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The challenges of health care provision in a multicultural society.

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Abstract

Australia is privileged to be a multicultural society, and while the country has been immeasurably enriched by multiculturalism, the health care system has been challenged to meet the ongoing and increasing needs of the diverse population (National Health and Medical Research Council, 2005: p4). As culture is vital to the provision of holistic and individualised care, it is imperative that culturally competent health care be available to all Australians (Cortis, 2003: p62). To provide culturally competent health care, while endeavouring to meet Australian Nursing Council (ANC) Competencies, nurses face many challenges (Blackford, 2005: p29). This paper will address the challenges of communication between patients and nurses, and the solutions required to overcome the existing barriers.

Nursing and the challenges of a diverse population

In the 60 years following World War II, Australia's post-war immigration program has brought over 5 million immigrants and refugees from more than 200 countries to a new life in Australia (Cameron-Traub, 2000: p236)(Australian Institute of Health and Welfare, 1997: p1). Many of these settlers come from non-English speaking and diverse cultural backgrounds and endured many hardships while endeavouring to adjust to a new language and way of life (Cameron-Traub, 2000: p237). In the 1970s, a multicultural policy was developed by the Federal Government supporting the right of Australians from all backgrounds to maintain, within the law, their cultural heritage, religion and language (Cameron-Traub, 2000: p237-238). In 1996, the term 'people of culturally and linguistically diverse backgrounds (CALDB)' was created to support the multiculturalism policy (Blackford, 2005: p29). Culture consists of the beliefs, way of life, philosophy, habits, behaviour and values that determine the sense of identity, self-worth and belonging to a particular group of individuals (Cortis, 2003: p55). Culture also affects the provision of health promotion, illness prevention and treatment and social roles and expectations that the patient healthcare provider encounters (Cortis, 2003: p55-56). It must be appreciated and understood that culture is not static, but rather, dynamic (Cortis, 2003: p57).

It is the right of all Australians to be provided with appropriate health care (National Health and Medical Research Council, 2005: p2). Although Medicare provides equitable access to health care services, people from 'CALDB' still experience barriers because cultural and language differences are not adequately addressed (National Health Strategy, 1993: p9). The inability to speak English should not be a barrier to accessing equity in health care (Khunti & Samani, 2003: p479). Despite information leaflets being published in various languages, verbal communication is still required between patient and nurse to describe symptoms and anxieties, and also for diagnostic and treatment information to be explained (National Health Strategy, 1993: p9).

Although the multicultural policy aims to include and support the rights of all Australians, requiring that each other's cultural differences be accepted and respected (Blackford, 2005: p29), this has created a challenge for nurses as mainstream services have remained monocultural with health care also reflecting a biomedical western ideology (Omeri, 1996: p20). Under the domain of Professional and Ethical Practice, ANC competency element 2.1 requires the nurse to 'practice in accordance with the professional code of ethics'. In doing so he or she accepts individuals and provides care regardless of factors including culture, race and religion (Australian Nursing Council, 2000: p7). Part of the vision of the National Health and Medical Research Council (NHMRC) is that the 'quality of life, health and wellbeing of citizens from linguistically and culturally diverse backgrounds are improved and the social exclusion of individuals, families and communities is reduced' (National Health and Medical Research Council, 2005: p2).

Nursing, and the entire health care team, is faced with many difficult, but fulfilling, challenges in meeting patient needs, while endeavouring to provide appropriate and culturally competent health care to these immigrants (National Health and Medical Research Council: 2005: p4). ANC Competency 3.5 provides for the spiritual, emotional and cultural needs of individuals (Australian Nursing Council, 2000: p10). Cultural competence is a combination of behaviour, attitudes and policies, carried out by professionals to work effectively in cross-cultural situations to improve health and wellbeing by integrating culture into the delivery of health care services (Cross et al, 1989 cited in National Health and Medical Research Council, 2005: p6).

Research shows that to meet these challenges, nurses require ongoing professional development to increase their cultural awareness, knowledge and skill (Cortis, 2003: p63). Cultural awareness is the

ability to be sensitive to the values, beliefs and practices of the patient's culture (Cortis, 2003: p57). Cultural knowledge is understanding specific physical, biological and physiological differences among people of 'CALDB' (Purnell & Paulanka, 1998 cited in Cortis, 2003: p57). Providing healthcare in a multicultural society requires nurses to have a knowledge of similarities and differences as well as recognising inequalities in health care (Cortis, 2003: p57). It is important that nurses understand problems and discrimination that Australians of 'CALDB' face in society (Cortis, 2003: p57). Cultural skill is the ability to sensitively conduct a cultural assessment which should be integrated into every nursing assessment for all patients, as culture is an integral part of a patient's life (Cortis, 2003: p57&62). ANC Competency 2.1 states that the nurse must carry out assessments while remaining sensitive to the individual's needs (Australian Nursing Council, 2000: p7). Cultural diversity or potential barriers to health care may not always be obvious to the nurse (Cortis, 2003: p57).

A major challenge for nurses in a culturally diverse society is communication, which is a vital component when providing health care (Symanski-Sanders, 'undated': p2). Under the domain of enabling, competency element 12.1 states that the nurse must communicate using formal and informal channels of communication and using an interpreter where appropriate (Australian Nursing Council, 2000: p23). Language, verbal and non-verbal behaviour, touch and silence are all forms of communication (Tate, 2003: p214). Misinterpretation of language often occurs as some words have different meanings in other cultures (Schaafsma et al., 2003: p186). Evidence shows that language differences are the most likely major barrier to the provision of culturally competent health care (Tate, 2003: p214).

To communicate effectively the sender must convey the message clear enough to be heard and understood by the receiver (Tate, 2003: p214). Language is more than just understanding the meaning of words (Riley, 2004: p57). Important aspects of verbal communication are tone and volume, the meaning of which can vary in different cultures. Thai people are quiet natured because talking too much indicates stupidity, while Cubans are proud to speak their language loudly as they love to socialize (Riley, 2004: p57). The willingness to share thoughts and feelings is also determined by culture. Europeans are happy to discuss their emotions, while Asians are reluctant to display their feelings. It is vital that nurses understand these aspects (Riley, 2004: p57).

Body language appears to be unimportant until the amount of information we communicate without using words is realized (Tate, 2003: p214). In Western culture, eye contact is expected when communicating with another person, while in Hispanic culture, respect is shown by looking downwards, as eye contact indicates arrogance and is only maintained with peers of the same gender (Tate, 2003: p214). Asians and Native Americans consider eye contact to be offensive (Luckman, 2000 cited in Riley, 2004: p59), while Muslim Arab women are only permitted eye contact with a male if that person is their husband (Riley, 2004: p59). Culture also determines the acceptability of touch. In Arab and Hispanic culture, certain parts of the female body may not be touched or examined by male healthcare professionals (Andrews & Boyle, 1999 cited in Riley, 2004: p58). Cultures also vary in degrees of closeness in personal space (Riley, 2004: p58).

Recent studies have determined that there is continued evidence of inequity among Australians of 'CALDB' frequently due to communication barriers (Blackford, 2005: p30). The lack of common language between patient and nurse can result in inadequate assessment leading to ineffective care, delayed recovery and discharge, misunderstanding of treatment, re-admission and poor health outcomes (Blackford, 2005: p30). Cultural differences can also influence the presentation and behaviour of patients (Khunti & Samani, 2003: p479), resulting in their admission to hospital unaware of the treatment to be received, which may be contrary to their cultural beliefs, or being sent home with a serious condition undiagnosed (National Health Strategy, 1993: p12). ANC competency element 3.4 states that respect for individuals in terms of their culture and social context must be demonstrated and the rights of others to their opinions must be respected (Australian Nursing Council, 2000: p10).

Serious legal implications can occur through the misunderstanding of communication. Although relatives and friends can often assist with communication, the issue of patient confidentiality may be breached and sensitive issues / decisions may cause family conflict (Mailhot, 1997: p48). ANC competency 2.4 states that 'Discussions concerning individuals... are restricted to relevant members of the health care team' (Australian Nursing Council, 2000: p8). When legislation requires that informed consent be obtained, it is preferred that the services of a medical interpreter, who is familiar with the patient's language and culture, be used (Mailhot, 1997: p48). ANC competency 12.1 states that the nurse should use an interpreter when required (Australian Nursing Council, 2000: p23). This creates a challenge for nurses as many health care facilities do not provide

interpreters (Blackford, 2005: p30). If health care professionals do not communicate understandably and sufficiently with patients of 'CALDB', freely and voluntarily given consent for procedures or treatment will not be obtained which will result in the tort of assault (Forrester & Griffiths, 2005: p129). Failure to respect the patient's wishes could result in the lodgement of a claim for battery or assault (National Health Strategy, 1993: p19). A claim for negligence may also be lodged if the patient suffers damages as a result of care / treatment (Forrester & Griffiths, 2005: p83).

Adequate provision of medical interpreters in health care facilities is essential to the delivery of culturally competent care (Riley, 2004: p55). The non-availability of health care providers who speak the language of the patient affects the extent to which people of 'CALDB' receive services which affect their health (McClelland, 1991 cited in National Health Strategy, 1993: p19). The patient's right of self-determination is violated, and non-provision of an interpreter denies the patient the human right of free speech (Kanitsaki, 1996: p91).

Essential to meeting the communication challenges faced by nurses is transcultural nursing, which was founded in 1974 by Madeline Leininger at the University of Washington School of Nursing (University of Washington, 2005: p2).

'Transcultural nursing goes beyond cultural sensitivity and diversity by allowing nurses to discover cultural care knowledge in order to develop nursing practices suitable to meet the nursing care needs of diverse groups in relevant, responsible and meaningful ways' (Omeri & Cameron-Traub, 1996: p15).

Although transcultural nursing has been strongly supported by the Royal College of Nursing in Australia (Leininger, 1996: p9), and courses are available at the Royal Melbourne Institute of Technology (RMIT, 2005: p1), there has been considerable educational resistance, limited support in Universities and health care facilities, and a lack of funds preventing transcultural nursing from being effective in Australia (Leininger, 1996: p10).

'As technology becomes an increasingly important part of healthcare, the essence of human caring becomes the most valued aspect of nursing. The diversity of populations and the uniqueness of the caring phenomenon in these diverse practice

settings provide the cultural basis of human caring' (Brown, 2001 cited in Riley, 2004: p52-53).

Although Australia is improving the health care response to Australians of 'CALDB' by developing policies at Federal and State levels, many strategies in place are still not meeting the needs of nurses, who are endeavouring to meet ANC Competencies (National Health and Medical Research Council, 2005: p4). There needs to be more emphasis on ensuring that nurse education reflects the diversity of our multicultural population and health care system (Commonwealth Department of Education, Science and Training, 2005: p2). Nurses have a responsibility to care for all people by identifying their needs and ensuring that they have the resources, skills and knowledge to provide culturally competent health care to all Australians.

'When we are able to provide equity in care, the social, financial and health benefits are enormous: improved health outcomes for people of CALDB; increased efficiency of clinical and support staff; and greater client satisfaction with services' (Blackford, 2005: p31).

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