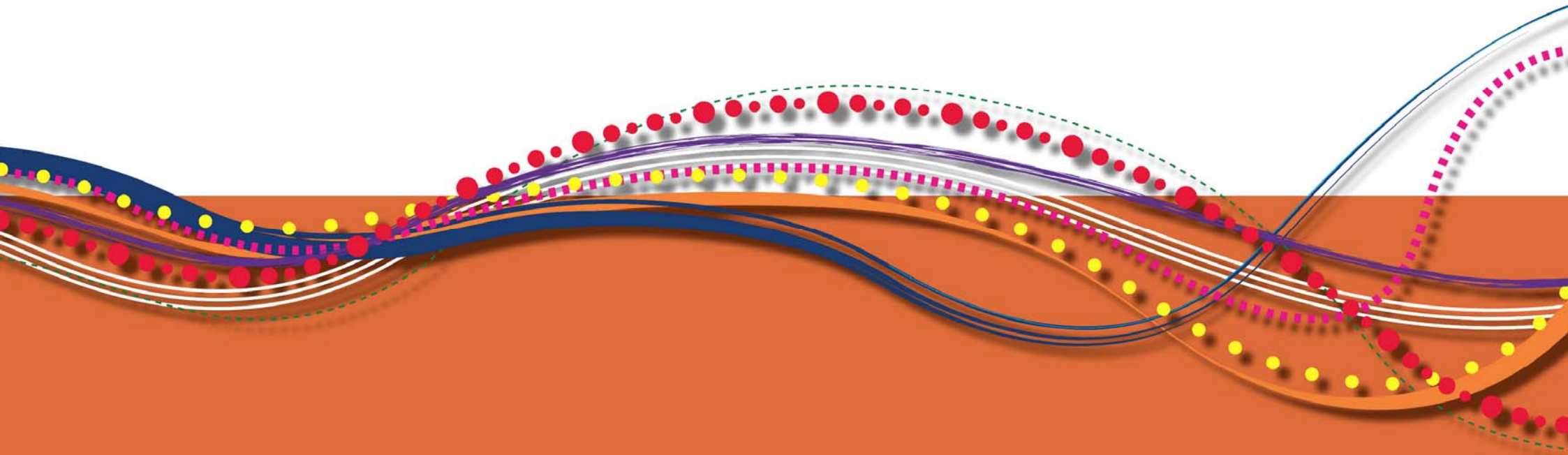


Queensland Health

Five Cross Cultural Capabilities

for **non-clinical staff**





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communication

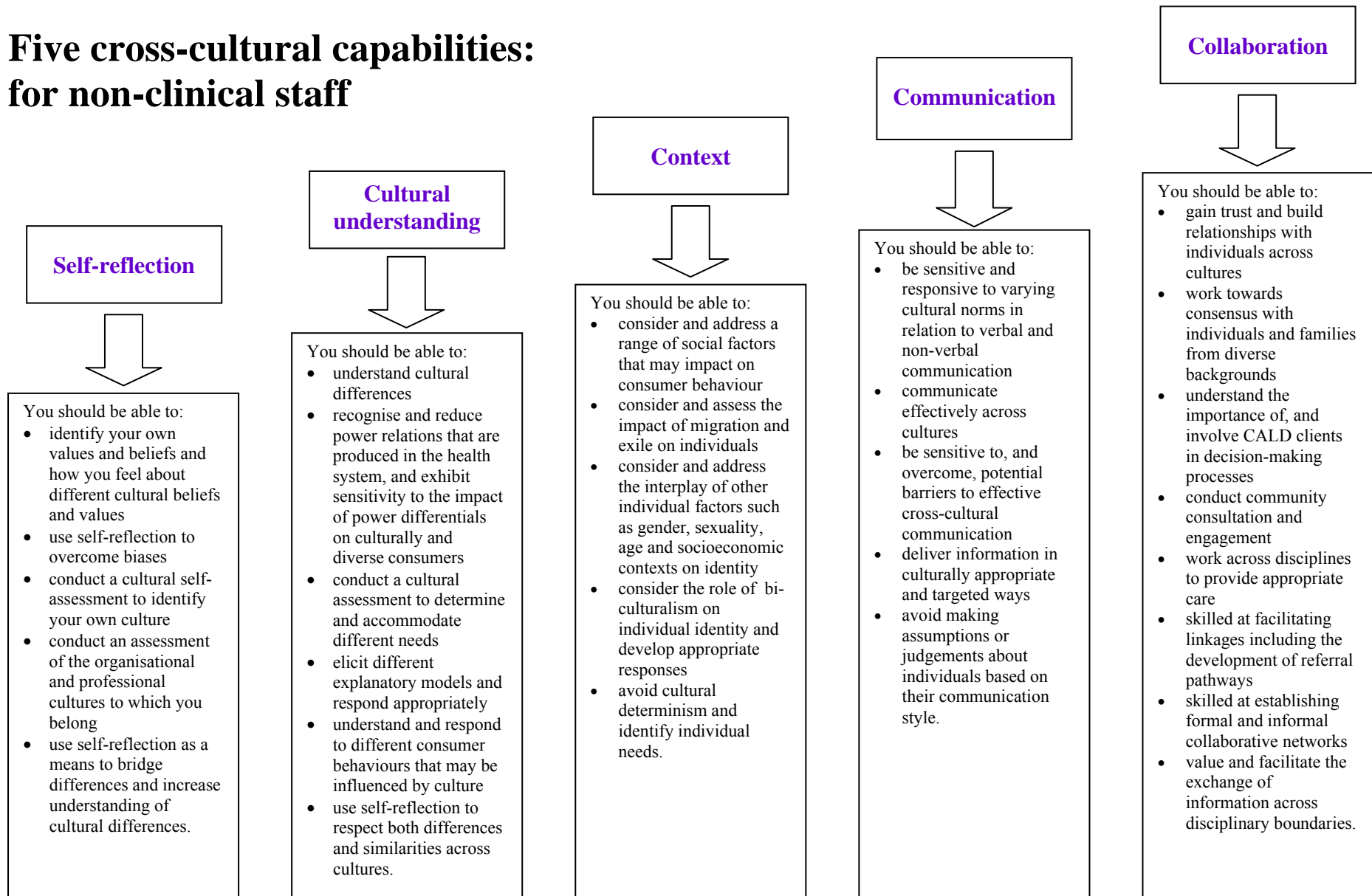
self reflection

context

collaboration

cultural understanding

Five cross-cultural capabilities: for non-clinical staff



The non-clinical skill set

Queensland Health administrative and non-clinical staff need to be aware of the pressures and requirements of its clinical workforce. All areas of the organisation – human resource management, education and training, leadership, service planning, and policy development – must consider and develop an organisational framework that enables and supports clinical staff to deliver culturally competent care.

In order for Queensland Health to be a culturally competent organisation, eight outcome areas must be met, as shown in Figure 1.



Figure 1: Queensland Health Organisational Cultural Competency Framework

These indicators of organisational cultural competence were identified as part of a literature review of existing national and international organisational cultural competency frameworks and organisational cultural competence. It should be noted that the evidence is very clear that one of the above elements can not be achieved in isolation of the others. For example, staff may have the knowledge and skills but no access to interpreters to action these skills. For these reasons, organisational commitment for all of the elements of cultural competency is required. As cultural competency is a developmental journey, a sustained commitment is required^{1,2}.

Culturally competent staff refers to all staff, not just clinical staff providing health care. The development of policies and plans guide the health services that are available across Queensland Health and the way in which these services are provided. If the policy makers and service planners are not culturally competent, it is likely that policies and plans developed will not be culturally inclusive or appropriate. This relates to policy and planning across all work areas of Queensland Health; across the health care continuum including prevention, treatment and maintenance, human resources and capital works. The cross-cultural capabilities for clinical and non-clinical staff are the same but applied through different considerations. For example, a clinician needs to understand and be able to apply the different explanatory models of health or their patients. A policy officer needs to understand that there are different explanatory models of health and ensure these aspects are built into policies and plans.

Cross-cultural capability one: self-reflection - understanding ‘self’

Self-reflection (sometimes expressed as ‘self-awareness’) has been identified by experts in the field as the most agreed upon aspect of cultural competency and an essential starting point. The Australian Government has included self-reflection as a competency specification in its guidelines titled Cultural Competency in Health: A Guideline for Policy, Partnerships and Participation (National Health and Medical Research Council, 2005). It is also the first competency employed by a number of health services including the New South Wales Health Department (South-East Illawara Area Health Services and Eastern Sydney Multicultural Unit). It is included in training modules delivered by the Centre for Ethnicity and Health and Judith Miralles and Consultants and in many international cultural competency modules such as Health Canada and the United States. The Victorian Department of Human Services’ Aboriginal and Torres Strait Islander Cultural Competence Framework also include self-reflection as a critical first step in developing cross cultural skills.

Self-reflection can simply be thought of as self-awareness and requires identifying both your strengths and areas for growth, particularly in relation to working across cultures. It also means being aware of your own biases and cultural values. This is the first **step** in achieving cultural capability and should be practiced across each of the cultural capabilities outlined in the strategy.

Before you can begin to have insight into diverse communities, individuals and groups, you need to understand and know your own culture and identity, whether this is your personal ethnic, spiritual or cultural heritage or your professional or organisational affiliations. Evidence has shown that our attitudes, whether we are conscious of them or not, have a direct and significant impact on the people around us³. Critical self-reflection involves being aware of your own culture and value systems to avoid biases or making assumptions about cultures or groups that are seemingly different from your own. Through self-reflection, health care professionals are able to acknowledge their own cultural beliefs and values, including their beliefs about health, which will allow them to make adjustments, where appropriate, to consider and work competently and sensitively across cultures.

“Only a self-aware physician can completely understand his/her reactions to or expectations of a patient, judge the extent to which personally held biases might influence the situation and attempt to manage that bias⁴” (p. 535)

Self-reflective practice avoids the common pitfall of ascribing ‘difference’ on to a cultural ‘other’. **Ethnocentrism** is a term used to describe the imposition of your own cultural values and beliefs onto another individual culture. It occurs when a way of doing things, outside your own personal worldview, is deemed invalid and inferior, and your culture is seen as the standard or the norm. **Stereotyping** occurs when different cultural groups are reduced to a set of core characteristics and seen as a ‘type’ devoid of a range of unique personal characteristics. It is

important to remember that stereotypes can be positive or negative and stereotypes are, in themselves, neither true nor false. Indeed some individuals do fit stereotypes. Steve Irwin, for example, in many characteristics conformed to stereotypes of Australian identity. Stereotypes, on the whole, overlook the complexity of individuals, and the individuality within groups. People from culturally and linguistically diverse (CALD) communities and backgrounds are often stereotyped, whereas white Anglo-Celtic Australians are more often described by their uniqueness and their individual personalities. People from CALD groups may be described purely in terms of their culture and community without any regard for personality or individuality.

Self-reflective practitioners are able to think about the ‘strangeness’ of their own cultural norms and practices before labelling a culture or way of doing things different from their own as strange or radically different. In doing so, they avoid **exoticism** – the tendency to view different cultures as inherently mysterious and incompatible with their own. Exoticism also often involves romanticising different cultures or seeing a different culture as inherently benign or simplistic.

In practice, the consequences of self-reflection would allow individuals to avoid making conclusions about difference and value judgements about different behaviours or actions. Self-reflection allows staff to reflect on their own cultural background and preferences and to also illuminate shared practices across cultures. It also prompts them to query their own assumptions and bridge divides or barriers between cultural groups.

Self-reflection has long been central to nursing practice but has also been established as a starting point for cross-cultural work, more generally, across disciplines.

- Self-reflection is the starting point for cultural capability. It is an established foundation of many disciplines and considered best practice in the field of cross-cultural work.
- Self-reflection should be integrated into all cultural competency training.
- Self-reflection starts by providing tools for developing a sophisticated framework for thinking about intercultural communication and engagement. It may then be practiced situationally, or as the need arises.
- Self-reflection increases individual cultural awareness knowledge and skills.

Examples of self-reflective practice in other training materials and in a health context

How to reflect on your own culture

Think about a time when you were with a group of people from another country, or even another part of Australia. What were the similarities and differences in culture?

What would you describe as your culture? How would you rank the following in order of importance: ethnicity, family, work, the future, diet and religion? Do you believe that your clients have the same priorities?

Consider the list of areas where cultural variations in beliefs and values frequently occur. Can you immediately determine your preferences? What about the preferences of a friend or current client? Would the choices you make in your role as a health professional be different from those for yourself or someone you care about?

Do you believe it is appropriate to discuss health issues with a client's family and friends? Why? What about discussing health issues such as menstruation, pregnancy and sexually transmitted disease with members of the opposite sex?

What does your body language say about you? How might a client from another culture interpret your posture, eye contact and the tone of your voice? Could your body language be communicating something different from your words?

As an individual, how do you value personal independence, family, freedom, meaningful work, spirituality, etc? How does this have an impact on your relationships with clients?

Continually reflecting on your reactions to your and your clients' cultures will assist you in providing culturally acceptable care⁵.

Questions to develop self-reflective practice

What client behaviours or practices make me feel uncomfortable?

How do I respond when I am frustrated?

What are my biases and prejudices?

What keeps me from understanding or putting myself in others shoes?

Do I believe other beliefs are valid?

When I judge others, what am I feeling?

Do I reflect on my status and how this might affect communication and interaction with others?

How do I feel when others make judgements or statements about me on the basis of my race, culture, ethnicity, gender or sexuality?

Summary of why understanding self is a capability:

The first step to recognising and having capacity to respond to the needs of all Queenslanders in terms of policy and planning processes is to be aware of your own needs and biases and how you may perceive others as a result. Providing the best health care to all people means understanding biases and using self-reflection as a way of gaining a deeper understanding of culture to avoid making assumptions or stereotypes about cultures other than your own. Providing the best health care involves the development and implementation of policies and plans which support the most culturally appropriate and inclusive standard of care. In addition, reflecting on one's own identity, status, position and belonging in the organisational culture will allow a standard of professional and ethical conduct that supports and values diversity in the workplace.

Knowledge	Skill	Behaviour
<p>1. You have a culture. It may be challenging to identify and recognise your own culture, your values, norms, biases and belief systems. Know that your culture may have an impact on the way you work with colleagues, patients and consumers from backgrounds different from your own.</p> <p>2. Organisational cultures exist and influence the way individuals work. Each organisation and health profession has its own set of unspoken norms and assumed shared knowledge, including a highly developed internal language, expertise and set of practices. These include beliefs and values about health.</p> <p>3. There are universal and shared norms across cultures; there are differences within cultures.</p> <p>4. It is important to recognise the institutional power your role within the health system grants you. The power differential between the health provider and consumer may often be exaggerated in relation to CALD consumers who are more likely to feel disempowered, reluctant to voice complaints about the health system and powerless to express dissatisfaction.</p> <p>Anglo-Celtic Australians may place a higher value on egalitarianism and may feel more empowered and entitled to speak as an equal to their doctor or supervisor, ask direct questions, and assert their needs and rights.</p>	<p>Can identify own cultural background and current status and identify and address biases.</p> <p>Can identify the organisational and professional cultures to which you belong, including exclusivity of customs and language. .</p> <p>Can identify universal norms or shared values across cultures. Can identify when differences result in feelings of discomfort or frustration and are able address these.</p> <p>Can identify the authority or power of your role within the organisation in relation to the consumer and can reduce power differences.</p> <p>Can empower CALD consumers by providing them with information and resources and ensuring their rights and responsibilities are understood. Can elicit feedback and involve CALD clients in decision-making.</p>	<p>Avoids marginalising culture and diversity by understanding it is everyone’s business. Addresses biases by seeking to better understand underlying reasons and to alleviate frustrations or dispel misunderstanding.</p> <p>Is inclusive and does not assume universal understanding of organisational culture and systems.</p> <p>Respects cultural differences and seeks to overcome barriers and bridge divides.</p> <p>Is ethical and does not abuse power. Is sensitive to imbalances of power and works to reduce these.</p>

Cross-cultural capability two: cultural understanding

Self-reflection is about identifying your own cultural values and belief systems, understanding that you do have a culture, and recognising your own culture may influence the way you work. Self-reflective practice helps you bridge differences by identifying commonalities and the power relationship, including the power to label a different cultural practice as ‘strange’ or incompatible with your own, or the dominant culture. Cross cultural capability is about building individual capacity to consider the impact of differences in views, beliefs and values and how these might play out across Queensland Health both in terms of policy and planning and in terms of workforce functioning.

All cultures have unspoken rules. A lack of understanding about these subtle and unspoken rules can lead to offence and inadvertently breaking social conventions. Behaviours can be incorrectly interpreted and lead to misunderstanding.

Attribution is the process whereby “we make assumptions about the motivation behind people’s behaviours based on what would make sense in our own culture.” Attribution includes the assumptions we make about why a person is behaving the way they do, i.e. what motivates the visible behaviour that we are observing, based on what would make sense in our own culture. An attribution may be positive or negative; an attribution may be correct or incorrect⁶.

It is impossible to know all the different rules that might exist across different cultural groups. However, it is possible to approach your work with the understanding that different and complex cultural conventions exist, and to seek out these conventions in order to both improve understanding, to adapt to whatever cultural codes you encounter, and to avoid inaccurately attributing negative characteristics onto a particular group or person.

It is not the purpose of the cross-cultural capabilities to outline specific details of each community group that you might work with. Cultural competency infers a set of capabilities; the knowledge, skills and behaviour required to work across cultures. The problem is that the term ‘cultural competency’ suggests that culture can “be reduced to a technical skill for which clinicians can develop expertise”⁷. (p. 1673) However, it is not that simple given the complexity and varying contexts in which culture exists. In fact, it is important to have humility or modesty about how much can be meaningfully and immediately understood about cultures different than your own⁸.

Having the capability to reflect critically on culture and to appreciate culture is complex and dynamic will prevent damaging stereotypes that have occurred in the past, when individuals have had a false sense of cultural competency.

It is therefore important to understand that cultural differences do exist and, wherever possible, the aim should be to respect differences. The purpose of this cross-cultural capability is to outline some broad cultural differences and how these might play out and need to be considered in everyday work contexts. Culturally sensitive approaches and responses are required to uphold Queensland Health's organisational values, and it is everyone's responsibility to improve the accessibility and responsiveness of services that the Queensland Government delivers to a diverse group of people.

Summary of why cultural understanding is a capability

- Lack of cultural understanding results in inequalities in health care (e.g. underutilisation of services, underutilisation of preventative health care, poor adherence to treatment plans as a result of a lack of translated information etc).
- Lack of cultural understanding will also limit the capacity to develop responsive and inclusive policies, plans and programs; it will inhibit the inclusiveness of the hospitals and physical environments we build.
- Culturally competent teams will be better equipped to prevent issues at work and to value diversity.
- Different cultural values may lead to misunderstandings which, if left, unresolved can impact on workplace satisfaction and team cohesion.
- Understanding that cultural differences exist is necessary for staff to respond to differences.

Knowledge	Skill	Behaviour
<p>1. Different cultural norms and practices exist and are often difficult to understand in a deep or meaningful way to someone unfamiliar with the culture.</p> <p>2. Gaining cultural understanding may require community consultation and gaining trust of diverse and emerging communities.</p> <p>3. Structural barriers, biases and challenges exist within the mainstream health system which impact on CALD consumers' access, experience and health outcomes.</p> <p>4. There are a number of culturally and spiritually-based and alternative health beliefs that CALD patients may use to explain and supplement their treatment and care. Understanding and working with these alternative and culturally-specific health beliefs improves health outcomes for CALD clients.</p> <p>5. Cultural differences may also determine a range of needs (e.g. diet and spirituality) that need to be planned for in the development of services.</p>	<p>Can identify potential different cultural norms and practices that exist.</p> <p>Is skilled at community consultation and developing links with community to develop a richer understanding and develop needs-based policies to determine and plan health services.</p> <p>Can access a range of information sources to develop a knowledge base about existing community groups and new and emerging communities.</p> <p>Can keep self and colleagues informed and accesses information for the staff and community.</p> <p>Is skilled at performing cultural analyses to identify and respond to barriers and biases in the system.</p> <p>Can develop clinical governance policies, frameworks and guidelines to support the elicitation of culturally-specific explanatory models and the embedding of cultural understanding in patient-centred care models. Individual care plans are able to accommodate or incorporate alternative or traditional models of care, whenever possible.</p> <p>Able to assess the potential impact of culturally blind policies and embed cultural awareness and specificity so that a range of cultural preferences may be offered or made available.</p>	<p>Treats each person as an individual that has their own cultural beliefs, norms and values which may need to be understood to support best health outcomes and productive workplaces.</p> <p>Exhibits modesty about cultural knowledge of other groups and recognises the limits of personal and professional knowledge.</p> <p>Is consultative and works with the community to gain a richer understanding of culture and to involve communities in the development of services.</p> <p>Values diversity; maintains respect for difference and shows respect by adhering to specific cultural protocols and frameworks.</p> <p>Is sensitive to biases and barriers in the system that impact on CALD people. Does not treat culture or multicultural issues as supplementary but integrates into all aspects of work.</p> <p>Embeds cultural understanding into all practices and is open to different to different health beliefs.</p> <p>Demonstrates openness to different belief systems including alternative health beliefs.</p>

Knowledge	Skill	Behaviour
<p>6. Australian health care and system is based on a Western individualist model. Policies tend to be based on the Western nuclear model of family.</p> <p>7. Same-sex clinical services are often preferable for many women. Different cultural gender norms may also determine the need for same-sex services for some CALD women.</p> <p>8. Cultural norms about how to behave as a patient/consumer exist.</p> <p>Behaviours interpreted as rude, or challenging may, in fact, signal that different cultural rules are operating.</p> <p>9. Your role within the health system grants you a level of institutional power that may be pronounced in relation to CALD consumers.</p> <p>10. Anglo-Celtic Australians value egalitarianism and may feel more empowered and entitled to speak as an equal to their manager or superior, ask direct questions, and assert their needs and rights.</p> <p>11. New recruits may feel disempowered or lack knowledge of the organisational culture and professional norms. These barriers may be pronounced for employees coming from a different country or different health system.</p>	<p>Amends standards of care and policies that are culturally insensitive.</p> <p>Can integrate CALD needs into all aspects of policy, service and human resource development planning.</p> <p>Can develop family-centred models of care and policies to accommodate collectivist cultures and extended family structures and responsibilities.</p> <p>Able to determine gender cultural norms and provide gender-specific services.</p> <p>Can look beyond own cultural norms about appropriate behaviour and identify if different cultural conventions are operating.</p> <p>Can identify the authority or power of your role within the organisation in relation to others and can reduce power differences.</p> <p>Can empower newly arrived overseas-trained colleagues through adequate orientation and resources, ensuring their rights and responsibilities are understood.</p>	<p>Recognises that Western individual models of family and health may not address the needs of culturally and linguistically diverse people.</p> <p>Is sensitive to different gender norms and able to provide services and information according to varying gender.</p> <p>Avoids making assumptions and seeks to improve cross-cultural understanding by considering different possible motivations.</p> <p>Does not abuse power and recognises that power is related to race and culture.</p>

Cross-cultural capability three: context

It is important to be able to put understandings of culture in context, and to understand the individuality or particular situation of a client or population group. Definitions of culture, therefore, need to consider the “complex combination of socio-historical factors and personal experiences that frame individual notions of ‘cultural identity’ and ‘belonging’”⁹. (p. 16)

- Culture is not static or homogenous: it is dynamic and can change, over time and place, just as individuals change over time and place – that is, according to context.
- Cultures are complex and dynamic and there can be a high degree of difference, and even discord, within a particular culture despite the existence of a set of dominant norms, values and beliefs.
- Culture does not always or solely determine or explain behaviour. Cultural determinism is the belief that culture alone determines or predicts behaviour. The kind of thinking that says “it’s because of his culture that he behaves this way ...” It is important to try to understand the range of factors that are influencing behaviour. Culture is not always the most important variable to consider. For example, the reason a CALD colleague is not ‘compliant’ with a treatment plan may not be because of different health beliefs; rather, it may be due to socioeconomic constraints and other social, emotional and financial factors.

To understand the situation of a client or population group the following contexts should also be considered:

- A person or community group’s context includes, but is not limited to the following: employment, housing, income, dependents, access to transport and childcare, health status (social determinants of health); and the context of country of origin and the migration process. The social context may be a more critical factor in accessing health services.
- There are a range of specific issues for refugees and humanitarian entrants that must be considered. In addition to complex and interrelated health issues, refugees (many now from sub-Saharan Africa) have little experience with the Australian health care system.
- From the moment a person from a CALD background arrives and settles in Australia, he or she is already in a different context and will undergo transformation from his or her cultural identity. The local Australian community also undergoes shifts in its identity (e.g. from Anglo-Celtic dominant to multicultural). This process is often referred to transculturation which is the dynamic and reciprocal exchange between cultures that results in the formation of something new.
- Many Australians are, in fact, bi-cultural and move fluently between two different cultures.
- A sense of belonging is a strong predictor of mental health and can be particularly acute for children of migrants.

Acculturation

- Acculturation is the term given to describe the process of adopting the cultural traits or social patterns of another group.
- Understanding where an individual colleague sits on this acculturation continuum can help predict their familiarity with mainstream services.

Knowledge	Skill	Behaviour
<p>1. Know that cultural considerations must be informed by context.</p> <p>2. Individual factors such as gender socioeconomic status, sexuality and social factors may be more important than considerations of cultural background.</p> <p>3. Culture can change according to context. Individuals vary in terms of their identification with their cultural or spiritual heritage. Historical factors can also contribute to new cultural norms and formations.</p> <p>4. Many nurses employed within Queensland Health are on temporary 457 Visas. Many 457 Visa holders wish to apply for permanent residency and may feel reluctant or unable to raise issues or leave an unsatisfactory work situation. Temporary visa holders are not eligible for a range of supports available to permanent residents or Australian citizens which may have an impact on their work-life.</p> <p>5. Refugees and humanitarian entrants may have endured social dislocation, severe trauma, famine, war and/or injuries. These experiences, particularly the experience of human rights abuses and torture (some of which may have occurred in hospital settings), may impact on refugee and humanitarian individuals demand for services as well as their interaction with health services.</p>	<p>Able to consider contextual factors alongside cultural considerations in undertaking assessments, developing care plans and providing services.</p> <p>Can elicit contextual information.</p> <p>Able to identify historical factors in cultural assessments.</p> <p>Considers intercultural and intergenerational issues in young people and in second and third generation CALD individuals.</p> <p>Skilled at identifying the needs of temporary staff and particularly new migrants.</p> <p>Can facilitate linkages and referral pathways for refugee clients.</p>	<p>Never assumes but seeks out further information to understand particular individual circumstances, personality and preferences.</p> <p>Avoids cultural determinism and stereotyping.</p> <p>Exhibits awareness of, and responsiveness to, social, emotional and cultural factors.</p> <p>Avoids assuming same level of belonging and cultural identification.</p> <p>Is sensitive to the issue of intergenerational and intercultural differences. Second and third generation CALD Queenslanders do not automatically discard their parents' or grandparents' cultural norms. Individuals may not fully appreciate the influence of their families' and communities' cultural norms and traditions on personal beliefs and values.</p> <p>Recognises and values the contribution of CALD nurses and other clinical staff recruited from overseas as temporary employees for Queensland Health.</p>

Cross-cultural capability four: communication

Communication capability in a cross-cultural setting refers to the capacity to overcome cultural and linguistic barriers to achieve shared understanding and convey information. It also requires the capacity to adapt communication styles, and take cues from people to achieve mutual understanding.

American studies have found that ethnic minorities receive less information about their health conditions and treatment from doctors than non-ethnic white Americans, as a result of a number of entrenched attitudes and factors including a lack of cross-cultural communication capability¹⁰. In addition, studies have also found that CALD patients have a preference for a service provider from the same cultural or linguistic background, feeling it will result in better understanding, communication and service¹¹.

Studies have also found that communication is a significant workplace issue. Communication is implicated in adverse events and documented in sentinel reporting literature as a major contributing factor¹²⁻¹⁴. Between-group conflict and poor integration across organisations compounds poor communication and is further implicated in adverse events, quality and safety¹⁵. Occupational health and safety may also be compromised by poor communication and exacerbated by cross-cultural communication barriers.

Communication, particularly among diverse groups, is a critical factor in developing collegial relations in the work team. “Research highlights a significant association between racial diversity and difficulties with communication and conflict resolution in teams”¹⁶ (p. 1413)

Without adequate diversity management strategies and cross-cultural communication training in place, health organisations stand to miss out on the benefits of a diverse workforce. This is particularly relevant for Queensland Health which relies on a highly skilled, overseas-trained and recruited workforce. One of the greatest barriers to integration of overseas-trained professionals, despite having English as a first or second language, is the Australian vernacular. Sarcasm, irony, and subversiveness are well appreciated Australian communication and humour styles that do not always translate well across cultures.

Cultural competent communication in the cross-cultural context also entails ‘linguistic competency’ which is defined as “the capacity of an organisation and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organisational and provider capacity to respond effectively to the health literacy needs of populations served.

The organisation must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- bi-lingual/bi-cultural or multilingual/multicultural staff
- cross-cultural communication approaches
- sign language interpreter services
- multilingual telecommunication systems
- videoconferencing and telehealth technologies
- print materials in easy to read, low literacy, picture and symbol formats
- materials in alternative formats (e.g. audiotape, Braille, enlarged print)
- varied approaches to share information with individuals who experience cognitive disabilities
- materials developed and tested for specific cultural, ethnic and linguistic groups
- translation services including those of:
 - legally binding documents (e.g. consent forms, confidentiality and patient rights statements, release of information, applications)
 - signage
 - health education materials
 - public awareness materials and campaigns¹⁷.

Knowledge	Skill	Behaviour
<p>1. Know that different cultural norms and styles in verbal and non-verbal communication exist (when to talk, eye contact, pacing and pausing, directness etc).</p> <p>2. The need to be directly and fully informed about health conditions is a Western cultural norm. In many cultures, it is not acceptable to directly inform patients about serious conditions or ask direct questions that might result in losing face, loss of hope or shame. Family members may gradually deliver ‘bad news’, downplay the harsh realities, or choose to conceal some information.</p> <p>3. Translating medical discourse into culturally appropriate and palatable terms can often improve health outcomes.</p> <p>4. Communication issues are found to be amongst the most common contributing factor in adverse events, patient satisfaction and outcomes¹⁸⁻²⁰. Language barriers are associated with adverse outcomes²¹.</p> <p>5. Interpreter services must be obtained for low-English proficiency speakers. Queensland Health guidelines stipulate that children and other family members should not be used as interpreters.</p> <p>Other factors in relation to dialect, class and gender may undermine the effectiveness of the interpreter services.</p>	<p>Can take cues from the other (e.g. eye contact, formality) and adapts or reciprocates accordingly to achieve a positive communication experience.</p> <p>Skilled at gauging the level and amount of direct information that a patient will tolerate and how this information will be conveyed by family members or carers. Skilled at working with families and carers to deliver information that is necessary such as informed consent and diagnoses and determining ways in which it can be sensitively delivered. (See also cultural capability five - collaboration).</p> <p>Skilled at employing cultural understanding to adapt communication style to suit audience and deliver messages in a culturally appropriate manner.</p> <p>Manages risk relating to language barriers and understands that a professional interpreter allows quality of care and ethical standard of care.</p> <p>Skilled at assessing when an interpreter is required by asking open-ended questions and asking clients to repeat, in their own words, the information that has just been given. Has training in working with interpreters and understands interpreter’s role.</p> <p>Is able to request an interpreter. Skilled at working with interpreters, building in time for pre-interview/briefing and identifying any barriers in relation to dialect, class, gender or other factors that may impede the quality of the service or the accuracy of information provided.</p>	<p>Avoids assumptions and works to understand different cultural norms in communication</p> <p>Does not attribute negative behaviours on to a person without considering further possible personal or cultural contexts.</p> <p>Treats all clients equally regardless of communication styles and English-language proficiency.</p> <p>Does not impose own cultural norms of communication on to others (i.e. doesn’t demand eye contact).</p> <p>Exhibits sensitivity to different cultural taboos around health.</p> <p>Views interpreter services as essential aspect of equitable quality care.</p>

Knowledge	Skill	Behaviour
<p>6. Verbal skills do not always equate to a high level of English proficiency or having adequate literacy or numeracy to comprehend complex written documents or lengthy discussions. Translated information may be required.</p> <p>7. Cross-cultural communication may require more time; building in more time for communication with patients in initial consults is likely to improve outcomes, compliance and understanding and avoid re-admission or additional consults²².</p> <p>8. Research shows that native English-speaking Australians tend to assume that speakers with ‘foreign’ or ‘thick’ accents are inferior, uneducated, stupid or even childlike²³. Culturally and linguistically diverse staff face discrimination because of the perception that they are not able to meet professional standards in oral and verbal communication.</p>	<p>Skilled at assessing literacy and sourcing translated materials.</p> <p>Capacity in giving clear information and skilled at summarising and clarifying information.</p> <p>Skilled at communicating with speakers whose first language is different.</p>	<p>Avoids making value judgements about non-English speaking people or speakers with low-English proficiency.</p> <p>Ensures the same standard of information and care is given to patients with low-English proficiency.</p> <p>Provides tailored care and takes the necessary time to ensure understanding.</p> <p>Values bi or multilingualism and does not prohibit conversation between people in languages other than English.</p> <p>Does not discriminate against persons whose first language is not English.</p> <p>Provides necessary support to colleagues whose first language is other than English.</p>

Cross-cultural capability five: collaboration

The Joanna Briggs Institute's systematic review of cultural competency best practices identified collaboration as an index of individual and organisational cultural competency. Its systematic review found that organisations that promote collaboration and work collaboratively with each other will improve services for culturally diverse populations and contribute to a work environment that supports diversity. Collaboration between health care providers and other agencies was indicated to improve care to culturally diverse patient groups. An increase in collaboration between health care providers and culturally diverse groups and their communities could also improve services and workforce productivity and satisfaction²⁴.

- Collaborative practice can refer to the capacity to work across group barriers in the health system and draw on expertise across disciplines to improve patient outcomes.
- Culturally competent health care is in itself a collaborative model of patient-centred care that draws on the very best theoretical research and available models developed in the humanities and social sciences and applied to the 'hard' science discipline of medicine.
- Collaboration encompasses clinical skills when working with CALD consumers to arrive at a mutually-agreeable care plan, where necessary and possible.
- Collaboration also includes community engagement as an essential principle of cultural competency. In reviewing what experts see as a fundamental component of cultural competency, all of the experts indicated some form of community collaboration – whether this is expressed as partnerships with non-government organisations, community consultation as an essential element of sound policy development and service planning, or development and support of community health workers and other cultural engagement models. Cultural capability is required to have the right knowledge, skills and behaviour to engage communities appropriately and effectively.
- Collaboration also infers productive and open exchange of information as well as compromise and respect for different perspectives.
- Collaborative individuals are skilled at building relationships, trust and developing networks. In diversity management literature, these are identified as 'soft skills' and are recognised as essential to the context of globalisation and to meeting the needs of CALD communities.

Greater participation by the patient in health care encounters has been found to improve patient satisfaction and improved adherence to treatment. In fact, in one study, CALD patients' blood pressure lowered in health care encounters where the doctor spent more time giving appropriate information, clarifying issues, and negotiating a mutually-acceptable care plan²⁵.

- The quality of clinical communication is related to positive health outcomes.
- Reduction in blood pressure was significantly greater in patients who, during visits to the doctor, had been allowed to express their health concerns without interruptions.

- Concordance between physician and patient in identifying the nature and seriousness of the clinical problem is related to improving or resolving the problem.
- Explaining and understanding patient concerns, even when they cannot be resolved, results in a significant decrease in anxiety.
- Greater participation by the patient in the encounter improves satisfaction, compliance and the outcome of treatment (i.e. control of diabetes and hypertension).
- The level of psychological distress in patients with serious illness is less when they perceive they have received adequate information²⁵.

All of these clinical outcomes rely on effective cross-cultural communication strategies and being open to consensus-building, negotiation and collaboration in the doctor-patient relationship.

In addition, the establishment of collaborative networks have been found to be a powerful tool, particularly in bringing together a community of practitioners dedicated to improving Aboriginal and Torres Strait Islander health outcomes.

Knowledge	Skill	Behaviour
1. Collaborative care planning achieves better patient experience and outcomes.	Is able to allow patients to express their concerns without premature reassurance, interruption or closure. Is skilled at identifying and addressing patients concerns or views on the nature of the presenting problem and validating these perspectives.	Is open to exchanging information and to alternative possibilities.
2. CALD consumers may distrust mainstream services and the Western biomedical model. Studies have found that Vietnamese and Chinese patients in Australia often use alternative remedies but are wary of disclosing their practices with mainstream health providers for fear of ridicule or prohibition.	Is skilled at building trust and cross-cultural relationships. Is skilled at accommodating different cultural health beliefs and alternative therapies.	Is results-oriented and seeks solutions to problems. Seeks and shares information from, and between, a range of resources, starting with the consumer/patient.
3. Collaboration and effective consultation with community organisations and members is required to determine community concerns and develop appropriate goals and programs.	Is skilled at working with consumers, carers and/or family members to set goals and determine mutually-agreeable options and processes.	Consultative and open to exchange of information.
4. Bi-cultural workers, community liaison officers and other community health workers are important models of care that can provide links between service and community and improve health outcomes for CALD consumers.	Can work effectively with bi-cultural, liaison officers or community health workers.	
5. Particularly disadvantaged CALD patients may have a complex range of interdependent needs stemming from isolation, dislocation and lack of integration into existing social networks and services. All of these stressors may have an impact on their health and wellbeing.	Skilled at facilitating linkages across services and professionals including providing referral to other required services for CALD clients.	

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