TRANSVERSING THE CULTURAL GAP - CULTURAL AWARENESS ON DEPLOYMENTS

Sound cross-cultural interactions are based on empathy, tolerance of ambiguity and the capacity to suspend judgement.

Eckermann & Dowd 1991 p 20

Key words: ADF, trust, cultural safety, education, values, collaboration.

SQNLDR JENNIFER DOWLING RN RM BNurs MNurs MRCNA

ABSTRACT

On deployments, nurses come into contact with clients from diverse cultural and linguistic backgrounds, as patients and also as team colleagues. Incongruent beliefs and attitudes about health and the use of health care services by people from other cultures are major barriers to providing optimum health care which, so far, been formulated within the context of Western scientific and cultural values.

In varying degrees we are all products of our cultural upbringing and we use our cultural knowledge every time we communicate. Being sensitive to the difficulties faced by people of other cultures can assist in overcoming communication barriers. This paper will explore the needs, attitudes, perceptions and understanding of nurses to the issue of cultural safety and explore the fact that nurses are in danger of becoming isolated in a cultural desert of their own making. There will also be a discussion on cultural awareness and education in a health context.

INTRODUCTION

Culture is a to a human group what personality is to an individual. The three services have distinctly different cultures and the conduct of joint exercises is, amongst other things, a form of cultural awareness training.

Realising that the epistemological foundations of nursing are affecting the quality of care, defence managers need to address the issue of education of ADF nurses in cultural diversity. Cross-cultural nursing is a growing area of study in graduate programs on the basis of theory and research, as it has been accepted that cultural values and beliefs influence the way nurse's practice. Cultural education is not only essential in initial nursing education, but also in postgraduate study, as an ongoing reassessment of our belief structure. Prior learning, family background, education and social contacts all affect the way people perceive cultural needs and value orientation. Introduction of the cultural element in nursing education will enhance the quality of care as all health professionals need to develop a deeper understanding of cultural differences, ethnocentricity and particularly, cultural safety and, therefore, be involved in the development of a theory of need built around the concept of praxis.

> Man is a holistic being with dignity and rights. Each individual is unique and has the right to design a specific lifestyle based on personal beliefs and values. Fulton (1985:26)

CULTURAL AWARENESS

Promotion of cross-cultural understanding will assist to breach the cultural chasm to provide acceptable and effective health care for indigenous Australians and other ethnic groups. Going beyond awareness and empathy we need to develop the skills towards flexibility in a cross cultural environment. One way this can be achieved with better education programs.

The nurse is often unaware of his or her own belief system, therefore it is even more difficult to understand another. Eckermann & Dowd (1991) espouse the theory that believing in cultural relativism is fundamental to valid cross-cultural equality. Eckermann etal (1994) explain this as 'an acceptance that different cultures represent the legitimate adaptation of different peoples to various historical, natural, socio-economic and political environments' (p11). In other words, question your beliefs, without abandoning them, and cease judging aspects of a culture you don't understand as another culture's needs can't be evaluated without consultation, as this may lead to ethnocentrism. The Royal College of Nursing Australia (RCNA) released this position statement in April 1998:1;

A transcultural perspective, underpinning nursing practice, enhances equality of access to opportunities and practices for culturally meaningful and acceptable health and nursing services.

LITERATURE REVIEW

Empirical evidence is the major component on literature in transcultural health issues and health differentials or other markers used in health status analysis do not necessarily measure those aspects of well being which other cultures consider significant. There is a paucity of Australian literature published on cross-cultural education and communication in Australia and, the available literature lacks consistency in terminology.

Although the published literature does suggest that education on cultural issues is absolutely essential, Holmes & Warelow (1997) note that there is little in the nursing literature about the concept of need, despite it's relevance to social welfare provision and again it is treated empirically. Needs has been discussed only in relation to Maslow's hierarchy and rarely subjected to critique except by Lawler (1991) and Holmes & Warelow (1997) state that few authors link care with the satisfaction of needs. There are some American studies incorporating rural and remote area nursing issues and the educational requirements, however, the American literature published is ten years ahead of Australia and the temptation to review the majority of these was resisted. The most exciting work is that done by New Zealand nurses on Maori cultural safety, a concept Australians are still pondering. I have attempted to use very little of Leiningers works, although it needed mentioning in parts, as I believe it is not necessarily appropriate to the Australian community and is beginning to show it's age.

CULTURE, RACE & ETHNICITY - AN EXPLANATION OF TERMS

The word culture is often confused with race and ethnicity and the terms are interwoven with the history of colonisation. Therefore the following definitions are provides for clarity.

1. ***Race*** is considered a biological term referring to a grouping of individuals who share distinct physical characteristics such as skin colour, hair texture or facial features and a racial group of people is those of the same race who interact with one another and develop some common cultural characteristics (Edelman & Mandle 1994). The concept has broadened to include social and political factors with the emerging view that race is not a biological reality (Bhopal 1998). However, the word race has been used to describe qualities of a group of people leading to the term racism.

2. ***Ethnic*** is derived from the Greek word ethos, meaning tribe, race, nation or people and is more recently associated with customs, socialisation and cultural patterns. It is a mix of cultural factors, which include ancestry, diet, religion, language and race, and is used interchangeably with the word 'culture'. An ethnic group is a group of people within a larger society that has contrasting values, rituals and maintenance that differs it from the larger group. Bhopal (1998) states that race and ethnicity are increasing used synonymously.

3. ***Culture***, as an element of ethnicity, consists of shared patterns of values, beliefs and behaviours that survive through the teaching-learning process (Edelman & Mandle 1994). Culture is never static, it is dynamic and changes to adapt to current needs, it is not instinctive and is learned through life experiences after birth (Eckermann et al 1994). Further, in 1940, Linton described culture as 'the sum total of knowledge, attitudes and behaviour patterns shared and transmitted by members of a particular group of people as well as their values, ideas and institutions (in: Manderson & Reid 1994:7) Explanations of other peoples and our cultures have frequently centered on what such people lack in comparison to ***our*** culture and

our beliefs (Ryan in: Eckermann 1994). Nolde & Smillie (1987) discuss culture as the learned ways of acting and thinking of a group which are transmitted from generation to generation, providing guidelines for living.

> Issues of dignity, choice and quality of care are the outcome of a mosaic of factors of which culture is but one.
> Manderson & Reid 1994:22

CULTURAL SAFETY

Cultural safety should underpin all nursing practice and it is based in attitude change as defined by the Hui Waimanawa, Christchurch, NZ :

> a requirement that the validity of (Maori) cultural values be recognised, especially as they relate to their perceptions of health, their tapu, and the holistic nature of their being...
> Ramsden as cited in Eckermann et al 1992:166

In 1992 the Nursing Council of New Zealand set standards for registration of nurses with the following definition of cultural safety:

> The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse's culture on own nursing practice. Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.
> Cooney 1994:7

1. Culture Shock

Culture shock occurs when well established habits no longer have expected consequences and will happen to most nurses on their first encounter with people of other cultures. Eckermann et al (1994) describe the four phases or stages of culture shock as:

a. *The Honeymoon Phase*: excitement and fascination, a new challenge
b. *The Disenchantment Phase*: values and habits conflict with local attitudes and beliefs. Crucial to adaptation as it makes or breaks nurses.
c. *The Beginning Resolution Phase*: beginning to function effectively as they change patterns of behaviour to compliment the environment.
d. *The Effective Functioning Stage*: enjoying the work and working more appropriately within the culture.

The above phases are, in my experience, a true indication of the definition of culture shock. Naivety in relation to cultural sensitivity would be part of the disenchantment phase, a concept that is not often understood when working with other cultures.

A fifth phase was described by Eckermann et al (1994) as being so complete in the transition as to not wanting to return to the previous lifestyle and beliefs, and even resent an absence or leave away from the work environment.

One of the stressors that contribute to culture shock is a differing style of communication. Both verbal and non-verbal forms can lead to inappropriate behaviour and tonal changes and body language may obscure the meaning of the message that is being conveyed. Communication among indigenous Australians is defined not merely by the words expressed but also what is left unsaid. Linguistic differences are a common source of friction and mistrust. Local etiquette needs to be observed and learnt quickly to avoid misunderstanding and inadvertently offending members of the community. Listening and observing are important skills in the early days and respecting the local traditions will lead to the *establishment of trust* which will enable nurses to work more effectively with indigenous people.

2. Cultural Relativism

Supporting a position of cultural relativism means suspending judgement about things we don't understand without abandoning our own beliefs, as our culture may not be appropriate for others. A group or community culture are appropriate for that group of people and nurses who work with culturally different groups should adopt a position of cultural relativism. It appears to be the most effective way to reduce cultural shock and increase cultural sensitivity.

Biomedical Model: The western biomedical model of health, which focuses on curative rather than holistic health, and also provides a conservative tool for health professionals. However, this ideology obscures the sociopolitical and economic origins of poverty, ill health and underdevelopment and the subsequent effect on health status (Saggers & Gray 1992 & Winch 1989).

Reid & Tromf (1991) state that sickness and death is explained in terms of activities of spirits and deities as these are the mediators between social behaviour and human health, and the traditions are complex and often difficult for westerners to understand.

We also need to be aware of the cultural beliefs of men and women when it relates to sexual or reproductive issues. This applies to most indigenous cultures ans sensitivity is very important.

THEORIES AND CONCEPTS

Perceptions and attitudes to the professional role and the barriers to the delivery of culturally sensitive and appropriate health care are seen as:

a. mainstream institutional ethnocentrism (health, education, legal etc)
b. information, awareness and communication deficits and ineffectiveness

(Kanitsaki: in Pauwels 1990:97)

Leininger (1990) stated that generally, health care professionals support the cultural value of optimum health as they regard it as their duty, however, this view may impede their professional judgement. Health professions may view culturally different people as being ' stupid, unintelligent or as hypochondriacs' which leads to a disempowering and devaluing process (Kanitsaki 1990 in Pauwels). Yet, this also flows the other way with people of other cultures misunderstanding the professional culture, roles and goals of westerner health professionals, and frustration's may develop as nurses feel both culturally and professionally isolated. Thorpe (1990) states that white professionals, and this included nurses, treated Aboriginals with attitudes ranging from outright racism to paternalism, which results in other cultures not accessing appropriate health care. Some cultures people perceive white authority as being uncaring, cold and negligent and Nolde & Smillie (1987) note that a frequently encountered cause of frustration and conflict, for all is the culturally defined concept of time. Time and punctuality are viewed differently from a white person's perspective as other cultures may have a more casual approach to punctuality and commitment. Commitment may mean a responsibility to fulfil an obligation. Understanding the system can be difficult and frustrating and you just have to accept it the way it is.

Resistance to Change

Changes to language, conversation and attitude need to adapt to ensure effective cross-cultural care. However, to implement change effectively, the ADF needs to prepare its staff by building awareness, understanding and commitment into the internal and orientation programmes. An increased interest in critical thinking by nurses is an essential skill in a changing and dynamic health system (Neill & Dluhy

1997). Kanitsaki (1988) believes our nursing education is dominant, monocultural, monistic and non-holistic and reflects the value orientations of Anglo -Australians, which is basically ethnocentristic. This belief encourages resistance to change, and the potential for value conflict in health care, which results in the disempowerment of people in less dominant cultures. A new approach incorporating a cross cultural input is required where the spiritual concept is recognised (Winch 1989) and if people feel threatened then there is resistance to change and therefore, there is then a need to be convinced of the benefit of change (Wass 1994). Nurses have the ability and are in a position to be a powerhouse of change and Johnson (1992) refers to this as assisting nurses to return to it's *raison d'être* - assisting people to achieve optimum health. However, nurses also need to release themselves from hegemonic practices and take control and responsibility for their education and practice.

The Ottawa Charter for Health Promotion (1986) states that to reach a state of complete physical, mental and social well-being, aspirations need to be identified and realised to satisfy needs and people need to change or adjust to the environment. Health is a resource for life, not the objective for living and the basic requisites for improvement in health are the fundamental living conditions - peace, shelter, food, income, sustainable resources, social justice and equity.

How then can we develop the appropriate cross-cultural skills necessary to promote good relationships and mutual understanding? It is:

- The capacity to communicate respect
- The capacity to be non judgemental
- The capacity to accept the relativity of ones own knowledge and perceptions
- The capacity to display emphathy
- The capacity to be flexible and
- The capacity for turn-taking (in discussions) and tolerance for ambiguity

CONCLUSION

The inequalities in health care in relation to culture, pose ethical problems as our code of ethics emphasises a humanitarian ethos which results in a difficulty to accept that health care is racist and therefore needs to change. Nurses need to recognise the complexity of relationships between bio-medical concepts and indigenous notions of well being. Respecting the spirituality of indigenous people we need to question how we understand ourselves as a cultural being, do you understand where you come from, do you know your own culture. You need to question how you earn cultural authority and what you understand by cultural safety.

We can't assume a rightness in the way we practice. We all have the same problems and cultures distinguish themselves by the specific solution they choose to resolve their problems.

In 1994 the then White paper emphasized the importance of Defence personnel having cross cultural skills and sensitivity to engage effectively with the complex diversity of the region . Many people asked why it was necessary to have training as most believe they understand cultural diversity. Do you?

Cultural understanding and appreciation does not mean giving up our own cultural values and beliefs, or giving in to the other side, it just allows better communication. It is about establishing trust and gaining acceptance.

To maintain a degree of preparedness there needs to be an understanding of cultural differences to achieve cooperation, reduce the potential for conflict and to maintain an effective and flexible Defence force.

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