the doubt
for their different understanding of parental responsibility. However, the
extended family are not part of the medical encounter for this doctor, so hold
less significance. The main way health professionals work with patients is
focused on the medical encounter and processes of direct communication (Humphrey, et al. 2001).

The interview with the uncle revealed the important role that the family played in Connor’s life:

Every holidays, every weekend, Friday you can guarantee Connor’s here … I’ve got a big family … we have a few meetings here, a lot of my aunties come up and say, “I thought Connor was your son”, I say “That’s my nephew”. When he was in hospital, they all brought presents to send up to him in hospital. (Bill, uncle)

The aunt and uncle reported seeing Connor in the hospital at night but had not seen any of the staff. For the uncle, looking after his family and Connor was part of his Maori culture which was very strong for him:

It is a very, very proud race. We love to take care of our own. Well I do, myself. (Bill, uncle)

The ethnicity of this family was generally not regarded as a significant issue, and thus cultural relativism did not figure in any assessment of their needs; in the end they missed out on the advocacy they were due. In this respect Connor’s case study was unlike those of Joshua and Zahra. Connor treated his family’s cultural background as a private matter and he did not talk openly about it. It appeared that he wanted to be normal and therefore not invoke difference in terms of his ethnicity. Having a chronic illness already contributed to his feelings of difference. Also, a fourteen year old may not want to be seen as different.

Connor did not discuss his strong relationship with his aunt and uncle with the health team, or in the interviews conducted with him by the ARC Project
team. This situation demonstrates how his ethnicity was contextual and not relevant for him in the hospital; however, the extended family could have assisted in solving some of the problems of ‘compliance’. This is where the principles of family centred care could have been relevant.

One doctor did not know the mother was Maori. This understanding may have been related to her mixed Maori/Anglo ancestry. Because the mother did not look ‘different’, ethnicity and cultural background were not seen to be an issue influencing their behaviour, as indicated by this comment from one of the doctors:

I put it as more a social [dimension]. His mother is a single parent with lots of responsibilities and her own health problems. I would have thought it was more social than cultural, but you might be right. We may need to ... (Alex, doctor 1)

The medical team expected the social worker to raise the social situation of Connor in team meetings. As explained by a doctor, when questioned about social considerations:

I think it’s very important, and that’s why we have a social worker to work with the family. (Alex, doctor 1)

Here the role of social work was constructed as separate to medical concerns. There is discussion in the literature about the difficult role that social workers undertake in hospitals where the social needs of patients are not a priority, especially in the current health environment of economic reform (Giles, et al. 2007; Keigher 1997). The social worker explained she sometimes had to assert her role due to the dominance of medicine in the team:
I think sometimes some of the social issues can be ... not undermined, but maybe downplayed in terms of their importance, but that’s where it’s my role to make sure that doesn’t happen, and that I continue to promote the issues that the family’s going through. But yes, within my team I feel very supported and comfortable that the team will ring or page if there’s an issue and say, “Can you please do that?” (Gai, social worker)

6.1.2  Lack of integrated care between the hospital and community services

The family and health team had different notions of how the illness should be managed. The family wanted to be able to manage the illness with their local doctor and health services, while the hospital expected the family to come for a visit when requested because of the severity of the illness. The family’s disadvantaged social situation made coming to the hospital difficult.

Trish explained that it was expensive to go to the hospital all the time and was difficult when she had to look after her other children. She felt one of the doctors was judgemental of her when she did not bring Connor to the hospital when he had a fever after a series of ear infections. She had tried to negotiate the hospital looking after this ear problem when he was hospitalised for shingles a few weeks previously, and did not feel she could come into the hospital again. From the perspective of the hospital, the mother was deviant and irresponsible for not bringing Connor back to the hospital when his conditions worsened. As Trish said:

This is where the argument is now with myself and the new doctor, where they’ve got to understand that I can’t just get up and go to [the hospital]. There are so many things to organise. I was talked down to
like I don’t know what’s wrong with Connor … I couldn’t do it. It was too far to go, I couldn’t afford it … It made me feel bad because, (it was like) I was an irresponsible mother. That’s how I felt. And I thought, “No, stuff youse. I’m not coming back.” (Trish, mother, F2)

In this instance, there was a clash of priorities between the hospital wanting to give specialised care and Trish trying to manage the boy’s illness closer to home. Trish took him to her local doctor who monitored him over a week.

The doctor in a subsequent interview did acknowledge the difficulty the mother had getting to the hospital, but still ranked face-to-face engagement in the hospital more highly than other forms of outside interaction.

I think the travel distance … and the cost of petrol … Trish has told me several times, it’s high … So often Trish would get here after five or six o’clock at night, which is the time when we’re not here. So there was a real inability to communicate well … that’s really difficult because we make decisions on a daily basis, treating someone medically, to try and communicate that to a parent when they’re not around, face-to-face, makes it quite difficult. (Kennedy, doctor 2)

The doctor acknowledged the social constraints but relied on clinical encounters and face-to-face communication in the hospital to make decisions. Biomedical research focuses on the importance of the practitioner-patient interaction in determining compliance. However, as discussed in Section 6.1.1 above, this approach is critiqued as not addressing the social factors determining adherence, including “the ideology of medical authority” itself (Humphrey, et al. 2001: 4). Muhajarine et al. (2006: 207) state:
Any meaningful effort to enhance children’s health must go beyond a focus on the biomedical and behavioural influences and seek to understand the economic conditions and social milieu in which families live and raise their children.

The management of HIV illness on a shared basis between the patient’s local practitioner and more specialised services is an increasingly common approach which is being promoted. Management of the illness at home embraces regard for the social well-being of the patient, instead of just focusing on the physical nature of the disease. However, in the case of HIV, this is difficult because of the patient’s need for constant care due to the failure of the immune system. The need for more integration between health services is of ongoing concern in the health system (NHPAC 2006; NSW Health 2007). Research has demonstrated that combining specialist with primary health care (with a general practitioner) can be effective, on the proviso that there is regular communication between the health providers because of the complexity of the illness (Gibb, et al. 1997; Smith, et al. 1996).

While the staff focused on Connor taking his medicine as prescribed, the family had a wider social notion of health, based on well-being. Recognition of these social conditions of health would have major resource implications such as meeting families after hours and in their homes. As Connor’s illness progressed, the medical staff stated it was also increasingly difficult to manage his acute condition in another hospital closer to the family as they were not specialised in HIV medicine.

6.1.3 Dominance of medical culture affecting negotiation

Staff did not reflect on the impact of the medical culture or their judgemental values in distancing the family from the hospital. The extent of animosity
between the staff and the family became apparent to us at a family team meeting we observed. The meeting was organised to discuss a treatment plan for Connor with a range of health professionals to address his resistance to the anti-viral medication. However, at this meeting there was emphasis on ensuring compliance through education, which was counterproductive to meeting the needs of the family. This was despite evidence that an increase in patient knowledge does not significantly lead to increased compliance (Humphrey, et al. 2001). The actions of the staff were not optimal to ensuring the open consultative process envisaged in family centred care (Chalmers and Rosso-Buckton 2008).

The staff used war metaphors to explain to Connor how to take his medicine properly so he could ‘fight’ the HIV virus. However, as noted by Fleischmann (2001: 476) “biomedicine’s crusade against disease” is not conducive to meeting the needs of the illness sufferer. The patient is actually disempowered when the virus is represented as the active agent. These metaphors, although meant to assist in understanding the process of disease, alienate and depersonalise the patient. During the meeting the boy had glazed eyes and did not hold eye contact with anyone.

Trish said she was not happy with the service, which distanced the staff even more from the family. She challenged the dominant discourse of being a compliant patient and family. There was a lack of advocacy for the family. The mother was also busy looking after the younger children during the meeting, which could have disadvantaged her from actively asserting her
views. The provision of child care or a ‘patient’s friend’ for instance may have assisted the mother.

There was also no discussion of why Connor did not want to take his medicine. During the meeting, Trish made the point that no one had asked Connor how he feels.

The team asserted their professional understanding of how the illness needed to be treated. However, research with adolescents has concluded “the most fundamental step in improving compliance is to identify the underlying reason for non-compliance in each case” (Dinwiddie and Muller 2002). Included in this is an examination of the “structures of power, authority and social control that compliance reinforces” (Humphrey, et al. 2001: 6), which Connor seemed to want to reject, as is the case with most teenagers.

The health team needed some commitment from the family. Rather than go through a process of negotiation, the family had to commit to an alliance with the health team. One of the doctors explained in a later interview:

   We need to have what we call a therapeutic alliance so Connor and Trish agree that this needs to happen and commit to it. We as doctors bring him to the table and say this is what your regime is going to be, and commit to it as well. (Kennedy, doctor 2)

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28 This term is used to refer to a paid staff member at the hospital whose job is to assist patients with any concerns they have with the quality of care.
A therapeutic alliance is defined as the relationship between the health professional and patient where both agree to shared “treatment goals and tasks” (Martin, et al. 2000: 438). The doctor was hopeful that the family would ‘commit’ to this regime.

This case study demonstrates the effect of the dominant culture on compliance and parental responsibility, which did not match the family’s notion of shared responsibility between the mother, aunt, uncle and Connor. Staff were then faced with the difficult task of trying to respect the mother’s insistence on shared treatment and responsibility, while they were aware that resources to make this possible were lacking. Advocacy did not feature prominently in this case study. The result was poor health outcomes for Connor and a lack of support compared to other patients and their families.
6.2 One approach does not fit all: Zahra and her family

**Zahra and her family**

Zahra is on dialysis for kidney failure. She is a 16 year old girl and was born in Libya. Aida, her mother, originally came from Cairo in Egypt and her father came from Sudan. The family lived in Sudan, Libya, Egypt then Sudan again. They came to Australia in 1999 as refugees because of their persecution as Christians living in Sudan (where there was a Muslim majority).

Zahra is primarily taken care of by her mother as her father died soon after they arrived in Australia. Zahra also has three older brothers who take her to dialysis. Zahra’s mother Aida has very little English and speaks an Arabic dialect. She is not employed and is learning how to drive. The family has a low socio-economic status with a lack of social support. The only other family in Australia are Aida’s in-laws, with whom she does not have a good relationship.

Zahra has kidney failure through improper management of spina bifida overseas. She was born in Libya but taken to Egypt for special treatment, as her family knew she had difficulty with her kidneys and walking. The family then went to Sudan after which they had to leave as refugees. Dialysis only started in 2006 at the children’s hospital (3 x 6 hours a week), so Aida was new to the experience.

The staff at the Renal Treatment Clinic said there was ‘non-compliance’ with the family arriving late for dialysis, and Zahra not taking her medicine properly. Some of the staff labelled this family, especially Aida, as ‘difficult’ as she was very demanding, asking for assistance with her own health. There were also communication difficulties between staff and the mother. The dialysis ward is mainly managed by the nursing staff who work long hours, while the doctors and social worker make occasional visits.

This family’s behaviour did not conform to the expectations of staff. The staff’s way of working with Aida enacted the notion of tolerating an unwanted situation as the staff had a duty of care for the child. Zahra’s mother, Aida, enacted a broader notion of health care than the staff expected in asking about her own health. These demands mainly affected the nursing
staff who lacked recognition of their workload in the hospital compared to other staff, which seemed to affect how they in turn struggled to work with this family. The social worker played a critical role in reflecting on, and in advocating for, the rights of the mother in consideration of her refugee experience.

Working with difference was time consuming and draining for staff. The social worker raised the possibility of providing a different service for this family, instead of just providing the same service, to be achieved through the support of an ethnic health worker.

6.2.1 Differing perceptions of care for child and for family

The dominant biomedical culture in the dialysis ward was characterised by an expectation by staff that families would follow the unspoken rules. The staff labelled Zahra and Aida as difficult in terms of complying with dialysis treatment. As explained by Lyn, a doctor in the dialysis ward:

It’s been a nightmare. An absolute nightmare working with them! I mean, just from the point of view of trying to manage a child with kidney failure … And we were really very unsuccessful in getting her to keep to any programme, and her mother seemed to be unable, unwilling to keep her to the programme … (Lyn, doctor, S1)

While the staff’s main concern was with the health of Zahra, Aida encroached on the staff’s time, asking for assistance more than the staff deemed was appropriate. Aida would ask for things that were not to do with kidney failure. For instance, Aida would ask for help with Zahra’s difficulty in walking (because of her Spina Bifida), social problems and with issues about herself. As explained by the doctor again:
I find that communicating with Aida is almost impossible even when I have an interpreter there. I’m usually trying to explain things to do with kidney disease … Aida listens to me for a bit and then goes off on a tangent about the legs, or this or that or something, or a particular letter she needs for housing or social security … And I don’t think that I’ve ever felt that I’ve actually ever communicated anything satisfactorily to her. (Lyn, doctor, S1)

Aida took the opportunity to ask about her own health as she spent so much time in the hospital. In the dialysis ward there was a blurring of boundaries between home and hospital as families spent 18 hours a week there. This meant staff and families had to tolerate each other’s behaviour. Despite this blurring of boundaries, one of the senior nurses in the ward, Jody, still tried to maintain a division between Zahra’s and Aida needs. Jody explained that the nurses were not trained to deal with some of Aida’s requests:

At times when Aida will follow them around and it’s busy in there and there can be some quite unwell children and she’s wanting them to take her blood pressure, or she’s wanting them to do her blood sugar, that they’ll snap at her. They’ll say, “No, I’m not doing it now … I’m looking after Zahra.” But they’ve also been advised by me … legally they shouldn’t be providing her medical care, and they’ll just have to make that quite clear to Aida. (Jody, nurse, S4)

This nurse tried to invoke legal boundaries for not being able to address Aida’s concerns, as professionally they are looking after Zahra, and the other children in the ward, as their first priority.

The mother does not follow the (unspoken) rules of only discussing kidney failure and so is labelled problematic. This is reminiscent of Schon’s (1991)
work which discusses how the knowledge base of professions is specialised, bounded and scientific and is not suited to dealing with social problems and systemic issues. While the doctor did not think it was appropriate for Aida to be asking for assistance about her own health, research suggests that children’s health is “inextricably linked to their parents’ physical, emotional and social health, social circumstances, and child rearing practices” (AAP 2003: 1541). ‘Family Pediatrics’ or ‘Family Orientated Care’ is described by the American Academy of Pediatrics (2003: 1556) as care which:

extends the responsibilities of the paediatrician to include screening, assessment, and referral of parents for physical, emotional, or social problems or health risk behaviors that can adversely affect the health and emotional or social well-being of their child.

In Australia the Health Care Policy relating to the Children and Families (AWCH 1999: 3) similarly promotes a:

... family orientated approach to child and adolescent health care, and works to ensure that the unique and specific non-medical, psychological, social, and behavioural needs of children and their families in the Australian health care system are recognised and met.

A more recent policy, Standards for the Care of Children and Adolescents in Health Services, recognises the need for family friendly care, and states that “health services should allow timely access to social work support for families in distress” (RACP 2008: 9). These policies indicate that Aida’s distress may have some impact on Zahra’s health; however Aida’s requests were classified as problematic.
The fact that Aida was dealing with a lot of psychological distress was confirmed in an interview where she spoke about having to do everything in a new country after her husband’s death:

I feel really rotten. I feel really depressed, and I feel that my chest is very tight … Sometimes, like I think to commit suicide. (Aida, mother)

Aida’s actions in the wards could also be related to her migration experience of looking after Zahra before they came to Australia where professional health boundaries may not have been so strictly maintained. Families from certain countries may not be used to chronic health care services (Anderson 1986), especially refugee families who may be in transition from one country to another.

One of the social workers reaffirmed that Aida’s demands are based on a lack of understanding of the health system:

She didn’t understand the boundaries of what the health system provides. She would come to see me with all kinds of things … she came in one day and she had a bill for the ambulance, and she had fines that the boys had got from fare evading on the train. So I had to say very clearly … I deal with the ambulance, that’s health. I don’t deal with things to do with the boys that are fare evading. You’ve got to take them somewhere else. No sense of who did what. (Jan, social worker 2)

The social worker is forgiving that Aida acts inappropriately because she does not know the system. Anderson (1986) has described how immigrant families may have been isolated from the dominant western ideologies in health care. In particular, immigrant women may lack English skills and may
not have been exposed to this dominant ideology if they have stayed at home looking after children. This seems to be the case with Aida whose husband supported the family before he died.

6.2.2 Advocacy for mother by the social workers

The dominant medical expectation of compliance and knowing how the health system works made the actions of Aida problematic. The social workers\textsuperscript{29} responded to this by becoming advocates for Aida. They also engaged in reflective practice.

In one incident, Aida had taken leftover food out of the fridge in the dialysis ward to take home to her family. This action upset the nurses, which resulted in the social worker Jan having to explain to the rest of the treating team some of the difficulties that Aida experienced as a refugee. This demonstrates the effects of the nursing staff having a normalised way of working with families, so when difference occurs, it is immediately viewed as problematic (as discussed in Chapter 5). This social worker focused on the cultural situation of the family, not on the nature of service provision (Manderson and Reid 1994). A second social worker went further in discussing how Aida’s problematic behaviour was related to broader organisational, cultural, language and service provision issues. This coincides with Fraser’s (2002) notion of recognising disadvantage in relation to dominant institutional structures and values, rather than just cultural factors of the client.

As explained by Jan, the dialysis social worker:
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\textsuperscript{29} There were two social workers: one from the dialysis ward and one from the spina bifida ward.
Sometimes the nurses, who are very busy and very stressed, see Aida as doing something that they don’t think is quite appropriate, and I remind them, well, she has come from a very difficult background. She and Zahra have both been traumatised in their background, so we have to try and understand why she might be behaving somewhat differently to some of the other parents … It’s to do with taking food home. The young people all get food sent up, and if it wasn’t all eaten she’d collect up what wasn’t eaten to take home to the boys… probably the boys wouldn’t have eaten … (Jan, dialysis social worker, S2)

Jan justifies Aida’s behaviour based on her being a refugee. This justification normalises Aida’s difficult behaviour for the nurses. The Australian *Practice Standards for Social Workers* (AASW 2003), examines existing policies and advocates change in order to meet the needs of diverse clients. The *Standards for Social Workers* in the US also acknowledges the role that social workers play in advocating against negative views of cultural difference, and in working with other staff to support their clients (NASW 2001).

Rene, the spina bifida social worker, explains in more detail that Aida’s behaviour is in relation to language issues, Aida taking the staff literally, and her not knowing the etiquette in the ward. Instead of focusing exclusively on the culture of the patient, this social worker acknowledges the contribution of the staff in terms of appropriate service provision (Manderson and Reid 1994). This has implications for the rules and procedures in the dialysis ward. Rather than the medical and nursing staff assuming parents know the rules, they need to put structures in place to cater for the family’s different understandings and experiences:
She very easily misunderstands what people intend for her to do … But generally, people should’ve thought before … they went up to the [fridge] and said these things were for the parents. And it was to make yourself a snack … And so she thought, these are for parents, and she obviously took some of them home. And people said she was stealing stuff. She wasn’t, she was just doing what they told her she could do, but that wasn’t what they intended … But she’s unable to actually interpret some of that correctly. And part of that’s related to language and part of it’s related to, she doesn’t know what people mean. She just takes it literally. (Rene, spina bifida social worker, S3)

Rene acknowledged the contribution of the staff to the misunderstanding rather than focusing only on the behaviour of Aida:

I just helped them realise what was happening and said that’s a staff issue, it’s not Aida’s issue. She’s been given incorrect information. They told her the right information, she took it her way. Don’t put it there, just put there what needs to be there, don’t have a whole stockpile of it. (Rene, spina bifida social worker, S3)

The social worker played the role of broker by moving the interactions beyond just labelling the family as difficult, to understanding why the situation occurred.

6.2.3 Providing different services to address inequities in care

The staff had mixed reactions to having more resources provided for refugee families. This raises the issue of whether patients from CALD backgrounds should receive the same, different or additional care. Not everyone can be provided with individualised care (Gould 1996). But there may be common
factors for groups of people. The interviews indicated that the way the hospital provided care was based on providing the same service to everyone. The social worker did not change the type of care provided, she just spent extra time with the family as issues arose.

When the staff were asked about the specifics of working with a refugee family, some said that everyone was different. This understanding exemplifies a politics of universalism which cancels out differences (Frankenburg 1993), as discussed in Chapter 5. Gustafson (2005: 5) argues that the assertion of a ‘commonality of the experience of difference’ when working with migrants in health care takes the responsibility off recognising and addressing differential power relations patients experience in relation to their different backgrounds. Health service research has shown that providing the same care can result in inappropriate care (Anderson, et al. 2003a; Phiri, et al. 2009; Ramsden 1993). Although one could not say that the staff did not go out of their way to assist Zahra’s mother, they continued to provide the same service.

The doctor explained that the service is the same for everyone, meaning the dominant Anglo Saxon approach prevails:

I don’t think any particular allowances are made for people who’ve come from anywhere except an Anglo-Saxon background, let alone ones who have come from a refugee background. Our system is the same standard system for everybody, so if they come to see me, we do the same history and examination. I might have an interpreter present, but nothing else … But we don’t have any specific – I mean, there probably is training available, if I was to go and look for it, but it
certainly doesn’t come up into my place, and neither, probably, would I have the time to do it. (Lyn, doctor, S1)

As outlined in Chapter 3, cross-cultural training is a prerequisite for all staff (CRC 2009) but not prioritised by managers at the hospitals.

The social worker explained the approach she uses is based on responding to issues as they arise in the dialysis ward. This is similar to the managers in Chapter 3 who react when there is a problem:

So every now and then, when Aida gets really annoyed about the difficulty – and she does have difficulty in getting in here – she’ll start to get later and later, and the Unit will get upset, and it does impact on the nurses and the rest of the patients, and so I have to go up and try and talk through, “How can we try and get here by half past one on Friday, rather than half past two?” (Jan, dialysis social worker, S2)

The needs of each family were negotiated on a case by case basis. In contrast to this approach, the occupational therapist working with this family highlighted the possibility of taking a more proactive approach, where staff would work with the family’s different needs but also pre-empt other issues they have witnessed occurring later on when families need help to negotiate the health system:

It would be very useful if we had an individual family service plan where we set out goals or set out ways that we could support families generally, before … little crises arose, so that we could actually make their long-term involvement as smooth as possible … So that things are pre-empted … (Marion, occupational therapist, S5)
This process would have resource provision implications as it would use the time and knowledge of staff who have experienced difficulties working with families.

An affiliated social worker raised the possibility of providing services which would address different needs of families from CALD backgrounds. Ethnic health workers could be provided to work with families who are unfamiliar with the health system:

> Probably what the hospital needs [is] more ethnic workers … and I’ve been saying for a long, long time, this hospital should have an Arabic worker … it would be a difficult job, because our Arabic speaking people come from many different countries … And even within the same country, they’re very, very different … But at least these people would have someone, especially people that are new to the country, who have got no understanding of the language or the practices …

(Rene, spina bifida social worker, S3)

Rene examines the need to have an ethno-specific worker who can better meet the needs of particular families, where equal treatment for families is defined by meeting differentiated needs (Gould 1996). This is similar to a cultural broker position (as suggested by managers and staff in Chapter 3).

### 6.2.4 Issues for nurses in working with cultural difference

Cultural competence is not just understanding the family, it relates also to the capacity of the hospital to provide services and resources. The interviews indicated that the staff’s frustrations were related to a lack of capacity and resources to deal with diverse needs.
Another issue of concern for nurses was that they lacked recognition for their contribution to health care. The way the nurses worked with some families from CALD backgrounds who did not fit the expected norm had a negative effect on the type of care provided and could lead to inequitable treatment. As discussed in Chapter 5, nurses’ time is already overstretched. This case study illustrates how a lack of recognition of the workload of nurses, combined with a non-compliant family, had implications for practice and inequities in care.

There was a lack of recognition of the contribution of the nurses. The dialysis social worker explained:

I don’t think people even think of them … When it’s Christmas time, for example, and presents go to all the wards, does anybody think about the Renal Treatment Centre? No! … They never shut down, and nobody even thinks about this, so they’re often the forgotten unit, and they work terribly hard. (Jan, dialysis social worker, S2)

The social worker is arguing for a form of ‘status recognition’ for the disadvantaged position of nurses compared to other health professionals. There has been a historic lack of recognition of nurses in comparison to doctors in acute health care (Bjornsdottir 1998), which relates to a lack of social, economic, cultural, symbolic and individual prestige (Meerabeau 2006). Studies demonstrate that nurses’ job performance and satisfaction increase if they are given more respect, control and responsibility over their work, which in turn can improve care for patients (George and Davies 2000).

Although Aida was demanding on all staff, the interviews indicated that it was the nurses who were most annoyed by her as she interacted with them the most. This was explained by a nurse:
We all become frustrated at times. It’s because you want to help them but sometimes you feel that Mum – I think because of Mum’s language and understanding … she always wants more. (Jody, nurse, SI4)

It is frustrating for nurses to spend extra time with families when their efforts are not valued in the hospital. Bjornsdottir (1998: 350) outlines that:

... nurses have found themselves in a system where primary emphasis is placed on technical efficiency, frequently at the cost of human relations.

According to this, the time spent on accommodating families is not valued or measured. Spending time with patients is immaterial labour and non-therapeutic in comparison to evidence-based medicine (Candlin and Candlin 2007).

The nurses were frustrated with this family and others turning up late for appointments or not at all. However, research has documented the difficulties refugee patients face in meeting appointments (RCA 2005); at the same time, it is important not to stereotype refugees as always being late. The NSW Refugee Health Service acknowledged the difficulties that Sudanese refugees had in attending appointments, which could be related to their unfamiliarity with hospital appointment systems in Australia, lack of social support and health services not being accessible in terms of transport and timing (Eastwood 2004).

The regime of dialysis was relentless for both families and staff, especially the nursing staff. A doctor explained that the nurses had become unnecessarily strict with some families. This indicates how the unsatisfactory
conditions of nurses in the hospital affected the ability of the hospital to cater for the particular needs of families:

We quite often have trouble with the nurses in the Renal Treatment Centre ... where they take a certain stand ... and there’s no flexibility. The families say, “Well, perhaps we could do it like this ...” “No, we’re going to do it this way! Yes, you’ve got to come at nine o’clock on Monday, and no, you can’t come at nine o’clock on Tuesday”.

(Lyn, doctor, S1)

The social worker defends the position of the nurses, but suggests that the hard line the nurses take could detrimentally affect the quality of care that culturally diverse families receive:

All hospitals are authoritarian, and they have to be ... particularly with dialysis, they have to do it properly or they won’t be performing their duty of care, but sometimes there are families you’ve got to try and protect from getting onto the wrong side of the treating team.

(Jan, dialysis social worker, S2)

Thus, the social worker has to support families who do not comply with the authoritarian structure of the hospital. The practical implications for families are that nurses can develop preformed judgements against them, and this can lead to inequities. The social worker then has the dual and potentially conflicting role of supporting both the staff and the family.

The interviews indicated that the demands that the mother placed on staff, and the strict nature of the dialysis regime, combined with the non-recognition of the nurses for their work effort, affected the nurses’ capacity for tolerance, and in some instances they were accused of being inflexible.
This reinforces the need for systemic support for nurses to deal with difference, as indicated earlier, to avoid the negative effect of judgemental attitudes on practice.

This case study highlights that in the health system there is little allowance for different needs of families to be addressed beyond the efforts of allied health staff to negotiate these needs as they arise. It also shows how medical and nursing staff see as problematic the meeting of these needs. Providing a different service to the family could have assisted the mother. Advocacy on the part of the social workers trying to extend the tolerance of staff is significant. Also evident is the lack of systemic support for nurses working with difference, and this has a negative impact on attitudes as well as practice, resulting in an absence of cultural competency.
6.3 Negotiating cultural complexity: Joshua and his family

Joshua and his family

Joshua is an eight year old boy. He had suddenly developed brain seizures after having a fever for several days. The hospital had to put him into a medically induced coma for nearly four months, and he stayed in hospital for another eight months before he returned home. He now has multiple disabilities.

Joshua was born in Australia, while his family originated in China. His immediate family members are his younger brother, mother, father, and a grandmother who lives with the family. The parents owned a newsagency which they worked in for long hours, but were trying to sell. While Joshua was in hospital the mother stayed home to look after Joshua’s brother and the shop, while the father and grandmother took turns in looking after Joshua in hospital. The father would stay overnight in the hospital while the grandmother would stay during the day. This care-giving arrangement in the hospital was unusual for staff as they said they would normally see the mother play a more prominent role. The grandmother does not speak English, so the staff had difficulty communicating with her. She also was very involved in the physical care of Joshua, to the point of potentially hurting him.

While the management at the hospital were eager for Joshua to return home after staying so long in the hospital, the rehabilitation team were trying to ensure Joshua had a smooth transition home where he would be appropriately supported. At the same time, the family were having difficulty accepting that their son now had severe disabilities and would need full-time care in their home, which would also need to be modified. They had received mixed messages from the health staff about Joshua’s prognosis which were related to: the tensions between the rehabilitation and neurology teams; the health team wanting to instil hope in families; the unusual nature of Joshua’s illness; and the difficulty they had in accepting their son’s illness.

In this case study the health staff we had most contact with were the rehabilitation team. The nature of this team, where the majority of the staff were from an allied health background, meant there was a focus on examining the social situation of the family. However, respect for cultural
diversity had limits due to the physical health of Joshua, the need for patient
flow and the availability of interpreters. This case study demonstrates how
these limits were blurred through the advocacy of the staff, and the benefits
of the family’s care-giving role in improving Joshua’s health, which assisted
staff to perform their job.

The allied health workers in the team took into consideration the impact of
both the hospital culture and the culture of the family in their interactions.
They engaged in reflective practice as they considered the impact of the
delay of the prognosis of disability by the doctors which may have
disadvantaged the family. They also considered how the family were
culturally disadvantaged compared to other families in the way they
responded to medical authority. Fraser’s (2002) notion of ‘parity of
participation’ helps to understand the staff’s perception of the family’s
situation.

6.3.1 Negotiating professional and institutional constraints with family’s
needs

Staff, especially the doctor and nurses, had a professional duty to look after
the physical health of Joshua, along with other patients in their care. This
meant there were medical limits to allowing the grandmother to look after
Joshua in a way which did not conform with the advised medical treatment,
as this could jeopardise Joshua’s health. There were also resource limits to
how long Joshua could stay in hospital and to how many times an interpreter
could be provided. These limits were not strict, but rather were blurred by
considerations of professional and civic duty, the benefits of family-centred
care and the advocacy of the rehabilitation team.
Subtle resource limits to recognising difference

There were subtle limits to ensuring services were culturally appropriate due to limited resources and the need for extra effort. Joshua’s father explained that the grandmother felt that staff used the fact that she could not speak English as an excuse for not helping. In an interview with the family in their home, the grandmother was asked about her impression of the care that Joshua has received. The grandmother explained:

Of course this area can be improved because I don’t speak the language, I’m using hand signals most of the time. Some of them, they pretend that they don’t understand me. Some of them, I ask for help, and they take a long time to come. (grandmother, F5)

If this was the case, staff were acting in a somewhat subtle way to impose limits on the type of care provided. Of course it is difficult to know the full story without also asking the staff. The staff said they used to use interpreters earlier in Joshua’s treatment, rather than later on. This demonstrates the effects of interpreters not being used consistently as outlined in Chapter 3.

The rehabilitation staff were respectful of the family’s need to sell their newsagency, which contributed to the delay in Joshua’s discharge; however, limits had to be imposed as the hospital management was pushing for him to be discharged. All hospitals are faced with the need for patients to move through the system to allow access for new patients (NSW Health 2003a). The staff therefore had to proceed with parallel planning for discharge to either the newsagency, where they were currently living, or to their new home where they were going to move after they sold the newsagency. It was
part of the advocacy of the allied health staff to extend the family’s stay, as will be discussed later.

*Medical limits to recognising cultural difference*

The doctor in charge was concerned that Joshua’s grandmother may have been pushing Joshua too hard in encouraging him to do exercises:

> We’ve just been trying to watch it from a distance to make sure he’s not being put in a compromising situation, and things seem to have settled down. But we have been a bit concerned at times that she might be pushing him too far, but our continued observation is that she does seem to respond to him appropriately, and … our concern hasn’t continued. (Parker, doctor, S1)

In this way, tolerance towards the grandmother was contained within professional limits of Joshua not being physically hurt. However, limits to tolerating cultural difference were not well defined. As outlined by Hodge and O’Carroll (2006: 52), “tolerance is a contrary, fuzzy principle, existing as more or less, not a thing in itself”. Staff were ‘concerned at times’ but continued to observe and assess the situation. Paradoxically, their professional altruism and civic responsibility meant allowing the family to look after Joshua the way they saw fit. The possibility of Joshua’s health being compromised by the grandmother’s actions had to be weighed against the benefits to his health of the family’s involvement.

*Health benefit of family involvement (family centred care)*

There were health benefits to letting the family look after Joshua which the staff accepted. The right of Joshua to appropriate health care and the right of the grandmother to express her cultural difference were not in strict
opposition. These circumstances were in line with intercultural dialogue, which recognises the cultural dimension to universal rights (UNESCO 2009) (as outlined in Chapter 5). Working with this family was not just about ‘enduring’ a situation. There were potential health benefits to letting the family look after Joshua the way they saw fit especially when it meant less work for staff and did not detrimentally affect Joshua.

As explained by one of the occupational therapists, the grandmother (referred to by the staff as ‘Po Po’, the Mandarin word for ‘grandmother’), was able to use her initiative to get Joshua to eat:

There’s been some things when they were trying to get him to eat, over what he would like to eat, and that was positive in that Po-Po took a lead in that, and did find food that he was happy to eat (Jay, occupational therapist 1, SI4)

The benefit of respecting the cultural knowledge of the grandmother was another reason for not setting definite limits. In the above case, the staff valued the knowledge of the grandmother over their own knowledge which supported the principle of family-centred (or friendly) care with positive benefits for the health and well-being of the child (American Academy of Pediatrics 2003; AWCH 1999; Goode and Jones 2007; RACP 2008).

The staff gave the grandmother a presumption of worth in line with Taylor’s (1994) principle of recognition of difference. The actions of the staff were in accordance with the notion of empowering minority cultures in the process of intercultural dialogue. This process:

… involves recognizing the ethnocentric ways in which mainstream cultures have often proceeded and making room for systems of
thought that recognise both ‘exoteric’ and ‘esoteric’ forms of
knowledge (UNESCO 2009: 10).

Addison, the nurse, also outlined the commitment the father and the
grandmother made to Joshua by staying overnight and looking after him
continuously, which had positive health results:

We’re very open to it. I think they’ve taught us a lot with the type of
cultural commitment that they have. (Addison, nurse, S2)

This nurse realised that the family’s type of care may be more beneficial than
the hospital’s notion of how the child should be treated:

We’re lucky in a sense that it’s a very good family. I’ve noticed though
with a Cantonese or Chinese family, they’re a lot more involved with
the child who is chronically ill like this and critically ill … (Addison,
nurse, S2)

Chinese families are classed as ‘good’ because of their involvement in trying
to help the child get better. They fit the dominant institutional values of
providing most of the care to the child in the hospital. Addison went on to
say that ‘cultural commitment’ helps with long term outcomes:

I didn’t think Joshua would survive … I think the cultural … I think
the family, especially grandmother and dad being so heavily involved
with his care and being at his side all the time has been a huge benefit.
And I’d noticed that with other cultural families too … I think the
more a family is involved, the better the outcome. But we don’t get a
lot of that now. (Addison, nurse, S2)
The nurse felt the cultural practices of migrant families bring major benefits to the health of the child, which it was felt Anglo-Australian families could learn from. Here, the health worker invokes the enriching contribution of multiculturalism, as discussed by Hage (1998).

Involvement of father assisted negotiations

Despite the challenges of working with the grandmother, staff were happy with the involvement and respect that Tom, the father, had towards the hospital staff. His involvement helped them do their job and seemed to extend their tolerance for the family. In the focus group when the staff were asked how they coped with not having the mother actively involved, the rehabilitation doctor, Parker, said:

> It’s not normally how we do business. We would normally be very much trying to have both parents available for our meetings, but Tom has been, the front, the face of the family, in terms of major communications, and he has made himself available. We’ve had to be a bit flexible about when we can be available for meetings [with him], but that’s OK, but he’s always said that it’s just him, his wife can’t come, so we’ve had to work with that. (Parker, doctor, FG1)

The father’s behaviour fitted into the hospital’s dominant ideology and expectation of having a responsible carer who was able to engage with health staff. The staff weighed up this benefit against the negative aspects of the grandmother’s over-involvement and mother’s under-involvement.

Honneth’s notion of the reciprocal nature of respect was enacted in this situation, which is based on the idea that respect is earned through contributing to society. People deserve recognition if their traits contribute to
society’s goals (Thompson 2006). The doctor went on to say the father was also easy to work with and therefore fitted the system:

Tom is such an amenable fellow to work with … He’s been very good to work with. Easy – I don’t know whether “easy” is the right word, but we feel that we’ve been able to engage quite effectively with him.

(Parker, doctor, FGI)

The father made their job easier because he respected them and their authority. He is labelled as ‘good’ and ‘easy’. Hodge and O’Carroll (2006) point to the reciprocal nature of tolerating difference where both sides have rights and duties which they abide by.

6.3.2 Cultural relativism and respect

The nurse and the two occupational therapists in the rehabilitation team were active in trying to consider the needs of the family. The nurse deployed cultural relativism to the point of essentialising the family’s ethnicity, resulting in a potential misrepresentation of their needs. The two occupational therapists involved in Joshua’s care did not just consider the ethnicity of the family but also considered the family’s cultural background, children’s health cultures, the status of their profession and their own age in explaining the behaviour of the grandmother.

While cultural relativist understandings provide an explanation for behaviour, they sometimes reduce people to particular ethnic stereotypes. This can have implications on practice if assumptions are made about the behaviour of families. For example, the nurse spoke about the family being ‘typically Chinese’, and on that basis predicted they would not want support for a disabled child when they take Joshua home:
I think because they have a disabled child, they want to just look after him … I’ve never seen any friends come in … Whereas in other cultures … I know with an Arabic family, the whole world comes … So that tells me that they’re keeping it to themselves, and that’s normal in their culture … I think they will find it hard when they close the door when they go home, and I worry about that …

(Addison, nurse, S1)

Contrary to these comments, however, in a meeting the family wanted all the information they could receive about assistance and support once Joshua returned home. For instance, they wanted to know if there was going to be regular physiotherapy visits and whether they could get special food delivered. When the family were interviewed after Joshua had returned home they welcomed the visits of the community health worker and the physiotherapist.

The nurse also thought that the family would not want Joshua to go to any institutional care:

They are going to look after him, but they are going to look after him quietly, alone … Usually it’s the close-knit family that lives within the household. They will look after the family member if there’s an injury. And also with the Greeks. If there’s a mental illness or an injury they will just keep that child at home … (Addison, nurse, S1)

In contrast to this view, Tom, the father, was very determined that Joshua would go to an integrated school. This demonstrates how the nurse’s assumptions, based on culturally relativist and essentialist notions of Chinese culture, were unwarranted.
Range of reasons for grandmother’s actions

The occupational therapists used cultural relativist understandings to explain the behaviour of the grandmother, but in addition they reflected on the type of service they were providing and how that interacted with the needs of the family. They were not just focusing on the culture of the family to explain the family’s actions but the nature of health service provision (Manderson and Reid 1994). This avoids the problem in health care where “focusing on distinctive cultural characteristics blinds one to the cultural context, the interrelationships between cultures within a country” (Polascheck 1998: 455).

In an interview, the occupational therapists were confused over whether the grandmother was intentionally refusing to care for Joshua in the way they had shown her:

> There were a couple of other examples of things that we found very difficult to get across, even with interpreters … I gave them a few ideas of activities they could do with him through the day to provide him with sensory stimulation, but I tried to be very clear that he needed rest periods as well … and she never really did what we were doing … didn’t give him breaks, and probably was more full on than we wanted her to be … I think it was to see how … what she was doing was going to help him more than what we were doing. (Drew, occupational therapist 2, S4)

The other occupational therapist reflected on the common belief of parents of sick children in the hospital that if they persisted they would overcome the physical odds of disease. In this way, the staff member is reflective of a common attitude of parents towards their children’s illness irrespective of
ethnicity. They also raised the possibility of the grandmother’s behaviour being related to her Chinese background:

> It’s a common problem for lots of families with children with a low responsive state … there’s usually a certain work ethos or … belief from media stories or something like that … the one-in-a-hundred person who worked unbelievably hard, and overcame amazing odds … You know that from your own cultural background, but I don’t know what might be playing in the Chinese culture, or particular superstitious beliefs, religious beliefs, or whatever. (Jay, occupational therapist 1, S4)

The occupational therapists went on to describe the possible reasons for her actions, but did not discuss the possibility she may have intentionally refused to act the way they requested. Interestingly, the term ‘non-compliance’ was not used in this case.

Jay further explained the notion of ‘saving face’ prevalent in some cultures, where someone would say yes, but do something else. In this way, she extends respect through the notion of cultural relativism:

> Each time we spoke to grandmother about things that we’d like her to do … she would agree … She didn’t really directly challenge us, but yet she continued to do what she wanted to do. So I don’t know whether that was a cultural thing as well … I think a lot of other families would say, “But why? Why do we have to do this?” I think that more stimulation is better … (Jay, occupational therapist 1, S14)

They understood the grandmother’s behaviour as possibly being ‘a cultural thing’ related to her ethnicity; however, it may have been difficult for the
grandmother to question what they were saying when there was not an interpreter there all the time. In the interview they had discussed how difficult it was to communicate with her without an interpreter. They discussed a service provision issue rather than just focus on cultural difference.

It’s always seemed that unless we’ve had an interpreter there, or Tom has given a very direct instruction to Po-Po, things won’t necessarily happen, or … we don’t get to hear that there’s actually a disagreement – that’s why she’s continuing on doing a particular thing. (Jay, occupational therapist 1, S4)

They were very willing to explore the range of possible social reasons for the grandmother’s behaviour. They also discussed the possibility that the grandmother’s behaviour reflected her willingness to take directions from her son but not the health staff. (It was revealed to us in an interview with the mother that the father was actually trained as a doctor. This may have explained why the grandmother valued his opinion so much). They then went on to explore how her behaviour could be related to their young age, and that it was therefore a generational issue:

I’ve often wondered too if there’s an age thing in it. I mean, I’m sure to Po-Po, we look extraordinarily young. (Jay, occupational therapist 1, S4)

The occupational therapists also reflected on the impact of their professional status, in comparison to doctors, on interactions with the family. In the focus group with staff, the occupational therapists said how it took the father a long time to respect their opinion over the prioritised medical opinion.
The occupational therapist discussions demonstrate the process of negotiation, extending respect, and reflecting on experience. They were enacting some of the principles of cultural safety and cultural competence of reflecting on the patients and their own values and culture (CCHCP 1999; Fitzgerald, et al. 1997; Hong 2001; Nursing Council of New Zealand; Eisenbruch 2001). This resonates with Schon’s (1991: 54) discussion of how professionals, when dealing with uncertainty, draw on a repertoire of past experiences and examples, a process called ‘reflecting in action’.

### 6.3.3 Negotiating systemic, organisational and professional constraints with family’s needs

The occupational therapists went further in recognising the impact of systemic, institutional and professional factors while also considering the needs of the family, including their economic situation and cultural background. They thereby reflected on how there was not a ‘parity of participation’ (Fraser 2002) for the family when interacting with health staff. This corresponds to the broader notion of cultural competence, of being reflective of professional and organisational cultures (CCHCP 1999; Hong 2001). They recognised how the family was disadvantaged in relation to the dominant cultural values in the hospital and how the family was systemically disadvantaged (Gustafson 2005). However, they still lacked power to challenge the medical hierarchy.

*Impact of reactive executive culture and systemic constraints*

The push from the Executive for Joshua to be discharged impacted on the ability of the rehabilitation team to perform their jobs properly. From their point of view the family could not leave the hospital until their home was modified. This demonstrates the effect of systemic constraints and
organisational culture on meeting the needs of the family. According to the Executive, there was no medical reason why the family could not go home. This upset the rehabilitation staff as they asked, “Doesn’t therapy count as treatment?” in one of the team meetings. They were also advocating for the role of allied health over that of medicine. They argue that allied health was essential to ensure good patient outcomes and could not be separated from medical needs. This discussion highlights the ongoing debate about the priority of medicine over other disciplines in the hospital. In fact, research has highlighted that the provision of multidisciplinary rehabilitation care does contribute to positive short term health outcomes for patients (Evans, et al. 1995).

The rehabilitation team discussed the tendency for the Executive not to take a proactive approach in considering the needs of the family. As outlined by one of the occupational therapists:

> It’s fine to have the pressure on moving people out of beds, and I quite understand the pressure they’ve got to accommodate the kids … but the time to push is from much earlier on, in admission, to make that clear to everyone … the Executive, in my view, has responsibility for cultural change in the hospital too, that we are helping people move towards the limits, and helping us work within the limits that we have, and I don’t ever see anything proactive on that. (Jay, occupational therapist 1, FG1)

These comments highlight the reactive tendencies of management as outlined in Chapter 3. In this case, the occupational therapists were demonstrating ‘public policy advocacy’ (Waterston 2002: 587) by seeking to change an aspect of the health system to benefit children generally, and the
status of allied health in particular. Waterston (2002) outlines how having an understanding of the political system is a skill needed for advocacy. The occupational therapists used their knowledge and experience to reflect on the constraints of the hospital system. They explained that the health professionals in the team took turns in taking a leadership role. In this case, it was the occupational therapists who took the lead. Having good team networking is also a skill needed for effective advocacy (Waterston 2002).

Impact of medical culture

The occupational therapists acknowledged that the medical culture of not discussing the prognosis of long term disability influenced the delay in discharge for the family. They then played an advocacy role in encouraging the neurologists to be upfront with the family. One of the occupational therapists explained:

The family has always been very hopeful that Joshua is going to make a full recovery, and I’ve always been very doubtful that that’s going to happen. So, from quite early on, I was pushing for the medical team to discuss that with Joshua’s family quite … directly … because until Joshua’s dad really accepted that this was going to be a long term thing, it was very difficult for us to do any work in terms of getting home modifications started or prescribing equipment. (Drew, occupational therapist 2, S4)

The factors indicated could have accounted for the delay in prognosis. The other occupational therapist went on to comment:

There has been some research done in the hospital that indicates that medical and nursing staff are poorly equipped to convey poor
prognosis or bad news to patients, the Child Health Initiative Review found that … that’s often an indicator of someone who’s going to have a long stay … and there are different reasons why that happens, … sometimes there’s liability issues as to how the injury [happened] or [how] the course of treatment has gone. Sometimes it is because they’ve had [an] unusual injury under a team that’s unused to permanent injuries (Jay, occupational therapist 1, S4)

Joshua’ illness was unusual so there was some uncertainty in the prognosis. He also made some unexpected progress. There is also the issue of medical litigation if the prognosis of the doctors was wrong. Wilson and Fulton (2000) discuss the rise in financial and emotional anxiety amongst doctors who have given a wrong prognosis and have been exposed to litigation. All these factors amount to organisational constraints which delayed the communication of a prognosis, preventing the family from making adequate preparations for the future.

Impact of family culture

The occupational therapists also reflected on the family being very trusting of the medical team, which may have disadvantaged them in not questioning the doctors:

The problem was exacerbated because of the way that the family accepted very much what the doctors were saying… and the doctors weren’t saying Joshua isn’t going to get better. They were still maintaining that hope, and I think maybe in another family who were maybe more familiar with the Australian system might question a bit more and seek a second opinion, or do their own research, or talk to other families (Drew, occupational therapist 2, S4)
In this way they were reflecting on the combination of the hospital culture and how the family’s trusting behaviour was different to other families. This strategy demonstrates cultural safety where the health professional is reflective of the impact of power relations between the provider and patient (Nursing Council of New Zealand 2005). They were conducting individual advocacy in promoting the interests of the family (Waterston 2002).

The occupational therapists recognised there was no parity of participation in this case (Fraser 2002), as the institutional cultural expectation was that families would speak up and know more about the health system. While not every family would know how the health system worked, there was some essentialism in advocating the difference of the family compared to other families. In line with Fraser’s (2002) principle of status recognition, they did not just point to the family’s ethnic identity, but also examined how the family was disadvantaged institutionally.

The occupational therapists took a leading role in negotiating the needs of Joshua’s family within the systemic and cultural constraints in the hospital. Occupational therapy literature has been reflective of the impact of professional values on practice (Fitzgerald, et al. 1997a); however, the occupational therapists in this case went beyond this, to negotiate the systemic, organisational and professional constraints with the cultural and social needs of the family. There were no strict limits to recognising difference: the benefits of family-centred care and family involvement extended the tolerance and respect of staff leading to better health outcomes for Joshua.
6.4 Conclusion

This chapter has discussed the range of factors affecting how staff negotiated the needs of the families within the constraints of the hospital. It demonstrates the impact of the systemic constraints in health care, dominant biomedical culture and personal values on health care provision. Staff expected that all families would take on parental responsibility, have values similar to their own, understand the health system, and fit into it. When families fail to fit into the model, as this thesis has explored, they may get on the ‘wrong side’ of staff. Staff may become judgmental, leading to a breakdown in communication, and ultimately poor health outcomes for children and families.

The way these staff viewed Connor’s and Zahra’s families had negative implications for the health of both children. Medical and nursing staff lacked the capacity and competence to work with cultural difference. Negotiation for their specific needs was not possible due to philosophical, systemic and professional constraints. The case study of Joshua highlights the importance of reflective practice on a number of levels including that of the health provider’s values, professional values, as well as institutional and systemic constraints. The staff were more accepting of the non-involvement of the mother and valued the involvement and knowledge of other family members.

This chapter affirms the argument of the more critical cultural competency and cultural safety traditions. Both argue that treating all patients in the same way is, in fact, inequitable when patients have divergent needs. As stated in Chapter 5, staff need skills to negotiate cultural complexity within the hospital and to address the specific needs of each patient and family.
There can never be a complete accommodation of cultural differences, as the hospital has too many constraints. This chapter explores the existence of tolerance as a practical reality of multiculturalism in the hospital.

In the case study of Joshua, when the father understood and respected the wishes of the hospital, then health staff were more tolerant. This resonates with the concept of reciprocal respect - gaining respect through performing duties. In the hospital, patients and families from CALD backgrounds attained better health care if they fit into the dominant system and tried to comply with treatment.

Reflective practice in accordance with status recognition was important in understanding the impact of the dominant cultural context of health care on patients. The case studies showed that an organisation's collective skills in exercising reflective practice are enhanced when it has adequate resources such as allied health staff, ethnic health workers, interpreters, support for nurses, cross-cultural training and adequate time for staff to conduct negotiation. Where these resources are lacking, as with the needs of Joshua’s and Zahra’s family, advocacy became important in generating more systemic support.

Consistent with the previous chapters, medical and nursing staff also lacked skills and competencies to handle cultural differences adequately. Families in this study received effective health care when one staff member in a team went out of their way to assist them. These individuals recognised the patient and family’s multiple forms of disadvantage to identify the tactical ways that services could effectively adapt to meet the needs of families.
7. Conclusion

In order to engage effectively with cultural diversity, hospital staff need systemic, organisational, professional support. It was found that as this support appears to be lacking, staff lack the capacity to work effectively. One corollary of evidence-based medicine, the dominant culture in the hospital, is that meeting the needs of families from CALD backgrounds is outside mainstream practice. In some instances, working with diversity became problematic, and this had negative implications for practice. It was usually allied health workers and staff from CALD backgrounds who were found to advocate and reflect on how families were disadvantaged and addressed inequities of care, rather than all staff having the awareness, skills and competence to work effectively with cultural diversity. This meant that if systems of support were not there, addressing inequities was dependent on someone in the team going out of their way to assist families. These staff engaged in protective practices such as cultural relativism, status recognition and relational positioning to assist families. Systemic recognition of the needs of CALD families is lacking in the current health environment of economic efficiency and reform.

7.1 Competing policies affect practice

The policies prioritised in the hospital were the ones relating to evidence-based medicine and efficiency rather than those urging provision of culturally appropriate care. The interviews with managers indicated that priority is given to meeting Key Performance Indicators such as ensuring short waiting lists and patient flow. The policies relating to identifying the needs of patients in order to provide culturally appropriate care did not
appear to be actively endorsed or implemented in practice. The interviews showed how there are multiple discourses in circulation but some are more dominant and reflect the values of the existing structures and institutions in society.

These findings support the view that practice is determined by a range of social, economic and political factors. The existence of one policy may not directly influence practice but can be influenced by the range of other policies in existence, some of which take priority over others. My findings suggest that practice was determined by the dominant ideologies in health of economic rationalism and evidence-based medicine, which took precedence over commitments to address social inequities.

The discourse contained in policy also affects practice. This was illustrated in the way culture was defined in the policy of multiculturalism, where essentialist notions of ‘culture’ prevail. This affected practice as staff often essentialised the culture of parents. This practice is not always negative, however, as it can be a starting point for negotiations (as shown in Chapter 5).

The main policies which influenced how staff worked with families from CALD backgrounds were the NSW Health equity of access and interpreter policies. However, the equity of access policy approach is critiqued as focusing on providing the same service to patients according to the principles of universalism, which in practice means difference is not addressed, as discussed in Chapter 3.
7.2 Lack of support diminishes capacity to work effectively with cultural diversity

Current cultural competency guidelines recommend that staff require support at the systemic, organisational and professional levels to give them the capacity to act appropriately. Findings from this research project suggest that staff lacked support on all these levels which diminished their capacity to work effectively with families from CALD backgrounds. Building this capacity is one of the objectives of NSW Health.

At the systemic level staff lacked support due to an apparent lack of cross-cultural training, inadequate data gathering and reporting mechanisms, and a lack of staff specifically trained to assist other staff working with patients from CALD backgrounds.

At the organisational level, staff were being pressured to treat patients as quickly and as efficiently as possible which compromised their attempts to meet patient needs. These factors combined to reduce the capacity of managers and staff to address cultural difference. Managers did not actively promote the diversity of staff. There was a reliance on staff from CALD backgrounds but inadequate support given to them.

At the professional level, acute care medical and nursing staff were constrained in their ability to meet families’ needs as they were focused on the physical and individual aspects of care. They said they also lacked institutional support in terms of guidelines, resources, training, cultural brokers and extra time. These constraints made working with difference problematic for nurses.
Staff therefore relied on allied health workers in the multi-disciplinary team to address the social needs of families from CALD backgrounds. They also called on one diversity health coordinator at each hospital. This meant addressing cultural difference was on the margin of health care practice. It was also reactive, not part of core practice. There were also nurses who viewed difference as problematic, preferring to treat patients according to mainstream Australian norms, which could have had negative implications on health care practice (Chapter 5). Chapter 6 demonstrates that social workers can only do so much in the biomedical dominated culture of the hospital (see the case study of Connor).

At an individual level, the case studies in Chapter 6 highlight the benefits of allied health staff reflecting on not only their own cultures but the cultures of medicine, the organisation and systemic issues. This was lacking among medical and nursing staff, as shown in Chapters 5 and 6.

7.3 Dominant institutional values disadvantage CALD families

The interviews with staff revealed that the dominant cultural values in the hospital promote an expectation that patients and their families will comply with a western biomedical model of health care, and thus may make difference problematic, and health care inequitable. Several medical and nursing staff expected families to have the same values and when these were not forthcoming, perceived families to be deviant. Some of the implications of this, as was discussed in Chapters 5 and 6, were that nurses spoke about there being favouritism towards families that fitted into the system. This was demonstrated with the case study of Zahra in the dialysis ward, where the nurses were stricter with families who were not compliant.
The interviews illustrated the effect of not just the dominant medical culture but mainstream cultures in Australia around parental responsibility, the rights of women and families being assertive in accessing disability services which were institutionalised in the hospital. In the case study of Connor, the mainstream values around parental responsibility disadvantaged the family, as the aunt and uncle played a major part in Connor’s care but were not actively involved in discussions with the health staff. Allied health managers and staff in this study recognised that families from CALD backgrounds may be at a disadvantage compared to dominant cultural values in the area of chronic care (Chapter 3, and the case study of Joshua in Chapter 6). I used Fraser’s notion of ‘status recognition’ to understand the recognition of disadvantage. Staff from CALD backgrounds also recognised when families were disadvantaged in line with the dominant cultural values around religion and the status of women (Chapter 4).

The recognition of disadvantage in Fraser’s ‘status recognition’ theory is similar to the more critical understanding of cultural competence and cultural safety where staff reflect on the impact of dominant cultures on service provision. Recognition of disadvantage in Fraser’s model goes further in entailing a redistribution of resources. However, this did not always occur in the hospital due to systemic constraints.

7.4 **Acknowledgement of cultural needs overridden by biomedical constraints**

The dominant biomedical approach in health care discourages staff from working with the complexities of patient needs. It is a reductive approach, with its exclusive emphasis on the physical health of the body. The interviews revealed that in acute care, clinical staff focused on the physical
condition of the child, so that working with the culturally different needs of child patients, as expressed through their parents, sometimes became problematic and were not effectively addressed (see Chapter 5).

The interviews indicated that nurses held liberal views on providing care, focused on the individual patient, not on recognising systems of disadvantage in health care, and this reaffirmed the literature. However, there were some nurses who did recognise disadvantage, but lacked the capacity to act. In Chapter 4, a nurse spoke about being unable to help a mother from a Muslim background with a disabled child who was disadvantaged.

In this study, some staff had a reductive understanding of a patient’s culture, equating it with their ethnicity. For instance, some medical and nursing managers relied on asking staff from migrant backgrounds how they should work with patients from a similar cultural background (Chapter 4). However, this and other research support the contention that this approach should not replace asking the family themselves.

Sociological literature notes that the recognition of cultural difference can sometimes be essentialist and reductive. This can be problematic if staff presume a patient’s needs based on their cultural background. This was the case with the nurse caring for Joshua in Chapter 6 who assumed that the family would not want assistance for their disabled child because of their Chinese background (where Chinese culture was associated with the value of self-reliance). This was not the case, as demonstrated by the assistance that the family welcomed after Joshua returned home.
7.5 Effective practice is dependent on successful negotiation of the cultural context of health care with the needs of families

As there was a lack of systemic support, effective health care for families from CALD backgrounds was dependent on an advocate in the team being able to negotiate the needs of families with the professional roles of staff, within the constraints of the health system. They needed to be able to reflect on the values and nature of health care, and recognise when families are disadvantaged. The findings in this research project demonstrated that the position of allied health workers in health organisations is critical, as are staff from CALD backgrounds. Staff also mentioned the need for a cultural broker or ethnic health worker.

In some instances allied health staff had to negotiate the cultural needs of parents that were in conflict with the right of the child to health care. This sometimes occurred as the medical and acute care staff prioritised the health of the child over the cultural rights of the parents. This demonstrates the tensions that can arise in situations where respecting cultural rights may mean an infringement on human rights. However, cultural rights and human rights do not need to be in opposition, according to the UNESCO principles of ‘intercultural dialogue’ if human rights are discussed in a culturally appropriate way. Situations encountered in this study confirmed the validity of the UNESCO position. For example in Joshua’s case (in Chapter 6), staff ensured that the boy’s health was not compromised by the actions of the grandmother and thereafter cautiously allowed her to look after Joshua the way she felt was right. In this way, staff valued the benefits of family centred care.

In other cases, staff felt the cultural rights of the father sometimes interfered with the right of the mother to have a say in the treatment of the child. For
example in Chapter 5, a social worker overcame this perceived dilemma by informing the mother about her rights but then told her to discuss treatment options with her husband. This approach is in line with NSW Health’s policy of informed consent.

7.6 Further research and changes in policy are needed

This study has demonstrated that current policy and procedures for staff working with families from CALD backgrounds are not adequate. There needs to be more research into health disparities for CALD patients and evidence of which cultural competence interventions work. Cultural competency models exist but the impact of not providing culturally competent care needs to be further researched and documented in terms of health outcomes and quality of care for patients from CALD backgrounds.

Multicultural health policies

NSW could develop specific standards and measurements for providing culturally appropriate care specifically in health organisations as has occurred in Victoria. This research suggests the need for better demographic data analysis to identify the needs of patients, as has been outlined in the review of EAPS in NSW.

Cultural competence

Cultural competence needs to be linked to mainstream health policies so there is more accountability and it becomes core business of the organisation. While government cultural competency guidelines refer to the impact of the professionals’ own cultural values, less progress has been made on measuring the impact of the provider’s professional culture, organisational
culture and systemic constraints, for instance, how a health professional is to address these barriers, especially when resources are lacking.

This research has demonstrated the benefits of staff reflecting on the impact of organisational, professional and individual cultures on service provision. Even when staff’s core activity is the physical health care of the child, they still need to avoid being dismissive of difference. Current social work policies in Australia reflect on the effect of personal cultures, but not on the impact of organisational cultures as in the US. This is an area that could be developed.

*Family Centred Care*

There is a need for development of family centred care policies in Australia. At present there are no clinical guidelines for paediatric nurses on how to implement family centred care. In relation to families from CALD backgrounds, there are no guidelines on the complexities of family centred care. One of the senior staff members in this study asserted that there need to be guidelines when there is a conflict between the needs of parents and the roles of health professionals.

*Integration of hospital and community services*

This research demonstrates that there needs to be better integration between hospital and community health services for children with chronic illness, as was apparent in the case study of Connor (in Chapter 6). Staff also commented in Chapter 5 that there was a lack of community services for children with disabilities. The lack of these services has meant children are
placed in hospital, which may be a burden for families as well as placing further stresses on an over-stretched hospital system.

*Managing diversity*

Policies in relation to managing diverse staff are under developed at a systemic and organisational level in health organisations. There is no overall direction for health managers like the models developed in the US for hospitals. Current policies in NSW which do relate to managing diversity, such as staff satisfaction surveys, are not analysed in terms of cross-cultural relations. This thesis has indicated that cross-cultural training could also be extended to include staff-to-staff relations as suggested in the US literature. This study supports hospitals creating guidelines on the appropriate use of language and cultural information by bilingual staff. Overseas trained staff also need specific support in adjusting to working in Australian hospitals.

*Future research and data analysis*

It is clear in the literature that there is a need for more research, evaluation and monitoring of inequities for patients from CALD backgrounds. There should also be consistent methods of data gathering and the development of an instrument for measuring culturally appropriate health systems and competent professionals. In the area of children’s hospitals, there is a need to record the cultural background of parents of child patients in the hospital, and for policy and procedures to be in place to accommodate and cater for cultural diversity.
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Appendix 1: Survey questionnaire for CHW staff

Survey for hospital staff

Cultural Diversity at the Children’s Hospital at Westmead

Introduction:

This questionnaire asks you to reflect on the daily challenges you face when working with cultural diversity amongst patients. The questionnaire takes approximately 30 minutes to complete. Please remember there are no right or wrong answers and that your responses are confidential. When answering questions, try to think of examples.

We would firstly like you to provide some general information about where you work in the hospital and background information about yourself.

General information:

Age: ............................................................
Sex: ............................................................
Cultural background:  ................................................
Parent’s cultural background:  ................................................
Do you identify with a religion? If so, which one?  ................................................
Which department/ward do you work in?  ................................................
How long have you been working at the Children’s Hospital?
........................................................................................................

What is your profession/occupation at the hospital?
........................................................................................................
Questions:

1. In your opinion, what does ‘cultural diversity’ mean?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

2. In your daily work experience, what are the most significant practical issues that you have come across when dealing with cultural diversity between staff, patients and parents/carers?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

3. Can you describe one experience/situation when you think cultural diversity has influenced the way you have carried out a particular job (this may have been a positive or negative experience)?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

4. Do you feel that cultural differences are recognised as important in the culture of your workplace? If so, in what ways? If not, why not?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

5. How would you describe the way cultural diversity functions among the range of hospital staff that you work with? Can you give an example?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

6. Hospital staff bring a range of cultural experiences and cultural backgrounds to their workplace. How do you think your experiences and background (for example gender, language, beliefs, ethnicity) influences how you work with different patients and their families? Can you give an example?
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………
   ………………………………………………………………………………………………………

Thank you for participating in this survey.
Please return this form to the secure box.
Appendix 2: Interview schedule for individual CHW staff members

Introduction:

In this interview I will ask you to think about how the cultural diversity of patients affects how you perform your job. The interview will take approximately one hour. Please remember there are no right or wrong answers. Your answers are confidential.

We would firstly like you to provide some general information about where you work in the hospital and background information about yourself.

General information:

Age:

Sex:

Cultural background:

Parents’ cultural background:

What language(s) do you speak at home?

Do you identify with a religion? If so, which one?

Which department/ward do you work in?

How long have you been working at the Children’s Hospital?

What is your postcode?

Questions

1. In your opinion what does cultural diversity mean to you?

2. Can you tell us a little bit about your family’s cultural background. If they migrated to Australia, how, when and why did they come?

3. What’s your education background and qualifications?

4. What’s your position in the hospital? And how did you come to gain that position?

5. Are you satisfied with your current job?

6. In your every day life, where do you get your information/form your ideas about ethnicity and cultural differences?

7. Can you describe the kinds of social interactions you have outside the hospital. Do they tend to be from the same cultural background as you? For eg what kinds of groups or activities are you involved in?

8. Do you think you bring your personal experiences with you into your workplace? (Find out details)
9. How do you feel about working at the hospital with people who have different cultural practices, and/or, how do you feel about taking care of people with different cultural practices?

10. From your daily observations what stands out when you think about culture, cultural diversity within the hospital?

11. Do you feel that cultural differences are recognised in your workplace? If so, in what ways? And, if not, why not?

12. Do you communicate with everyone at work in English? (If not, find out more).

13. Have you ever been asked or carried out informal interpreting at work?

14. Are you aware of any situations where a staff member has informally interpreted for a patient. If so, can you describe the specific circumstances?

15. In your daily work experience, what are the most significant practical issues that you have come across when dealing with cultural diversity between staff, patients and parents/carers?

16. Can you describe any experiences or situations when you think that someone’s cultural practices have influenced the way you have carried out a particular job? (This may be a positive or negative experience).

17. What resources are available to assist or support you when working with cultural diversity at work?

18. How did any one or more of the ‘general information’ questions above influence your daily work practices?

19. What do you think about the process and content of this research?

20. After having talked about these issues, has your opinion about the meaning of cultural diversity changed? (Ask if there are any other issues around cultural diversity and health care that the interviewee would like to discuss.)

(July 2005)
# Appendix 3: Managers interviewed at CHW and SCH

<table>
<thead>
<tr>
<th>Description of position</th>
<th>Health background</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1 Medical/Clinical manager</td>
<td>Medical</td>
</tr>
<tr>
<td>M2 Member of the Executive</td>
<td>Medical</td>
</tr>
<tr>
<td>M3 Director of Nursing</td>
<td>Nursing</td>
</tr>
<tr>
<td>M4 Community/Ambulatory care manager</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>M5 Finance and Corporate Services</td>
<td>Administrative</td>
</tr>
<tr>
<td>M6 Chief Resident</td>
<td>Medical</td>
</tr>
<tr>
<td>M7 Quality and Clinical Risk Manager</td>
<td>Nursing</td>
</tr>
<tr>
<td>M8 Clinical Manager</td>
<td>Nursing</td>
</tr>
<tr>
<td>M9 Medical/Clinical Manager</td>
<td>Medical</td>
</tr>
<tr>
<td>M10 Clinical/Medical/Nursing Manager</td>
<td>Nursing</td>
</tr>
<tr>
<td>M11 Allied Health/Occupational Therapy Manager</td>
<td>Allied Health</td>
</tr>
<tr>
<td>M12 Nursing and Clinical Governance Manager</td>
<td>Nursing</td>
</tr>
<tr>
<td>M13 Medical and Clinical Governance Manager</td>
<td>Medical</td>
</tr>
<tr>
<td>M14 Mental Health/Ambulatory Manager</td>
<td>Mental Health</td>
</tr>
<tr>
<td>M15 Clinical and Ambulatory Manager</td>
<td>Allied Health</td>
</tr>
<tr>
<td>M16 Workforce Development Manager</td>
<td>Human Resources</td>
</tr>
<tr>
<td>M17 Executive Member</td>
<td>Medical</td>
</tr>
</tbody>
</table>
Appendix 4: Interview questions for managers

1. What is your position?
What are your responsibilities?
How does your position fit in within the broader hospital executive?
What is your professional background?
Do you still work in clinical practice or are you just involved in administration?
What attracted you to working in a children’s hospital?

2. Sydney has become such a multi-culturally diverse society, how does this impact on the work that is carried out here at the hospital?
   - How does this impact on the workforce?
   - How does this impact on service provision for particular communities?
   - How does this impact on the way different hospital departments carry out their work? For e.g. would either policies or issues around cultural diversity be carried out differently in the Emergency Department compared to the Burns Unit?

3. What sort of recruitment programs have you in place that are aimed at attracting staff from overseas?
   - Why do you need these recruitment programs? What sort of need are they filling?
   - Which countries are involved in this recruitment?
   - What kinds of positions do you recruit? (more relevant for doctors)
   - What kind of numbers in these various positions are recruited?
   - What is the impact on other staff of these recruitment programs?
   - Do these positions tend to be short or long-term positions?

4. How do you think health staff working with diversity issues in an adult hospital might differ from working with diversity in a children’s hospital?

5. Can you tell me about policies that you think impact on your organisation when working with cultural diversity at the hospital? (you’ll be given a list, jot them down and then)
   - ask about each of these policies in more detail
   - ask how these policies affect the staff
   - ask how these polices affect service provision

Which policies seem to be most successful and which ones do you think are more problematic?
   - Why and how? (Unpack the answers)
   - How does the organisation respond to negative feedback in relation to cultural diversity issues – the feedback might be either from staff and/or children and their families.

6. In your position have you ever come across negative feedback in relation to cultural diversity issues either from staff and/or from children and their families?
(Depending on the answer, follow up on response. For e.g. could you explain in detail how this situation came about; how did the different people involved respond; what was the outcome; was the issue taken any further within the organisation? etc.)
7. Can you describe the kinds of institutional support and resources around cultural diversity training and education available to staff?
- How well utilised are they?
- Are they mandatory or optional?
- What do you think the problems or shortfalls are?

8. By the way, what sort of diversity is there among the senior executive at this hospital e.g. age range, gender, cultural background, discipline background etc. (This can be asked anytime during the interview – judge according to the person and interview when appropriate)

9. Who might be identified as potential key personnel within the organisation whose work you think impacts significantly on integrating or marrying the vision of positive cultural diversity policies and those of staff’s daily practices?
- What is it that they do? (Why is this such a good strategy or model?)
- What are the implications for this at the hospital-wide level?
- Can you describe why this is such a good strategy or model?
Appendix 5: Interview questions for health teams

CULTURES OF CARING: CULTURAL DIVERSITY AT SYDNEY CHILDREN’S HOSPITAL AND THE CHILDREN’S HOSPITAL AT WESTMEAD

Interview topics for professional health staff

- Introductions
- Explanation of purpose of interview
- Explanation of duration of interview and confidentiality issues

Demographic and general information:

- Age
- Sex
- Cultural background
- Language(s) spoken at home
- Religion
- Position
- Role
- Length of time at hospital

Child and family:

- Knowledge of the family (eg. their cultural background, English language ability, religious beliefs, length of time in Australia, socio-economic status, primary care-givers in the family, parenting practices)
- Diagnosis of child’s illness
- Proposed/actual treatment plan for child by the hospital

Staff member:

- Staff member’s role in the hospital treatment
- Roles of other health professionals involved in the treatment
- Working relationship between the health professionals caring for the child

Culture, health care and the family:

- Family’s understanding of the cause of illness
- Child and family’s reaction to the illness
- Family’s understanding of the appropriate treatment
- Child’s and parents/carer’s response to the treatment given by the hospital
- Family’s role in the child’s treatment
- Effect of family’s cultural beliefs and practices on treatment
- Effect of family’s social circumstances on treatment
- Family’s use of alternative/complementary medicines
- Communication with particular family members (by individual team members and other team members)
- Challenges of working with the family
- Treatment decision making protocol with team members and family
- Details of how family have been discussed in health team meetings
- Challenges of working in professional health teams when looking after child
- Changes in relationship between family and other health team members since looking after the child
Appendix 6: Focus group questions for multidisciplinary teams

CULTURES OF CARING: CULTURAL DIVERSITY AT SYDNEY CHILDREN’S HOSPITAL AND THE CHILDREN’S HOSPITAL AT WESTMEAD

Focus group topics for professional health staff

Introduction

• Introductions
• Explanation of purpose of focus group
• Explanation of duration of focus group and confidentiality issues

Themes

A: Working as a professional health team

1. Structure, composition and functional aspects of working together as a team
2. Structure, function and dynamics of working relationships between team members in the care of the child
3. Communication between team members; professional and team issues
4. Challenges of working together in a team
5. Cultural dynamics of teamwork in the hospital

B. Working with children and families

6. Socio-cultural factors impacting on the everyday interactions associated with the treatment of the child
7. Communication between the health team and the family
8. Challenges of working with families from CALD backgrounds
9. Treatments and decision-making protocols between team members and family
10. Patterns of negotiation between family and team members in the care of the child
11. Impact of cultural beliefs and practices of family on treatment of child in hospital
12. Institutional support for teams working with cultural diversity at the hospital