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Preface

The challenge in revising a textbook is a balancing act between retaining what has endured and adding what has changed since its last edition. The essential focus of *Patient and Person* has endured as a text for nurses who want to understand how to establish interpersonal contact with patients—not as patients but as people whose unique experiences are significant to their nursing care. In addition, the practical and applied focus of *Patient and Person* has been maintained because nurses need to understand patients’ experiences on more than a de-contextualised, theoretical level.

The basic structure of the overall text also remains intact. The first four chapters include background material for the ‘skills,’ which are dissected and explained in Chapters 5–8. Experiential learning activities are incorporated throughout these chapters. These activities are designed to focus on the development of skills in a practical, workable manner. The ‘skills’ are then placed into particular contexts in Part III (Chs 9–11). Structural changes have been made to each chapter, with the inclusion of key concepts identified at the outset and the addition of a research highlight in each chapter.

Content changes made to the fifth edition of *Patient and Person* are the inclusion of new, updated and restructured information. Chapter 4 has been completely revised to reflect contemporary thinking in relation to culture and health, with an emphasis that healthcare organisations themselves are imbued with cultural values and meanings which may not work in harmony with all patients. The material about non-verbal communication has been moved from Chapter 4 and placed in Chapter 5, *Listening*. Chapter 6 has been restructured so that the revised discussion of empathy appears at the outset of the chapter in order to give it prominence as a central concept in nursing care. Chapter 10, which was entirely new in the fourth edition, now has a section on dealing with anger and aggression as there is a reported increase in this interpersonal phenomenon, and nurses need to know how best to respond to it. As a consequence of this addition, the material about relating to children has been removed; communicating with children is a specialised skill and reviewed more comprehensively in paediatric nursing textbooks. The section on relating to older people has been retained because most nurses will interact with an ageing population.

As with previous editions, research evidence has been updated and revised. Selecting appropriate research findings for a book such as this proved somewhat challenging because of the type of evidence that is available on the topic of patient–nurse relationships. Much of the research evidence about patient–nurse relationships is descriptive and theoretical in nature. Those readers who are familiar with the
evidence-based practice movement will appreciate that this is not the ‘strongest’ evidence possible, in the sense that cause–effect relationships between healthcare interventions and patient outcomes are not established. The type of evidence provided is appropriate because the material in this book is not concerned with the clinical interventions themselves. It is not a book about psychotherapy—that is, intervening in particular ways of talking to patients in order to alter their thoughts, feelings or behaviours. Rather, it is a book with information about how nurses can be therapeutic in their everyday interactions with patients.

Another challenging aspect of writing a book about interpersonal aspects of nursing is the tension between the need to capture the complexity of interpersonal connections and the need to present concrete guidelines and general rules for beginning nurses. Beginning nurses, like novices in any discipline, rely on guidelines and rules. In presenting rules and guidelines, there is an inherent danger of a ‘cookbook’ approach. Such an approach assumes there is a rational, objective, ‘right’ way for nurses to interact with patients. Recipes such as ‘Combine three open-ended questions with two empathic statements, add one large tablespoon of support and reassurance, then mix well for 10 minutes during an interaction with a patient’ are simple to understand but inadequate in addressing the intricacy of patient–nurse interactions.

In meeting this challenge, I have tried to avoid an oversimplified approach to using interpersonal skills by including discussion of the contextual variables that need to be considered. I have done so in the hope that the guidelines and rules presented in this book will not be interpreted as prescriptions or recipes.

The use of the word patient is purposive. Although I do not want to perpetuate the problems of treating patients as passive recipients of nursing care, this term is one that is most frequently recognised in nursing. The central point of the book—that patients should be treated as people—speaks for itself about the humanistic basis of my philosophical beliefs. The term nurse is used in the generic sense to refer to any level of nurse, from students of nursing to experienced registered nurses.

In the book I use stories to help support and illustrate the theoretical information provided. These stories are based on real-life events, with names and other identifying details changed on order to maintain confidentiality.

Finally, I want to emphasise that I realise that skills are not learnt simply by reading about them in a book. While this book offers guidelines and suggestions for developing interpersonal skills in nursing, the best way to learn them is by interacting with patients. In listening to and understanding patients’ experiences of health and illness, nurses will come to appreciate that their real teachers are the people who happen to be patients.

JS-P, Sydney, 2013
Acknowledgments

A special note of appreciation is extended to all the students of nursing whom I have had the pleasure of teaching over the years. Your questions, although often challenging, expanded my thinking, sharpened my focus and enriched my insights into the struggles of learning interpersonal skills. The many experiences you shared in class helped develop the stories in this book. Also, your comments on the activities used in this book assisted in their development and refinement.

Thanks also to my colleagues and the numerous people who have provided feedback on the other editions. Your comments were encouraging and helpful in the production of this edition. Special thanks to all the people who continue to make this book a success.

I appreciate the ongoing assistance provided by staff at Elsevier, especially Elizabeth Coady and Libby Houston. You have been encouraging, helpful and very patient.

Finally, I would like to acknowledge my family. I am grateful to my mum, dad and sister who enabled me to understand the importance of caring for others. Thanks to my sons, Richard and Russell, who always find ways of keeping me from taking myself too seriously. My most enthusiastic applause goes to my husband, Charles, who continues to provide the support that was needed to sustain the effort in the preparation of the manuscript.
How to use this book

*Patient and Person* is a textbook about the practice and theory of developing interpersonal skills in nursing. Incorporated throughout Chapters 3–8 and 10 are various learning activities designed to provide a means by which skills can be developed and theoretical concepts understood. The text that precedes and follows each activity reinforces the point of that activity. For this reason, it is essential that the activities be used in their context (i.e. that they *not* be separated from the text).

Activities throughout the text adhere to a standard format. Importantly, this serves to develop a working pattern of reflection and enquiry. The activity structure comprises two major sections: *process* and *discussion*. The process includes detailed instructions for completing the activity, setting the parameters of the learning experience. The discussion contains exploratory statements and questions designed to encourage reflection on and dialogue about the learning experience, focusing attention on the theoretical concepts highlighted in the learning experience.

Defining learners as both *participants* and *members* in activities is an intended feature. ‘Participants’ denotes an entire learning group; ‘members’ specifically refers to people within a smaller group (i.e. participants who are part of a subdivided total group).

Some activities are identified with the symbol (followed by a page number), which indicates there is further material in the appendix, primarily intended for those instructors who are facilitating learning through the use of the activity. (It is useful to note at this point that the appendix itself is organised on a chapter-by-chapter basis, preceded by some very useful information to assist facilitators conducting practical sessions.) When an activity in the text is identified with the symbol , this should immediately alert the facilitator to read the additional information for that activity in the appendix, on the page indicated, before proceeding. Activities are characterised by symbols as follows:

- **Person** indicates that the activity is to be completed in solitude
- **People** indicates that the activity requires group interaction and discussion
- **People** indicates that the activity can be completed in solitude, although learning is enhanced through group interaction.
The use of cross-referencing between chapters is of considerable value, due to the overlap between concept and skills. Readers can therefore refer back and forth between chapters, reinforcing and building their understanding of both theory and skills.

The book is not intended for use as a workbook. Therefore, I recommended that readers record all written responses and notes to activity instructions on separate sheets of paper. These should be retained in a folder (or similar) for later revision and future reference, especially because some activities build on the results of previous activities.

**Activities**

3.1 What do I have to offer patients?
3.2 Feedback from patients
3.3 Difficulties in self-sharing
3.4 Beliefs about helping in nursing practice
3.5 Expectations of nursing
3.6 Personal benefits of nursing
3.7 Needs that may interfere
3.8 Characteristics of effective helpers
3.9 Assessment of current skills
3.10 Guide to self-reflection
3.11 Self-assessment of specific skills
4.1 Is there an Australian culture?
4.2 Feeling different
4.3 Responding to pain
4.4 Working with an interpreter
5.1 Listening goals in nursing
5.2 Indicators of listening
5.3 Easy or hard to listen to
5.4 Physical attending
5.5 Attending and non-attending
5.6 Non-verbal expressions of feelings
5.7 Listening for content
5.8 Listening for feelings
5.9 Listening for themes
5.10 Recalling messages
5.11 Responses that indicate listening
6.1 Your usual style of responding I
6.2 Recognising the types of responses
6.3 Your usual style of responding II
6.4 Paraphrasing: have I got it right?
6.5 Building a feeling-word vocabulary
6.6 Reflecting feelings
6.7 Connecting thoughts and feelings
7.1 Developing exploratory responses I
7.2 Ways of exploring: questions versus statements
7.3 Converting probes into prompts
7.4 Questions and statements for conducting a nursing history
7.5 Effects of ‘why’ questions
7.6 Alternatives to ‘why’
7.7 Recognising types of questions
7.8 Exploring patient cues
7.9 Cues and inferences
7.10 Developing exploratory responses II
7.11 Patient interview
8.1 Situations requiring reassurance
8.2 Ways nurses reassure patients
8.3 Reassuring interventions
8.4 Sharing information
8.5 Self-disclosure
10.1 Becoming assertive
10.2 The generation effect
10.3 Experiencing sensory deficits
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CHAPTER 4

Considering culture

KEY CONCEPTS

- Culture and ethnicity
- Stereotyping
- Healthcare culture
- Cultural beliefs of health and illness
- Cultural competence
- Cultural safety
- Culturally congruent care
- Language differences
- Using interpreters

Introduction

The material throughout this book continuously emphasises the importance of understanding the patient as a person with a unique perspective of the world. Nurses who come to understand an individual patient are able to work through the patient’s own unique perspective in order to ‘see through the patient’s eyes’. These perspectives of the world, be they those of nurse or patient, are based on cultural beliefs and values. Therefore, a central aspect of understanding another person is an appreciation of differences in cultural meaning. Differences in cultural understanding commonly lie outside conscious awareness. That is, cultural understandings are often taken for granted. It is for this reason that nurses need to develop conscious awareness and appreciation of cultural diversity when interacting with patients. Doing so forms the basis of culturally congruent nursing care. The development of cultural competence is an ongoing process for cultural congruence, as is the promotion of cultural safety in nursing practice.

CHAPTER OVERVIEW

This chapter begins with a general discussion of culture and its specific relationship to healthcare. Issues relating to the danger of cultural stereotyping are discussed. The culture of healthcare is reviewed, especially in light of cultural perceptions of health and illness. Concepts such as cultural safety and cultural competence are highlighted
as vital processes in the development of culturally congruent care for patients. Challenges faced when there are language differences between nurse and patient are discussed, as are guidelines when using the services of interpreters when interacting with patients.

What is culture?

When considering the influence of culture, there is a tendency to think that culture is something that pertains to others and not the self. Likewise, it is often viewed as something that is ‘exotic’ or ‘foreign’, such as rituals pertaining to death and burial. Of utmost importance is the recognition that culture is something that pertains to every human being. Everybody has culture.

Culture encompasses a view of the world that is shared by a group of people and learnt through social interactions within the group. This includes a wide range of behaviours, values, beliefs, attitudes and customs, and is reflected in the language, dress, foods and social institutions of a group; culture determines how people live, how they view the world and how they communicate (Bearskin 2011; Schim et al. 2007). These values and beliefs are often taken for granted and are therefore not always in conscious awareness.

Culture provides the framework for a particular society’s way of life; it influences the way social life is regulated and guides interactions between members of a social group. Cultural understandings affect the way members of a group make sense of the world. Culture shapes perceptions, decisions and relationships with others. A particular social group’s culture is reflected in all aspects of everyday life, including customs, greetings, methods of communication, attitudes to the family, beliefs about marriage, attitudes to illness and approaches to healthcare (Kirmayer 2011).

Healthcare organisations will also have particular cultures, with a shared language and customs that influence how care is delivered. The care practices within an organisation will reflect cultural values and beliefs. Those new to that culture must learn the cultural ways in order to become part of that group. The importance of organisational culture is recognised as influencing patient care, satisfaction and outcomes, as well as nurse satisfaction (see Ch 11).

CULTURE AND ETHNICITY

Culture is often confused with ethnicity. They are not the same. Although members of an ethnic group usually share cultural customs and beliefs, ethnicity alone does not make a culture. Ethnicity refers to belonging to a certain race or group of people. It is usually biologically determined (e.g. a member of the Semite race of people). Ethnicity, which may shape a person’s identity, is determined by birth. Culture, on the other hand, can be shared by members who choose to embrace a particular way of life. For example, the Australian culture is shared by many people of diverse ethnic backgrounds.

Activity 4.1 illustrates the difficulty in describing the ‘typical Australian’ and the futility of attempts to deny the diversity that exists within a particular group. There is always diversity within a cultural group and this is one of the problems with stereotyping; it denies individual and subgroup variation.
Cultural stereotyping

Stereotyping is categorising individuals into groups based on an oversimplified set of characteristics. For example, a stereotypic Australian male wears thongs and stubbies and has a beer in hand. This tends to produce a narrow and biased viewpoint; people are reduced to a few characteristics. The ultimate danger, however, involves generalisation of these stereotypes in their extreme forms, and an associated reluctance to recognise the extent to which individual differences do exist within all groups.

When nurses rely on stereotypes and act on them, they miss an opportunity to get to know the person on any more than a superficial level. The cost of not getting close enough to patients to gain insight into their respective individualities may result in
a failure to identify and meet their specific needs, thus compromising quality nursing care.

The menace inherent in stereotypes is that they are intransigent, pervasive, self-fulfilling and self-perpetuating. If a patient is viewed by nurses as ‘a typical hysterical Mediterranean patient’, all interactions will be coloured by that perception. When nurses apply the stereotype of a ‘druggie’ (i.e. irresponsible, immature, needy and worthless), they avoid taking the risk of coming to know and value the patient. Nurses need to continually challenge their own use of stereotypes in order to minimise the influence they exert on patient–nurse interactions and nursing practice.

The tendency to stereotype can be lessened by recognising the influence that values have on behaviour (see Ch 3) and by appreciating the range of values that lie behind the behaviour of specific groups. To be truly culturally aware, it is important to recognise that while there are differences between different cultural groups, there are also as many or even greater differences within them. Nevertheless, cultural stereotypes do exist and they tend to be remarkably resistant to change.

More importantly, stereotypes can lead to stigmatising people and even racism (Durey et al. 2011; Johnstone & Kanitsaki 2010) by reducing people to simplistic categorisations that can affect their access to and experience of healthcare. Consider the following example:

_Brenda has strong links to and relationships with Indigenous Australians because of her heritage and identity. People sometimes find her background confusing because she has pale skin and blonde hair. When people seem genuinely interested, she always takes the time to explain the meaning of being an Aboriginal Australian. On the afternoon that she arrived at a hospital emergency department (ED) with her seriously ill two-year-old son, she had no time to explain anything, although she ticked the box on the admission form to identify her son as an Indigenous Australian._

_She came to the ED of a busy metropolitan hospital because her son was having an extreme allergic reaction to peanuts. That day her family and friends had come together for a children's birthday party for her five-year-old daughter. The party was a large gathering of toddlers and preschoolers who enjoyed an afternoon's festivities. Near the end of the party, following the cutting and eating of the cake, she noticed her two-year-old was showing signs of a severe allergic reaction. She had seen it before and knew exactly what to do._

_Not knowing for sure what had caused the reaction, she administered adrenaline and set out for the local hospital, a two-minute car trip from home. On the way, she remembered that she had decorated the cake with 'hundreds and thousands' that had been stored in a jar that previously contained peanuts. Her two-year-old reacted immediately after eating the cake._

_On arrival she quickly explained what was happening to the triage nurse in the ED. She told him of her son's history and the events of the day, stating that she and her son needed to be seen immediately as her son has severe allergic reactions to peanuts. The nurse's response was not in keeping with the seriousness of the circumstances and he asked her to be seated. She became quite distressed, stating in a loud voice that she and her son must be seen immediately. He replied, 'Have a seat and wait like everybody else.'_

_Knowing she had no time and knowing of another hospital two minutes away she picked up her son, who by now was unable to walk, and went to the second hospital. There, her son was stabilised in the ED and admitted to the intensive care unit._
Although he recovered physically, Brenda had difficulty recovering emotionally from her treatment in the ED of the first hospital; she felt traumatised.

She retained the services of a lawyer and obtained the ED record of her son’s admission under the right to freedom of information. On the record she read: ‘Aboriginal woman, dishevelled, wearing dirty clothes, with two-year-old child in her arms, loudly demanding to be seen immediately. Child appears dirty, unkempt and possibly neglected, not in keeping with developmental milestones as he is crawling. Strong smell of alcohol on mother’s breath. Mother seems hysterical and believes child is having a reaction to peanuts. Not able to confirm allergy. Plan is to contact the children’s services department and have the child seen by a social worker. Mother told to wait. Triaged to category 3.’

Brenda filed a formal complaint against both the hospital and the nurse. She was pleased to hear that this resulted in action being taken against the nurse, who was removed from further triage duty. Brenda was satisfied knowing that this nurse would not have further opportunity to make decisions that could have dire consequences purely on the basis of a racial stereotype.

Brenda’s story is extreme, but true. It illustrates what can happen when people make decisions on the basis of stereotyping. Had the nurse asked a few pertinent questions, he would have found logical explanations for the circumstances. First, attendees at a preschool children’s birthday party will often have soiled clothing at the conclusion. Second, Brenda did have one glass of champagne at the start of the party, well over an hour before she arrived in the ED, so was unlikely to be inebriated as the nurse suggested. Third, her son was unable to walk because he was critically ill by the time he arrived at hospital. Unfortunately, the nurse made decisions not on these facts but on his image of ‘an Aboriginal’ (i.e. a stereotype).

Culture and healthcare

There is substantial evidence that the cultural background of patients has an impact on quality and safety of healthcare delivery and outcomes. For example, Indigenous people in both Australia and Canada experience health disadvantages, lower life expectancy and poor use of healthcare services when compared with non-Indigenous people (Bearskin 2011; Katterl & Bywood 2012; van Schaik & Thompson 2011). Likewise, people from a culturally and linguistically diverse background also experience poorer health and access to healthcare than those of the mainstream society (Allotey et al. 2002; Bolton et al. 2004; Henderson et al. 2011). A failure to appreciate the cultural differences between patients and healthcare professionals has been shown to negatively impact on the quality of care and patient satisfaction (Flores et al. 2002). A lack of understanding of a patient’s culture can result in negative patient outcomes and actual patient harm (Green-Hernandez et al. 2004). Limited English proficiency, along with racial and ethnic factors, is associated with heightened risk for medical errors (Mattox 2010).

There are numerous reasons for these disparities and inequalities in health and healthcare; for example, transport problems, socioeconomic status and educational factors. However, those that are most relevant to the subject matter in this book are cultural perceptions and belief systems about health and illness, language barriers and healthcare providers’ poor awareness and understanding of cultural healthcare practices. Each of these has direct bearing on the mismatch between healthcare as it
is delivered and the healthcare language and cultural needs of people who are served by a healthcare delivery system.

THE CULTURE OF HEALTHCARE

The disparities and inequalities in healthcare of culturally diverse patients are due, in part, to the actual culture of healthcare itself. Healthcare systems and institutions are themselves imbued with shared values, beliefs, practices and rituals that construct and are constructed by their culture. Nurses working in such systems may not be consciously aware of these cultural norms as culture tends to be ‘taken for granted,’ and viewed as ‘the way things are.’

In the Western world the culture of healthcare is dominated by a biomedical view of health and illness that determines how problems are recognised and what is worthy of attention (Kirmayer 2012). The Australian healthcare system is monocultural, with Western ideology being dominant and even ‘imposed’ on patients (Blackford & Street 2000). Healthcare is disease-oriented, based on understanding of pathophysiology and psychopathology. Understanding a disease from this scientific perspective is based on notions of objectivity that are generalised to all people. Illness, on the other hand, is what a patient experiences (i.e. from a subjective perspective). The former is case knowledge, while the latter encompasses both patient and person knowledge (see Ch 1).

Patients’ personal, subjective experiences of illness are imbued with cultural meaning, which may or may not fit biomedical explanations of ill health. For example, Indigenous peoples of Australia believe that disharmony and discontinuity cause ill health and healing seeks to reintegrate people with one another and with the environment (van Schaik & Thompson 2011; see also Research highlight). In many Indigenous cultures the development of cancer is viewed as fate or destiny, or as punishment or payback for wrongdoing (Shahid & Thompson 2009). Pacific Islanders believe that singing and dancing, along with herbal and natural remedies, helps to cure illness (Henderson & Kendall 2011). Knowledge developed in the field of biomedical science does not accommodate such understandings as diseases and their cause and cures are viewed through a different lens.

Nurses from social and cultural backgrounds that are different from the patient may not understand cultural meanings of health and illness, especially if they operate from an exclusively biomedical orientation. Likewise, patients whose health beliefs are different from those supported by the biomedical model may be reluctant to share these beliefs with nurses. Differences in illness-related behaviour may occur because of disparity between biomedical thinking and cultural beliefs.

In addition, the ideology of Western healthcare is based on the autonomous individual, with high value placed on independence and self-agency (Cioffi 2006). This orientation may not accommodate people from cultures in which collective identity and interdependence take precedence over individual autonomy and independence. For example, individual autonomy in Indigenous cultures means honouring the family and community rather than the individual (McGrath & Phillips 2008a). Therefore consent to healthcare treatment involves obtaining permission from the right person(s) within the family, and this can extend to a wider community. The standard process of consent to treatment does not match cultural sensibilities.
RESEARCH HIGHLIGHT

Indigenous Australians’ health beliefs


Background

One reason that Indigenous Australians experience higher cancer mortality than non-Indigenous Australians is the difference in health beliefs. Healthcare providers who do not understand these beliefs run the risk of providing care that is not appropriate. More importantly, treatment options that are offered may not be either understood or accepted because they do not fit these health beliefs.

Purpose of the study

This article is a review of the literature in order to summarise what is known about the health beliefs of Indigenous Australians regarding cancer and its biomedical treatment. Also included is a review of Indigenous Australians’ views about bush medicine treatments for cancer. Comparing the two belief systems may enable healthcare providers to accommodate both treatment types.

Method

Through a systematic process articles were selected for review if they addressed one of the following topics: Indigenous Australians’ beliefs about bush medicine, biomedical treatment of cancer and comparison of the two.

Key findings

Five themes were revealed in the reviewed literature. First were concerns about the toxicity, side effects and potential disfigurement from biomedical treatment. Next was a feeling of disconnect with healthcare providers; for example, there is no Indigenous word for cancer. The third theme related to fears about being away from home if treatment required relocation to a hospital that was far from home. In addition Indigenous Australians held beliefs about disease aetiology that differed from biomedical beliefs. Finally, there was a failure of biomedical treatments to address holistic health in the same manner as bush medicine treatments.

Implications for nursing practice

Indigenous Australians should be involved in the design of healthcare, especially in relation to maintaining connection to their community and social structures. It is especially important that treatment information provided to Indigenous Australians be presented in a manner that accommodates beliefs systems. Most of all, it is important that nurses elicit Indigenous Australians’ understanding of the causes of cancer, and become familiar with their belief systems.
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The current movement in healthcare, evidence-based practice in which approaches to care are based on the 'best available evidence', can result in 'one size fits all' attitude that can exclude cultural sensibilities (Whitley et al. 2011). Importantly, nurses should recognise that the majority of the evidence is based on research that excludes people who don't speak English!

In a similar vein nurses often hold the common misconception that equity in healthcare means that 'every patient is treated exactly the same'. This misconception stems from the fact that nurses recognise their moral and professional responsibility to care for patients regardless of their ethnic background, cultural beliefs, religious practice or even how they are dressed. Equity in healthcare means that people have equal access to care, not that they are cared for in exactly the same way. Approaches to individual patients must be adjusted and adapted not only to meet their unique needs but also to accommodate their cultural values and beliefs.

Adjusting and adapting approaches to individual patients can be particularly challenging when patients are from a culture that is not understood or, worse, rejected. This poor understanding (or outright rejection) is not always in conscious awareness, as it often stems from ethnocentrism, a tendency to see the world as having one standard—that of one's own cultural group—and to judge other cultural groups in relation to it. An ethnocentric individual is unlikely to perceive or acknowledge differences in the ways that people view the world, and to fail to appreciate the advantages of living in a culturally diverse society. Ethnocentricity is also present in the healthcare system itself. To interact effectively with people from different cultural groups, nurses need to become aware of an inherent tendency to be ethnocentric.

PERCEPTIONS OF HEALTH AND ILLNESS

The influence of culture is particularly evident when considering the meaning of illness because beliefs and explanations about health and illness are often culturally

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ACTIVITY 4.2 Feeling different

**Process**
1. Think of a time when you were in a group of people and you felt different. The basis for feeling different could be based on skin colour, ethnicity, age, gender, body size or type of clothing.
2. Depict how you felt by drawing a picture or writing words on a piece of paper.
3. Record how you got the message that you were different.
4. Share your experience with another person.

**Discussion**
1. What was the basis of feeling different?
2. How did it feel to be different?
3. What would have helped in the situation?
4. What conclusions can be drawn from the experience of feeling different?
determined (see illness representation, Ch 9). For example, some groups of people believe that illness is a punishment for past wrongdoings, with suffering being a means of atonement. Other groups of people may share a belief that illness is nothing more than chance. That is, there is no reason other than the ‘luck of the draw’ for becoming sick.

For example, some social groups hold strong beliefs that members who are well have an obligation to pay respect to the sick and to attend to their needs. Family and friends are expected to visit the sick, provide them with home-cooked food and help them to rest and regain their health. The sick, in turn, have an obligation to accept these attentions. Making brave attempts to care for oneself, and indicating that such attentions are not needed, may be regarded as ill-mannered.

The approaches of the above-described groups contrast with those who place a high value on independence and avoidance of relying on others beyond what is absolutely necessary. Attempts to get well quickly and to resume normal roles are admired and praised by other members of such groups. In these cultures, people who are sick have an obligation to make every effort to minimise the time that they are dependent on others. Nurses who, due to their own cultural backgrounds, value such independence may have trouble understanding the patients who do very little for themselves in relation to healthcare.

Differences in healthcare practices can lead to serious misunderstanding between patients and healthcare professionals. For example, there are traditional Vietnamese healing methods that include ‘coin rubbing’ to dispel poisons believed to be responsible for colds and flus. This practice may result in marks and breaks on the skin, which could be interpreted as child abuse when the practice is used by a parent or grandparent (Narayan 2010; Suh 2004; Wolf & Calmes 2004).

Culturally aware nurses realise that much of their world is socially constructed and that the way it is constructed largely depends on their own cultural beliefs. In becoming culturally aware, nurses develop an understanding and acceptance of the differences that exist between different groups of people and are more willing to investigate the practices and rituals that are associated with different cultural groups.

The initial step in developing cultural awareness is to increase understanding of one’s own culture. This is best done through the process of reflection about the origin and nature of a personal value and belief system. For example, nurses might reflect on how illness was perceived and managed in their family of origin. Of central importance is a reflection on how members of the cultural group ‘expect’ people to behave when ill. For example, in some cultures people do not complain when in pain, while in others a dramatic outward expression of pain is accepted as ‘normal’.

**CULTURALLY CONGRUENT CARE**

Culturally congruent care is respectful of and responsive to the patient’s culturally based values and beliefs. It is based on mutual understanding between nurse and patient. There are four elements to this care: an appreciation of cultural diversity; an awareness of individual patients’ cultural values and beliefs; sensitivity to differences between and within different cultures; and skilled know-how when interacting with patients, especially when nurse and patient come from different cultural backgrounds (Schim et al. 2007). In providing culturally congruent care, nurses must be receptive to learning from patients, as it is the patient who can best explain their values and beliefs.
ACTIVITY 4.3 Responding to pain

Process
1. When you were a child and you felt unwell ... 
   a. How did others expect you to behave?
   b. Were you encouraged to complain or express discomfort and pain?
   c. Were you permitted to take time off school and your other usual activities, or just expected to carry on as usual?
   d. Were you given special treats when you were ill?
   e. What attempts were made to help you recover; for example, special food, medications, staying in bed or going to see a doctor?
2. What were told about why you became unwell; for example, not enough sleep, not eating well?
3. Were you held responsible for your illness?
4. What role were you expected to play in recovering?
5. Form small groups of six to seven people and discuss your answers.

Discussion
1. What similarities were there in the responses to the questions? What were the differences?
2. What special treats did people get when they were ill? What types of food were offered?
3. What were some of the reasons people were given for becoming ill?
4. What were some of the actions that people took to get better?

There are different approaches to conceptualising culturally congruent care (Fuller 2003; Williamson & Harrison 2010). The first is based on identifying the particular traits, values, customs and beliefs of identified cultures, which can be found on lists of cultural characteristics and traits (e.g. Clark et al. 2010). Learning about culture in this manner produces a cognitive understanding of cultural groups, and it is assumed that it will result in culturally congruent care. This approach is problematic and considered to be old fashioned (Kirmayer 2012) because it can lead to superficial understandings that are based on stereotypes and fails to take into consideration that there is as much diversity within cultural groups as between them. More importantly, this traditional view does not consider the relationship between nurse and patient in relation to power and privilege (Doutrich et al. 2012).

Another approach to culturally congruent care is through developing ‘cultural humility’ (Kleinman 1988, cited in Fuller 2003, p. 783). Cultural humility means that the nurses appreciate that their culture, both as an individual and as reflected by healthcare culture, is not the yardstick by which patients should be evaluated; this is the opposite of an ethnocentric view. Rather than relying on a set of cultural attributes or adhering to popular beliefs about a culture, culturally humble nurses will enquire into the individual patient’s personal interpretations and beliefs (Kleinman 2006).

The development of cultural humility is an ongoing process of awareness and reflection (see Ch 3). Nurses who are ‘culturally humble’ will not impose their value
system on a patient, but rather enter the relationship with openness to different ways of seeing the world. They are ready to learn from the patient and negotiate care that is based on the patient’s cultural belief systems (Coffman 2004). In doing so, they may develop cultural competence.

**CULTURAL COMPETENCE**

Cultural competence is a multidimensional concept currently used to describe the conditions necessary for appropriately delivering healthcare that is culturally congruent. Cultural competence encompasses awareness, knowledge, understanding, sensitivity, tolerance and skill (Rosenjack Burchum 2002; Schim et al. 2007; Suh 2004; Wolf & Calmes 2004). It is directly related to the capacity to understand fully a patient’s perspective and, more importantly, to provide healthcare that incorporates this perspective.

Culturally competent practitioners will have the desire and motivation to seek cultural encounters to obtain further knowledge and skill (Campinha-Bacote 2003). That is, cultural competence is an ongoing process in which nurses continually strive to deepen their understanding and appreciation of cultural diversity (Green-Hernandez et al. 2004; Schim et al. 2007). Like cultural safety, cultural competence extends beyond the individual nurse, and includes developing healthcare systems that are culturally congruent to the population being served.

Nurses who work with a specific population of people should make every effort to learn about that group’s cultural beliefs, values and healthcare practices. For example, Australian Aboriginal cultures, although having much diversity within them, hold a tradition of not using a deceased person’s name because doing so calls their spirit back to earth (McGrath & Phillips 2008b). A nurse could inadvertently disturb this sensibility by asking for specifics of family members’ names when collecting healthcare information. Culturally competent nurses would know not to do so. When nurses routinely care for a population of patients whose language is different from their own, their cultural competence will include making an effort to learn a few key words or phrases in the language that is used by that population. Doing so can not only prevent misunderstandings but also demonstrates a sincere desire to be ‘for’ the patient.

Each of these approaches to addressing issues of culture and healthcare, cultural congruence, awareness and competence is based on the individual nurse, and fails to take into account either the relationship between nurse and patient or the overall context of healthcare. The broader concept of cultural safety encompasses both.

**CULTURAL SAFETY**

Although necessary, awareness of cultural diversity is not sufficient for professional nursing practice that is culturally congruent. Nurses are morally and professionally bound to provide care that is safe. The notion of safety extends beyond physical and psychological parameters to include care that is culturally safe (Polaschek 1998; Ramsden 1993; Richardson 2004). Developed in New Zealand by nurses who were discontent with the nature of healthcare, cultural safety is becoming widely recognised internationally as an important cultural concept in healthcare (Bearskin 2011; Doutrich et al. 2012; Downing et al. 2011; Kirmayer 2012; McEldowney & Connor 2011; Nguyen 2008; Williamson & Harrison 2010).
Cultural safety is more than simply learning about cultural practices and beliefs; it is an ethical standard that recognises the position of cultural groups and how they are perceived. Culturally ‘unsafe’ care includes any actions in which the patient feels humiliated or alienated (Bearskin 2011). Imposing an ethnocentric biomedical perspective on illness while dismissing beliefs that do not fit a biomedical model is an example of culturally unsafe practice.

Unlike notions of ‘cultural awareness’ or ‘cultural sensitivity’, which can be evaluated by professional standards, cultural safety can only be judged by the patient or recipient of care (McEldowney & Connor 2011; Richardson 2004). Cultural safety does not mean that all recipients of care are treated the same, as is often touted as the key to cultural awareness and sensitivity. Rather, the tenets of cultural safety imply that nurses adjust their care in accordance with the cultural sensitivities of each individual patient.

Cultural safety is more than recognition of the uniqueness of cultural identity and the need for equity in healthcare. Cultural safety also includes recognition of social structures that disempower cultural groups. It is a means by which nurses examine healthcare structures that disadvantage some people, rendering them powerless in that structure (Doutrich et al. 2012; Kirmayer 2012; Richardson 2004).

Culturally safe nurses recognise social structures that account, in part, for lack of access to adequate healthcare for some cultural groups. Culturally safe nurses accommodate and respect a diverse range of views on health and healing. They are not set in one particular pattern of thinking about illness, be it a biomedical orientation or one that derives from their own cultural background.

Reflection on and in actions (Ch 3) is the key to becoming culturally safe (Doutrich et al. 2012). To become culturally safe nurses need to engage in the process of continuous contemplation as to how their own culture and the culture of healthcare is impacting on every interaction with patients.

**LANGUAGE DIFFERENCES**

In certain situations it is likely that patients will have difficulty understanding the language used by nurses. At such times it is common for nurses to use a third person to act as an intermediary.

With patience and care, it is possible to convey simple information to a person who has minimal English. It is important to speak slowly and clearly. Avoid using jargon and phrases that can be readily misunderstood, such as ‘that wound seems to be breaking down; we had better keep an eye on it.’ It is best to use plain, correct English, avoiding ambiguities and, above all, avoiding forms of ‘pidgin’ English, which is used to simplify language but may actually make it more confusing. For example, a nurse may ask a patient, ‘When you see doctor, what he say?’ Ambiguity in tense may cause patients with little English to wonder if the interaction under discussion was in the past or is to occur in the future.

It is also important for nurses to recognise that nonverbal communication varies across cultures, especially in relation to eye contact. In some cultures it is considered rude to look directly into another person’s eyes, especially if that person is in a position of authority. Staring at the floor could indicate that the patient is listening and remaining silent demonstrates respect (Maier-Lorentz 2008).
Where the difficulty is related to the non-English speaking background of the patient, a member of a medical interpreter service may be brought in to translate. If this is not possible, a member of the patient’s family who does speak English is often asked to act as an interpreter, but this has potential problems.

Where the interaction difficulty is related to the age of the patient (e.g. a young child) or to specific communication problems (e.g. an intellectual disability), members of the family or individuals who are familiar with the patient are commonly used. It should always be remembered that interacting through a third person increases the likelihood of misinterpretation or reinterpretation of the content. This may be due to the filtering process associated with a third person, and the interpretations and meanings attached to the content by that person. In addition, the intermediary may make a conscious decision to alter the meaning by omitting, adding or distorting the content of the message, or patients may withhold information because of the personal relationship that exists between themselves and the intermediary.

All of the alterations to the content mentioned in the previous paragraph are more likely to occur in situations where the topic under discussion creates a high level of discomfort for those involved in the interaction (e.g. if a male adolescent is asked to interpret while his mother’s personal and obstetric history is taken, or an unfamiliar, middle-aged male is interpreting for a female adolescent patient who is being questioned about her sexual activity).

The following situation illustrates problems that may occur when an untrained interpreter is used:

*A Lebanese cleaner was asked to interpret for a couple who had given birth to an infant with Down syndrome or ‘mongolism’. The cleaner told the parents that they had given birth to a ‘Chinese baby,’ a literal translation. This caused a great deal of conflict between the husband and wife and was not cleared up for many months. This situation would have been avoided if a trained healthcare interpreter had been used.*

Australian healthcare systems have established health-interpreter programs to meet the need for interpreters with the expertise required to work within health-related areas. If it is necessary to use an untrained interpreter in an emergency situation, a professional interpreter should be employed as soon as possible to check the understanding of the patient and the family. Working effectively with an interpreter is a skilled activity, and there are enormous advantages in making the effort to acquire the skill.

Interpreters who are trained to work in the healthcare system are able to translate medical terminology accurately and have proven useful in bridging gaps between the culture of the health professional and that of the patient. Misunderstandings arising both from language barriers and from differences in cultural beliefs and practices may, therefore, be prevented or minimised with the help of a trained interpreter. Whenever important or sensitive discussion is needed, or when complex information is sought or given, it is important that an interpreter, bound by the ethic of confidentiality that applies to all healthcare professionals, is involved.

It is important to appreciate that the role of interpreter involves dilemmas and challenges. In a recent study (Butow et al. 2012) it was found that interpreters find it difficult to simply be a ‘conduit’ of spoken language. They were challenged by the need to also act as a culture interpreter both to the patient in explaining how the healthcare system operates and also to the clinicians in providing explanations as to
the meaning of certain behaviours. In this regard they may play a role as a patient advocate. A real challenge for them was the requirement that they remain emotionally neutral; when patients became distressed it was difficult for them to not try to provide comfort.

**GUIDELINES WHEN USING AN INTERPRETER**

Prior to the interview, it is important that the interpreter is briefed about the purpose of the interview. The interpreter should have the opportunity to meet the patient, explain the purpose of the interview and establish a level of rapport. This is especially important if there is to be a discussion of sensitive and private matters. In instances when sexual or personal details must be discussed, it may be important that the interpreter be of the same gender as the patient. There is a general tendency for

**ACTIVITY 4.4 Working with an interpreter**

**Process**

1. Form as many groups of three as possible where two members of the group are fluent in the same language, which should not be English. The remaining participants are observers.
2. Using the given situations, one foreign language speaker plays the role of a nurse and the other an interpreter. The third person plays the role of the patient. If there is more than one group, different groups can play each situation. Alternatively, the same group can play the two situations consecutively.
3. The role-play is set in an emergency department where a patient has been admitted with severe asthma. Emergency treatment has been instituted and the patient is now breathing more comfortably. The nurse has arranged for an interpreter to help collect information for a nursing history. For the purpose of this role-play, any nursing history format may be used.

**Situation A:** The nurse and interpreter face each other and the nurse directs questions to the interpreter using the third person. For example, ‘Has he/she ever been in hospital before?’; ‘When did he/she have his/her last meal?’; ‘Is he/she allergic to any medications?’ The role-play ends when the history is completed.

**Situation B:** The nurse introduces the interpreter to the patient. The interpreter sits next to the patient. The nurse addresses questions directly to the patient. After the history is completed, the nurse asks the patient if they have any questions about any aspect of treatment or care. Answers are directed to the patient, not to the interpreter. After the interview, the nurse is the first to leave while the interpreter stays and chats briefly with the patient before leaving.

**Discussion**

1. How did it feel to be the ‘patient’ in situation A? How did it feel to be the ‘patient’ in situation B?
2. What difficulties did the ‘nurses’ in situation A experience? What difficulties did the ‘nurses’ in situation B experience?
3. What principles should be observed when working with an interpreter? Compare your answers with the following text about using interpreters.
people of all cultural backgrounds to feel more comfortable discussing personal matters with a person of the same sex.

During the interview, the interpreter should be seated next to the patient. This allows the interpreter to take on the role of the patient’s ally so the patient is less likely to feel outnumbered and disadvantaged. The nurse should maintain eye contact with and speak directly to the patient, not to the interpreter. This helps the nurse to develop a relationship with the patient, as well as facilitate observation of the patient’s non-verbal communication.

The interaction usually works best if the interpreter is able to interpret the words simultaneously, as they are spoken. This is the ‘trailing’ method of interpreting and is most likely to promote a good rapport between the patient and the nurse. In the other type of interpreting, consecutive interpreting, the patient completes a whole sentence or phrase before it is translated. Regardless of which approach is used, it is especially important to assure mutual understanding by paraphrasing and clarifying.

On completion of the interview, the nurse should leave the room first, allowing an opportunity for the interpreter to chat with the patient. It is important to avoid engaging the interpreter in lengthy discussions in which the patient is not involved. Further discussion between the nurse and the interpreter should be left for another time, as the interpreter should be seen to be aligned with the patient, not the nurse.

Although an interpreter should be used whenever there is important information to convey, it is often necessary to manage without an interpreter when interacting with a patient who has limited English. At times, there may not be an interpreter who is immediately available. Therefore, it is important for nurses to prepare for such times by learning key phrases for the population that is being served. In addition, a list of basic words in the patient’s language should be compiled for use by all staff.

Chapter summary

As societies become increasingly culturally diverse, nurses are challenged to appreciate and accommodate the multiple perspectives on health that cultural diversity brings. This chapter is a beginning step in developing such appreciation and accommodation. Material in the chapter has focused on the importance of understanding cultural diversity and developing nursing practice that is culturally safe. In addition, the chapter has enabled nurses to consider some of the impediments to such understanding (e.g. cultural stereotyping). Some of the challenges of working with interpreters and communicating non-verbally have also been reviewed. Readers should bear in mind that this chapter represents a very brief introduction to the challenges of cross-cultural communication.

References


